AN INTERNATIONAL CONTINENCE SOCIETY (ICS) / INTERNATIONAL UROGYNAECOLOGICAL ASSOCIATION (IUGA) JOINT REPORT ON THE TERMINOLOGY FOR CHILDBIRTH TRAUMA

NEED FOR A WORKING GROUP ON CHILDBIRTH TRAUMA

A: Background and current definitions

- The existing terminology on childbirth perineal trauma, due to its increasing complexity, and variations might be updated by a clinically-based consensus report.
- Pelvic floor and lower urinary tract terminology had the benefit of a Joint International Urogynecological Association/ ICS Report published in 2010[1]. That report[1] doubled[2] the number of "most common" diagnoses to six (6) from those contained in earlier combined male/female terminology reports[3,4], despite the significant advances made by those earlier reports[3,4]. It also prompted the development of subsequent combined IUGA/ICS female terminology reports [5-11]. These include reports on different surgical and conservative managements, pelvic organ prolapse (POP), prosthetic and native tissue complications, anorectal dysfunction and sexual health[5-11].
- Obstetric trauma may affect the anatomy and function of multiple pelvic floor compartments and organs and may result in different pelvic floor disorders. Different MeSH terms and keywords have been used in guidelines and reports on the management of some aspects of obstetric trauma for example anal sphincter injuries. In the most recent RCOG Green Top Guidelines on the management of third and fourth degree perineal tears, relevant MeSH terms and keywords that were used for identification of evidence included the terms: 'human', 'female', 'childbirth', 'obstetric', 'perineum', 'third degree', 'fourth degree', 'anal sphincter', 'tear', 'injury', 'rupture', 'damage', 'incontinence', 'faecal', 'anal', 'repair', 'surgery' and 'sutures'.
- The most widely used terminology for obstetric anal sphincter injuries was introduced in the classification described by Sultan and was adopted by the International Consultation on Incontinence and the RCOG [12, 13]:
  - First-degree tear (injury to perineal skin and/or vaginal mucosa).

- Second-degree tear (injury to perineum involving perineal muscles but not involving the anal sphincter).
- Third-degree tear (injury to perineum involving the anal sphincter complex).
    - Grade 3a tear (<50% of external anal sphincter (EAS) thickness torn).
    - Grade 3b tear (>50% of EAS thickness torn).
    - Grade 3c tear (Both EAS and internal anal sphincter (IAS) torn).
    - Fourth-degree tear (injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa).

- The term 'anorectal mucosa' has been used instead of anal epithelium in this guideline.
- Obstetric anal sphincter injuries (OASIS) encompass both third- and fourth-degree perineal tears.
- Anal incontinence is defined as the complaint of involuntary loss of flatus and/or faeces affecting quality of life.
- Rectal buttonhole tear: If the tear involves the rectal mucosa with an intact anal sphincter complex, it is by definition not a fourth-degree tear[14].

These are a few examples that highlight the importance of a terminology report on Obstetric Trauma.

Further examples refer to episiotomy. Publications towards a standardization of the definition of types of episiotomy have been found in the literature[15]. There is no consensus on the definition of *episiotomy dehiscence*, which may vary in severity from a superficial skin detachment to extensive separations involving anal sphincters and rectal mucosa[16]. A wound gaping of more than 0.5cm[17] or complete separation of mucosa of at least 50% of the episiotomy length, have been proposed.

Various definitions of levator ani muscle injury, according to method and technique of assessment, i.e., clinical palpation, ultrasonography or magnetic resonance imaging have also been proposed[18].

Similarly attempts to establish definitions in lower urinary tract symptoms in relation to childbirth have previously been published[19].

In general, there is lack of standardisation in definitions used for different types of injuries and defects, resulting in a variation in the reported research evidence. There is a need for an

integrated report on terminology of all aspects and systems affected by childbirth trauma. Consensus in definitions and resolution of controversies should be a priority[20].

B: SCOPE

- A core report on childbirth trauma is required to
    - (i) incorporate all developments in knowledge and practice in the last 14-15 years;
    - (ii) achieve and exceed the overall clarity, specificity and coverage of similar documents;
    - (iii) prompt the development of follow-on reports: e.g. on surgical and conservative managements, on pelvic floor, urinary tract, anorectal function and dysfunction and sexual health.
- The aim of this Working Group will be to provide a comprehensive, consensus-based Terminology Report that will aid clinical practice and research.
- The Report would be clinically based and would aim to be as user-friendly as possible.
- It would include the following sections:
    - A clear introduction
    - Symptoms
    - Signs
    - Investigations
    - Imaging
    - Main Diagnoses
    - Treatments.
- The Report would be definitional with any necessary explanations or descriptions included as footnotes. It would be appropriately referenced.
- The Report would give an alphanumeric coding to each of definitions.
- The Report would be contemporary. Any relatively new concepts in the literature that offer promise but may need further validation and research may be included and defined in an Appendix.

- The Report would be subject to multiple rounds of internal (WG) review (12-16 anticipated), external review (4-6 reviewers) and ICS/IUGA membership (website) review.

MEMBERSHIP OF WORKING GROUP (Anticipated)

• Chair

• Members (up to 15)

DURATION (Anticipated)

• 18 – 24 months

• 30 months (maximum)

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