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Margie Polden Memorial Lecture: Bridging the gap between obstetric and colorectal services for obstetric anal sphincter injuries

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Abstract

Obstetric anal sphincter injuries (OASIS) associated with vaginal deliveries are the main cause of faecal incontinence (FI) in women. There has been a three-fold increase in OASIS in the past decade, and there is a higher incidence in first-time mothers. While it is possible that these injuries are becoming more common, it is more likely that detection is improving. Faecal incontinence has a two-stage presentation: although some women develop symptoms shortly after birth, most present during or after the menopause. Despite a range of effective therapeutic options, most people with FI do not seek care, and those who do often delay seeking treatment. Women should be reviewed in a perineal trauma clinic following the birth, and those who still have ongoing symptoms should have an endoanal ultrasound before being referred to relevant services. Physiotherapists are core members of the pelvic floor team, and it is vital that they receive FI training and education in order to improve the screening and management of this condition.

Keywords: colorectal surgery, faecal incontinence, multidisciplinary team, obstetric anal sphincter injuries, obstetric services.

Introduction

There has been a significant increase in awareness of the physical and psychological consequences of giving birth and women's pelvic health in the past 12 months. This is partly because of the controversy over mesh surgery for urinary incontinence (UI) that has been highlighted in the media, and partly because of campaigns launched by groups such as the Birth Trauma Association (www.birthtraumaassociation.org.uk), the National Childbirth Trust (www.nct.org.uk) and Mumsnet (www.mumsnet.com).

There has been a three-fold increase in obstetric anal sphincter injuries (OASIS) in the past decade (Thiagamoorthy *et al.* 2014). While the overall incidence is 3.7%, the frequency of OASIS is higher in primiparas, and has been reported to be 6.1% (NMPA Project Team 2017). Although it is possible that these injuries are

becoming more common, it is more likely that detection is improving; either way, the consequences are under-recognized. One in 10 women who experience difficulty controlling their bowels present with the signs and symptoms of faecal incontinence (FI), and childbirth and OASIS are significant risk factors (Sultan *et al.* 1994). Faecal incontinence has a two-stage presentation: although some women develop symptoms shortly after giving birth, most present during or after the menopause.

Despite a range of effective treatment options, most people with FI do not seek care, and those who do often delay accessing treatment. While as many as 50% of women with UI seek care (Brown *et al.* 2017), the estimated global rates for FI are lower, ranging from 10% to 30% (Johanson & Lafferty 1996; Bharucha *et al.* 2005; Brown *et al.* 2017; Muñoz-Yagüe *et al.* 2014). An e-mail survey of postnatal care involving 1224 women that was conducted by the Mumsnet website highlighted similar issues in the UK (Mumsnet 2016). One-third of the participants who had sustained a third- or fourth-degree perineal tear believed

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Table 1. Barriers to accessing treatment for faecal incontinence

Type of barrier	Themes identified from the literature
Patient and clinical	The normalization of the problem by healthcare professionals, and or friends and family (e.g. “It’s normal!” or “What do you expect? You’ve had a baby!”)
Patient	Not knowing the right questions to ask
Patient	Feeling too embarrassed
Clinical	Lack of a clear pathway
Clinical	Lack of specialist expertise
Clinical	Lack of availability of services

that they had received inadequate advice, 42% reported that they were incontinent 3 months after birth, and 70% of the latter group did not seek help for this problem.

What causes the delays in patient presentation?

There is a delay between the onset of symptoms and seeking help that averages 2–5 years for women and 3–7 years for men (Davis *et al.* 2010; Brown *et al.* 2017). However, there have only been a small number of studies investigating the barriers to obtaining treatment that are encountered by women with FI (Wilson 2007; Rasmussen & Ringsberg 2010; Tucker *et al.* 2014; Olsson & Berterö 2015; Keighley *et al.* 2016; Helewa *et al.* 2017). In her foreword, Professor Christine Norton acknowledged the limited evidence available in the National Institute for Health and Clinical Excellence (NICE, now National Institute for Health and Care Excellence) guidelines (NICE 2007), particularly highlighting the lack of patients’ perspectives on the outcomes that they consider to be important. The barriers to accessing treatment for FI are presented in Table 1.

How do healthcare professionals influence the screening and diagnosis of faecal incontinence?

Clinicians working in primary care and women’s health units appear to be biased towards screening for UI rather than FI (Brown *et al.* 2018). This may stem from the natural pathway from obstetrics to urogynaecology, and the placement of women’s health physiotherapy within obstetrics and gynaecology. Many women’s health units in the UK do not have a named colorectal surgeon or colorectal pelvic floor nurse to work with, which can create barriers for referral, and a reduction in awareness and knowledge of the patient pathway. In a survey of local general practitioners, the present author found that

two-thirds had not had any training in FI, and 72% felt that they had not been sufficiently informed about the condition (Cornish 2018).

A lack of training and low confidence in managing a health condition has a direct impact on the care that is provided to patients, and also on the likelihood of them being screened for the condition. A survey of primary care providers in the USA found that screening rates for UI (75%) were much higher than for FI (35%). Healthcare professionals were twice as likely to screen for and felt better informed about managing UI than FI (Brown *et al.* 2018). In Spain, the Grup Incontinencia Fecal Terrassa (GIFT, Spanish for “Terrassa Faecal Incontinence Group”) developed an educational workshop for healthcare professionals on FI, and monitored the reported incidence of the condition before and after the intervention (Ribas *et al.* 2017). The GIFT project demonstrated an increase in the incidence of FI diagnosed in primary care, and also a reduction in treatment delays experienced by patients who had been identified as symptomatic. This finding has been reiterated by Brown *et al.* (2018), who found that those professionals who believe that they are sufficiently well informed to treat FI are more likely to screen for the condition. This suggests that interventions that are intended to improve healthcare professionals’ confidence in treating FI may also improve screening rates.

Improving education and awareness amongst professionals

The MASIC (Mothers with Anal Sphincter Injury in Childbirth) Foundation was launched in March 2017 by Professor Michael Keighley. Its aims were to improve awareness about and management of FI after OASIS, and also to reduce the incidence of these injuries (see also pp. 20–21). The MASIC Foundation has already run a number of educational workshops, and is now helping women to set up local support groups (www.masic.org.uk).

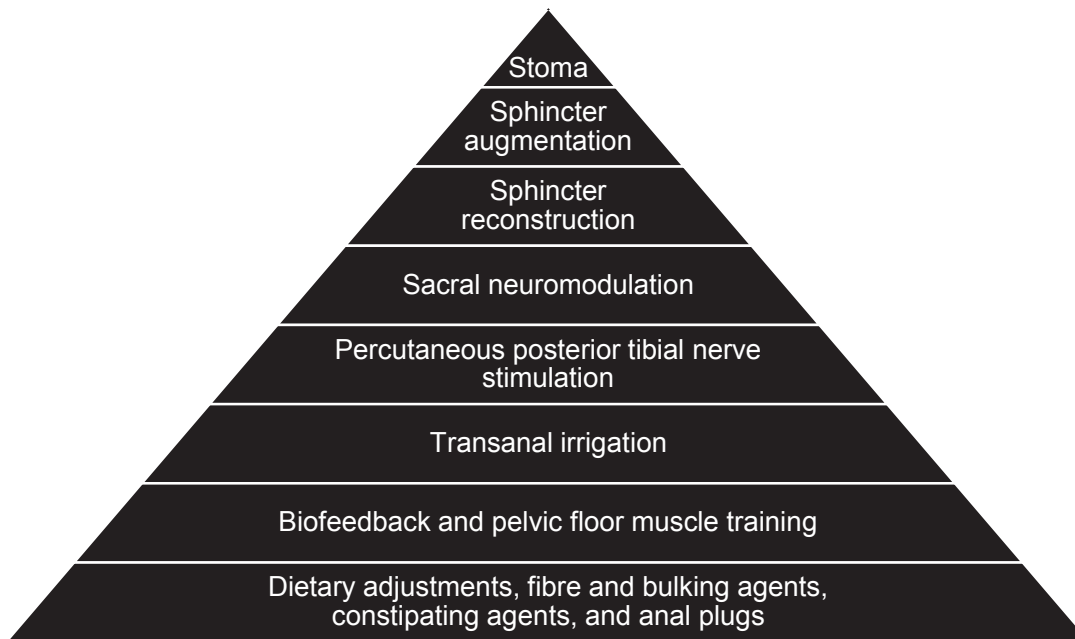


Figure 1. Faecal incontinence treatment pyramid.

The Pelvic Floor Society (www.thepelvicfloor.society.co.uk) is the association that colorectal surgeons are encouraged to join if they have an interest in pelvic floor dysfunction. It provides education and training, and sets standards of service. Physiotherapists are also encouraged to join, and membership is free if you are already a member of POGP since the organization is aware of the importance of the multidisciplinary team (MDT).

What are the treatment options for faecal incontinence?

Approximately 50–80% of patients with FI will be successfully managed with conservative treatment (Duelund-Jakobsen *et al.* 2015). Two guidelines provide clear and comprehensive information about the commissioning and management of FI (NICE 2007; ACGBI 2017). Figure 1 illustrates the treatment options that are available for individuals with FI.

What if conservative treatment options fail?

The pelvic floor MDT meeting is a forum where management options can be discussed. Any relevant investigations and radiology images should be presented, and a management plan formulated that can be discussed with the patient. The surgeon should talk about: (1) the surgical and non-surgical options that are appropriate for each patient's individual circumstances; (2) the risks and benefits of each procedure; and (3)

having realistic expectations of the effectiveness of any treatment offered, including the long-term outcomes.

Possible surgical treatments include:

- secondary sphincter repair;
- sacral neuromodulation;
- injectable biomaterials; and
- colostomy.

Secondary sphincter repair is an option for selected patients who have a sphincter defect of at least 90°. In a review of the long-term results of anal sphincter repair for FI, Glasgow & Lowry (2012) reported that, while this was initially successful, function was not maintained in the long term. The study with the longest follow-up suggested that only 6% of women had good or excellent continence 10 years later (Bravo Gutierrez *et al.* 2004).

Sacral neuromodulation (also known as sacral nerve stimulation) was first introduced as a treatment for incontinence in 1995. In this procedure, an electrode is inserted, typically in the S3 foramen, to provide low-amplitude electrical current via a battery-operated stimulator. The NICE guidelines suggest that a trial of sacral neuromodulation should be offered to those patients for whom a secondary sphincter repair is inappropriate (NICE 2007). If a pilot of at least 2 weeks demonstrates a successful outcome, then a permanent procedure can be offered. The success rates reported in the literature vary from 60% to 80% (Jarrett *et al.* 2005). However, few authors have published long-term outcomes, and

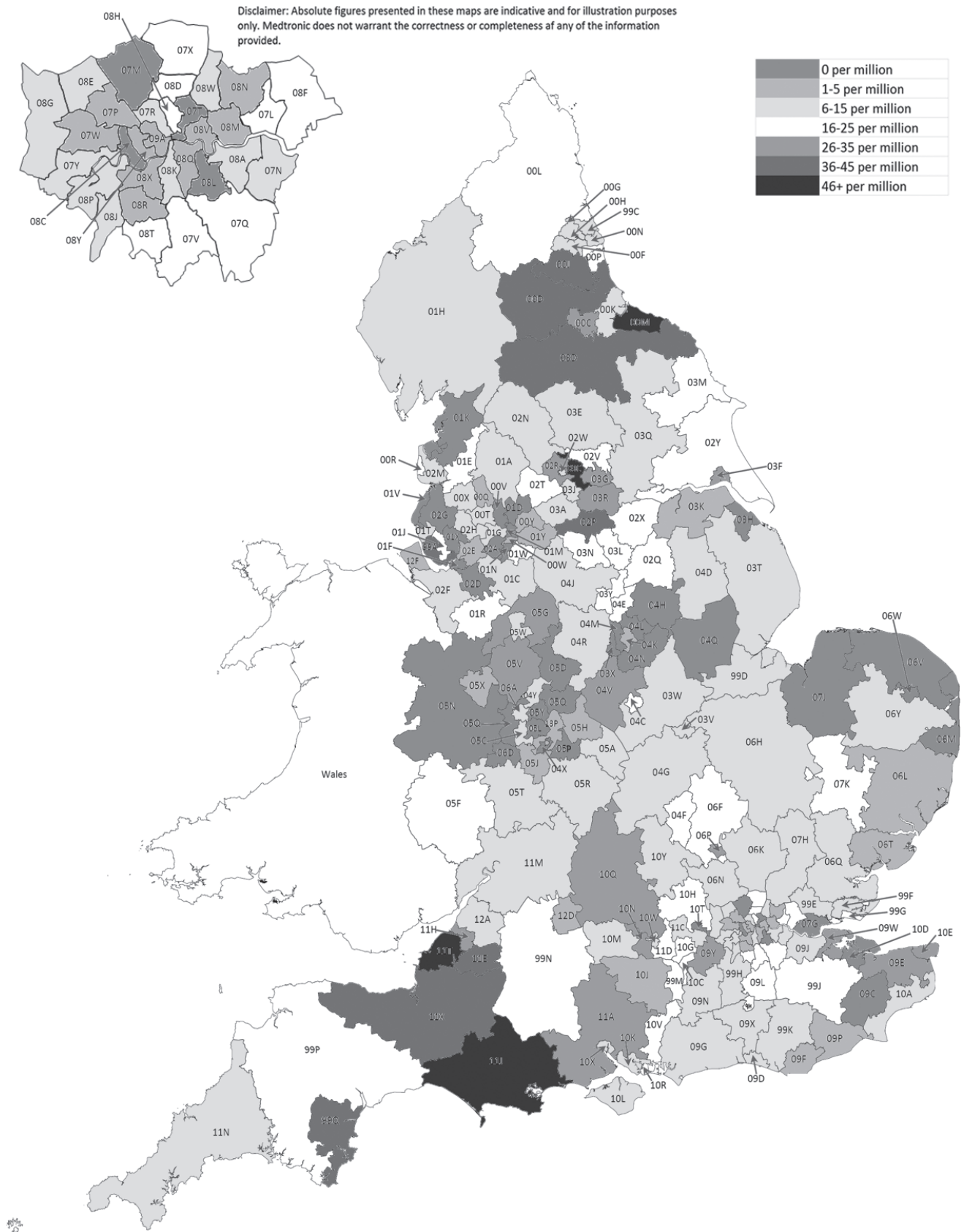


Figure 2. Levels of access to sacral neuromodulation across England and Wales in 2016 (data supplied by Medtronic plc, Dublin, Ireland).

those that have done so have suggested that there is some deterioration after 10 years (Thaha *et al.* 2015). Access to sacral neuromodulation varies

across the UK (Fig. 2), with Wales being the only devolved country that does not have a commissioned service for this form of therapy.

Bridging the gap between obstetric and colorectal services

The Royal College of Obstetrics and Gynaecology (RCOG) has produced clear guidelines for women who have sustained third- or fourth-degree OASIS (RCOG 2015). Such patients should be reviewed in a perineal trauma clinic following the birth, and those who still have ongoing symptoms should have an endoanal ultrasound (EAUS) before being referred to relevant services (e.g. colorectal surgery and continence services). There is some variation in the provision of these services across the UK, and it is important for each department to have a defined clinical lead in perineal trauma and named colorectal leads to aid pathway progression (Webb *et al.* 2014).

All women who have sustained OASIS in a previous pregnancy, and who are symptomatic, or have abnormal EAUS and/or manometry, should be given the option of an elective Caesarean birth.

Both of the above statements require the routine use of EAUS, but the RCOG recognizes that “there are current limitations in availability, image quality, interpretation skills and patient acceptability” (RCOG 2015, p. 9). However, recent advances in EAUS and manometry mean that portable devices that may be able to overcome some of these barriers are now available. There are increasing opportunities to develop a role for clinicians who employ these devices in their practice. For physiotherapists who would like to use ultrasound scanning as one of their assessment and treatment techniques, several universities offer postgraduate certificates and diplomas, or Master’s modules in obstetric, gynaecological and/or abdominal scanning. Formal mentorship programmes add to these opportunities by ensuring the quality of the assessments. Further information is available on the website of The Pelvic Floor Society (PFS 2017).

The future

The next few years will be a significant opportunity for all pelvic health professionals. It is important that the professions work together to develop a pelvic health team because it apparent that there is no “one size fits all” treatment for patients with FI. Physiotherapists are core members of the pelvic floor team, but there is a disparity between the number required and those available.

It is vital that physiotherapists working in pelvic health services are given FI training and

education to improve the screening and management of this condition. If you do not currently work with a colorectal team, consider this an opportunity to build bridges within your service: you can have a positive impact on patient outcomes for those who suffer from this stigmatizing and disabling condition.

Conflicts of interest

None.

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