

Severe Anal Tears Can Cause Postpartum Urgency

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

WHITE SULPHUR SPRINGS, W. VA. — Women who experience a fourth-degree tear during delivery are significantly more likely to have persistent anal sphincter defects leading to fecal urgency or incontinence than are women with a third-degree tear, Catherine M. Nichols, M.D., said at the annual meeting of the South Atlantic Association of Obstetricians and Gynecologists.

Third-degree tears are much more likely to heal without persistent sphincter defects, which are associated with up to an 18-fold increase in the development

of new postpartum bowel symptoms, said Dr. Nichols of Virginia Commonwealth University in Richmond.

Her prospective cohort study included 56 primiparous women,



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DR. NICHOLS

of whom 39 experienced a third-degree tear and 17 a fourth-degree tear at delivery. There were no significant demographic differences between the groups. The mean age of the study

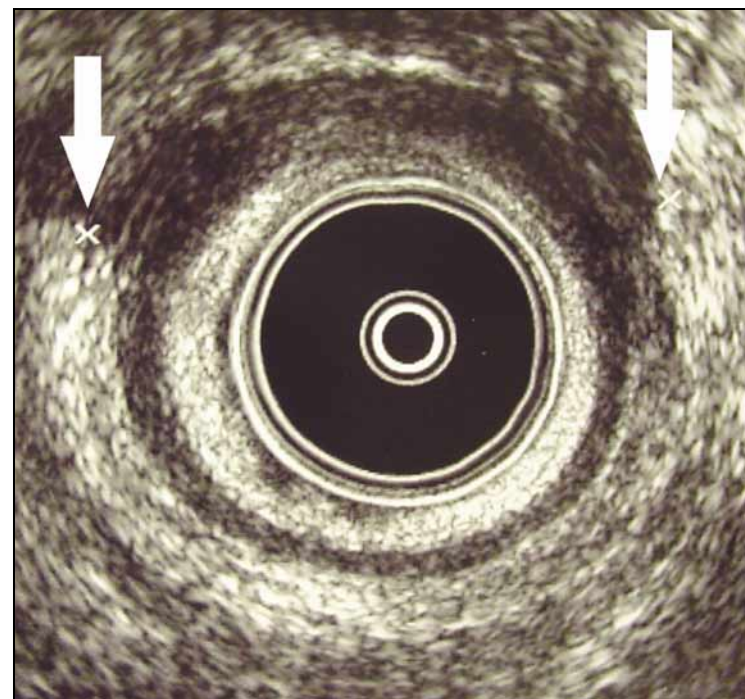
participants was 25 years.

Infant birth weight (median about 3,400 g) was similar in the two groups. Women who had a fourth-degree tear had a longer second stage of labor than did those with a third-degree tear (133 minutes vs. 78 minutes). Forceps deliveries occurred in 21% of the third-degree group and 47% of the fourth-degree group. Shoulder dystocia was more common in the fourth-degree group (24% vs. 13%), as was persistent occiput posterior position (24% vs. 13%) and midline episiotomy (76% vs. 49%).

After delivery, all of the women completed the Manchester Modified Bowel Function questionnaire to assess predelivery bowel function. At 6 weeks post partum, all women were examined at a dedicated perineal clinic, where they completed another questionnaire to assess new bowel symptoms and received a pelvic exam and an endoanal ultrasound exam to determine the state of both internal and external anal sphincters.

Of the 56 participants, 21 (38%) reported new bowel symptoms, which were incontinence to liquid stool or gas (14 women) and fecal urgency (19 women). Among those reporting new symptoms, 59% had a fourth-degree tear and 28% had a third-degree tear.

Disruption of both sphincters



Arrows indicate an area of disruption in the external anal sphincter (circular hyperechoic region). The internal anal sphincter (adjacent circular hypoechoic region) is intact.

COURTESY DR. CATHERINE M. NICHOLS

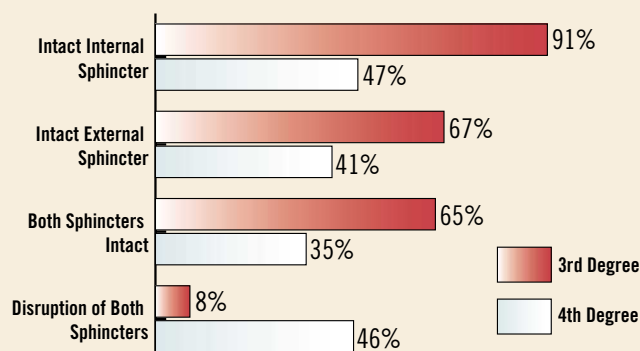
was more common among fourth-degree-tear patients. (See box.) Conversely, most women with third-degree tears had both sphincters intact.

Intact internal sphincters were found in significantly more women with third-degree tears than in those with fourth degree tears. Intact external sphincters were found in 67% of women with third-degree tears and in 41% of those with fourth-degree

tears, but this difference was not statistically significant.

There was a very strong correlation between sphincter disruption and development of new symptoms. Women with an isolated defect of the external sphincter were 15.7 times more likely than those with no defects to report symptoms, and women with combined defects were 18.7 times more likely to report new symptoms.

Condition of Sphincters by Tear Status



Source: Dr. Nichols

KEVIN FOLEY, RESEARCH/SARAH GALLANT, DESIGN

WHI Data: Oral Estrogen Raises Risk of Gallbladder Disease

BY KATE JOHNSON
Montreal Bureau

Oral estrogen therapy significantly increases the risk of gallbladder disease and gallbladder-related procedures, according to a new analysis of data from the Women's Health Initiative.

The results "demonstrate for the first time in a randomized, double-blind trial, in otherwise healthy postmenopausal women, that the risk of adverse biliary tract outcomes was substantially increased" by estrogen alone or estrogen plus progestin, reported Dominic J. Cirillo of the University of Iowa, Iowa City, and his colleagues (JAMA 2005;293:330-9).

"These findings suggest that oral estrogens are causally associated with gallbladder diseases," they reported.

According to Wulf H. Utian, M.D., executive director of the North American Menopause Society, the WHI data on gallbladder disease are not surprising. "This is exactly in line with what we've known for easily 25 years and doesn't change anything in terms of what physicians have been doing in practice," he said in an interview. "It's a confirmation. It shows the risk is no greater than what was originally identified and may even be slightly lower ... If it weren't for the fact that it is WHI

data, most journals would have probably rejected the paper, saying, 'What's new?'"

In this WHI analysis, 8,376 women who had undergone hysterectomy were randomized to 0.625 mg/day of conjugated equine estrogens or placebo. Another 14,203 women without hysterectomy were randomized to estrogen plus progestin, given as CEE plus 2.5 mg/day of medroxyprogesterone acetate.

Mean follow-up was about 7.1 years in the estrogen-only arm and about 5.6 years in the combination therapy arm. The annual incidence of any gallbladder event (cholecystitis, cholelithiasis, or cholecystectomy) was 78 per 10,000 person-years for women in the estrogen-alone group, compared with 47 per 10,000 person-years for those on placebo. This meant that there was an excess of 31 events per 10,000 women annually with estrogen use, for a hazard ratio of 1.67.

For women in the combination therapy arm, the incidence was 55 per 10,000 person-years for the treatment group, compared with 35 per 10,000 person-years in

the placebo group. This meant there was an excess of 20 events per 10,000 women annually with estrogen use, for a hazard ratio of 1.59.

In both the estrogen-alone and the combination therapy groups, the vast majority of gallbladder procedures were cholecystectomies (hazard ratios of 1.93 in the estrogen alone group and 1.67 in the combination therapy group). Gallbladder diseases were evenly divided between cholecystitis (hazard ratios of 1.8 and 1.54, respectively) and cholelithiasis (hazard ratios of 1.86 and 1.68, respectively). The magnitude of the effect was not influenced greatly by the presence or absence of progestins, the authors reported.

The findings are "in the same direction, but of a greater magnitude" than the findings of the Heart and Estrogen/progestin Replacement Study (HERS), which showed a 38% increase in hospitalizations for gallbladder disease, they noted.

The current analysis of the WHI data "suggest that the risk continues to increase with longer exposure" to combi-

nation therapy," the authors noted.

They added that unlike the HERS trial, women in the WHI did not have preexisting cardiovascular disease and were geographically dispersed across 40 clinical sites.

"Therefore, these results should be more generalizable to healthy postmenopausal women in the United States without previous gallbladder disease," the researchers noted. "The increased risk for gallbladder events should be addressed in the decision-making process for women considering menopausal hormone therapy."

The study authors note that their findings cannot necessarily be extrapolated to other types of estrogen therapy and other routes of administration.

Dr. Utian said there are some good indications in the basic literature that transdermal estrogens are safer in this regard. However, the authors note there's at least one study that found that "exogenous estrogens, given either transdermally or orally, affected physiologic markers in a pattern that favored gallstone formation" (J. Clin. Endocrinol. Metab. 1998;83:410-4). "Further study is needed to help determine if transdermal administration of estrogen therapy has the same effect on biliary tract outcomes, since the first pass effect would be lessened," they noted.



These WHI data are not surprising and they don't change anything in terms of clinical practice.

DR. UTIAN