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MANAGEMENT OF OBSTETRIC ANAL SPHINCTER RUPTURE – The way forward

Aim of the study:

Obstetric Anal Sphincter Rupture (OASR) is a major cause of faecal incontinence resulting in maternal morbidity and rising litigation. However, there is lack of consensus on the definition of OASR and its ideal management. MEDLINE search revealed no randomised-controlled trials examining the best method of managing OASR and subsequent delivery Observational studies suggest that the overlap repair with Polydioxanone sutures using antibiotic cover give a better long-term outcome. There were no published trials to find out the best way to follow-up the patients and method of subsequent delivery. There was no uniformity in the definition of OASR in the standard obstetric textbooks. The aim of the study is to evaluate the current management of OASR amongst the UK consultant obstetricians, coloproctologists and trainee obstetricians.

Methods: A questionnaire was sent to all consultant obstetricians and gynaecologists (n=1510) and coloproctologists (n=385) in the UK and trainee obstetricians in West Midlands and South Thames regions (n=207).

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Results:

793 (53%) consultant obstetricians, 126 (61%) trainee obstetricians and 90 (23%) coloproctologists responded. 45% of the consultant obstetricians and 26% of trainee obstetricians still define a complete or partial external anal sphincter (EAS) tear as a second-degree tear. 50% of consultant obstetricians and 56% of trainees use the overlap technique for EAS repair where as 89% of coloproctologists recommend overlap technique. Over 65% of the obstetricians use vicryl for the repair of EAS where as 46% coloproctologists use Polydioxanone. 28% of coloproctologists recommend colostomy for anal mucosal tears where none of the obstetricians recommend so. 20% of consultants and 14% trainees would consider caesarean section as the only option for subsequent delivery while 71% of coloproctologists would recommend so. 65% of consultant obstetricians and 62% of trainees did not receive satisfactory training in the management of OASR.

Conclusions:

This survey highlights the inconsistency amongst obstetricians and coloproctologists in the definition, repair technique and subsequent management of OASR. Lack of randomised controlled trials regarding the best management of OASR leading to wide variation in practice and sub-optimal training may affect the incidence of faecal incontinence following OASR. We were surprised to find that more than half the obstetricians claimed that they were practising the new overlap technique (without formal training) that is still being evaluated by a randomised controlled trial. We propose to outline a programme of formal training, a protocol of recommended practice and follow-up based on the best available evidence until randomised control trials find the best answer.