n n o n o D n

be inserted and the woman should be taken to the theatre as soon as possible. Repair of OASIS in the delivery room may be performed in certain circumstances after discussion with a senior obstetrician. [*New 2015*]

Figure of eight sutures should be avoided during the repair of OASIS because they are haemostatic in nature and may cause tissue ischaemia. [*New 2015*]

A rectal examination should be performed after the repair to ensure that sutures have not been inadvertently inserted through the anorectal mucosa. If a suture is identified it should be removed. [*New 2015*]

n q o o o p p o no o

The torn anorectal mucosa should be repaired with sutures using either the continuous or interrupted technique. [*New 2015*]

n q o o o p p o n n n p n

Where the torn internal anal sphincter (IAS) can be identified, it is advisable to repair this separately with interrupted or mattress sutures without any attempt to overlap the IAS.

n q o o p n n p n

For repair of a full thickness external anal sphincter (EAS) tear, either an overlapping or an end-to-end (approximation) method can be used with equivalent outcomes.

For partial thickness (all 3a and some 3b) tears, an end-to-end technique should be used. [*New 2015*]

C o o r m r

o o o p p o o n p n n

3-0 polyglactin should be used to repair the anorectal mucosa as it may cause less irritation and discomfort than polydioxanone (PDS) sutures. [*New 2015*]

When repair of the EAS and/or IAS muscle is being performed, either monofilament sutures such as 3-0 PDS or modern braided sutures such as 2-0 polyglactin can be used with equivalent outcomes.

When obstetric anal sphincter repairs are being performed, the burying of surgical knots beneath the superficial perineal muscles is recommended to minimise the risk of knot and suture migration to the skin.

r omp n

o o p o n p n n

Obstetric anal sphincter repair should be performed by appropriately trained practitioners.

Formal training in anal sphincter repair techniques should be an essential component of obstetric

The use of postoperative laxatives is recommended to reduce the risk of wound dehiscence.

Bulking agents should not be given routinely with laxatives. [*New 2015*]

Local protocols should be implemented regarding the use of antibiotics, laxatives, examination

1. Purpose and scope

p po o n o p o n n on no n n

Third-degree tear: n o p n n o n n p n o p

Grade 3a tear: n o n n p n A n o n
Grade 3b tear: o n o A n o n
Grade 3c tear: Bo A n n n n p n A o n

Fourth-degree tear: n o p n n o n n p n o p A n A n no o

n n o n n on n o o o on p o n n n o o n p o n n n o q o p o o on on no o n n o n p o o n

Obstetric anal sphincter injuries (OASIS) n o p o n o p n

Anal incontinence n o p n o n o n o o n o n q o

A p o n n n n o on n n n p o p n o n o o

7. Repair of OASIS

[illegible]

Repair of third- and fourth-degree tears should be conducted by an appropriately trained clinician or by a trainee under supervision.

Repair should take place in an operating theatre, under regional or general anaesthesia, with good lighting and with appropriate instruments. If there is excessive bleeding, a vaginal pack should be inserted and the woman should be taken to the theatre as soon as possible. Repair of OASIS in the delivery room may be performed in certain circumstances after discussion with a senior obstetrician.

Figure of eight sutures should be avoided during the repair of OASIS because they are haemostatic in nature and may cause tissue ischaemia.

A rectal examination should be performed after the repair to ensure that sutures have not been inadvertently inserted through the anorectal mucosa. If a suture is identified it should be removed.

[illegible]

2 [illegible]

The torn anorectal mucosa should be repaired with sutures using either the continuous or interrupted technique.

[illegible]

3 [illegible]

Where the torn IAS can be identified, it is advisable to repair this se[illegible]

n n o on o o p n n n n po op
p o o o n p A p

14. Recommendations for future research

B C C B o N
C n o o n p n
o p onop p o p n n

Appendix I: Explanation of guidelines and evidence levels

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