Case Presentations

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Case 1

- 30 Female ; 1st baby
- Asked to see 5 days post delivery
- Recognised tear at time of delivery which her obstetrician had repaired
- Very painful perineum
- Gentle examination reveals obvious rectovaginal fistula
- Prepared for surgery same evening due to severe distress

Case 2

- 25 female ; 1st baby
- Asked to see few hours after delivery
- Examination after repair by her Obstetrician revealed ? Rectovaginal fistula
- Prepared for surgery on the same night

EUA and proceed 1st Case

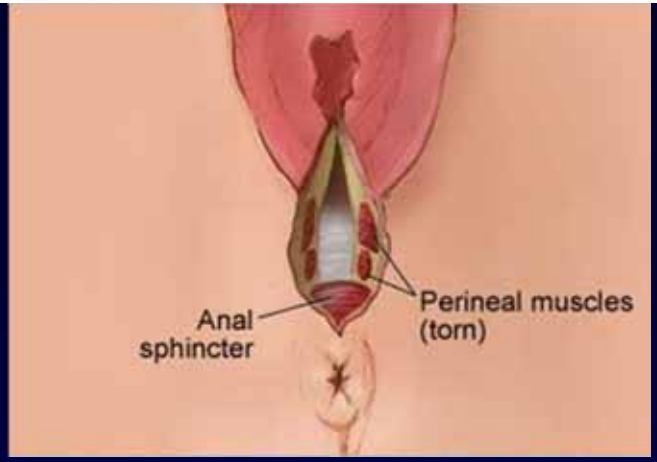
- EUA - - confirms rectovaginal fistula
- Previous repair taken down completely
- Some pus noted
- ? Sepsis as cause of breakdown
- Infact tear extending several centimetres proximally into pelvis
- Open book presentation
- Anatomical reconstitution

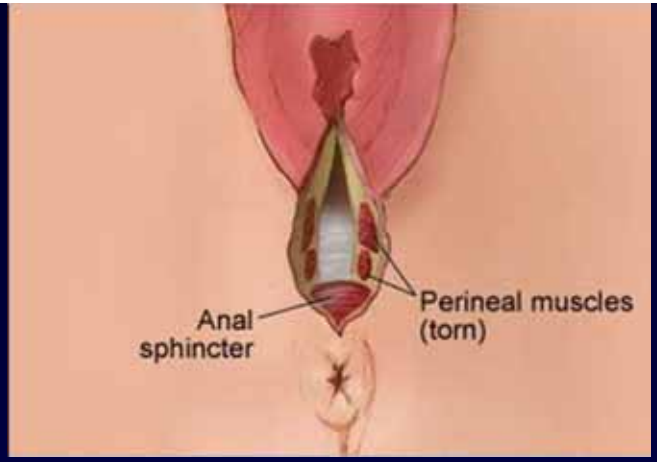
EUA and proceed 2nd Case

- EUA - - 4th degree tear
- Previous repair taken down completely
- Open book presentation
- Anatomical reconstitution

Classification of tears

- 1st degree tear – Vaginal mucosa +/- small skin lacerations
- 2nd degree tear – perineal muscles only – not anal sphincters
- 3rd degree tear - Involves parts of anal sphincter complex
  - a <50% of EAS
  - b >50% of EAS
  - c EAS + IAS
- 4th degree tear – above + rectal mucosa


Anal
sphincter
Perineal muscles
(torn)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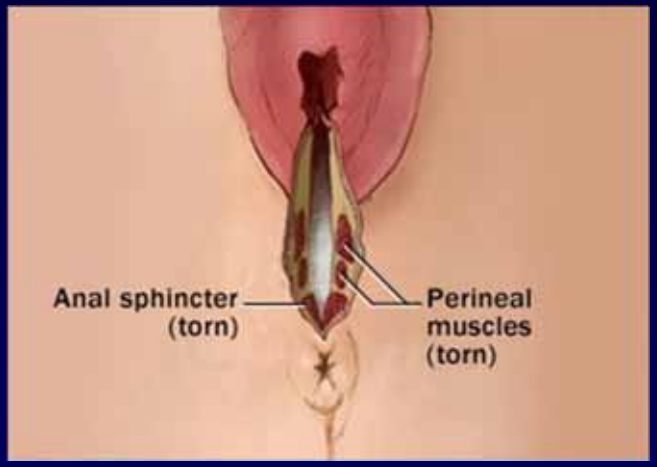
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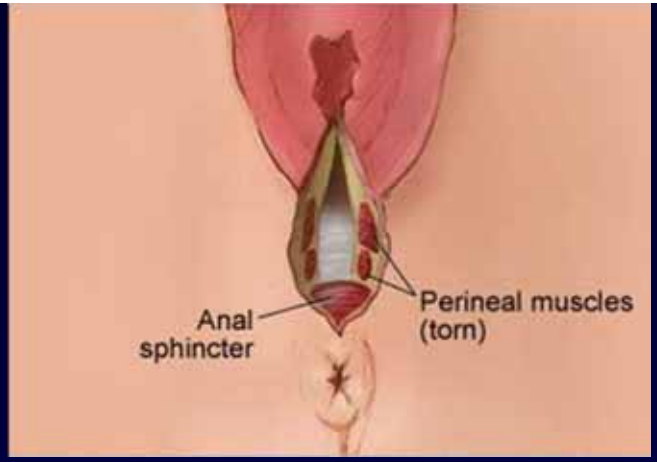
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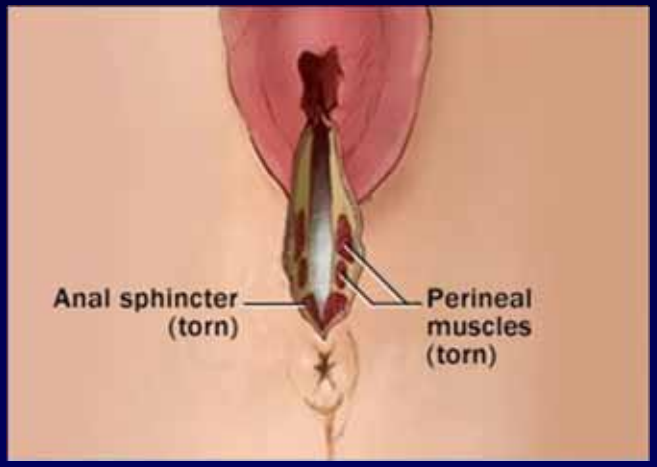
Anal sphincter
(torn)
Perineal
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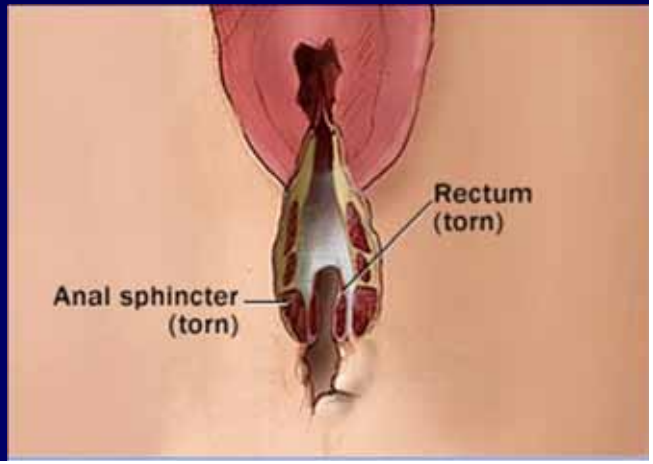
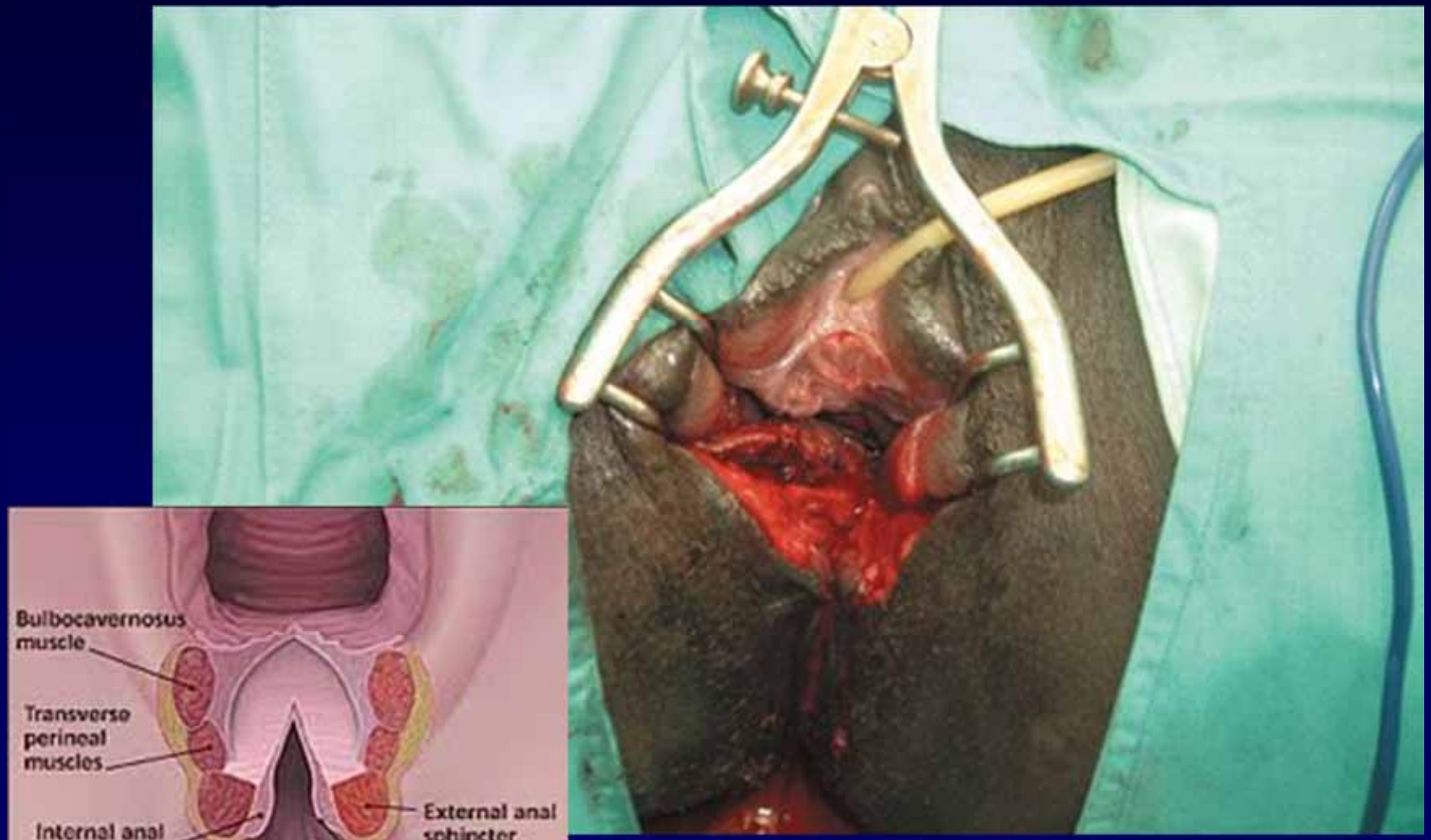

Rectum
(torn)
Anal sphincter
(torn)


Bulbocavernosus muscle
Transverse perineal muscles
Internal anal sphincter
External anal sphincter
Rectal mucosa

What options do we have ?

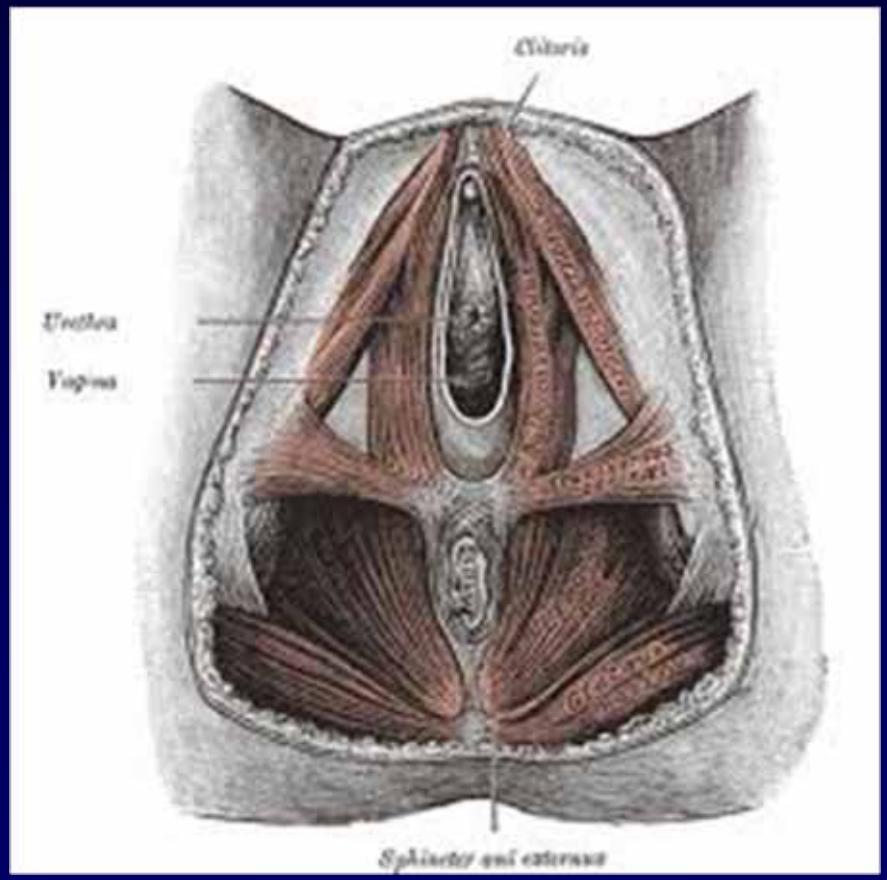
Historical overview

- Perineal suturing documented through out the ages
- Failure rate very high due to infection ‘unwashed hands’
- Late 19th century – confined to bed with legs tied together to encourage secondary healing
- Surviving victims of failed repair reduced to a life of misery

Anatomical reconstitution

Absorbable sutures

- Anorectal mucosa
- Anal sphincters – IAS/EAS
- Levators
- Perineal muscles
- Vaginal repair
- Drain
- Rectal exam
- Packs



Post-operative

- Low residue diet 5-7 days
- Antibiotics
- Bed rest
- Analgesia
- Fecal softeners if necessary
- Pelvic floor muscle exercises from about 6 weeks

  (to ensure recruit pelvic floor muscles for long term pelvic floor rehabilitation)

Follow-up

1st Case

- Completely asymptomatic – at 1 year follow-up

  (Initial urgency and flatus incontinence 1st 8-12 weeks)

2nd Case

- 1 month – doing well
- Continent
- Sensation returning

Risk factors

- Nulliparity
- Asian sub-continent ethnicity
- Female Genital Mutilation
- Large baby
- Previous history of obstetric anal sphincter injury
- Precipitate or faster than expected second stage
- Instrumental birth; active second stage longer than 1 hour
- Inappropriate maternal position (e.g. lithotomy position)
- Midline episiotomy or an inadequately angled mediolateral episiotomy which functions like a mid-line.

Outcome

- 0.2-6% incidence globally - ? Mauritius
- Up to 50% may experience functional complications despite early injury recognition and repair
- **Early diagnosis and anatomically correct repair key to minimising morbidity**
- 50-80% good function at 12 months
- Flatus incontinence and urgency in others - ‘mild’
- Disastrous complications – fecal incontinence and rectovaginal fistula

Diverting colostomy in acute tear

- Need for colostomy extremely controversial – lack of data
- Last 20 years – no prospective trials evaluated need for colostomy
- Colorectal surgeons favour colostomy more than Obstetricians
- Unlike penetrating anorectal trauma – obstetric lacerations are low energy injuries with minimal tissue loss
- Wound well supplied with blood immediately post delivery
- Reserve colostomy for complications of repair in certain cases

Planning for next birth

- Vaginal delivery associated with worsening of existing symptoms or developing fecal incontinence
- No role for prophylactic episiotomy for next birth in reducing risks
- Advise C Section