Guideline for Management of Obstetric Anal sphincter Injury

85% of women will sustain some degree of perineal trauma with vaginal delivery. In University Hospital Wishaw, our current rate of 3rd / 4th degree tears is 1.6% (2019)

Definition:

First degree- Injury to perineal skin only.

Second degree- Injury to perineum involving perineal muscles but not involving the anal sphincter.

Third degree-Injury to perineum involving the anal sphincter complex

- Less than 50% of external anal sphincter (EAS) thickness torn.
- More than 50% of EAS thickness torn.
- Both EAS and internal anal sphincter (IAS) torn.

Fourth degree-Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium

Note

- Buttonhole tear is a separate entity where the tear involves only anal mucosa with intact anal sphincter complex .If not recognised and repaired this type of a tear may cause ano-vaginal fistulae.
- When in doubt, classify to higher degree

Incidence

The following factors are associated with an increased risk of a third degree tear:

- Birth weight over 4 kg (up to 2%)
- Persistent occipitoposterior position (up to 3%)
- Nulliparity (up to 4%)
- Induction of labour (up to 2%)
- Epidural analgesia (up to 2%)
- Second stage longer than 1 hour (up to 4%)
- Shoulder dystocia (up to 4%)
- Midline episiotomy (up to 3%)
- Forceps delivery (up to 7%)

Prevention

Consider mediolateral episiotomy for instrumental deliveries.

Perineal protection at crowning can be protective.

Warm compression during the 2nd stage of labour reduces the risk of OASIS.

Repair

Ideally repair should take place in an operating theatre, under regional or general anaesthesia, with good lighting and with appropriate instruments. Repair of OASIS in the delivery room may be performed in certain circumstances after discussion with a senior obstetrician. This may be necessary due to labour ward or theatre activity. It is important that there is adequate lighting, equipment and anaesthesia present in the room with staff to support the operator.

Surgeon

Repair should be performed by a practitioner confirmed as competent or under direct supervision.

Surgical technique

Anorectal mucosa – continuous or interrupted sutures, 3-0 Vicryl

IAS – interrupted or mattress sutures, not overlapping. 3-0 PDS or equivalent.

EAS – full thickness tear can be repaired with overlapping or end to end sutures. If partial thickness, use end to end sutures. 3-0 PDS or equivalent

Bury the surgical knots under the superficial perineal muscles.

2-0 vicryl rapide for the remainder of the tear as normal.

Documentation

Document type of tear
Complete relevant perineal repair section on Badger
Document PR at end of procedure
Documentation of equipment check, needle and swab count

Postoperative Management

Broad spectrum antibiotics are recommended to reduce risk of wound dehiscence and infection.

Co-amoxiclav 1.2g IV single dose
followed by Co-amoxiclav 375mg 8hrly orally for 7 days

Or if penicillin allergy

Clindamycin 600mg IV single dose
followed by Clindamycin 150mg 6hrly orally for 7 days

In dwelling catheter - can be removed after 24 hours or once mobile, whichever is earlier, unless any other indication.

Laxatives – 2 week course – 10ml BD lactulose or Fybogel 1 sachet BD.

Ensure seen by Physiotherapist prior to discharge

All women should have a debrief prior to discharge.

Postnatal review appointments should be made with the relevant consultant for all women with a 4th degree tear or if clinical situation results in recommendation for postnatal review. All women are not seen routinely, rather they can be referred in the postnatal period if ongoing issues and can be referred by the community midwife or health visitor.

The GP discharge letter should include detail about the 3rd/4th degree tear.

Postnatal review – if experiencing pain or incontinence at 6-12 weeks postnatal – referral to specialist gynaecologist or colorectal surgeon should be considered.

Prognosis

60-80% of women are asymptomatic at 12 months postnatal.

Future deliveries

Women should be counselled regarding options for future deliveries.
Recurrence rate 6-8% therefore aim for vaginal deliveries especially if asymptomatic after counselling and agreement by patient
If the woman remains symptomatic, she should be counselled regarding the option for elective caesarean section.

References

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