CARE OF 3RD AND 4TH DEGREE TEARS

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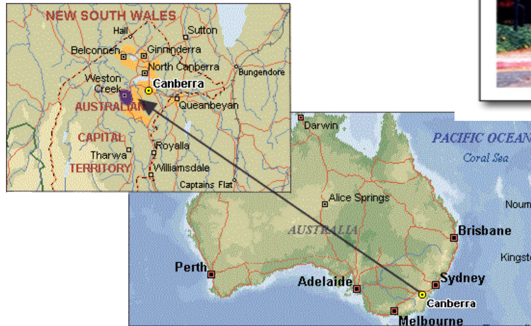
CANBERRA



CANBERRA

- 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

BACKGROUND

- 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)

BACKGROUND

- 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

TCH OASIS

- 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

TCH OASIS

- Aperients from Day 1 (Normacol®, Metamucil®)
- Oral analgesia and avoidance of rectal medications except topical haemorrhoidal
- Review by physiotherapists Day 1
- Referral to OASIS

TCH 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

TCH OASIS

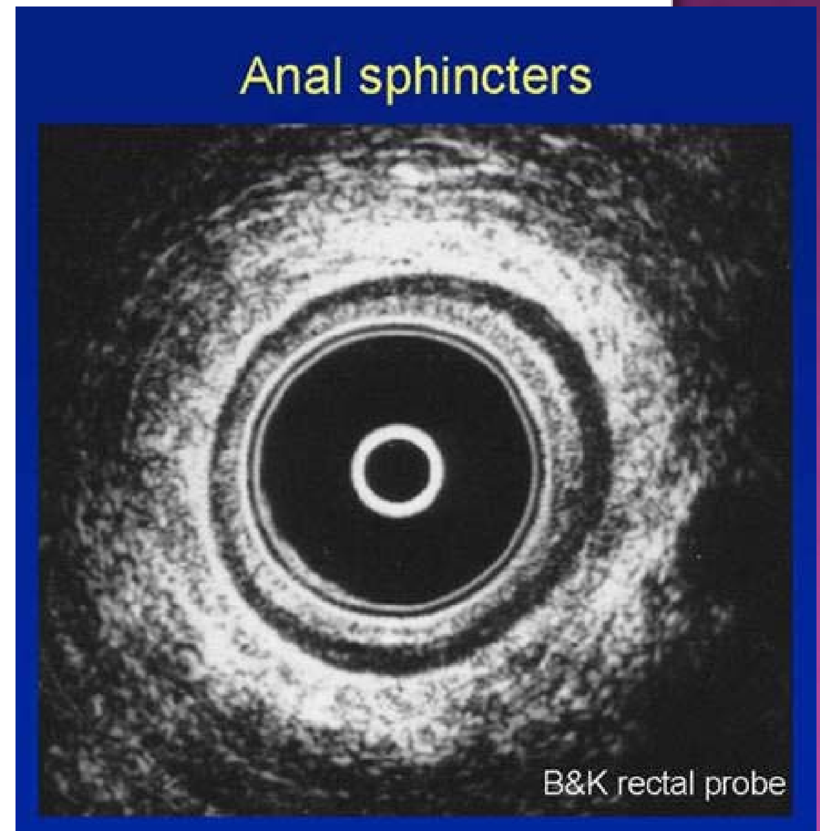
- First visit is to establish relationship and review initial healing process
- One-on-one visit with physiotherapist and review of pelvic floor strength and technique of exercise
- Referral to other health professionals if required
- Management plan established including timing of next visit

TCH OASIS

- 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.

TCH OASIS

- Third visit.
- Review of symptoms and testing
  - Clinical history and examination
  - Manometry
  - Endoanal ultrasound



TCH OASIS

- 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

TCH OASIS

- 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

TCH OASIS

- 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%
  - 2nd visit 97%
  - 3rd 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!

CURRENT LITERATURE

- Multidisciplinary approach
  - Centres of Excellence
  - Balance of views
  - Consistency of approach

REPAIR TECHNIQUES

- 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

NEXT BIRTH

- 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 v symptomatic (later) repair
  - Knowledge based on delayed repair
- Role of pelvic floor health
  - Premenopausal v 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……..

THANKYOU

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