CARE OF 3RD AND 4TH DEGREE TEARS

Dr Anne Sneddon
Director of Obstetrics and Gynaecology
Lecturer, ANU Medical School
The Canberra Hospital
CANBERRA

[Map of Australia and New South Wales]

[Image of a street with autumn trees]

[Image of mountains and a valley]

[Image of a park with people sitting on a bench]
Capital city of Australia
Population 350,000 but surrounding region of 500,000
Seat of government of Australia
Perfect place to live and Australias best kept secret
CANBERRA HOSPITAL
Third and fourth degree tears are a reflection of quality of maternity services.

Rates are difficult to determine due to non-standardised definitions but in general run at about 1-3% of clinically detectable lesions.

Ultrasound studies point to sphincter disruption in 31% of all vaginal deliveries (Sultan 1994).
Controversy should still exist about the relevance of 3rd and 4th degree tears.

Recent figures from medical indemnity groups in Australia, suggest an increasing trend toward litigation with regard to perineal trauma.

Increasingly used as a reason for maternal request for elective caesarean section.

In many areas the incidence of dysfunction is not known because of non or under-reporting.
TCH OASIS

- Tertiary referral centre with approx. 2800 births per year
- All patients with a clinically recognised 3rd or 4th degree tear are referred
- Established in 2001
- Single obstetric specialist
- Multidisciplinary clinic
TCH OASIS

- Evidence based clinical guideline developed with multidisciplinary input
- All women placed on a Clinical Pathway
- Repair performed by senior staff or under supervision
- Regional anaesthesia minimum
- Recommended OT
Recommended minimal 2/0 Vicryl for sphincter and overlapping repair for 3b, 3c and 4th degree tears. Most now use PDS

Antibiotics: minimal stat dose at repair
- Course at repairers discretion
Aperients from Day 1 (Normacol®, Metamucil®)

Oral analgesia and avoidance of rectal medications except topical haemorrhoidal

Review by physiotherapists Day 1

Referral to OASIS
Scheduled visits at 2 weeks, 6-8 weeks and 6-12 months
Multi-layered interaction
Individualised care
No referral necessary
Self referral at anytime
Training and education of registrars
First visit is to establish relationship and review initial healing process

One-on-one visit with physiotherapist and review of pelvic floor strength and technique of exercise

Referral to other health professionals if required

Management plan established including timing of next visit
The second visit includes a routine postnatal visit with specific urinary and rectal function review.

- Routine postnatal clinical examination and specific anorectal examination
- Specific physiotherapy intervention included.
Third visit.

Review of symptoms and testing

- Clinical history and examination
- Manometry
- Endoanal ultrasound
The fourth visit is to formulate a birth plan which incorporates:
- Woman's choice
- Factors which may preclude a subsequent vaginal birth
- Preventative factors for vaginal birth

Recommended before next pregnancy
Women who have a subsequent pregnancy are then seen twice in the next pregnancy:
- 20 weeks to document a birth plan and review of symptomatology
  - Discussion re minimisation of recurrence
- 36 weeks to confirm birth plan and review symptomatology
- Cohort of women who are in a subsequent pregnancy
- These women have been seen at 6 weeks and are to have anorectal physiology at 6-12 months.
RESULTS

- 302 women have been referred
- To date there have been no medico-legal complaints by women who have attended the clinic
- Retention rates are
  - First visit 100%
  - 2<sup>nd</sup> visit 97%
  - 3<sup>rd</sup> visit 82%
Results

- Psychological health
  - May be first time out of house
  - Desensitising
  - Positive approach
  - Referral for those who may have PND
  - Area for study most needed
RESULTS

- Increasing referral via GPs from outside TCH
  - GSAHS
  - Other public institutions
  - Private referrals.
Advantages of our clinic

- Consistency of approach
- Positive approach
- Multidisciplinary
- Teaching
- Review
- Opportunity for research
DISADVANTAGES OF OUR CLINIC

- Operator dependent
- Could be seen as a threat
- Physiotherapist is a bully!
Multidisciplinary approach

- Centres of Excellence
- Balance of views
- Consistency of approach
Suture material
- RCOG guideline absorbable sutures
- Improved results with PDS for sphincter

Overlapping v anastomosis
- Conflicting data but overlapping for complete appears better in our clinic
- Best data from Fernando et al (n=64) showed decreased pain, and defaecatory function at 12 months NNT=4.
REPAIR TECHNIQUES

- Gynaecologist v colorectal surgeon
  - 1 RCT showed no difference
  - Some units repaired by colorectal surgeons but have to wait until next morning.
REPAIR TECHNIQUES

- Conducted by trained personnel
- Operating theatre
- GA or regional anaesthesia
- Careful exam pre suturing
- Anal mucosa best sutured with knots tied in anal canal.
- Anal muscle repaired with PDS sutures
- IAS identified and repaired separately
- Careful exam and documentation.
**POSTPARTUM CARE**

- **Antibiotics**
  - Inadequate data: Cochrane database

- **Aperients v constipators**
  - 1 RCT which shows better outcomes with aperients

- **Analgesics**
  - None specific for 3rd/4th degree tears
  - Combination, regular paracetamol+/- codeine and NSAIDS
  - Avoidance of rectal medication in postnatal phase
Follow Up

- Obstetricians v colorectal surgeons
  - Anorectal physiology
  - Birth and other sequelae
- Physiotherapy
  - No long term studies on intensive PFE and effect on outcomes
- Other
NEXT BIRTH

- Elective caesarean v vaginal birth
  - Only definite indication for c/s is secondary repair for symptomatic tears.
  - Current general practice is
    - If symptomatic elective c/s

- Preventative measures
  - Perineal massage
  - Birth position
    - Left lateral, 4 pt kneel
Recurrence rate around 3%

Data on relevance is poor
  - Increase in dysfunction

No evidence that episiotomy is protective
  - Best data suggests poorer function
LONG TERM SEQUELAE

- Incontinence
  - Flatus incontinence common
- Early vs symptomatic (later) repair
  - Knowledge based on delayed repair
- Role of pelvic floor health
  - Premenopausal vs menopausal
HOW TO SET UP A CLINIC

- Get someone interested!
- Ask the right questions
- Make it multidisciplinary!
- Make it women focused
- Make it honest
- Collect the data
Every woman knows that having children is a balance of consequences........
Further recommended reading:

- Perineal and Anal Sphincter Trauma
  - Abdul Sultan, Ranee Thaker, Dee Fenner Editors
  - Springer Press