Repair of Spontaneous Perineal Laceration at Delivery, a Cultural Taboo: A Case Report

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SUMMARY

Although genital trauma is a recognized maternal complication of vaginal birth, the presence of skilled birth attendants at delivery and judicious use of episiotomy has been shown to reduce this risk to the barest minimum. Prompt repair of these traumas averts the resultant complications that may arise. A case of a booked 18-year-old nulliparous Guinea-Conakry woman with a second-degree perineal tear who declined repair due to a cultural reason is presented. The need for supervised delivery as well as immediate and long-term health implications of her decision is discussed.

Keywords: *Perineal laceration, Genital trauma, Skilled/unskilled birth attendant, vaginal delivery/childbirth, custom, belief, haemorrhage*

INTRODUCTION

Trauma to the perineum or vagina is a recognized complication of vagina birth[1]. However, studies have shown that the frequency and degree of injury sustained is a reflection of the quality of services rendered and or the level of the skill of the birth attendant at delivery [2,3,4]. Furthermore, the World Health Organization recently suggested that Maternal Mortality ratio and the proportion of births attended by skilled health personnel should be used to monitor the progress of achieving the 5th Millennium Development Goal (MGD), which aims to improve maternal health [5]. In addition, evidence abounds that the use of antenatal care facility alone by parturient do not proffer optimal benefits; rather, the presence of skilled birth attendants at delivery either at home or in a health care facility remains a crucial factor [6, 7].

Opinion differs as to whether or not to repair first degree perineal lacerations [8], however repair of second degree perineal tear or more is incontrovertible [9].

Improper repair or failure to repair a perineal tear after delivery may cause excessive haemorrhage leading to shock, pain, sepsis, urinary and or feacal incontinence [10, 11, 12]. Later, the poor healing may cause gynaetresia or deficient perineum and these abnormalities may result in lack of coital satisfaction and marital disharmony [11]

CASE REPORT

A booked 18-year old nulliparous Guinea-Conakry housewife presented at the University College Hospital (UCH), Ibadan, Nigeria on the 26th of March, 2006 with a 5-hour history of bleeding per vaginum following spontaneous vaginal delivery of a live female baby at 39-weeks gestation. The bleeding was profuse with passage of clots. There was generalized body weakness but no dizzy spells or fainting episodes. Uterotonics were not administered. The placenta was spontaneously expelled. She had no previous episodes of blood dyscrasias. The delivery process was supervised by her aunt (unskilled attendant) at home because there was no vehicle to convey her to the hospital during the early hours of the day (02:00hours) when she was discovered to be in labour. The baby's birth weight was 3.2kg. She registered for antenatal care at our hospital at 13-weeks gestation and her booking parameters were as follows: weight-65.0kg, height – 1.59m, haematocrit – 30%, urinalysis – normal, blood group – O rhesus positive, hemoglobin electrophoresis – AA and blood pressure of 120/

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70mmHg. All her subsequent routine antenatal visits were uneventful. She had 2 doses of tetanus toxoid at 21 and 26 weeks respectively. Obstetric ultrasound done at 36-weeks was essentially normal. Examination revealed a conscious young woman who was pale with cold extremities. The respiratory system was essentially normal. The pulse rate was 108 beats per minute, blood pressure was 90/50mmHg and the heart sounds were normal. The abdomen was full; the uterus was firm and compatible with 18-week gestation.

The vulva was smeared with blood. There was no active vaginal bleeding. A second degree perineal laceration extending to the lower 3cm of the posterior vaginal wall was identified. The cervix was normal. Rectal examination was normal.

An assessment of primary postpartum haemorrhage due to genital tract laceration was made. The woman was resuscitated with intravenous fluids (Normal Saline). Parenteral supertonics (ergometrine), opiod analgesics (pethidine) and antibiotics (intravenous augmentin) were given. The immediate haematocrit was 25%. Two units of blood were cross matched for her. She was counselled for examination under anaesthesia and repair of the laceration but this was declined. The patient stated that it is against her cultural belief to have her genitals repaired following delivery. All pleas by the managing team (midwives, residents and the consultant) were turned down by the patient. The vagina was then packed with sterile gauze after cleaning with antiseptic solution. The vaginal pack was removed 12 hours later and bleeding had subsided. Vulva toileting was performed with lukewarm water mixed with antiseptics. She was then trained on Sitz bath twice daily and after every toilet use. The antibiotics and analgesics were changed to oral (tab augmentin and tab morphine) after 24hours and continued for five days. She was discharged home on the 7th post partum day with a packed cell volume of 26% on haematinics and was offered Norplant implant for contraception. At the 6th week post natal clinic, she had no complaints and the perineal tear had healed by secondary intention. The vaginal length was about 8cm with no evidence of gynaetresia.

DISCUSSION

The conduct of childbirth remains a turning point in determining the outcome of pregnancy any where in the world. This reality forms the basis of the unanimous opinion that the presence at delivery of skilled health care personnel in the art of midwifery is pivotal to the principle of making pregnancy safer (Safe Motherhood) [13, 14].

Studies have shown comparable outcomes in both the home and facility-based deliveries of low risk pregnancy that were conducted by skilled birth attendants [5, 15]. Although, childbirth complications may arise even in skilled hands but, these are usually promptly treated [16].

Many reports have noted that a higher proportion (60 to 70%) of women in developing countries including Nigeria deliver their babies in the presence of unskilled birth attendants [5, 6]. This situation is often accompanied by catastrophic outcomes in many cases resulting in either a permanent disability or maternal and or perinatal mortalities [7].

What is worrisome now is the growing trend of women seeking antenatal care at recognized health facility but fail to deliver with skilled personnel [6]. Reasons that have reported for this attitude ranges from various forms of delays, religious beliefs, socio-cultural taboos and poverty amongst others [17, 18, 19]. Many a time when complication arises, these women are not promptly referred due to socio-cultural beliefs on the likely cause of the problem [18]. The Guinean woman presented though had her antenatal care at a tertiary hospital failed to deliver in the hospital due to lack of transportation and therefore suffered a second degree perineal laceration.

Although, perineal injuries do occur after vaginal delivery in all settings yet, the availability of skilled supervisor helps to reduce the incidence and severity. Second and third degree perineal tears when they occur usually from improperly conducted delivery are promptly repaired to prevent excessive blood loss and unnecessary blood transfusion in most cases.

Culture in most African countries is passionately upheld and in many communities measures are put in place to ensure the enforcement

of these cultural beliefs. Some times, these beliefs may be beneficial while in other situations they are harmful [20].

The woman presented refused the repair of the second degree perineal tear because of her cultural belief despite the excessive bleeding and repeated counselling. At the follow up clinic, the area of the tear had healed by secondary intention and the vaginal length was within normal limit. Although, she was fortunate to have escaped blood transfusion and the associated risks; the long term problem of deficient perineum and social challenges are still there.

We separately interviewed the patient and her aunt who conducted the delivery while still on admission. They both stated that it is a taboo in their culture to repair a genital tear following delivery. Although, both of them could not offer any reason for this prohibition, they explained that a particular local herbal preparation is usually used to cover the wound area. Consequently, we have started recruiting women with the same sociocultural background for a focus group discussion on this challenging belief and practice.

It is imperative that health care workers emphasize the need for women to deliver with skilled personnel in attendance to avert the occurrence of complications.

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