



Commentary

Severe perineal trauma is rising, but let us not overreact



Hannah G. Dahlen, RN, RM, BN (Hons), Grad Cert Mid (Pharm) MCommN, PhD, FACM (Professor of Midwifery)*, Holly Priddis, BM, BN (Hons) (PhD Candidate), Charlene Thornton, BN, Grad Dip Mid, MSc Med (Res), MSc Med (Clin Epi), PhD (Post doctoral Fellow)

School of Nursing and Midwifery, University of Western Sydney, Locked Bag 1797, Penrith 2751, NSW, Australia

Introduction

Severe perineal trauma (SPT)¹ experienced during childbirth is a serious morbidity for women, impacting on short and long-term physical and psychological wellbeing (Signorello et al., 2001; Macarthur and Macarthur, 2004; Priddis et al., 2013; H. Priddis et al., 2014). SPT is defined as a third degree tear, which involves injury to the perineum involving the anal sphincter complex; or a fourth degree tear, which involves injury to the perineum involving the external, internal and epithelium of the anal sphincter (Royal College Obstetricians and Gynaecologists, 2007). It does appear that severe perineal trauma is rising in several developing nations; including Australia (Kettle and Tohill, 2008; Baghestan et al., 2012; Dahlen et al., 2013) (Fig. 1) and this should be a concern to health practitioners. It is important that thoughtful, appropriate and co-ordinated multidisciplinary action is taken and that this action is based on high level evidence, and most importantly is acceptable to women. Overreacting, or reacting without a full understanding of the problem at hand should never be acceptable in today's enlightened, evidence based health care environment. Consideration of possible unintended consequences and acceptability to women is most important when making major changes in clinical practice.

Risk factors for SPT

There are several risk factors for SPT identified in the literature and these are often divided into antenatal and intrapartum risk factors. Antenatal risk factors associated with an increased incidence of SPT include primiparity, maternal age (very young and older), ethnicity (Asian), nutritional status, previous experience of SPT, larger fetal weight, abnormal collagen synthesis, shorter

perineal bodies and possibly male sex (Rizk and Thomas, 2000; Deering, et al., 2004; Kettle and Tohill, 2008; Dahlen and Homer, 2008; Dahlen et al., 2013; Priddis et al., 2013; Dahlen, 2014). Intrapartum risk factors include fetal presentation and position (in particular occipito-posterior positions), episiotomy (especially midline episiotomy), instrumental birth (especially forceps delivery), a prolonged second stage of labour, the birth position adopted by the woman during second stage, and an obstetric emergency such as a shoulder dystocia (Robinson et al., 1999; Signorello et al., 2000; Kudish et al., 2006; Gottvall et al., 2007; O'Mahony et al., 2010; Dahlen and Priddis et al., 2013; Dahlen, 2014). Forceps delivery in particular appears to bring with it the greatest risk of SPT, with extensions to episiotomy being a major contributor (Fig. 2).

The Norwegian retrospective cohort study impacting practice

In 2012 Laine et al. (2012) published the findings of a retrospective cohort study that compared the incidence of SPT (referred to by the authors as OASIS) in a university hospital in Norway, over two separate time periods: 2003–2005 and 2008–2010, prior to, and following, the implementation of a perineal protection programme (Laine et al., 2012). The training programme consisted of four main features:

1. Good communication between the accoucheur and the delivering woman.
2. Adequate perineal support.
3. A delivery position that allows visualisation of the perineum during the last minutes of delivery.
4. Episiotomy only on indication (avoiding medial episiotomies due to related increased risks of severe perineal trauma).

The incidence of SPT was examined over two separate time periods. Secondary measures involved an analysis of pre-determined maternal and fetal risk factors for SPT, including shoulder dystocia, instrumental birth, prolonged second stage, epidural anaesthesia and occiput posterior (OP) presentation. The authors reported a significant reduction in the incidence of OASIS over the two time periods following the introduction of the

* Corresponding author.

E-mail addresses: h.dahlen@uws.edu.au (H.G. Dahlen), h.priddis@uws.edu.au (H. Priddis), c.thornton@uws.edu.au (C. Thornton).

¹ We use the term severe perineal trauma (SPT) instead of the commonly used term OASIS as it is more respectful to women who have experienced this morbidity. There is nothing that remotely resembles an OASIS about SPT and women who have experienced SPT find the term offensive (Priddis, in press).

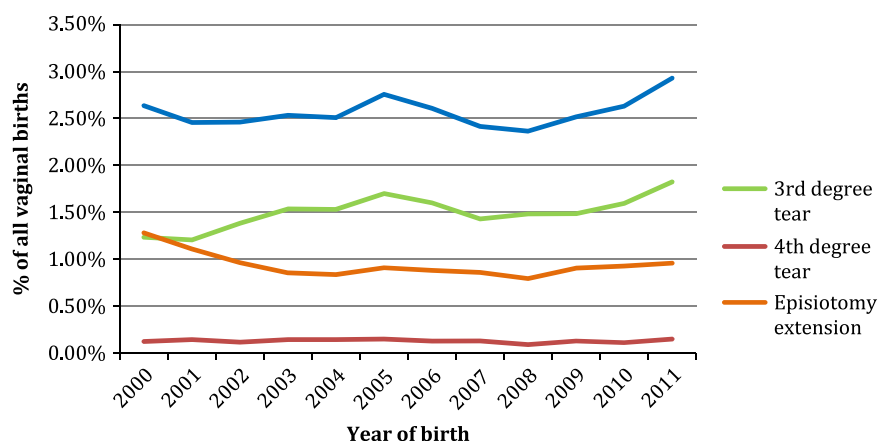


Fig. 1. Severe perineal trauma specified by type as a % of all vaginal births (NSW 2000–2011).

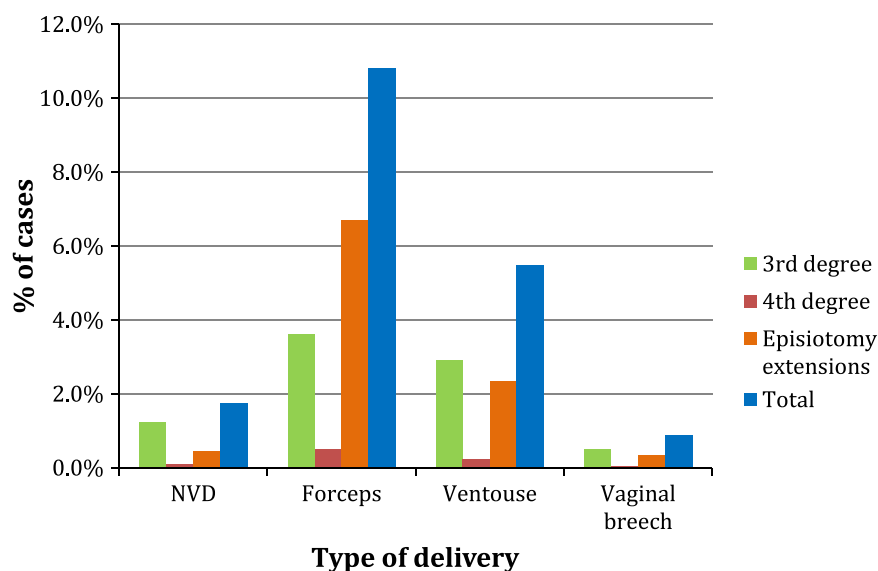


Fig. 2. Severe perineal trauma with mode of birth expressed as a % of type of all vaginal births (NSW 2000–2011).

perineal protection training programme (4% in 2003–2005 versus 1.9% in 2008–2010).

Following the release of this study there was great enthusiasm in the obstetric community to take up the training programme (personal communication). Some obstetricians and midwives felt that the rise in SPT was to do with changes in clinical practice, such as moves to a more ‘hands poised’ technique during the birth and the increase in alternative birth positions. Enthusiastic support for implementing the training protocol has spread beyond Norway to several other countries including Australia. Professional bodies and health departments have expressed concern and asked for action and SPT guidelines to be developed (personal communication). So, is this a problem? Let us examine the components of the Laine package of care alongside Level 1 evidence. Let us also look at what else may be going on with changes in SPT rates in recent years.

Good communication

Good communication between the accoucheur and woman giving birth should be central to maternity care. This can become complicated when the language spoken by the health provider and woman is different. In a prospective cohort study undertaken by the first author in Australia we asked midwives to complete a form following every woman who experienced SPT for two years in two

hospitals, documenting some of the factors at the birth they thought contributed to the trauma (Dahlen et al. 2007). Midwives reported poor communication as a significant contributing factor in their opinion. This included being unable to communicate with the woman during the birth and also the birth attendant being unprepared for the birth (Dahlen et al., 2007). In discussion groups that followed the study, midwives felt communication was one of the most important things in minimising perineal trauma. An example of this was telling the woman to breathe as the baby’s head was born. The woman may not understand the midwife and push expulsively, leading to a less controlled birth. SPT rates vary for women born in countries other than Australia where English is often a second language (Dahlen et al., 2007; Dahlen et al., 2013). While communication may be a factor in these rates, other factors are probably also at play. Relationship based care, support and the appropriate use of interpreters and culturally appropriate support workers are important in enhancing communication with women who are giving birth.

Adequate perineal support

When considering risk factors for SPT both midwives and obstetricians have questioned whether or not perineal support leads to better outcomes. This may include hands on or hands off/ poised and perineal techniques such as the ‘perineal pinch’ or

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