3rd and 4th-degree perineal tears: two cycle audit

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INTRODUCTION

Obstetric anal sphincter injuries (OASIS) are third- and fourth-degree perineal injuries occurring during delivery affecting 6.1% primigravida and 1.7% multigravida[1].The overall incidence in the UK is 2.9% (range 0-8%). OASIS can produce significant long-term morbidities including anal incontinence, dyspareunia, and chronic perineal pain. Severe complications, such as fistula or abscess formation can require secondary surgical repair. Accurate diagnosis, appropriate repair, and close follow-up are essential to healthy healing and to improve outcomes for women. Neglected or missed tears or faulty repair may also present an inherent source for litigation.

OBJECTIVE

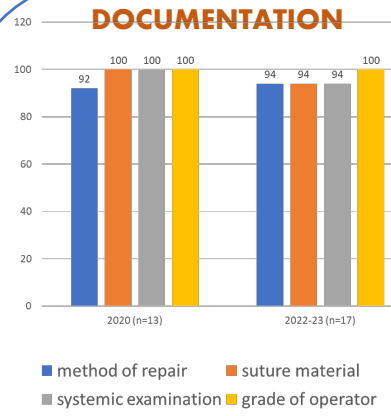
To compare local practice with RCOG standards of care for women who have sustained OASIS following vaginal delivery

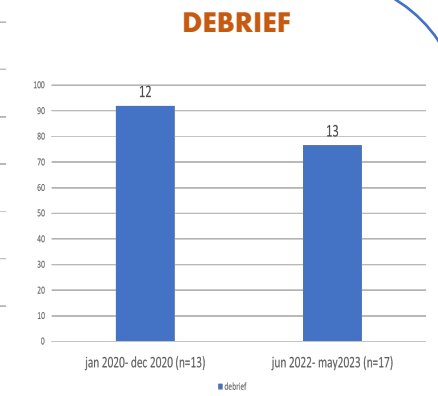
PATIENTS AND METHODS

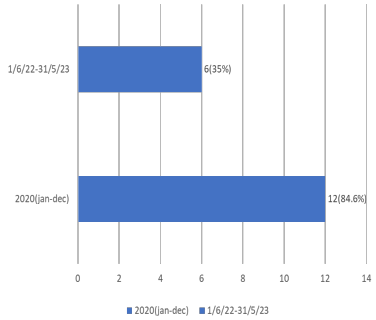
This is a two-cycle audit conducted in obs/gyne dept DGRI. The first cycle was done over 12 months in 2020. The second cycle was done over 12 months from 1/6/22 till 31/5/23. Collected data audited against recommended standards in RCOG, guideline 29 includes 100% evidence of adequate documentation of systemic examination, suture material, method of repair, and grade of operator, prophylactic antibiotic, postoperative advice (debriefing) and a follow-up appointment.

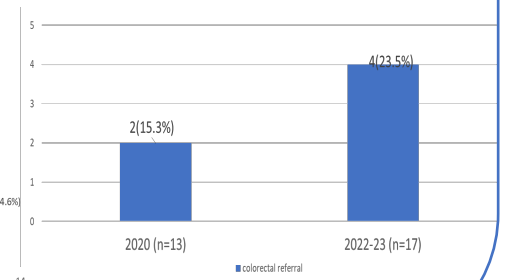
RESULTS

Twelve of 1147 (1.13%) women in the first cycle and 17/1060 (1.55%) women in the second cycle sustained OASIS. The slight increase in frequency may be due to an increase in instrumental delivery in the second cycle. Most women received care consistent with guideline standards for documentation of the repair of OASIS and prophylactic antibiotics in both audit cycles. Debrief was documented less frequently, fewer women attended for postnatal review, and more women were referred to the colorectal service in the second cycle.









DISCUSSION

There was high adherence to the guidelines for inpatient care in both audits with a need for small improvement in debriefing documentation. Despite all women being referred for postnatal review, the rate of attendance was recorded to be low (65% no-show) in the second audit versus 15.4% no-show in the first audit. Also, women referred to colorectal were noted to not have been seen in both audit cycles The RCOG Guideline is quite clear that protocols should be designed locally based on available services. Because colorectal cannot provide this service locally, we plan to refer symptomatic women to the urogynaecological clinic instead

CONCLUSION

There remains work still to be done. We propose improving staff awareness by continued education and email reminders for debriefing documentation. Text message reminders before the postnatal follow-up appointment are suggested to improve the attendance rate. A dictated letter to the patient by the managing consultant will be beneficial. Symptomatic women will be referred to the urogynaecology clinic instead of colorectal. We plan to update local hospital guidelines and to reaudit in 6 months to assess the effectiveness of these interventions.

REFERENCES

1. Royal College of Obstetricians and Gynaecologists (RCOG). The management of third- and fourth-degree perineal tears: Greentop Guideline No 29.