

Tear repairs: an educational initiative broadened

An interview with Dr Jackie Smalldridge

The recent RANZCOG Annual Scientific Meeting in Auckland, New Zealand included six sessions that had Practice Review and Clinical Risk Management (PR&CRM) activities associated with them. Over 150 Fellows in total attended these sessions, completed the practice review activities and were subsequently allocated points in this category.

One of these sessions was based on third and fourth degree tear repairs. Dr Jackie Smalldridge, a Fellow of the College who is an in hospital clinical assessor for the colposcopy module, with a special interest in urogynaecology, developed, organised and conducted this workshop.

The workshop was held on the on the first day of the ASM at the Surgical Skills Training Centre, which is part of the Department of Surgery, Faculty of Medical and Health Services at the University of Auckland. Dr Smalldridge had run this type of workshop before but only for registrars. 'We started trying to improve our detection of [perineal tears] by training up the midwives and doctors to recognise them better, but in parallel with that, we started running workshops for the registrars on how to do third and fourth degree tears because they had only ever learnt informally from a consultant if they had to be there to do a repair. They had never been formally trained in it, so we set up the training program.'

THE NATURE OF TEARS

Up to one in four primiparous women suffer from altered faecal continence following



labour and about one in three demonstrate evidence of anal sphincter injury after vaginal delivery. Up to 50 per cent of women with third or fourth degree perineal tears during childbirth suffer from faecal incontinence. The most important aspect of managing third and fourth degree tears, Dr Smalldridge admits, is recognising them in the first place. 'I think that if people think about what changes they can make, they can educate the midwives or doctors or whoever they work with to examine their patients properly after delivery and not to miss them. That will possibly have the biggest impact, recognising it.'

Patients presenting with faecal incontinence proved to be a catalyst into the initial audit of third and fourth degree tears at Middlemore Hospital, instigated by Dr Smalldridge. 'Back in 1998, I got one of the registrars in the hospital to do an audit

of patients having third degree tears because that is thought to be a strong indicator for later faecal incontinence. When she looked back, it became apparent that most of the repairs were getting done in a variety of different ways, for example, incorrect suture material, incorrect anaesthetic, not good follow up at all. That prompted us to do an evidence-based literature review and decided on a protocol for managing third degree tears. We did a prospective audit of that and found that our rates in the unit of third and fourth degree tears was really low. We thought "Well, either we are fantastic obstetricians or we are missing lots.'

AN EDUCATIONAL INITIATIVE BROADENED

The two initial registrar workshops that were held during the year prior to the ASM

received such positive feedback that this prompted Dr Smallldridge to incorporate one into the ASM program. With the workshop being a mixture of theory and 'hands on' exercises, registrars had the opportunity to practice their skills. 'They were hungry for knowledge and they enjoyed the hands on with the modified pig sphincters, which we used. We have been using male and female pig anal sphincters, which is a bit more realistic than working on a model. We got good feedback from them and we have modified the theory presentation a little bit for the ASM.'

The ASM workshop was limited to 12 participants due to the nature of the session and ran for three hours. The program included an initial theory component consisting of some key speakers who provided clinical knowledge and refresher information on anatomy and physiology along with investigations of faecal incontinence. 'Mr Andrew Connelly, our colorectal surgeon, did a couple of presentations about physiology and the management of faecal incontinence and then my colleague Jyoti Kathuria did a talk on what to do if someone has had a tear, for example, what should be their subsequent obstetric management, which is always a



tricky question.'

Dr Kathuria's presentation was a valuable update on current research and trends in the repair of perineal repairs. 'It is good to review the literature and give people a sense of what is the correct thing to say to patients at the moment as it is changing all the time with more research being done. However, Jyoti very succinctly summarised the literature so it made it quite easy to determine what should be done in subsequent pregnancies, following a repair.'

During the theory session there were also some videos shown which demonstrated

repairs and techniques. This brought the participants up to speed for the next session which was the practical skills element. Dr Smallldridge explained that participants started practising on 'a latex purpose-built model of an anal sphincter with the anatomy completely correct'. Participants were required to repair the tears with the appropriate suture material. It was after this initial procedure that they used the modified pig sphincters.

Dr Smallldridge clarifies why the mixture of theory and practical exercises is so important. 'On a whole, the balance of the background theory and the "hands on" elements was right. It is important to have the background theory first. It would not work if it was all practical. The practical side of things proved extremely popular, because it is not often that you get a chance to do that. It was also very informal which helped. Most people found it quite fun. We got a few suggestions on how we could improve it but overall people found it a very worthwhile experience.'

POSITIVE PRAISE FROM A WIDER AUDIENCE

Feedback is always an important part of



any information session, and this was no exception for the perineal tear repair workshop. The informal atmosphere allowed open discussion and plenty of opportunity for questions as the session progressed. The ASM workshop was shown to provide a diversity of views, reflective of the backgrounds of the participants. 'We always have interesting discussions, the participants have always got different questions from different perspectives that sometimes you haven't thought of beforehand. You know rural Australian specialists differ from New Zealand registrars, so there were a few interesting questions that came up.'

One of those provincial Australian specialists was Dr Paul Howat, a Fellow from Mooroolbool in Queensland. He described the workshop as being 'well-researched, well thought out and well presented' and would love to see similar workshops held for Provincial Fellows. 'It was by far the most useful event at the ASM', he stated.

Another measure of the success of this method of learning was with the practice review element, which consisted of a questionnaire completed by participants prior to undertaking the workshop and then completing the same questionnaire at the conclusion of the session. Sixty-seven per cent of participants improved in their post workshop knowledge of third and fourth degree tears, with the average improvement being 20 per cent. The results of this was fed back individually to participants along with the overall results for the entire workshop group and the correct answers.

Due to the success of the workshops, Dr Smallldridge is keen to run more and is hoping to have the session as a continuing educational initiative. Two are planned for 2004. Initially, the workshops were planned for registrars, but following the success of the

ASM workshop, Dr Smallldridge is keen to open them up to the wider Fellowship. 'We have had a lot of feedback from people at the conference who heard about the workshop and were quite keen to participate next time. We could do the questions pre- and post- again and have an ongoing program of workshops. And hopefully people who have done the course can do a prospective audit and get some more CME points.'

Dr Smallldridge does not envisage any problem in replicating the workshops, as long as there is access to the materials required and the location is suitable. 'Luckily for us, we have an excellent surgical skills training centre, so Jan Gardener [administrator of the Surgical Skills Training Centre] and Liv Weekly who run it are experts in finding the right materials and organising the venue,



so in fact, it was, apart from finding the pig sphincters and modifying them a bit, it was fairly straight forward. In other bigger centres where there are surgical skills training centres, it could be easy to reproduce.'

FUTURE DIRECTIONS

So what has happened as a result of the initial audit that was performed at Middlemore in 1998? The audit results led to the instigation of a management protocol and the development and running of Dr Smallldridge's management workshops. 'We

are actually in the middle of another audit now. We have instituted this program of every obstetric tear being checked by a senior midwife, or registrar or consultant. We are in the middle of reviewing the results of that because it appears that our pick up rate for major perineal traumas increased dramatically and I am going to present that at the New Zealand Continence meeting later this year.'

Dr Smallldridge recognises that the management plan for perineal repairs goes beyond just the recognition of the situation and involves updated education and training for clinicians to ensure appropriate care and successful patient outcomes. 'Apart from using the right suture materials and repairing the way they should, the crucial point was that patients need to be followed up. That was an important learning point that people took home. The feedback that we got from them was overwhelmingly positive.'

As a result, patient care in third and fourth degree tears has been highlighted as an ongoing issue of concern and is being recognised and treated in a manner reflective of the serious nature of the injuries themselves. 'I think there has been a huge improvement in the number of women that are being detected and then they are getting the right operation in the right conditions, and then are getting followed up. I am following them all up in my urogynaecology clinic. So I think that it has completely transformed the management of tears just because of the change in awareness really.'

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Reference:

1. Clinical Practice Guidelines: Management of Third and Fourth Degree Tears. Royal Women's Hospital, Carlton, Victoria.

RVF Support Network Inc

An interview with Wendy Powell

Wendy Powell has been a long-term sufferer of a recto-vaginal fistula (RVF), which occurred during the birth of her first son in 1997. As with most serious perineal tears, the shock and impact that this injury caused to both Wendy and her family resulted in ongoing suffering in a variety of emotional, physical and social aspects of her life. 'It destroys social interaction, it is embarrassing and painful, it requires ongoing surgery and physiotherapy. The prognosis is uncertain and it will infringe on your family relationship', Wendy explains. However despite three, unsupported painful years of enduring treatment and repair of the fistula, Wendy had decided to 'do something about this' and so the Recto-Vaginal Fistula Support Network (RVFSN) was conceived.

BUILDING A NETWORK – A COLLABORATIVE APPROACH

The network currently consists of a management team of volunteers and its main goal is to provide support in a variety of forms for women who endure this type of tear. 'Primarily we see ourselves providing the realisation that [sufferers] are not alone with their injury. That they can discuss personal matters such as self-image, relationships and the practicalities for their condition.' Wendy explains that with this particular type of tear resulting from the birth of a child, there are additional pressures and ramifications that women have to cope with, other than the specific injury itself. 'Not only are you dealing with a newborn baby and all the demands that entails, you are adjusting to parenthood, coming to grips with the

medical world, facing surgery or ongoing surgery, physical pain, tiredness, embarrassment, dealing with disappointments if surgery fails, any long term effects of this injury, not to mention your personal relationship'.

Due to the nature of these type of injuries, the situation in which they occur and the widespread effect that they can have on the many different aspects of a woman's life, it is important that there are many points of contact among the health profession to guide women to the support network. 'One of our aims is for health professionals, such as obstetricians and colorectal surgeons to make their patients aware of our information, by providing our contact details. We would like to inform GPs, maternal health nurses and physiotherapists of our existence as these people may come into contact with someone suffering an RVF.'

As the women who endure these injuries are not the only people affected, Wendy recognises a wider role for the network to assist families of sufferers as well. 'While a patient is in the thick of it, so to speak, and bears the physical and emotional aspects of the injury, partners and other family members need information and support so they can come to terms with the impact this injury can have. This can be as much a shock to them as it is to the sufferer.'

HEALTH INFORMATION FROM A VARIETY OF SOURCES

Over the past two years, the network has been able to assist a small number of

women who have discovered its existence and are seeking help and support for their own experiences of RVFs. Regular meetings of the management team have been held in order to discuss the direction of the network and to develop ideas to promote its existence. The plan to increase awareness includes development of a website, which is currently under construction and will 'provide a channel for sufferers to contact us and access information', as well as nurturing a closer relationship with health professionals for a collaborative approach to assisting women enduring this type of trauma. 'Going forward, our intention is to provide information and contact details regarding our network to relevant health professionals, and to hold regular briefings for interested parties. We will offer brochures and a newsletter and will provide information via a website in development. We value the opportunity to introduce ourselves to all health professionals.'

The information that will be available on the website will be a combination of personal experiences from sufferers like Wendy, as well as some images and basic medical information. 'This information will help someone going through this injury to have a clear understanding of what is happening to their body and provide helpful ways of dealing with the injury in the form of medical, stomal (if required), specialised physiotherapy, psychology and other useful links.'

One of the sources of this information is Dr Nicholas Rieger, a colorectal surgeon based in Adelaide, who has been able to

provide the network with answers to questions which have helped form the basis to the website content, as well as his own medical papers that have been written on the subject of RVFs. 'Valerie Jenkins from the RANZCOG has also been a tremendous help and fully supportive of our group as well as providing two other valuable contacts which we will take up shortly.'

It is this combined support between the RVFSN and the medical profession that Wendy recognises as being so important to the overall treatment of a tear for a woman. It is also recognised that this would be a reciprocal situation in that the network would also play a role in guiding women to receive appropriate care and assisting them in sourcing the information and advice that they require. 'There is no "one stop shop" containing all relevant information. You need expert medical advice, emotional support, specialised physiotherapy and stomal support.' However, giving out medical advice is not an option the Network intends to adopt. 'The RVF Support Network will not give treatment for a recto-vaginal fistula, or purport to give medical advice to members. Neither will it practice or promote therapies of doubtful or unproven value to people with a recto-vaginal fistula.'

ONGOING SUPPORT

The network has received some financial backing from the Department of Human Services as well as a donation from NEC Australia. However to date, most of the funds have been sourced by the network team through their own efforts, such as a movie night which called on the support of family and friends, and seeking free advertising in local newspapers. Wendy admits that it is not an easy road that lies ahead. 'We will be looking to plan a calendar of dates for fundraising throughout the year.

Actioning them becomes no small task with such a small team of already fully employed helpers.'

Wendy hopes that the information and support that the network is able to provide in the near future is available to anyone who needs it. From her own experiences, it is evident that Wendy and the management team of the network are keen to be able to assist women undergoing the trauma of a recto-vaginal fistula in as many ways as they can. 'In a nutshell, there are many support groups

for various illnesses and injury out there. There is no support group available for a fistula, especially sustained in childbirth. We sincerely hope very few women need our help but if they do we would like to be there to support them.'

For further information about the RVF Support Network, contact Wendy Powell, tel +61 3 9593 3011 or email rvfsn@telstra.com

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