

Third and Fourth Degree Tears: A Retrospective Audit of Practice over a 12 month Period at a Tertiary Sydney Hospital

Davies B, Spear V, Bisits A, Lyons S
The Royal Hospital for Women, Sydney

Introduction:

Third and fourth degree perineal tears complicate 5.7% of births in first delivery¹. Complications include pain, infection, wound breakdown and pelvic floor dysfunction, including urinary and faecal incontinence. Principles of management include use of broad-spectrum antibiotics^{2,3,4}, adequate analgesia, laxative use^{3,5} and pelvic floor physiotherapy.^{6,7,8,9,10} Guidelines aid in ensuring implementation of evidence-based management in the inpatient setting and inpatient specialty clinics have been used in the outpatient setting to address the unique needs of women with OASIS in the longer term.^{11,12} Attendance at the OASIS follow-up clinic at a tertiary Sydney Hospital was noted to be low and a retrospective clinical audit was performed to review clinical practice, including attendance at follow-up.

Aims

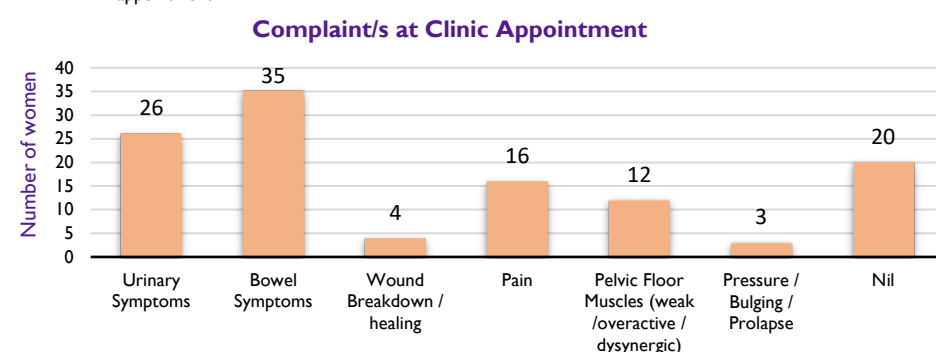
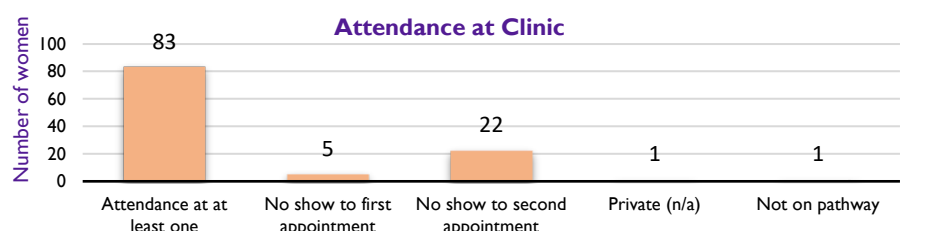
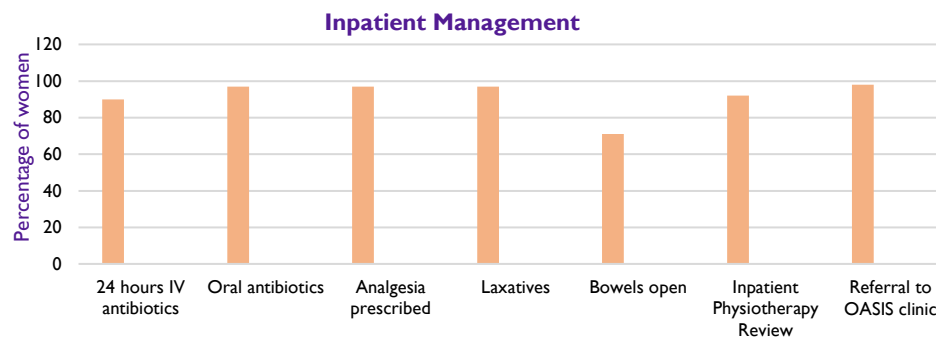
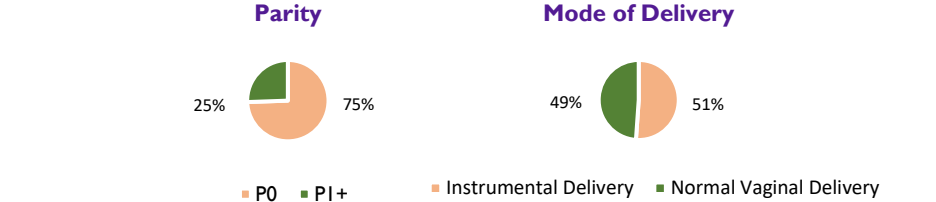
- Over a 12-month period, examine the number of women who sustain OASIS. Identify how many receive care consistent with local guidelines, including inpatient antibiotic and laxative use, referral to physiotherapy and referral to OASIS clinic.
- Of the women referred to OASIS clinic, identify the number of women who attend follow-up (4 weeks and 4 months).
- Identify the presenting complaint at follow-up.

Methods

The 12-month period between 01 July 2021 – 30 June 2022 was reviewed via 'eMaternity' to access the names of women who sustained OASIS. The electronic medical record files of these women were then reviewed to establish adherence to local guidelines, referral and attendance to OASIS clinic and principal complaint/s.

Demographics:

Number of Births	3 rd / 4 th Degree Tears
3812 (3732 women)	90 (2.3% births) (2.4% women)
Perineal Trauma	Number of Women
3a tear	40
3b tear	35
3c tear	12
4 th degree tear	3



Results:

The vast majority of patients received inpatient care consistent with local guidelines. All women were referred to OASIS clinic. 92% of women attended a follow-up appointment and the majority had at least one symptom or concern. Attendance to 4-month follow-up was much lower, with a 24% no-show rate.

Discussion:

Inpatient management was mainly consistent with the local guidelines. Of women who attended follow up, the majority had at least one symptom (most commonly urinary or bowel symptoms) and this provided an opportunity for physiotherapy referral or assessment if this had not already occurred and further follow up to be arranged. There was a low rate of wound breakdown or infection and these were managed with oral antibiotics and outpatient monitoring. The 24% 'no-show' rate at 4 month follow up has implications for providing evidence-based care as the 4-month visit was when endoanal ultrasound was discussed, the gold standard for assessing anal sphincter function. There are also implications for the use of clinic time, which may be better utilised.

Conclusion

Although there was high adherence to guidelines for inpatient care, rate of attendance to the OASIS clinic for outpatient follow up was low, despite many women having symptoms at initial appointment. Since this audit was performed, the OASIS clinic has commenced sending text message reminders to women prior to appointments and this has been noted to improve attendance thus far. There are plans to re-audit to assess the effectiveness of this intervention.

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