International Continence Society August 22-26, 1999 29th Annual Meeting Denver, Colorado USA

Category No. 3 | Video Demonstration | Ref. No. 177

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Title (type in CAPITAL LETTERS): **AUDIT OF HOSPITAL PROTOCOL FOR MANAGEMENT OF THIRD DEGREE TEARS**

Aims of Study Third degree perineal tears occur in 0.5-2% of vaginal deliveries. In the available literature, risk factors for third degree tear are cited as: birthweight > 4kg, first delivery, operative delivery, occipito-posterior position. We carried out an audit of the third degree tears in our hospital in 1997 (a tertiary centre with 6300 deliveries per year). From the literature available and on the advice of local colo-rectal surgeons, we developed guidelines for the management of third degree tears in our unit. We have re-audited the results of the first year of the new guidelines (1998), including follow-up of the patients, in order to assess the impact of our new guidelines on patient morbidity.

Methods The new guidelines include repair of the perineum in theatre by a Specialist Registrar (at least 4 years post-qualification), under general or regional anaesthesia, with 2/0 non-absorbable Prolene used for an overlapping repair of the external anal sphincter. The Prolene is buried and the repair completed with 2/0 Vicryl. Antibiotic cover/aperients are prescribed and follow up occurs at 6 weeks in our Pelvic Floor Clinic. Patients were identified by a search of the hospital data system and case-notes were hand-searched to confirm the findings at 6 week follow-up. If patients had not been seen, a postal questionnaire was sent out.

Results 1997 data: There were 44 third-degree tears (1% of vaginal deliveries). 86% of the women were primiparous and 14% were Para 1. 84% of the babies were below 4kg in weight. The majority of the staff managing the delivery were midwives performing normal vaginal deliveries (64%); medical staff managed 36% (ventouse 22% and forceps 14%). Suturing was carried out in theatre in 70% of cases under regional block or GA, mainly by an Specialist Registrar (66%). Prolene was used in 65% of sphincters, Vicryl in 33%, catgut in 2%. There were 2 cases of Prolene migration out of 28 repairs with this material (7%), both of which required a re-fashioning procedure.

1998 data: There were 51 third degree tears (1% incidence), and 74% of women were primiparous, 18% Para 1 and 8% Para 2. Again, the majority of deliveries were performed by midwives (75%) with medical staff managing 25% and average birthweight was 3.7kg. Episiotomy was performed in 33% of cases, but in only 7 out of 38 normal deliveries. Prolene was used in 76% of repairs, PDS in 8% and Vicryl in 16%. 80% were

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repaired in theatre. Follow-up has been completed in 37 out of 51 (73%) of cases so far: 41% complained of bladder symptoms (incontinence in 32%) and 32% complained of bowel symptoms (urgency in 19%, frequency in 11% and soiling/leak in 11%). Of concern is the finding that non-absorbable suture material caused discomfort in 10 out of 30 (33%) women who were followed-up having been repaired with Prolene or PDS. So far 4 women have required re-fashioning procedures.

Conclusions In our unit, the obstetric profile of women having a third degree tear is at odds with previous reports, since the majority are normal deliveries of infants weighing less than 4kg. Possibly the role of episiotomy needs to be re-evaluated. Although our colorectal colleagues prefer non-absorbable sutures for secondary sphincter repair, there is a significant morbidity from its usage which must be explained to the bladder symptoms (incontinence in 32%) and 32% complained of bowel symptoms (urgency in 19%, frequency in 11% and soiling/leak in 11%). Of concern is the finding that non-absorbable suture material caused discomfort in 10 out of 30 (33%) women who were followed-up having been repaired with Prolene or PDS. So far 4 women have required re-fashioning procedures.