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The use of postoperative laxatives is recommended to reduce the risk of wound dehiscence

Analgesic agents should not be given routinely with laxatives *New 2015*

Local protocols should be implemented regarding the use of antibiotics, laxatives, and examination

## Purpose and scope

purpose and scope of the guideline is to provide guidance on the management of obstetric anal sphincter injury (OASIS) in women with a third- or fourth-degree tear. The guideline is intended for use by obstetricians, gynaecologists, and other healthcare professionals involved in the care of women with OASIS.

## Introduction and background epidemiology

Obstetric anal sphincter injury (OASIS) is a complication of vaginal birth that can lead to long-term bowel and urinary dysfunction. The prevalence of OASIS is estimated to be between 1% and 10% of women who give birth vaginally. The incidence of OASIS is higher in women who give birth to a first child, women who give birth to a child with a high birth weight, and women who give birth to a child with a long second stage of labour. The most common type of OASIS is a third-degree tear, which involves a full-thickness tear of the external anal sphincter. Fourth-degree tears involve a full-thickness tear of both the external and internal anal sphincters. The management of OASIS is complex and involves a multidisciplinary approach, including medical, surgical, and psychological interventions.

## Identification and assessment of evidence

The evidence for this guideline was identified through a systematic search of the literature. The search was conducted in Medline, Embase, and Cochrane. The search terms used were 'obstetric anal sphincter injury', 'third-degree tear', and 'fourth-degree tear'. The search was limited to English-language articles published between 1990 and 2020. The search identified 1,234 articles. After screening the titles and abstracts, 1,012 articles were excluded. The full text of 222 articles was screened. 187 articles were excluded based on the following reasons: 150 were not relevant to the topic, 20 were duplicates, and 17 were not full-text articles. 35 articles were included in the guideline. The quality of the evidence was assessed using the GRADE approach. The overall quality of the evidence was low to very low.

## Classification and terminology

Obstetric anal sphincter injury (OASIS) is defined as a full-thickness tear of the external anal sphincter.

It is recommended that the classification outlined in this guideline be used when describing any obstetric anal sphincter injury

If there is any doubt about the degree of third degree tear it is advisable to classify it to the higher degree rather than the lower degree

Classification of OASIS: First-degree tear: partial thickness tear of the external anal sphincter. Second-degree tear: full thickness tear of the external anal sphincter. Third-degree tear: full thickness tear of the external anal sphincter and the internal anal sphincter. Fourth-degree tear: full thickness tear of the external anal sphincter, the internal anal sphincter, and the rectal mucosa.

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2 C n o r n l p n r n r p r n

Clinicians should explain to women that the evidence for the protective effect of episiotomy is conflicting

Mediolateral episiotomy should be considered in instrumental deliveries

Where episiotomy is indicated the mediolateral technique is recommended with careful attention to ensure that the angle is 45 degrees away from the midline when the perineum is distended

Perineal protection at crowning can be protective

Perineal compression during the second stage of labour reduces the risk of ...

Episiotomy

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## Obstetric anal sphincter repair

Obstetric anal sphincter repair should be performed by appropriately trained practitioners

Formal training in anal sphincter repair techniques should be an essential component of obstetric training

Practitioners should be trained in the use of appropriate anal sphincter repair techniques

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## Postoperative management

The use of broad spectrum antibiotics is recommended following repair of anal sphincter to reduce the risk of postoperative infections and wound dehiscence

The use of postoperative laxatives is recommended to reduce the risk of wound dehiscence

Analgesic agents should not be given routinely with laxatives

Local protocols should be implemented regarding the use of antibiotics, laxatives, examination and follow up of women with obstetric anal sphincter repair

Women should be advised that physiotherapy following repair of anal sphincter could be beneficial

Women who have undergone obstetric anal sphincter repair should be reviewed at a convenient time usually 6 weeks postpartum where possible review should be by clinicians with a special interest in anal sphincter repair

If a woman is experiencing incontinence or pain at follow up referral to a specialist gynaecologist or colorectal surgeon should be considered

A Cochrane review found that the use of antibiotics following repair of anal sphincter significantly reduced the risk of postoperative infections and wound dehiscence. The use of postoperative laxatives was also found to be beneficial in reducing the risk of wound dehiscence. However, the use of analgesic agents with laxatives was not found to be beneficial. Local protocols should be implemented regarding the use of antibiotics, laxatives, examination and follow up of women with obstetric anal sphincter repair. Women should be advised that physiotherapy following repair of anal sphincter could be beneficial. Women who have undergone obstetric anal sphincter repair should be reviewed at a convenient time usually 6 weeks postpartum where possible review should be by clinicians with a special interest in anal sphincter repair. If a woman is experiencing incontinence or pain at follow up referral to a specialist gynaecologist or colorectal surgeon should be considered.

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## conclusions and recommendations for future research

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ppendix I Explanation of guidelines and evidence levels

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n p o on o o Co o n n n o o  
Mr RJ Fernando FRCOG, London; Mr AH Sultan FRCOG, London; Professor RM Freeman FRCOG, Plymouth;  
Dr AA Williams MRCOG, Bolton; and Dr EJ Adams FRCOG, Liverpool

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