

Third Degree Tear

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Abstract

Objective: To know the incidence of third and fourth degree perineal tears, with the aim of reducing the incidence and improvement in management of women who sustain them.

Methods: A Computer search of the midwife' database (Euroking) for the time period 1st Jan. 2000 to 31st Dec. 2000.

Results: 74% of women in study had no episiotomies, only 26 % of ladies with episiotomies had perineal tears. The inference to be drawn was that episiotomies have protective effect if timely and adequately performed. In post natal follow-up visit 13 % of ladies had poor sphincter strength and they were referred to physiotherapy department for pelvic floor exercises. One patient underwent Fenton's Operation due to dyspareunia. Occasional incontinence was seen in 8 % of cases, which improved over the time without any intervention.

Discussion & Conclusion: The classification of perineal tears in the literature is confusing and explains the inconsistency in definition by Doctors and midwives. The inference drawn from the study was that episiotomy has got protective role against perineal trauma (347 episiotomies were performed out of total 2450 deliveries, only 26 % of women in the study had perineal tears who had episiotomies. Doctors should pay more attention to note keeping.

Keywords: Perineal Tear; Episiotomy; Anal Sphincter Dysfunction; Incontinence

Aims and Objective

To know the incidence of third and fourth degree perineal tears, with the aim of reducing the incidence and improvement in management of women who sustain them. It was planned and carried out in Maid stone hospital, and SHO Dr. Uma Pandey calculated the data. In the literature search only one RCOG Guideline was found (valid until sept 2002) which describes materials and methods used in perineal repair but there is no reference made to prevention & management, therefore several sources were found on Medline Literature search & they were quoted.

Materials and Methods

A Computer search of the midwife' database (Euroking) for the time period.

1st January 2000 to 31st December 2000 elicited 23 women who had third/fourth degree perineal tears. This was 0.94% of the total birth. Of these 21 sets of notes were found (91%) & 2 sets of notes could not be located. A Retrospective analysis was carried out from the available patient notes.

Definition of perineal tear:

- Any disruption of the anal sphincter irrespective of the anal epithelium involvement, should be classified as a third degree tear [1].
- Third degree tear: partial or complete disruption of ext. anal sphincter;
- Fourth degree tear: is complete disruption of external & internal sphincters and rectal mucosa [2,3].
- A laceration including fibres of the ext. anal sphincter (third degree tear);
- A laceration including mucosa of anal canal (fourth degree tear) [4].

Results

In the study 13 women were <30 years of age who had 3rd degree tear, as compared to 10 women who were >30 years of age. The inference was that younger age group had a higher risk of tear although there were no figures available to make comparisons.

15 women were primigravida, 8 were multigravida, which indicated that primips have a higher chance of tear. Two studies had shown similar findings [5,6].

74% of women in study had no episiotomies, only 26 % of ladies with episiotomies had perineal tears. The inference to be drawn was that episiotomies have protective effect if timely and adequately performed. The only randomized trial of episiotomies ever performed in 1984 showed that episiotomies have a protective effect, although data was not statistically significant [7]. Other studies varied in their findings. One found that it made no difference to spontaneous third degree tears though perineal tears are increased [8]. One differentiated between degrees, finding an increase in 3rd and decrease in 4th degree lacerations [9]. Two studies found that a decrease in episiotomies was accompanied by significant decrease in perineal trauma [10,11].

70 % of mothers had babies >3.5 kg., there are studies which show similar data [12,5]. No women had diabetes mellitus & in the study all the women were Caucasian. Only one woman delivered by forceps & two were ventouse delivery, rest all deliveries were normal, implying that normal deliveries require vigilance and instrumental deliveries are being managed with care.

30 % of women had 1st stage lasting >12 hrs & 17% had 2nd stage lasting >2 hrs. Therefore protracted labour does influence the incidence of perineal tears by other factors. In 87% of cases a midwife conducted the delivery & a specialist registrar in 13 % cases.

In 39 % of cases suturing took place in theatre & in 13 % on labour ward, & was not recorded in 47 % of cases. Local analgesia was used in 26 % of cases, 8 % had epidural, 17 % spinal, 13 % GA and was not recorded in 26 % of cases.

During post natal period laxative was prescribed to 78 % of cases, antibiotics to all ladies, follow-up was arranged in 78 % of cases. Continence was not recorded in 26 % of cases.

Complications involved bleeding (5 cases), shoulder dystocia (one case), & fourth degree tear (one case). One lady had sigmoidoscopy by surgeons because she had very unusual tear, although rectal mucosa was found intact. One case had tear extending to right fornix.

In post natal follow-up visit 13 % of ladies had poor sphincter strength and they were referred to physiotherapy department for pelvic floor exercises. One patient underwent Fenton's Operation due to dyspareunia. Occasional incontinence was seen in 8 % of cases, which improved over the time without any intervention.

Discussion

The classification of perineal tears in the literature is confusing and explains the inconsistency in definition by Doctors and midwives. The inference drawn from the study was that episiotomy has got protective role against perineal trauma (347 episiotomies were performed out of total 2450 deliveries, only 26 % of women in the study had perineal tears who had episiotomies). Although the inference is quite contrast to study conducted in University of California (1976-1994) [10].

It was felt that stitching should be done in theatre with full relaxation of pelvic floor muscle, as it relaxes the Levator ani and make stitching easier and healing is a lot better.

It was felt absolutely essential to give laxatives and antibiotics to all women who sustained third degree/ fourth degree tear.

Conclusion

- In Maidstone Hospital, Maidstone, a study showed that out of 2450 deliveries, 0.94 % had perineal tears.
- This audit showed that factors such as birth-weight, parity (primip) do have an effect on the incidence of perineal tears. However there was no evident

relationship between instrumental deliveries and perineal tears as contrary to books and other studies.

- Post natal care of women who sustained perineal tears needs to be more thorough.
- Episiotomy, if performed timely and adequately does have a protective role against perineal tears.
- Mothers with big size baby should be given more attention by senior obstetric staff.

Recommendations

- Deliveries should be by experienced persons and episiotomy to be performed if indicated.
- To perform anorectal physiological test and endosonography in women who had sustained a previous 3rd degree tear (esp. if symptomatic).
- Follow-up with colorectal surgeons should be arranged.
- Women who have compromised anorectal function or significant sonographic anal sphincter defects should be counseled and offered Caesarean section.
- Consultant Obstetrician and colorectal surgeons should be present during stitching of fourth degree tear.
- Doctors should pay more attention to note keeping.

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This may be due to better care by experienced obstetric staff in the mothers requiring instrumental deliveries.

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