Evaluation of a Perineal Care Clinic -
What special care can we offer women with complex pelvic floor issues?

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Set-up to provide standardized quality care

Previously – no long-term follow-up or support

Need was identified as result of previous RCT’s - (MOMS & OASIS)

Main purpose - to improve the outcome for women following perineal injury

Looked at various models
UHNS Model

- **Weekly midwife-led clinic:** -
  - Morning clinic – 3rd or 4th degree tears (6 weeks P/N)
  - Afternoon – other perineal problems

- Backed by two lead consultant obstetricians - ‘PCC’ runs alongside antenatal clinic

- Monthly multidisciplinary meeting – care pathway

- Prompt treatment

- Theatre input
Members of Multidisciplinary Group

- PCC lead specialist midwife
- Two lead consultant obstetricians
- Senior obstetric physiotherapist
- Consultant urogynaecologist
- Senior manometry technician
- Urogynae specialist nurse
- Two colorectal surgeons
- Consultant radiographer
- Continence advisor
Referrals

- Referral system – Midwives, GP’s, Practice Nurses, Health Visitors, Consultants

- Women referred with:
  - Dehisced perineal wounds
  - Perineal pain – long-term problems
  - Superficial dyspareunia
  - Third and fourth degree tears
  - Urinary or faecal problems
  - Concerns regarding previous perineal trauma
  - Pre-pregnancy and antenatal concerns
Some of the problems seen in the Perineal Care Clinic
Short-term Problems

- **Pain** (up to 80% at 2 to 3 days postnatal & up to 44% at 10 days)
- **Causes**
  - Haematoma
  - Infection
  - Wound dehiscence
  - Excessive granulation tissue
Dehisced wounds > 24hrs

- Allow healing by secondary intension:
  - Swabs and antibiotics
  - Advise - pain relief, diet, hygiene & pelvic floor exercises
  - Follow-up in PC Clinic as necessary
  - Observe for prolific granulation tissue
  - Corrective surgery if necessary – 3 to 6 months postpartum
Long-term Problems

- **Perineal pain** (7% up to 12 months postpartum)
- **Dyspareunia** (15 – 20% up to 12 months)
- **Pelvic floor dysfunction**

  - **Causes:**
    - Poor anatomical re-construction
    - Misclassification of trauma
    - Scar tissue
    - Adhesions – introitus or labia
    - Split labia
    - Vulvodynia – (17 to 20% of women – Amitriptyline)
    - Non specific
Superficial dyspareunia

Main causes:

- Tight introitus - tight bands of scar tissue at introitus
- Perineal scarring – poor anatomical alignment
- Breast feeding – vaginal dryness / reduced libido
- Split labia
- Psychological – body image
- Fear of pregnancy
Management of dyspareunia

- **Prompt sensitive treatment**
- **Conservative** -
  - Perineal Massage
  - Lubrication – position
  - Psychosexual counselling
  - Reassurance
- **Surgical** -
  - Division of scar tissue
  - Modified Fenton’s procedure at 3 - 6 months post delivery
Urinary & Faecal Incontinence

- **Up to 34% of women will have urinary incontinence following childbirth**
  - If it persists beyond 3 months – 92% continue to have urinary incontinence at 5 years postpartum (Victrup 2001)

- **Reported rates of incontinence following anal sphincter injury vary between 7% and 59%**
  - Prevalence depends on success of primary repair
  - Compensate initially
  - Becomes worse following menopause
Antenatal Pelvic Floor Muscle Exercises

This analysis shows antenatal PFMT is associated with a significant reduction in the incidence of postnatal urinary incontinence - RR 0.66, CI 0.51-0.85
Follow-up third/fourth degree tears

Perineal Care Clinic
(6 weeks)

Asymptomatic

Discharge – PCC
subsequent pregnancy

Symptomatic

Physiotherapy/ Biofeedback

Follow-up
(6-8 months)

Symptomatic

Endo-anal scan & anal manometry
PC-MDT

? Will need - EAS repair or conservative management
Obstetric injury – post repair

Defect in IAS remains between 10 & 3 o’clock

The EAS has been repaired but scaring / defect remains between 12 & 3 o’clock
Management of subsequent deliveries

- Subsequent vaginal birth – may increase symptoms of anal incontinence
- If asymptomatic & EAS defect > 2hrs – discuss option of El LSCS
- Severe symptoms & evidence of sphincter damage – ? offer vaginal delivery and then secondary repair depending on symptoms & woman’s preference
- No evidence to support prophylactic episiotomy for future delivery
- If woman aims for SVD – experienced midwife
Cases discussed MDT (n = 102) – recommended mode of delivery

- **LSCS**
  - PC-MDT recommendation: 44
  - Actual Delivery: 38

- **Vaginal**
  - PC-MDT recommendation: 58
  - Actual Delivery: 64

6% recurrence
Bowel Symptoms

- No symptoms: Pre pregnancy 69, 6wks post pregnancy 77
- Urgency: Pre pregnancy 10, 6wks post pregnancy 7
- Anal Incontinence: Pre pregnancy 8, 6wks post pregnancy 7
- Mixture: Pre pregnancy 15, 6wks post pregnancy 8
- Lost FU: Pre pregnancy 3
Discussion

- Increasing number of new referrals to clinic – 2004 (n = 226); 2005 (n = 452); 2008 < 500
- Most problems were not seen or were managed in an ad-hoc manner
- Enables investigation of persistent problems & mismanagement of perineal trauma – feedback regarding individual practice
- Multidisciplinary input – cost efficient
- Reduces gynaecology outpatient clinics waiting lists
- Evaluation – women are very satisfied
Comments from users

61 women commented (47 very satisfied, 12 satisfied, 2 dissatisfied) –

- I thought the treatment was excellent – wish clinic was running when I had my first child
- Not embarrassed at all due to caring consultation by specialist midwife
- Went away feeling more positive and reassured
- I was well impressed
- If the perineal care clinic continues with the same service as I received it will be a success – please don’t allow it to degenerate to the antenatal “cattle-market”
Conclusion

- Perineal care clinic successful in terms of uptake and evaluation
- Template which other units are emulating
- Midwife-led clinic having immense impact on the quality of care women receive in the UK
Thank-you