Total rupture

Yogyakarta oktober 2019

Total rupture

- Incidence
- Anatomy
- (sub)total rupture
- Suture technique
- prevention
- Advice next delivery

Incidence

- 1-11% (median/medio-lateral episiotomy)
- 20-59% incontinent after total rupture (Sultan 2002)
- Under diagnosis? Over diagnosis?

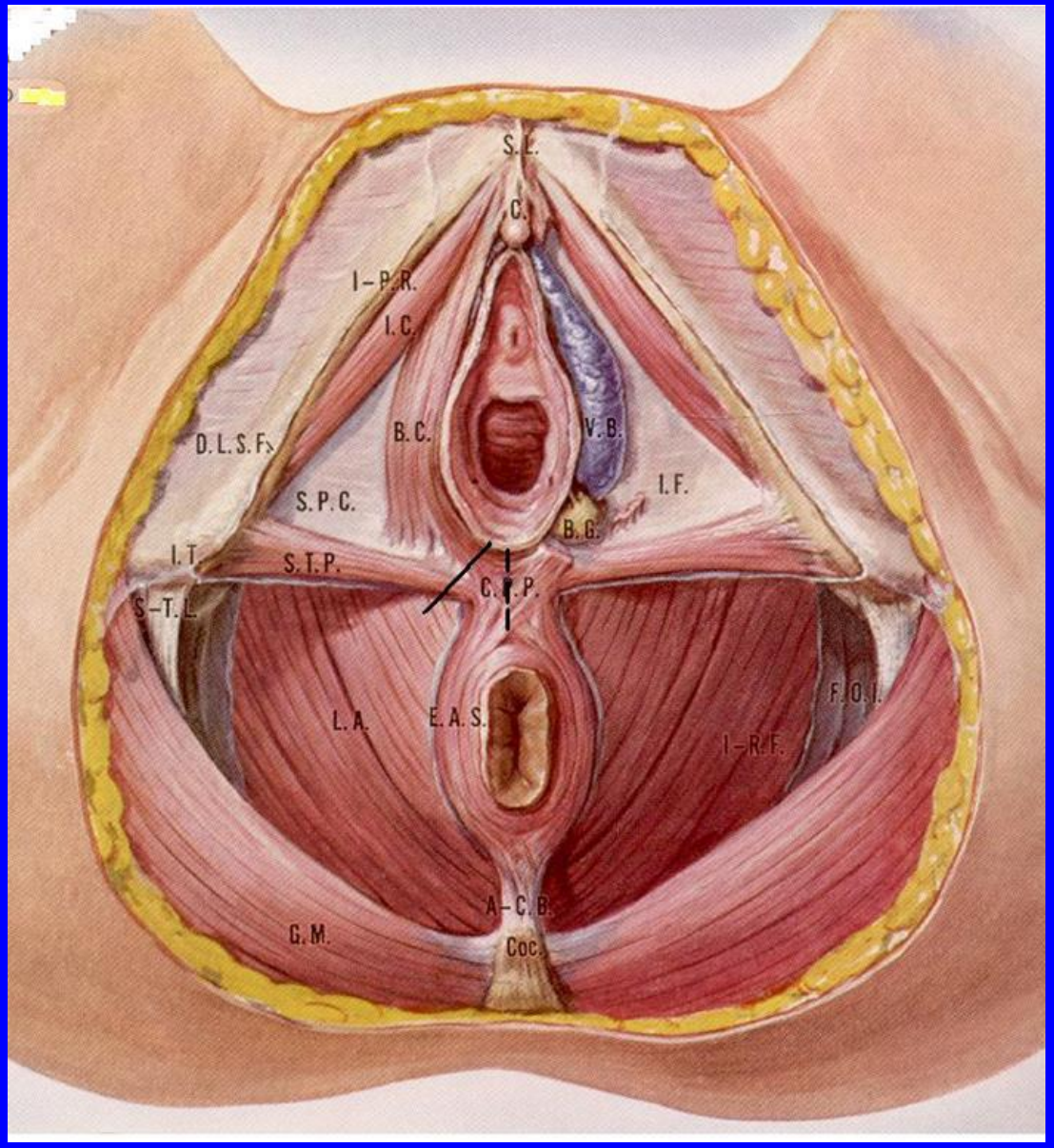
Risk factors

- Episitomiy
- Assisted delivery; Forceps>> Vacuum delivery.

- Macrosomia

- Prolonged second stage.

Anatomy


S. L.
C.
I–P. R.
I. C.
D. L. S. F.
B. C.
V. B.
I. F.
S. P. C.
B. G.
I. T.
S. T. P.
C. P.
S–T. L.
L. A.
E. A. S.
F. O. I.
I–R. F.
A–C. B.
G. M.
Coc.

Definition

- first degree: vaginal epithelium and skin
- 75-85% of all women develop a “tear”. Br J Midwifery. 2018;26:574
- 6-19% all women complain after 1 year still about dyspareunia. Int Urogynecol J Pelvic Floor Dysfunct. 2016;27:1513-23

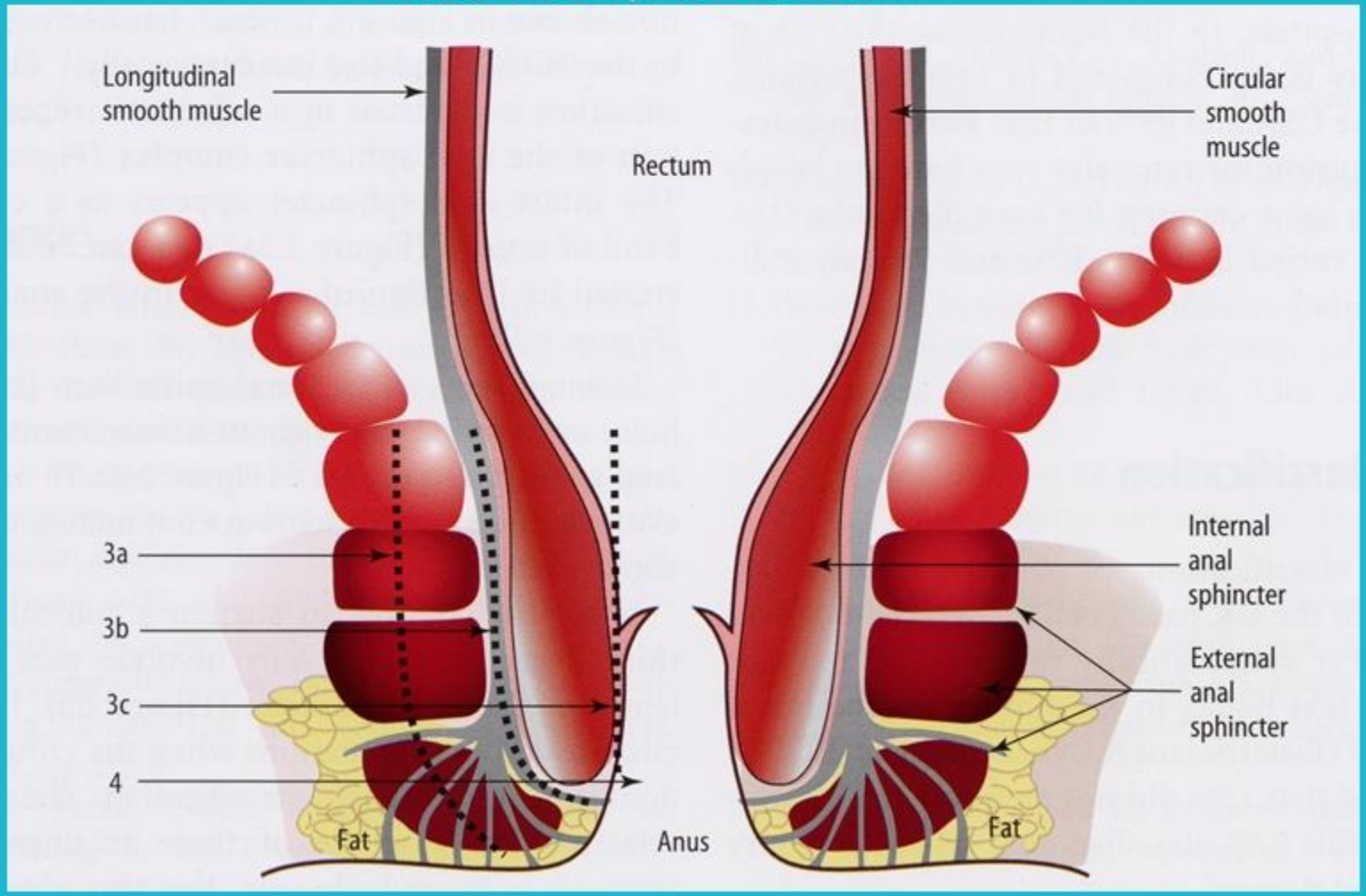
- Second degree: perineal muscles,perineum, anal sfincter intact.

Definition.

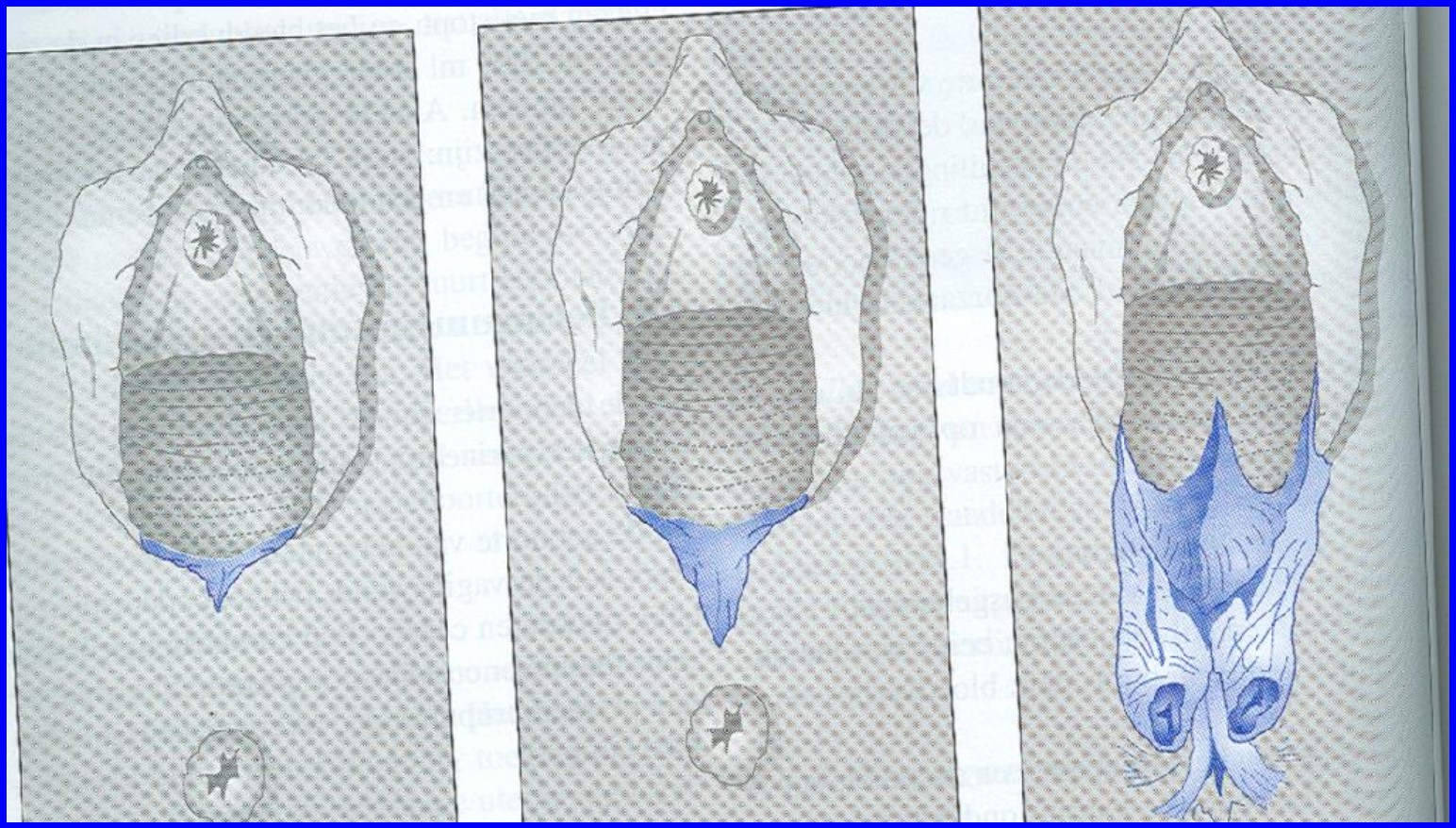
- Third degree: anal sfincter
- A <50% external anal sfincter
- B > 50% external anal sfincter
- C internal anal sfincter
- Fourth degree: anal epithelium/mucosa

Classification of 3rd / 4th degree tears

Sultan AH, Clinical Risk 1999;5:193-6
RCOG GreenTop Guidelines 2001
International Consultation on Incontinence 2002
NICE 2007; ACOG 2014



definition



Suture technique

- End to end
- overlapping

End to End

- Continentie achieved in 76%
- (Jorge and Wexner 1993)

- after 5 years only 50%
- (Malouf et al 2000)

randomisation

- Fitzpatrick (2000)
- 112 primiparae
- No significant difference, trend better outcome overlapping

- Fernando (2004)
- 64 patients 1 year follow up end to end: more urge faecal incontinence

Prevention

- Primairy prevention : elective C section.

Secundary prevention

- Go for spontaneous delivery.
- If necessary VE preferable to FE
- Mediolateral episitomy
- Restricted episitomy
- Position of mother duringe delivery
- Prolonged second stage
- Recognition and correct repair

Subsequent delivery

- Recurrence rate 4-5 %
- ***No complaints:*** vaginal delivery unless a defect in sfincter is detected (ultrasound).
- Elective episiotomy not proven to be useful.

- ***Mild complaints***: Elective C section.

- ***Complaints:*** sfincter repair before delivery, than elective C section. Other option: delay repair until completion of family.

Protocol Sultan

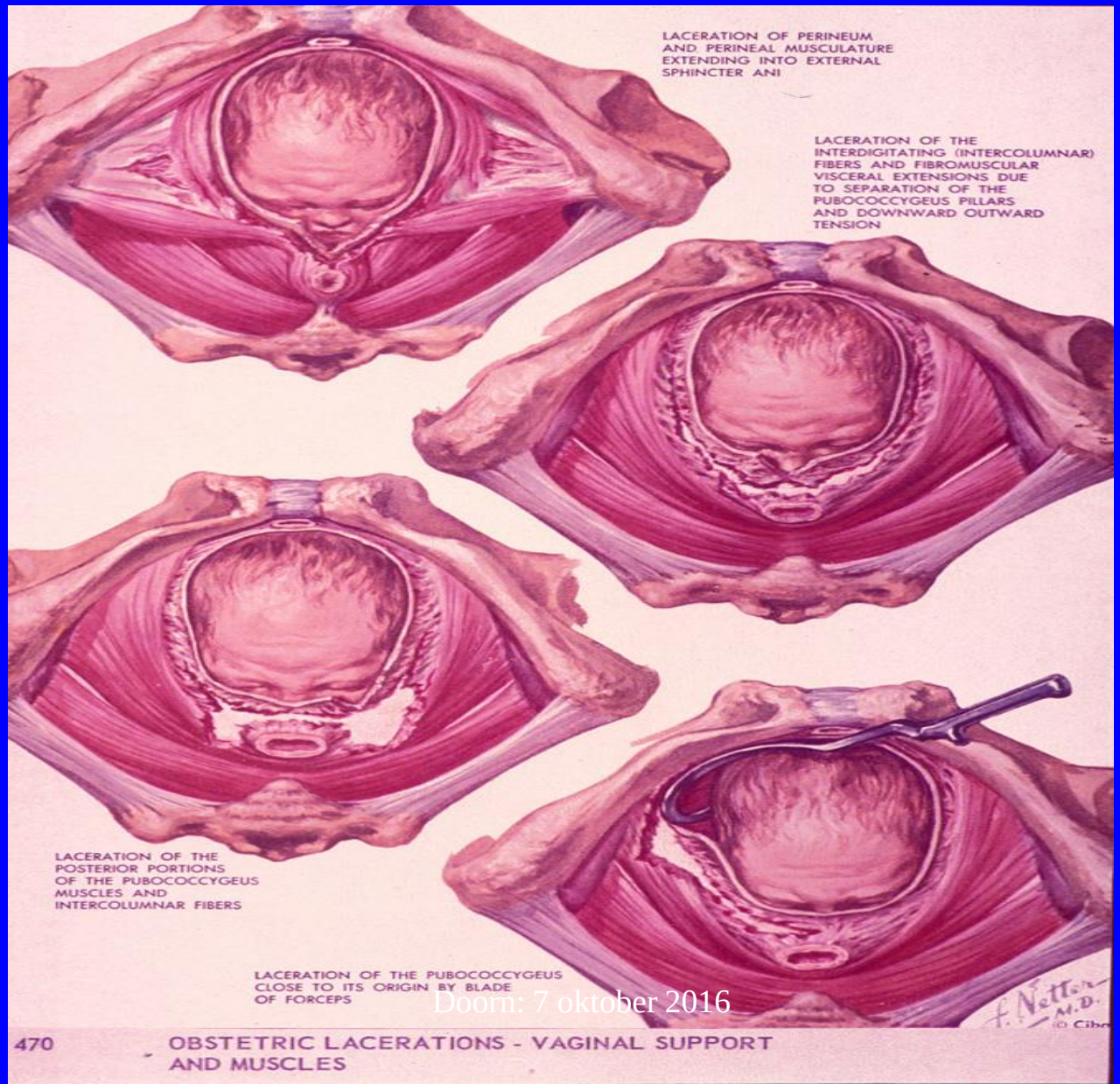
- Repair in OR with regional or general anaestesia.
- Experienced doctor or resident with supervision.
- Monofilament (PDS/ no vicryl for anal sfincter).
- Close external sfincter seperate from the internal sfincter.
- reconstruct perineum
- Laxantia
- AB profylaxis: single dosage at induction.

conclusion

- Recognize!
- Train!
- Follow up!!!

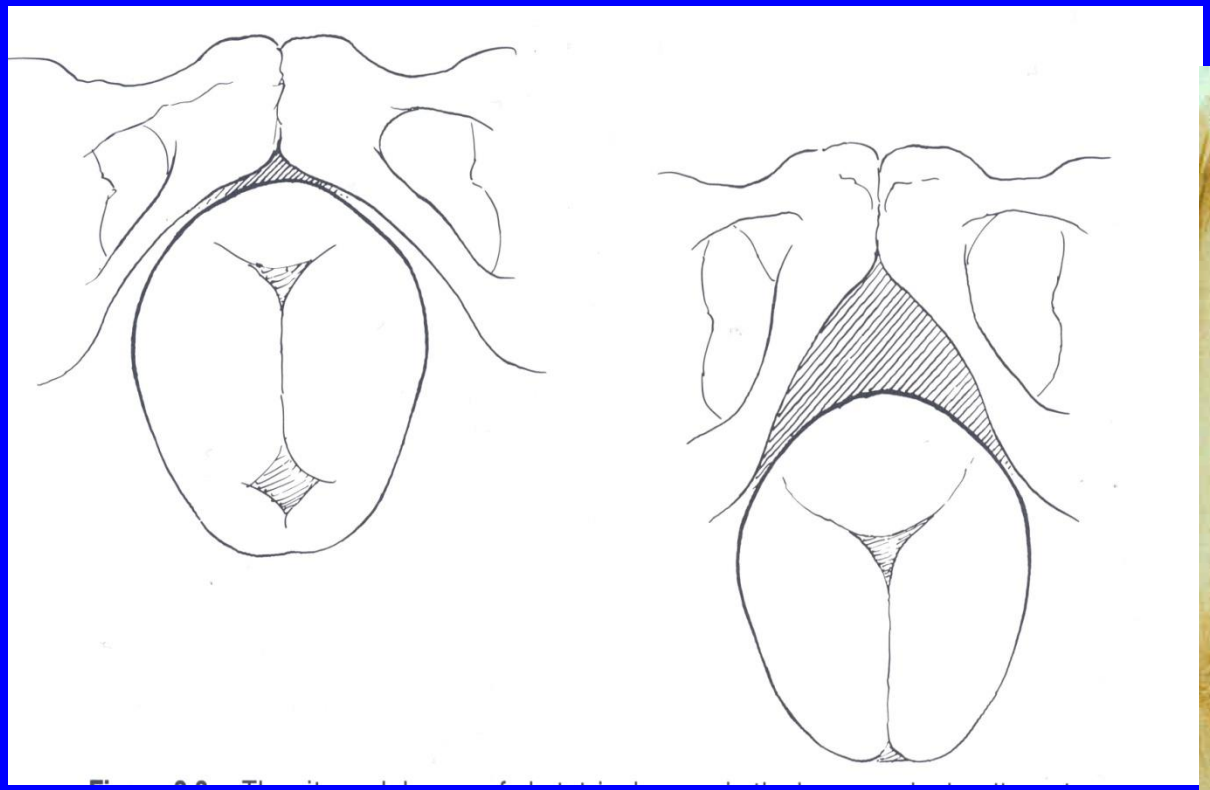
- Protocol!

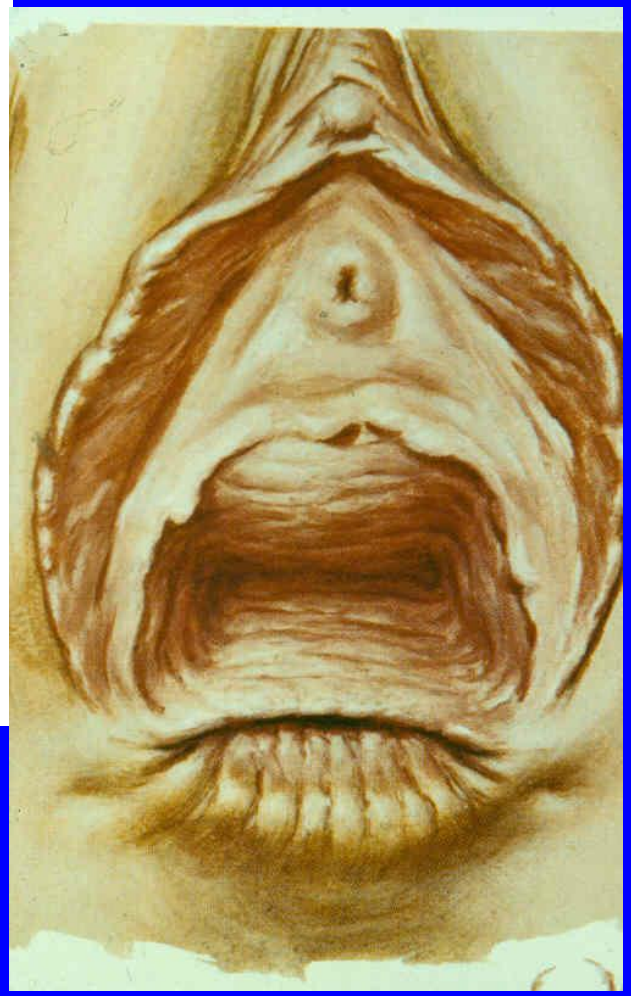
Overdistension.



Doorn: 7 oktober 2016

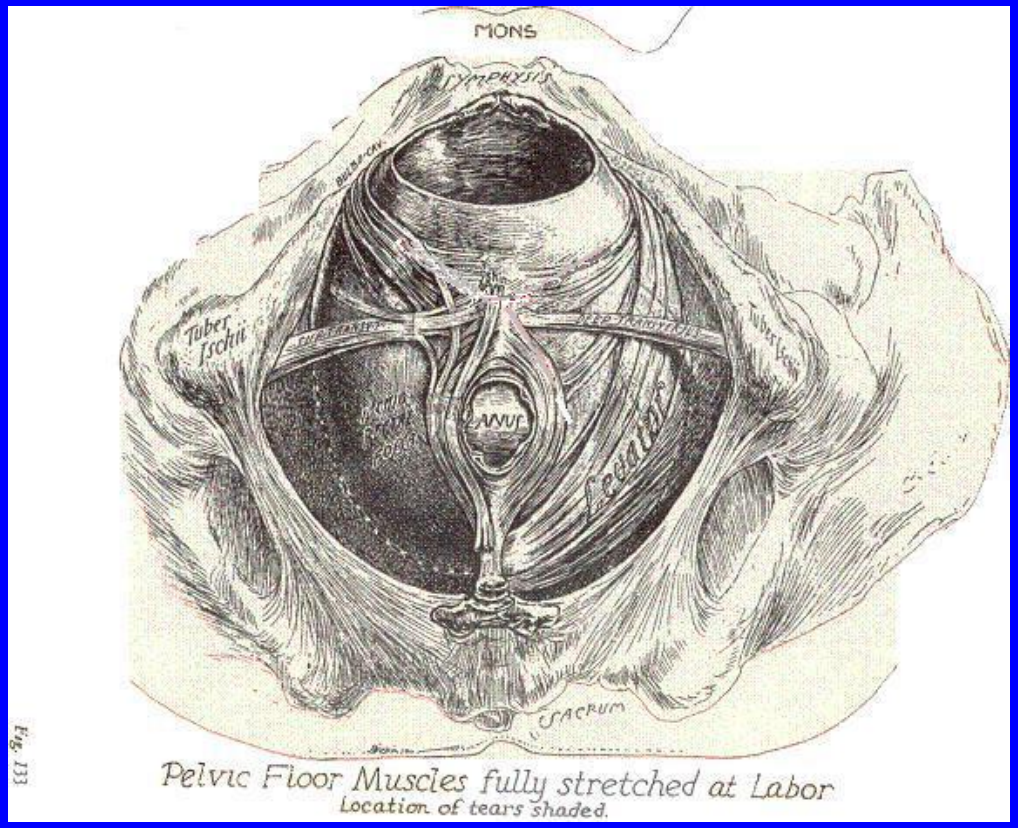
obstetrische paradox





intact perineum ?

- “Platz vagina”
- avulsion
- sfincter defect
- rectumlaesie



Episiotomy;

Episiotomy is defined as a surgical incision in the perineum to enlarge the vaginal introitus and facilitate delivery of the fetus.

Sir Fielding Ould, an obstetrician, introduced this procedure into obstetric practice in 1742.

Selective or routine?

the use of medio-lateral episiotomy during vacuum delivery or forceps delivery is strongly associated with reduction in the rate of obstetric anal sphincter injuries (OASIS) in both primiparous and multiparous women.

Van Bavel J, Hukkelhoven CWPM, de Vries C, Papatsonis DNM, de Vogel J, Roovers JWR, et al. The effectiveness of mediolateral episiotomy in preventing obstetric anal sphincter injuries during operative vaginal delivery: a ten-year analysis of a national registry. Int Urogynecol J. 2018;29

No routine episiotomy!

The Cochrane review of 2017 concluded that selective use of episiotomy in women (where a normal delivery without forceps is anticipated) significantly reduces the risk of severe perineal trauma and, therefore, the rationale for conducting routine episiotomies
to prevent severe perineal trauma is not justified by current evidence.

How to perform an episiotomy

- Which angle?
- Median?
- Mediolateral?
- Always?
- Left or right?

Only 13 % of doctors and midwifes made a correct epi.!

Midwifery. 2015;31:197-200

At least 60° in relation to the central line when the head of the baby crowns, this results in an angle of 40° after childbirth. Int J Gynaecol Obstet. 2011;112:220

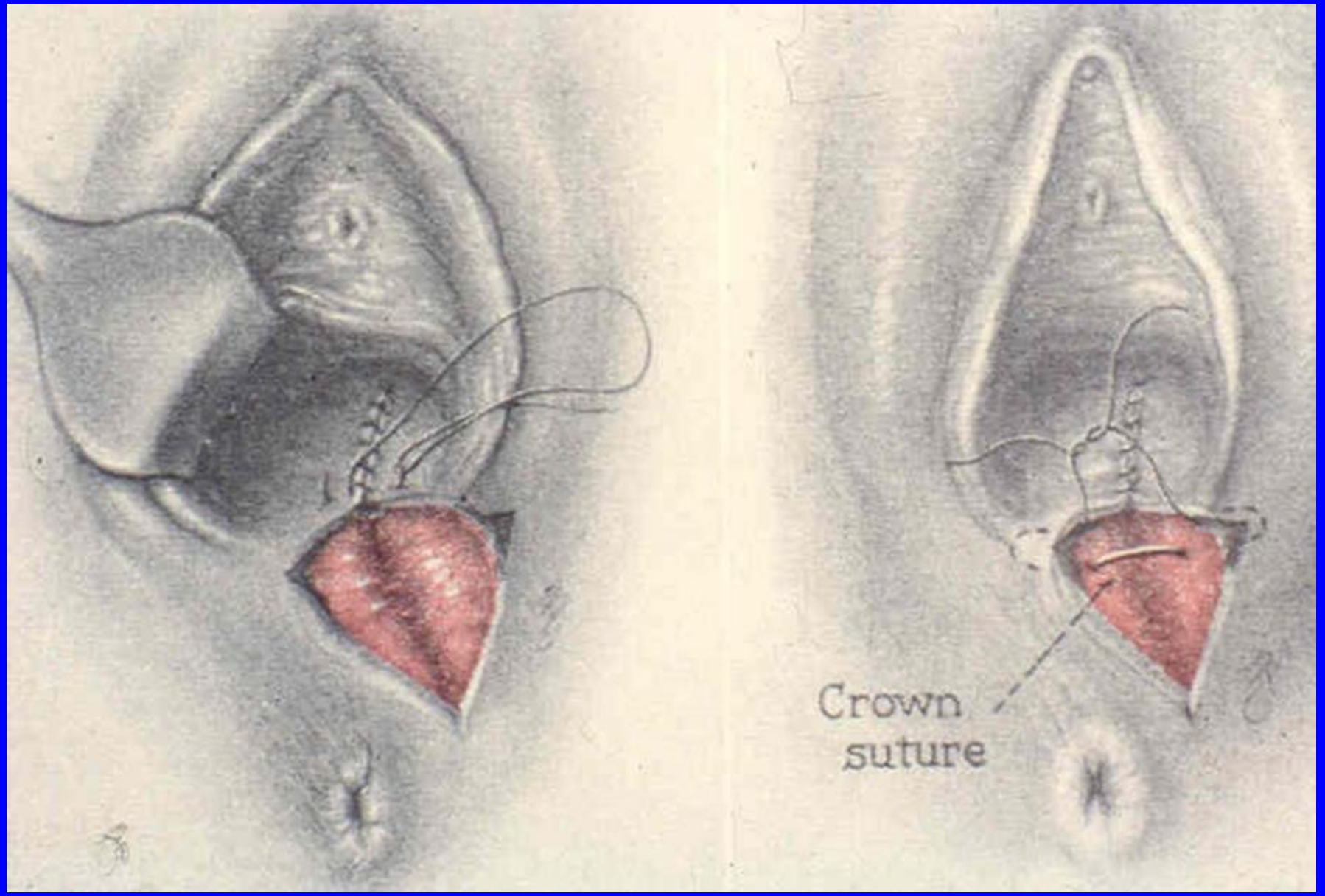
The risk for anal Sfincterlaesions increases with 50%, time and again when the angle in relation to the central line decreases with 6%.

Episiotomy: how to suture?

Continuous technique!

Continuous technique results in less pain, no suture removal, less use of painkillers, less dyspareunia, better anatomic result and can be performed faster.

Continuous and interrupted suturing techniques for repair of episiotomy or second-degree tears. Cochrane Database Syst Rev. 2012;(11):CD000947.


Crown
suture