

# A Survey Of North-West England Obstetric Trainees On The Management Of Major Perineal Trauma

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## Abstract

**Background:** Third and fourth degree tear is a highly litigious procedure and associated with significant maternal morbidity. A survey was arranged to evaluate current practices among trainees. **Aims & Objectives:** The survey was established to evaluate the views and practices of middle grade obstetricians against the recommendations of the RCOG green top guideline. **Methods:** The obstetric specialist registrars in the North-West England were asked to complete a questionnaire in March 2007 on their current practices in managing a third and fourth degree tears. **Results:** Most trainees reported practices that were in broad agreement with the RCOG guidance. One-third of the trainees had not attended a training course and similar proportion also admitted to not routinely giving adequate counselling to women about the long-term effects of the injury. **Conclusion:** There is evidence that the majority followed recommendations of the guideline. There were areas of care where adherence to guidance could be improved to reflect their relevance in medico legal defence such as practitioners training and counselling.

## INTRODUCTION

Third and fourth degree tear is a major cause of maternal morbidity after vaginal delivery, with the resulting anal incontinence leading to considerable physical, emotional and psychological damage. The Royal College of Obstetricians and Gynaecologists (RCOG), recognising the steady increase in the litigation cases associated with this procedure and the dissatisfaction among UK obstetricians in the management of major perineal tears, produced a guideline in 2001<sup>[1,2]</sup>. This guideline has just recently been reviewed. When the RCOG announced its planned review of this guideline we undertook to study how this guidance had influenced practice among the middle-grade obstetricians in the North-West Region. The key recommendations of the previous guideline are summarized below (see Box 1)

The survey was established to evaluate the views and practices of middle grade obstetricians against the recommendations of the RCOG green top guideline published in 2001. We hoped the practice would have changed, bringing more uniformity in management practices and demonstrating more confidence among obstetricians compared to a previous UK survey where only one third of UK obstetricians felt they were adequately trained and the majority highlighted their deficiencies with training in the management of third degree tears.<sup>[2]</sup> Our survey examined

attendance of formal training courses, preferred operative techniques, immediate post-operative management steps and their assessment and counselling regarding the long-term impact of the injury.

### Box 1: Summary of RCOG Guideline No 29

All women having a vaginal delivery should have a systematic examination of the perineum, vagina and rectum to assess the severity of damage prior to suturing. All women having instrumental delivery or who have extensive perineal injury should be examined by an experienced obstetrician, trained in the recognition and management of perineal tear.

Currently there is no reliable evidence to show that the overlap method is superior to the end-to-end (approximation) method.

A repair carried out in an operating theatre, under regional or general anaesthesia is likely to be associated with improved outcome.

The use of monofilament sutures such as Polydioxanone™, compared with sutures such as catgut or polyglactin suture materials, may be associated with less infection and better Long-term function of the anal sphincter complex.

Obstetricians in training need specific instruction about the repair of third and fourth-degree tears.

The use of broad-spectrum antibiotics intra-operatively and in the postoperative period is associated with less postoperative infection and wound dehiscence. The use of postoperative laxatives is associated with less postoperative wound dehiscence.

All women who have had a third and fourth-degree tear repaired should be offered a planned follow-up at 6–12 months by a gynaecologist with an interest in anorectal dysfunction or a colorectal surgeon. If symptomatic, they should be offered endoanal ultrasonography and anorectal manometry and referred to a colorectal surgeon for consideration of secondary sphincter repair.

Subsequent vaginal delivery may worsen anal incontinence symptoms. All women who had a third and fourth-degree tear in their previous pregnancy should be counselled regarding the risk of developing anal incontinence or worsening symptoms with subsequent vaginal delivery. If symptomatic or with abnormal endoanal ultrasonography or manometry, the option of elective caesarean section should be discussed. If asymptomatic, there is no clear evidence as to the best mode of delivery.

It is essential to document clearly the anatomical structures involved, the method of repair and suture materials used and that all instruments, sharps and swabs are accounted for. The woman needs to be fully informed about the nature of the injury and importance of subsequent follow-up.

## METHODS

The obstetric specialist registrars in the North-West England were asked to complete a questionnaire in March 2007 on their current practices in managing third and fourth degree tears. 41 obstetric trainees at a regional trainees meeting were given questionnaires.

## RESULTS

In our survey the respondents were categorized into junior (specialist registrars year 1-3 [SPR1-3]) and senior trainees (specialist registrars year 4-5 [SPR4-5] / staff grade obstetricians). The survey was conducted at a regional trainees meeting attended by 41 trainees, each trainee present partook in the study, thus giving a 100% response rate. The results of the survey are represented in Table 1:

Figure 1

Table 1

	Yes	No
Have you received formal training for 3rd degree tear repair?	13 (32%)	28 (68%)
Do you always classify third degree tears?	35 (86%)	6 (14%)
Do you always repair your third degree tears in theatre?	39 (95%)	2 (5%)
Do you always counsel patients about long term anal problems?	29 (71%)	12 (29%)
Do you always counsel patients about worsening symptoms in subsequent pregnancies?	24 (59%)	17 (41%)

Figure 2

Table 2

	Yes	No
How many days of post-operative lavatives do you usually prescribe?	5-7 days	15 (37%)
	10 days	12 (29%)
	14 days	14 (34%)
What is your preferred post-operative antibiotic?	Augmentin	10 (24%)
	* Cef + Met	31 (76%)
What is your preferred repair technique?	Approximation	13 (32%)
	Overlap	28 (68%)

\* Cef + Met is an abbreviation of the combined antibiotics cephalixin and metronidazole.

Of the trainees that participated in the survey, there were more junior (58%) than senior trainees (42%). Only 68% of the trainees had attended a formal training course in major perineal trauma repair (Table 1). The majority of those who had not been on courses (96%) were senior trainees. Most trainees (86%) classified the tears in their reports according to the classification described in the RCOG guideline Number 29 and 68% preferred the overlap method over the approximation method. 95% of trainees regularly performed all 3<sup>rd</sup> and 4<sup>th</sup> degree tears in theatre. Cefalexin and metronidazole were preferred antibiotic regime over augmentin. The use of laxative varied widely with 37% giving it between 5 -7 days, 29% for 10 days and 34% for 2 weeks. Counselling about long-term anal symptoms and worsening symptoms in subsequent deliveries showed similar patterns with about a third of trainees not giving regular advice.

## DISCUSSION

In most cases a similar pattern of practice was observed in the responses to our questionnaire among both junior (Year 1-3) and senior trainees (Year4-5 / staff grades), which was broadly consistent with the RCOG guideline. With most of the specific recommendations there was greater than 90% positive response rate.

In areas within the guideline where evidence was unclear, practice was much more varied. For example, in the use of laxatives to reduce postoperative dehiscence, the length of

days varied widely between 5 and 14 days though the guideline recommends 14days.

The survey however highlighted two specific areas where there was non-adherence among about 1/3 of the respondents, which we considered significant, given the litigious nature of this condition.

The RCOG recommends the need for formal training, noting that appropriately trained practitioners are more likely to provide consistently high standard of repair and thus reduce morbidity. Our survey shows that 28% of the respondents had not attended a formal training course. Equally interesting was the fact that 96% of those that those who had attended no perineal trauma course were in year 4/5 or staff-grades obstetricians. All those who had had formal training agreed it had impacted positively on their practice.

This result was unexpected, but given the fact that regional training courses only recently became popular, the more senior trainees presumably would have had in-house training when courses were less common. In the current climate of competency based modular training, attending a formal training course, even in addition to in-house training, seems to be a more widely acceptable evidence of adequate training.

Intra-operatively, only 9% (3 respondents) admitted to not sending all their patients into theatre. All of these respondents were senior trainees. It is not clear from the questionnaire if they did not send their patients because the anal sphincter was partially severed( e.g. less than 3a{ of the RCOG classification- i.e. less than 50% of the thickness of the external anal muscle)) Overall the preferred technique for repair was the overlap method (66%) even though there is no evidence of its superiority over the approximation method.

The last 2 paragraphs of the RCOG guideline make good practice recommendations for a follow-up programme which is aimed at the identification of, both early and late anal symptom presentation and need for appropriate counselling regarding subsequent pregnancies. Evidence in the literature suggests there are instances of symptoms appearing after the 6 weeks or worsening of initial symptoms with passage of time. Most colorectal surgeons would expect to follow such patients for over 12 months [2]. While the guideline clearly state that there are no randomized controlled trials to suggest best method of follow up, it advises a follow-up plan of up to an initial 12 months. We believe the guidance from the

RCOG provide a good safety net for early identification and management of symptoms. 30% of the respondents don't routinely counsel patients regarding need for follow-up to 12 months.

Additionally, 1/3 of the respondents will not routinely inform women attending the 6 week postnatal clinic appointment about the possibility of late symptoms, where to seek help or else the risk of worsening symptoms with subsequent vaginal delivery. Such counselling, notes the RCOG is "of utmost importance and must be documented. Counselling forms an essential part of management of these patients. Chou argues in his article discussing lessons learnt from litigation cases in obstetrics that 'in reducing medico-legal issues, an established standard of care must be combined with good communication which is effective, empathic and clear. [3]

A recent survey among solicitors and barristers in medico-legal practice reports that 83% of them had used or witnessed the use of guidelines in litigation cases in the last 3 years. Most of the legal practitioners agreed there is an increased use of guidelines in medico-legal cases and that the Royal Colleges' guidelines are the most popularly quoted. [4].

### **CONCLUSION**

The practices of trainee obstetricians were in broad agreement with the RCOG green-top guideline. One third of trainees had not attended a formal training course . The variation in reported practice was more evident in the postoperative care and counselling. This variation is partly due to the lack of evidence for best practice, which is an inherent weakness in the guideline.

We felt the various regional training workshops had done well to improve training in this area of care but more randomized controlled studies are required to inform better postoperative care. There was a need to highlight to trainees the need for careful counselling about the long-term impact of these injuries and the possible effects of subsequent vaginal delivery. A lack of documented evidence of such discussion could reflect negatively on medico-legal defence, since evidence suggests lawyers are increasingly referring to our college guidelines.

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## **References**

1. RCOG Green-top Guideline No. 29. Management of third and fourth –degree tears following vaginal delivery. 2001 Jul.

2. Fernando RJ, Sultan AH, Radley S, Johanson RB. Management of obstetric anal sphincter injury – the way forward. Proceedings of the 29th British Congress of Obstetrics and Gynaecology, Birmingham 2001: Abstract 347.
3. Chou MM. Litigation in obstetrics. A lesson learnt and a lesson to share. Taiwanese Journal of Obstetrics & Gynecology 2006 Mar; 45(1): 1-9.
4. Samanta A, Mello MM, Foster C, Tingle J, Samanta J. The roles of clinical guidelines in medical negligence litigation: A shift from the Bolam standard. Medical Law Review 2006 Autumn;14: 321-366.

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