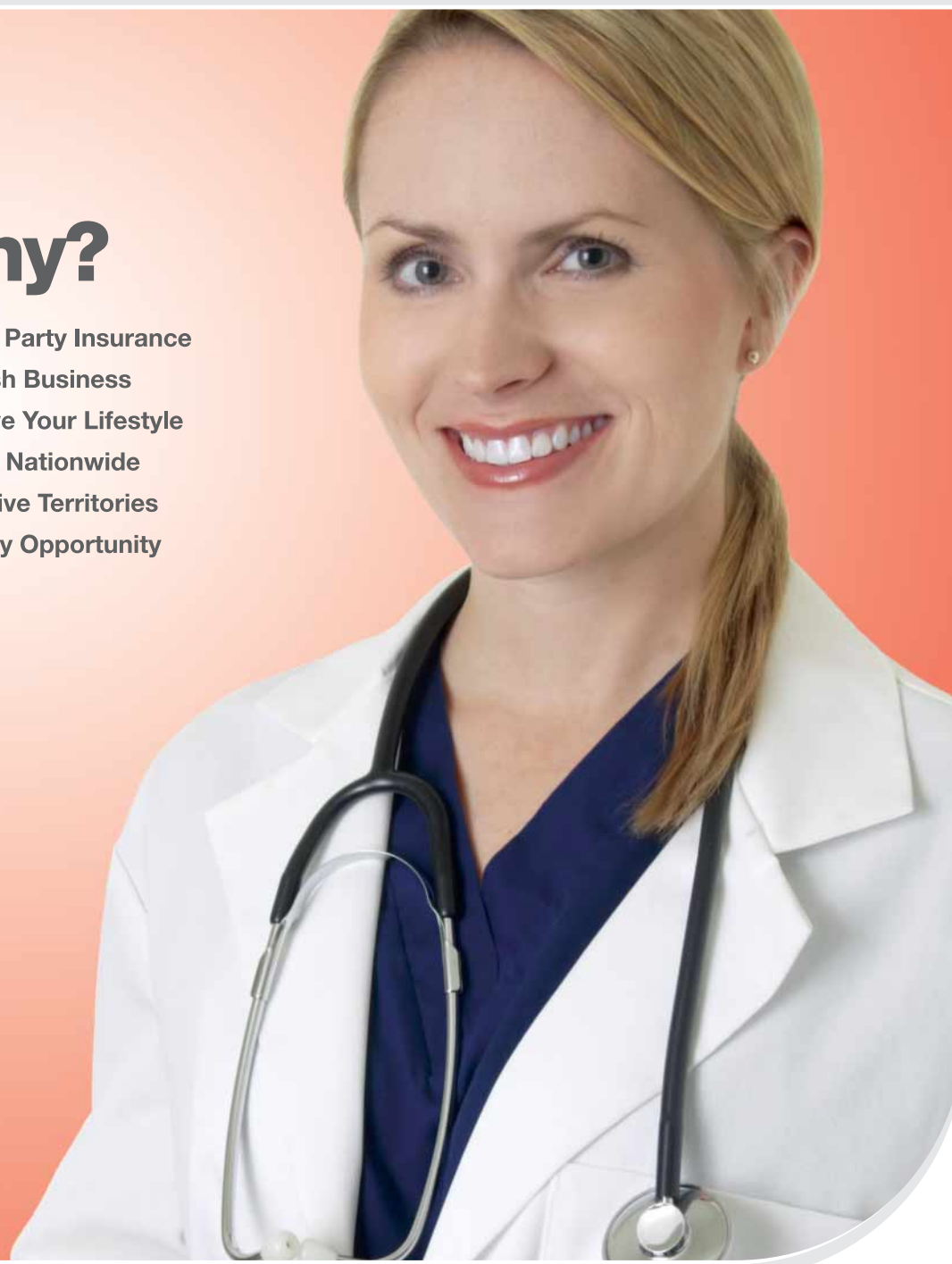


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Episiotomies: When and If They Help

BY HEIDI SPLETE
 Senior Writer

WASHINGTON — Often, the best episiotomy may be no episiotomy, Dr. Lily A. Arya noted at the annual meeting of the American College of Obstetricians and Gynecologists.

That said, episiotomies are needed in some cases, and sometimes wound dehiscence requires additional repair, said Dr. Arya, a urogynecologist at the University of Pennsylvania Medical Center in Philadelphia.

The need for episiotomies remains a subject for debate. Dr. Arya cited a recent study that compared routine episiotomy, selective episiotomy, and no episiotomy, and found no significant difference in the incidence of minor lacerations or fecal incontinence (*Acta Obstet. Gynecol. Scand.* 2004;83:364-8).

"Sometimes, if you let nature take its course you will only end up with minor lacerations," Dr. Arya said, although she added that she favors selective episiotomies. The surgeon's challenge lies in trying to deduce whether significant tearing might occur.

Mediolateral episiotomy has several advantages over median episiotomy if the surgeon decides to proceed, Dr. Arya said. Although the midline episiotomy involves less bleeding, pain, and dyspareunia, the median technique tends to cause more fecal incontinence and a greater risk of anal sphincter injury.

Mediolateral episiotomy, on the other hand, will not prevent tears, but it will not cause tearing, either.

The traditional strategy in dehiscence cases has been to reopen the wound and perform a secondary repair in 3-4 months.

However, the wound can be debrided and repaired almost immediately if there is no infection. "Infection from an episiotomy is extremely rare," Dr. Arya noted. If infection is present, the wound can be debrided on an outpatient basis until all necrotic material is gone and pink, granulating tissue is achieved, and a repair can usually be performed within a week.

Closures for episiotomy dehiscence are similar to those for perineal tears, but Dr. Arya recommends incorporating some tissue from the sides of the wound to close with two layers. The repair will bring the transverse perineal muscles together.

"Make sure you don't leave gaps in the submucosa; that is what will cause a fistula," she noted.

To minimize the patient's postoperative discomfort, Dr. Arya recommends stool softeners for 6 weeks, antibiotics for the first 48 hours, and a low-residue diet for the first 72 hours to postpone bowel movements and prevent the patient from becoming constipated.

Fecal incontinence remains a significant problem in women, and the majority of cases stem from obstetric trauma, said Dr. Najia N. Mahmoud, a colorectal sur-

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geon at the University of Pennsylvania, Philadelphia.

Many women who present with fecal incontinence have managed for long periods of time by employing a range of coping strategies. Their tricks include avoiding travel, reducing food intake and exercise, wearing dark clothing and multiple absorbent products, and only visiting places with readily accessible bathrooms. Dr. Mahmoud's strategy for evaluating fecal incontinence starts with an examination of the patient.

"A lot of what you learn about the patient's incontinence comes from the physical exam," she said. Unless the physical exam is confusing in some way, anal manometry and pudendal nerve testing do not add much to the diagnosis. "I don't think these are necessary for people with obvious signs of fecal incontinence." However, endoanal ultrasound allows for an anatomic description of the injury and

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helps with surgical planning for patients who are good surgical candidates. Incontinence to solid stool constitutes the most common indication for surgery.

Biofeedback with a trained physical therapist can be helpful both pre- and postoperatively for patients with mild or moderate fecal incontinence (incontinence to gas or urgency), as well as for patients who aren't immediate candidates for surgery, she said.

In addition, Dr. Mahmoud said that she makes an effort to modify the patient's diet. "It's imperative that you investigate the underlying causes of diarrhea and modify the bowel movements," she said. In many cases, the incontinence will resolve once diarrhea is under control.

Most people don't consume as much fiber as they think they do, so Dr. Mahmoud prescribes a daily dose of fiber wafers with 6 ounces of water for incontinent patients or those with soft or loose bowel movements. The consistent fiber consumption seems to result in a better-formed stool and improved continence, and provides a good adjuvant therapy to either conservative strategies like biofeedback or surgical solutions such as sphincter reconstruction.

Surgery is rarely necessary for patients with incontinence to liquid stool and flatulence, she emphasized.

An overlapping sphincteroplasty is an appropriate surgical plan for patients with sphincter defects who are consistently incontinent to solid stool. The technique is generally successful; data from a 2000 study of 40 patients showed an 81% success rate immediately following surgery, and a 51% success rate after 40 months.

To optimize outcomes, be sure to address patient expectations, and remind them that the return to normal muscle and sphincter function is slow, and can take up to 3 months. Kegel exercises can

help strengthen the muscles during recovery, she said. Infection rates are low—less than 8%—in overlapping sphincteroplasty patients, but the presence of infection increases the failure rate.

The most significant factor in a successful sphincter repair is its durability, and constipation must be prevented to preserve the intactness of the repair in the immediate postoperative period.

"Constipation is the enemy of a sphincter repair in the first week or two," Dr. Mahmoud said. She uses a combination of treatments including milk of magnesia, fiber, and stool softeners, and mineral oil, to help steer patients through recovery. ■

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