

## MANAGEMENT OF OBSTETRIC ANAL SPHINCTER TRAUMA – A SURVEY ON VIEWS OF TRAINEES IN THE STATE OF WALES, UNITED KINGDOM

### **Background and aims of study**

Obstetric anal sphincter injury is considered as the most important risk factor for faecal incontinence in women. There are differing views among obstetricians on management of such injuries. Evidence regarding the management is predominantly based on observational studies and so far there is only one randomised controlled trial.<sup>1</sup> The Royal College of Obstetricians and Gynaecologists (RCOG) of United Kingdom publish evidence-based clinical guidelines on current best practice in various aspects of Obstetrics & Gynaecology. These guide the health professionals to achieve and maintain high standards of clinical care. These guidelines are constantly reviewed to incorporate new evidence.

The salient features of the RCOG guideline<sup>2</sup> on Management of third and fourth Degree Perineal Tears Following Vaginal Delivery (2001) are: **1.** Classification: Third degree tear; 3a: Tear involving less than 50% thickness of external anal sphincter (EAS) complex, 3b: Tear involving more than 50% thickness of EAS, 3c: tear including internal anal sphincter (IAS). Fourth degree tear; injury to the perineum involving EAS and IAS and rectal mucosa. **2.** A repair carried out in an operating theatre, under regional or general anaesthesia is likely to be associated with improved outcome. **3.** The use of monofilament sutures such as Polydioxanone gives better long-term function of the anal sphincter complex. **4.** Obstetricians in training need specific instruction about repair of such injuries and formal training for the repair needs to be incorporated into the obstetric curriculum. **5.** Use of appropriate antibiotics, laxatives, adequate follow-up and plans for subsequent delivery are advised.

### **Aim**

1. To evaluate the current practice of management of obstetric anal sphincter trauma amongst Welsh Obstetric trainees in accordance with the guidelines.
2. To explore training issues regarding management of 3<sup>rd</sup> and 4<sup>th</sup> degree perineal tear.

### **Study design and method**

An anonymous questionnaire based on the RCOG guideline was prepared. It was sent to all non-consultant grade obstetricians in training and non-training posts in December 2003 and analysed in March 2004. Questions relating to current position, classification of perineal injury, unit protocol, acute management, follow-up and training issues were included.

### **Results and interpretation**

Ninety-four non-consultant grade obstetricians were identified, of which, 53 responded (56.4%). Majority of units (n=75.5%) had a protocol and 77.4% of clinicians correctly classified the degree of perineal trauma. Incorrect classification was noted more so with senior trainees (22.6%).

Most (n=96.2%) repairs are performed in theatre. There was a variation in the anaesthesia used with 5.7% quoting repair under local anaesthetic. During repair, 68% of doctors had initial senior supervision. The preferred technique for repair was the overlap procedure (n=71.7%). Polydioxanone (PDS) (n=88.7%) was used for sphincter repair.

The choice of antibiotics included Cefuroxime and Metronidazole (37.7%), Co-amoxiclav (35.8%), Co-amoxiclav and Metronidazole (18.9%), only Metronidazole (3.8%). The duration of antibiotic therapy ranged from 1 to 14 days. All used postoperative laxatives. Majority (93.5%) offered follow-up, but timing and place of follow-up varied. Most respondents (75.4%) agreed to a minimum of one hospital review in the first year.

Only two thirds (66%) had undergone any formal training. Majority (92.4%) agreed that formal training is mandatory in the initial years of training. Most responses suggested the level of training to be between good (32.1%) and average (35.8%). Most comments suggested mandatory formal training, refresher courses and consultant supervision.

### **Concluding message**

Three quarters of units have a protocol and most obstetricians are aware of the correct classification. High levels of adherence to some recommendations of the guideline (repair in theatre, choice of anaesthesia, suture material, routine antibiotics, laxatives) were noted. It is interesting to note that overlap method is more preferred, despite lack of evidence regarding the superiority of this method. The guideline does not specify the duration of antibiotic therapy and recommend any specific antibiotics; this is reflected in the variation in response. Majority prefer hospital follow up, but the timing and place would be guided by local protocols and availability of special interest clinics.

Most trainees agreed with the RCOG recommendation that formal training should be incorporated into the obstetric curriculum, although 36% (including some senior trainees) never had formal training. Senior supervision during repair and trainee satisfaction can be improved by increasing consultant involvement in labour ward. Increasing the awareness of national guidelines, development of local protocols, mandatory formal training and regular refresher courses can aim to reduce morbidity and litigation associated with anal sphincter injury.

### **References**

1. Fitzpatrick M, Behan M, O'Connell PR, et al. Randomised clinical trial comparing primary overlap with approximation repair of third degree tears. *Am J Obstet Gynecol* 2000; 183:1220-4
2. Adams EJ, Fernando RJ. Management of third and fourth degree perineal tears following vaginal delivery, Guideline No 29 (2001). Royal College of Obstetricians & Gynaecologists, London, United Kingdom.