



PPHS North East and North Cumbria SOP: One Stop Perineal Clinic Following OASI

Purpose

- To provide high quality care to women recovering from obstetric anal sphincter injury (OASI)
- To reduce the risk of pelvic floor dysfunction in patients who have sustained OASI
- To provide individualised counselling regarding mode of delivery in future pregnancies for women who have sustained OASI, based on results of endoanal ultrasound and anorectal manometry in line with RCOG (Royal College of Obstetricians and Gynaecologists) guidance.
- To provide prompt investigation for women suffering with anorectal symptoms following OASI, thus minimising follow-up visits and streamlining referral to Colorectal services.

Scope

Obstetricians, midwives, pelvic health physiotherapists, urogynaecologists and gynaecologists with a special interest in perineal trauma across the eight Foundation Trusts.

Introduction

Obstetric anal sphincter injury (OASI) occurs when a birth-related perineal tear extends into the anal sphincter complex, potentially involving the external anal sphincter, internal anal sphincter and anorectal mucosa, depending on the depth and nature of the injury¹. OASI can be associated with significant physical and psychological morbidity including perineal pain, wound dehiscence and delayed healing, anal incontinence and other pelvic floor problems such as urinary incontinence and sexual dysfunction². Anal incontinence (involuntary leakage of flatus (gas) and/or stool) can occur from the time of the birth or may present later in life, often after menopausal changes have taken place³.

The Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline recommends that all women with obstetric anal sphincter injury are reviewed at 6-12 weeks postpartum in order to identify and address any ongoing symptoms, as well provide an opportunity to discuss mode of delivery in future pregnancies¹. They also recommend that women who are symptomatic at this follow-up appointment are referred to a specialist gynaecologist or colorectal surgeon for endoanal ultrasound (EAUS) and anorectal manometry for further investigation and management¹.

Subsequent vaginal delivery after previous OASI is associated with a recurrence rate of 7.2% compared with a background risk of 1.3% for women delivering their second baby who have not had a previous OASI⁴. The Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline recommends that all women who have sustained OASI in a previous pregnancy and who are symptomatic or have abnormal endoanal ultrasonography and/or manometry should be counselled regarding the option of elective caesarean birth for subsequent deliveries¹. Evidence shows a residual defect in the external anal sphincter on



endoanal ultrasound is associated with a higher risk of anal incontinence after subsequent vaginal birth⁵.

A “one-stop perineal” clinic with endoanal ultrasound scan, anal manometry, pelvic health physiotherapy assessment and counselling, and urogynaecology specialist review is becoming the gold standard practice for following up women with OASI in the UK^{2,6}.

The most established perineal clinic in the UK is at Croydon University Hospital. Their protocol suggests that pregnant women who have previously sustained an OASI, could be safely offered a vaginal delivery if they have a sonographic defect of the external anal sphincter of less than 1h on the clock face (30 degree angle) and an incremental squeeze pressure of more than 20 mmHg⁷.

A study published from Croydon in 2018 by Jordan et al demonstrated that following this protocol, women who had a subsequent vaginal delivery had no significant change in anorectal symptoms, although squeeze pressure at 3 months postpartum was significantly lower. Interestingly, in the subgroup analysis of patients who sustained a second OASI (10% of vaginal delivery cohort), there was no significant change in bowel symptoms or anorectal manometry, and no new defects on EAUS². Similar protocols have also been followed by Karmarker et al at Imperial College London and Fitzpatrick et al at The National Maternity Hospital Dublin, and produced comparable results^{8,9}. In addition, up to 35% of asymptomatic women with a history of OASI are found to have abnormal anorectal studies, and are therefore at increased risk of developing anal incontinence in future⁶. Anorectal studies using endoanal ultrasound scan and anal manometry can provide women with important information about the extent of their injury, its healing, and any residual defects which will allow them to make an informed, individualised decision about their mode of delivery in a future pregnancy, and thus potentially safely reduce unnecessary caesarean sections, without worsening symptoms².

Women should be seen following an OASI at a “one-stop perineal clinic”, where they will be seen and assessed by a team including a Pelvic Health Physiotherapist, Pelvic Floor Midwife and Urogynaecologist. At this clinic, women have their clinical review as well as anorectal investigations, enabling discussion regarding future delivery and reducing follow-up visits for those requiring onward referral. In time, the aim is to also see pregnant women with previous OASI who have no formal plan for delivery.

Pathway for patients diagnosed with OASI

1. 3a, 3b, 3c or 4th degree perineal tear diagnosed and managed surgically according to RCOG Green-top guideline¹. Surgical documentation to include detail of repair and diagram of the injury on BadgerNet ‘*Episiotomy, Tears and Perineal Trauma*’ and ‘*Perineal repair*’ form (appendix 1).
2. Patient discharged with adequate analgesia, antibiotics and laxatives. Advice given regarding pelvic floor exercises, perineal hygiene, avoiding constipation, and bowel emptying positions and techniques. RCOG OASI Patient information leaflet provided (on paper or via Badgernet). Inform patient to expect upcoming appointments with pelvic health physiotherapy and the One-Stop Perineal Clinic. Operating surgeon to complete referral to physiotherapy and arrange appointment in One-Stop Perineal Clinic in 3-6 months. Provide information regarding Birth Reflections service. Obstetric debrief appointment to be arranged separate to above appointments at discretion of consultant obstetrician if deemed necessary.



3. Telephone consultation with Pelvic Health Physiotherapist within 2-4 weeks of delivery. If any problems identified that require face-to-face review earlier than next appointment - provide advice about how to arrange review with midwife/GP/O&G according to presentation.
4. Face-to-face physiotherapy appointment within 6-12 weeks of delivery for clinical assessment and pelvic floor muscle retraining. If problematic symptoms, consider fast-tracking the One-Stop Perineal Clinic appointment. Any issues that require onward referrals to Birth Reflections or Psychosexual counselling can be made at this time.
5. One-Stop Perineal Clinic appointment at 3-6 months postnatal. Anorectal manometry results are likely to be more accurate closer to 6 months as more time has been allowed for recovery of function, however some patients may warrant earlier review at 3 months, particularly if symptomatic.

Patients with complex second-degree tears or wound complications to be booked into perineal clinic at consultant discretion.

One-Stop Perineal Clinic

Joint clinic run by pelvic health physiotherapist, urogynaecologist or gynaecologist with special interest in perineal trauma. If a Pelvic Health Midwife is available, they may also form part of the clinical team delivering this service. One-stop assessment, investigation and management to include the following components:

1. Brief debrief regarding injury (by gynaecologist). If separate debrief regarding obstetric events is required refer to Birth reflections or Consultant Obstetrician involved.
2. Clinical assessment of pelvic floor symptoms (urinary, bowel, vaginal, sexual), vaginal and rectal examinations, assessment of pelvic floor muscle strength and function. We recommend the use of a patient reported outcome measure (PROM) as an adjunct to clinical assessment to provide baseline objective quantification of symptoms as well as facilitate disclosure of intimate symptoms¹⁰. All units are asked to use the Wexner score with additional PROMs as local arrangements and symptoms dictate.
3. Assessment of progress with pelvic floor muscle training by pelvic health physiotherapist using the Oxford Scale Classification and comparing outcome to baseline. Link to POGP Pelvic floor muscle exercises leaflet and the Squeezy app.
4. Offer patients endoanal ultrasound and anorectal manometry in order to provide further information on the extent of injury, healing, residual defects and to inform counselling for future pregnancies. If the patient is asymptomatic and her family is complete/she has already decided she would plan a caesarean section for future deliveries, there is no indication to perform anorectal studies. Performing anorectal studies on asymptomatic patients, in whom the results will not influence care, may increase health-related anxiety unnecessarily if a 'defect' is detected. Anorectal studies may be performed by the pelvic health physiotherapist and/or the gynaecologist, though it is the responsibility of the medical staff to provide supervision where required in terms of test interpretation and troubleshooting



5. Offer further treatment of pelvic floor dysfunction according to national guidance and arrange onward referral to Colorectal Services if ongoing faecal incontinence^{11,12}.

6. Counselling about mode of delivery in future pregnancy by gynaecologist:

Discuss the following information with the patient, taking into account her preferences, to make an individualised and informed plan for mode of delivery in a future pregnancy in line with RCOG and NICE guidance^{1,11};

-Current urgency or incontinence symptoms

-Extent of previous injury and success of the repair undertaken

-Psychological effect of the previous trauma

-Recurrence rate of OASI – 7.2% for women who have sustained OASI during first delivery vs 1.3% for women who did not.

-Risk of worsening anorectal symptoms

-Results of endoanal ultrasound and anorectal manometry (see appendix 2)

-Patient preferences

-Pros and cons of planned vaginal delivery (some of whom may require emergency caesarean section during labour) vs planned caesarean section (of whom about 1-5% may have a vaginal birth), in terms of recovery, surgical risks, implications for future pregnancies

-Importance of pelvic floor exercises in future pregnancies to reduce risk of worsening symptoms

NB The role of this clinic is to give the woman information about her recovery from OASI and an opinion on suggested mode of delivery in future pregnancies based on this. Mode of delivery would still be re-visited in future pregnancies via Consultant Obstetrician Antenatal Clinic. The anorectal studies are one factor in the shared-decision making process.

7. Ensure documentation from the clinic will be accessible to Midwifery/Obstetric team in future pregnancies as well as Urogynaecology/Colorectal teams for any further follow-up required. Send the patient and the GP a copy of the clinic letter.

Once established, we also aim to open the one-stop clinic up to antenatal appointments for those women who have a history of OASI and no formal delivery plan, or who wish to revisit the assessment and counselling offered in the one-stop clinic. It is important to note that following the pelvic health assessment and anorectal studies offered in this clinic, a proposed plan for mode of delivery may be suggested, however formal delivery plan will be finalised in antenatal clinic with the involvement of a Consultant Obstetrician.

Special considerations for a patient who has sustained a 4th degree tear



-You may wish to see this patient at 3 months postnatal in the One-Stop Clinic due to the higher risk of pelvic floor symptoms. As function may not have fully recovered by 3 months, it is reasonable to offer endoanal ultrasound/anorectal manometry at the 3 months appointment as well as repeat anorectal studies at 9-12 months postnatal.

-If the patient has had a colostomy, consider a modified proctogram 'porridge' test to assess anal continence, as well as endoanal ultrasound/anorectal manometry prior to colostomy reversal. This will be at the discretion of the Consultant Colorectal Surgeon involved, who will lead the postnatal care in this instance.

Recommendations for audit of one-stop perineal clinic

We recommend keeping a detailed database of patients attending the one-stop perineal clinic for audit and service evaluation purposes, as well as regular audit of the following parameters:

- Number of patients who have sustained OASI who are referred to pelvic health physiotherapy
- Number of patients who have sustained OASI who attend physiotherapy
- Number of patients who have sustained OASI who are referred to one-stop perineal clinic
- Number of patients who have sustained OASI who attend one-stop perineal clinic
- Number of patients attending one-stop perineal clinic who undergo anorectal studies
- Number of patients with isolated abnormal endoanal ultrasound
- Number of patients with isolated abnormal anorectal manometry
- Number of patients with abnormalities in both anorectal studies
- Number of patients referred to Colorectal services
- Feedback on patient satisfaction and experience of the service

We strongly recommend sharing of data and discussion of experience via the Northern Urogynaecology Forum. We also recommend keeping a record of patient outcomes following future pregnancies using the database, to facilitate data sharing and pooling via the Northern Urogynaecology Forum. Please see appendix 3 for the proposed data items to be recorded in the database.

Training provision for introduction to endoanal ultrasound and anorectal manometry to Perineal Clinic

Training requirements will vary according to prior experience, but there are a number of training opportunities available according to need:

- POCUS (through Absolute Physio) (mandatory for new practitioners)
- THD Course (machine-specific) (mandatory for new practitioners)



- NHS Lower GI Physiology module – available online
- POGP CPD module – currently in development as of May 2024
- Newcastle University Clinical Sciences MSC – Lower GI Physiology and Endoanal ultrasound – delivered by Salford Royal Hospital
- Anal Ultrasound Masterclass delivered by Croydon University Hospital
- Guy's and St Thomas' Pelvic Floor Disorders 3-day Course
- Mentorship (mandatory for new practitioners)
- THD Representative support

For those practitioners who are new to performing anorectal studies, we recommend attendance at the POCUS and THD Course, as well as completion of at least one of the CPD modules. We also recommend arranging mentorship with a clinician already trained in anorectal studies who is able to join you for the first few clinics until both you and your mentor feel you are ready for independent practice. The local THD Rep is also a valuable source of technical support and is happy to attend clinics.

The PPHS has budgeted to fund attendance at the POCUS course for the individuals put forward from each trust, as part of the pump-priming of the service.

References

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2. Jordan PA, Naidu M, Thakar R, Sultan A. Effect of subsequent vaginal delivery on bowel symptoms and anorectal function in women who sustained a previous obstetric anal sphincter injury. *Int Urogynecol J* 2018 Nov;29(11):1579-1588. doi 10.1007/s00192-018-3601-y
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5. Sangalli MR, Floris L, Faltin D, Weil A. Anal incontinence in women with third or fourth degree perineal tears and subsequent vaginal deliveries. *Aust N Z J Obstet Gynaecol*. 2000;40(3):244-8.
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10. Gray, T., Li, W., Campbell, P., Jha, S. & Radley, S. Evaluation of coital incontinence by electronic questionnaire: prevalence, associations and outcomes in women attending a urogynaecology clinic. *Int. Urogynecol J*. 2018 29:969–978. doi: 10.1007/s00192-017-3380-x.
11. National Institute for Health and Care Excellence (NICE). NICE Guideline [NG235]: Intrapartum care. September 2023. <https://www.nice.org.uk/guidance/ng235>



12. National Institute for Health and Care Excellence (NICE). NICE Guideline [CG49]: Faecal incontinence in adults: management. June 2007. <https://www.nice.org.uk/guidance/cg49>

Appendix 1 Badgernet documentation of OASI

Episiotomy, Tears and Perineal Trauma

Xxtest, Maternity (NHS: NOT RECORDED | Hospital Number: 2261334)
26 Oct 02 (Age at Birth: 20) | Queen Elizabeth Hospital, Gateshead, Tyne and Wear, NE9 6SX
G1 P1+0 | Baby 1 DOB: 18 Jan 23 at 13:52 (39+5) | No. of Babies: 1 | Booking BMI: 24.02 | Current BMI: 25.82 | Blood Group: A+ |
NHS Confidential: Patient Identifiable Data

Episiotomy, Tears and Perineal Trauma

Intact Perineum Yes No

Episiotomy Yes No Not Known

Tear 3rd Degree Tear(3a) - Less than 50% of EAS thickness torn ➔ Tear Definitions

Other Trauma to Vaginal Tract ▼

Illustrate Tear/Trauma No Image

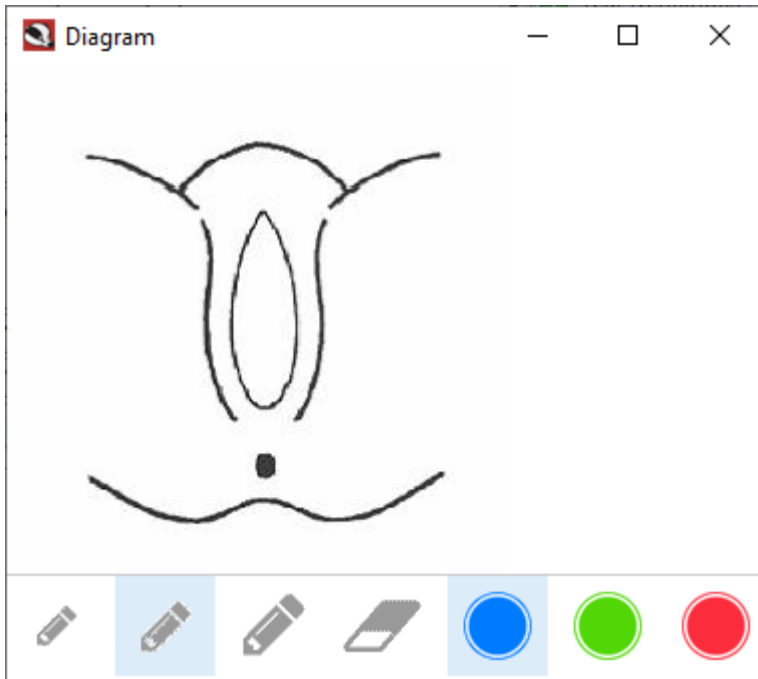
PR Examination Performed Yes No

PR Examination Details NAD

Repair Required Yes No Yes - Declined

Countersignature Required Yes No N/A

➔ Perineal Repair





Perineal Repair - This input form shows if Perineal Repair required = Yes (Labour and or Delivery)



Xxtest, Maternity (NHS: NOT RECORDED | Hospital Number: 2261334)

26 Oct 02 (Age at Birth: 20) | Queen Elizabeth Hospital, Gateshead, Tyne and Wear, NE9 6SX
G1 P1+0 | Baby 1 DOB: 18 Jan 23 at 13:52 (39+5) | No. of Babies: 1 | Booking BMI: 24.02 | Current BMI: 25.82 | Blood Group: A+ | PN 79wks, 5d | Current
NHS Confidential: Patient Identifiable Data

Perineal Repair

Discussed with Woman Yes No

Consent Obtained Yes No

Location Sutured

Type of Trauma Sutured

Analgesia and/or Anaesthesia For Perineal Repair

Catheterised Yes No

Indwelling in Situ Yes No

Tampon in Situ Yes No

Date and Time Suturing Commenced at

Same Suture Material Throughout? Yes No

Rectal Examination Before Suturing Yes No

Outcome of Rectal Examination

Vaginal Wall Sutured

Perineal Muscle Sutured

Perineal Skin Sutured

Labia Sutured

Sutured By

Use current user...

Suturing Supervised No Yes

Additional Perineal Repair Notes

Post Suturing

Swab and Needle Check

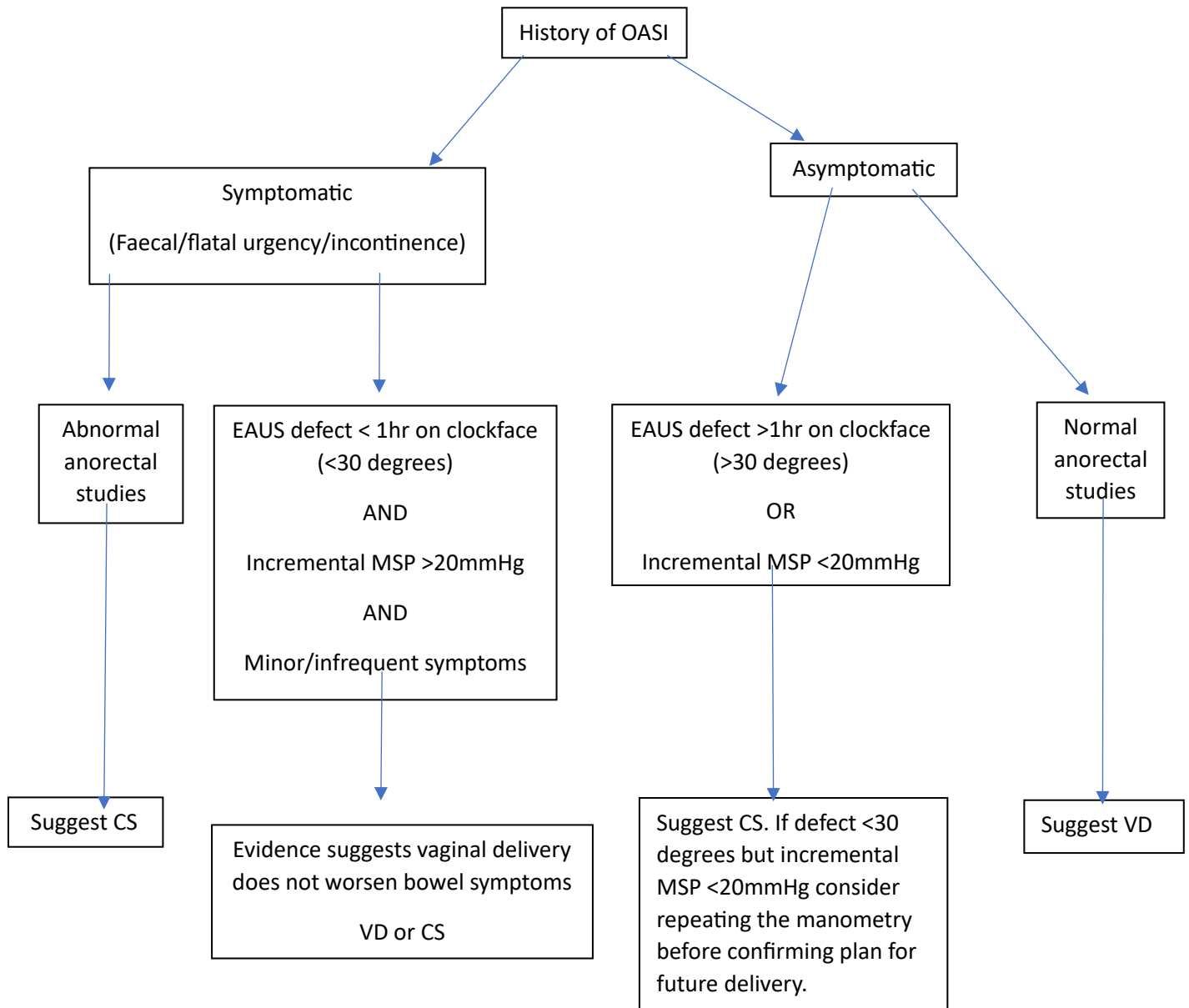
Vaginal Examination Following Repair Yes No

Rectal Examination following Repair Yes No

Rectal Exam Notes



Appendix 2 Mode of delivery counselling according to anorectal studies



NB: This flowchart provides a guide to mode of delivery according to anorectal studies only; all other factors listed in the guidance above should be considered in the shared decision-making process, including patient preference.

Abbreviations: OASI Obstetric anal sphincter injury

EAUS Endoanal ultrasound scan

MSP Maximum squeeze pressure

CS Caesarean section

VD Vaginal delivery

Appendix 3 Database for One Stop Perineal Clinic



Anonymised patient identifier

Age

Parity

Date of delivery

Grade of OASI

Week 2 physio teleconsult yes/no/DNA

Week 6 physio face-to-face appt yes/no/DNA

One stop clinic FU duration e.g. 3/12 postnatal, 6/12 postnatal

Flatal incontinence yes/no

Faecal incontinence yes/no – solid/liquid only/transient symptoms now resolved

Wexner score

EAUS result

- Defect < 30 degrees
- Defect > 30 degrees
- No evidence of injury

ARM – incremental squeeze pressure > 20mmHg/squeeze pressure > 20mmHg

- Actual incremental squeeze pressure

Decision for future mode of delivery - planned vaginal delivery/elective caesarean section/undecided/family complete

Onward referral to Colorectal team yes/no

Additional comments

Future pregnancy outcome

Future delivery date

Future mode of delivery normal vaginal delivery/ventouse/forceps/caesarean section

Recurrent OASI yes/no If yes grade of OASI 3a/3b/3c/4th

Worsening of bowel symptoms post delivery yes/no

One stop clinic FU duration e.g. 3/12 postnatal, 6/12 postnatal

Flatal incontinence yes/no

Faecal incontinence yes/no – solid/liquid only/transient symptoms now resolved

Wexner score



EAUS result

- Defect < 30 degrees
- Defect > 30 degrees
- No evidence of injury

ARM – incremental squeeze pressure > 20mmHg/squeeze pressure > 20mmHg

- Actual incremental squeeze pressure

Decision for future mode of delivery - planned vaginal delivery/elective caesarean section/undecided/family complete

Onward referral to Colorectal team yes/no

Additional comments