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3 **AN INTERNATIONAL CONTINENCE**
4 **SOCIETY (ICS) / INTERNATIONAL UROGYNECOLOGICAL**
5 **ASSOCIATION (IUGA)**
6 **JOINT REPORT ON THE TERMINOLOGY**
7 **FOR THE ASSESSMENT AND MANAGEMENT OF OBSTETRIC PELVIC FLOOR DISORDERS**

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12 **Terminology for Obstetric Pelvic Floor Disorders**

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Abstract**Aims**

The terminology of obstetric pelvic floor disorders should be defined and reported as part of a wider clinically oriented consensus.

Methods

This Report combines the input of members of two International Organizations, the International Continence Society (ICS) and the International Urogynecological Association (IUGA). The process was supported by external referees. Appropriate clinical categories and a sub-classification were developed to give coding to definitions. An extensive process of 11 main rounds of internal and 2 rounds of external review was involved to exhaustively examine each definition, with decision-making by consensus.

Results

A terminology report for obstetric pelvic floor disorders, encompassing 305 separate definitions, has been developed. It is clinically-based with the most common diagnoses defined. Clarity and user-friendliness have been key aims to make it useable by different specialty groups and disciplines involved in the study and management of pregnancy, childbirth and female pelvic floor disorders. Clinical assessment, investigations, diagnosis, conservative and surgical treatments are major components. Illustrations have been included to supplement and clarify the text. Emerging concepts, in use in the literature and offering further research potential, but requiring further validation, have been included as an appendix. As with similar reports, interval (5–10 year) review is anticipated to maintain relevance of the document and ensure it remains as widely applicable as possible.

Conclusions

A consensus-based Terminology Report for obstetric pelvic floor disorders has been produced to support clinical practice and research.

TABLES

Table 1: Total, new and changed definitions (compared with previous ICS Reports).

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1 INTRODUCTION

Obstetric pelvic floor disorders encompass a range of anatomical and functional changes associated with pregnancy and childbirth. Pelvic floor trauma refers to injuries of the different anatomical structures of the pelvic floor and commonly occurs at the time of the first vaginal childbirth. Perineal and vaginal as well as anal sphincter trauma following delivery are the most commonly described types of obstetric trauma. However, different aspects of the pelvic floor may become affected through tissue rupture, compression, stretching, with associated nerve, muscle and connective tissue damage.

Perineal trauma affects millions of women with an incidence of over 91% in nulliparous women and over 70% in multiparous women(1) and has a potentially significant impact on daily activities, psychological wellbeing, sexual function and overall quality of life (2). Anal sphincter injury is clinically diagnosed in 1-11% of women following vaginal delivery (3). Recently documented increases in the reported incidence have been attributed to improved training and awareness around anal sphincter injury (3) (4).

No single document encompasses all elements required for classification, diagnosis and treatment of obstetric pelvic floor disorders. Such a report requires a full outline of the terminology for the different types of obstetric trauma, symptoms, signs, clinical assessments, imaging and functional investigations, the most common diagnoses, prediction, prevention, and management.

The aim of this Working Group was to develop a Terminology Report as a definitional document, collating the definitions of those terms, related to obstetric pelvic floor disorders. This document will include definitions of perineal and pelvic floor trauma and associated disorders. Definitions of pelvic floor disorders that occur during pregnancy and up to 12 months postpartum will be considered for inclusion, for the purpose of this document. The rationale for this choice was based on evidence around the effect of pregnancy, childbirth and postnatal factors on the pelvic floor and the natural history of pelvic floor function recovery postnatally as well as possible influences of breastfeeding.

As obstetric pelvic floor disorders encompass a wide range of anatomical and functional changes, it could potentially give rise to all definitional terms involving the entire pelvic floor. Important definitions already defined in existing terminology documents are acknowledged and presented where relevant. Explanatory notes on definitions have been expanded, where applicable as footnotes. Emphasis has been on the inclusion of terms in the relevant peer-reviewed literature. The aim is to assist clinical practice as well as research by developing a repository of appropriately selected and defined terms that will advise communication among

professionals at different levels in the area of pelvic floor clinical practice as well as obstetric practice and research.

Disorder is a disruption of normal physical function, a disease or abnormal condition.

Trauma is defined as physical injury or a deeply distressing or disturbing experience.

Injury is a form of physical trauma that refers to impact on the relevant anatomical tissues and structures.

Obstetric pelvic floor disorders refer to effects of pregnancy and childbirth on anatomy and function of the pelvic floor.

The methodology followed for the selection of terms and the process of consensus on definitions is presented in Appendix 1 (A1).

This Terminology Report is inherently and appropriately a definitional document, collating the definitions of those terms, i.e. “words used to express a defined concept in a particular branch of study” (5) concerning obstetric pelvic floor disorders. Existing, new and revised terms have been included.

In line with all the other joint ICS-IUGA female-specific terminology reports, every effort has been made to ensure this Report is:

(1) User-friendly: It should be able to be understood by all clinical and research users.

(2) Clinically-based: Symptoms, signs and validated assessments/investigations should be presented for use in forming workable diagnoses for obstetric pelvic floor disorders and associated dysfunctions. Sections 1-4 will address symptoms, signs, investigations, diagnoses for associated dysfunctions. Sections 5-7 will list the terminology for prediction, prevention and evidence-based management for obstetric pelvic floor disorders.

(3) Origin: Where a term’s existing definition (from one of multiple sources used) is deemed appropriate, that definition will be included and duly referenced. A large number of terms in obstetric pelvic floor disorders, because of their long-term use, have now become generic, as apparent by their listing in medical dictionaries.

(4) Able to provide explanations: Where a specific explanation is deemed appropriate to describe a change from earlier definitions or to qualify the current definition, this will be included as an addendum to this paper. Wherever possible, evidence-based medical principles will be followed.

Table 1: Total, new and changed definitions (compared with previous ICS Reports).

Section	New Definitions / Descriptors	Changed Definitions / Descriptors*	Unchanged	Total
Introduction & Symptoms	39	1	30	70
Signs	25	3	48	76
Investigations	11	n/a	33	44
Diagnoses	29	1	29	59
Prediction and Prevention	19	n/a	11	30
Management	8	n/a	18	26
Total	131(43%)	5 (2%)	169 (55%)	305

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159

160 Previous ICS and ICS/IUGA Terminology Reports that will be referenced are the 2010 IUGA-ICS Joint
 161 Terminology Report on Female Pelvic Floor Dysfunction(6), 2019 ICS Terminology Report on Male Pelvic
 162 Floor Dysfunction(7), 2016 ICS-IUGA Joint Terminology Report on Female Pelvic Organ Prolapse(8), 2017 ICS-
 163 IUGA Joint Terminology Report on Female Anorectal Dysfunction(9) and 2020 ICS Report on the Terminology
 164 for Female Pelvic Floor Fistulas (10).

165 It is suggested that acknowledgement of these standards in written publications related to obstetric pelvic
 166 floor disorders, be indicated by a footnote to read as follows: “Methods, definitions and units conform to
 167 the standards jointly recommended by the International Continence Society and International
 168 Urogynecological Association except where specifically noted”.

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2 SECTION 1: SYMPTOMS

1.1.Symptom: Any morbid phenomenon or departure from the normal in structure, function or sensation, experienced by the woman and indicative of disease or a health problem. (11)^{FN1.1}

1.2 Lower urinary tract symptoms

1.2.1 Storage symptoms: Lower urinary tract symptoms occurring during the bladder storage phase(7).

1.2.1.1 Bladder filling (sensory) symptoms: Abnormal sensations experienced during bladder filling(7).

1.2.1.2. Urinary incontinence (UI): Complaint of involuntary loss of urine experienced during the bladder storage phase (7).

1.2.1.2.1 Stress urinary incontinence (SUI): Complaint of involuntary loss of urine on effort or physical exertion including sporting activities, or on sneezing or coughing (7).

1.2.1.2.2 Urgency urinary incontinence (UUI): Complaint of involuntary loss of urine associated with urgency (7).

1.2.1.2.3 Mixed urinary incontinence (MUI): Complaints of both stress and urgency urinary incontinence, i.e. involuntary loss of urine associated with urgency and also with effort or physical exertion including sporting activities or on sneezing or coughing (7).

1.2.1.2.4 Coital urinary incontinence: Complaint of involuntary urine loss during or after coitus. This symptom might be further divided into that occurring with penetration and that occurring at orgasm (12).

1.2.1.2.5 Nocturnal enuresis: Complaint of involuntary voiding that occurs at night during the main sleep period (i.e. bedwetting) (13).

1.2.1.3 Urgency: Complaint of a sudden, compelling desire to pass urine which is difficult to defer (6) (7) (14) (15).

1.2.1.3.1 Coital urinary urgency: Feeling of urgency to void during vaginal intercourse (12).

1.2.1.4 Nocturia: Complaint that urine is passed during the main sleep period. Having woken to pass urine for the first time, each urination must be followed by sleep or the intention to sleep. This should be quantified using a bladder diary (7) (13).

1.2.2 Voiding symptoms: Lower urinary tract symptoms experienced during the voiding phase (experienced during micturition) (7).

1.2.2.1 Hesitancy: Complaint of a delay in initiating voiding (when the individual is ready to pass urine).(7)

1.2.2.2 Slow (urinary) stream: Complaint of a urinary stream perceived as overall slower than previous performance or in comparison with others (7).

1.2.2.3 Intermittency (intermittent stream): Complaint of urine flow that stops and starts on one or more occasions during one voiding episode (7).

205 **1.2.2.4 Straining to void:** Complaint of the need to make an intensive effort to either initiate, maintain or
 206 improve voiding or the urinary stream (7).

207 **1.2.2.5 Spraying (splitting) of urinary stream:** Complaint that the urine passage is a spray or split rather than
 208 a single directional stream (7).

209 **1.2.2.6 Position-dependent voiding:** Complaint of having to take specific positions to be able to void
 210 spontaneously or improve bladder emptying, e.g. leaning forwards or backwards on the toilet seat or voiding
 211 in a semi-standing position (6).

212 **1.2.2.7 Dysuria:** Complaint of pain, burning or other discomfort during voiding. Discomfort may be intrinsic
 213 to the lower urinary tract (e.g. bladder or urethra), external or referred from other adjacent similarly
 214 innervated structures e.g. lower ureter (7).

215 **1.2.3 Post micturition symptoms**

216 **1.2.3.1 Need to immediately re-void (“encore” or “double” voiding):** Complaint that further micturition is
 217 necessary soon after passing urine (cessation of flow) (7).

218 **1.2.3.2 Post-micturition incontinence:** Complaint of a further involuntary passage of urine following the
 219 completion of voiding.

221 **1.3 Anorectal and defaecatory symptoms**

222 **1.3.1 Feeling of incomplete bowel evacuation:** Complaint that the rectum does not feel empty after
 223 defecation. May be accompanied by the desire to defecate again (7).

224 **1.3.2 Straining to defaecate:** Complaint of the need to make an intensive effort, by abdominal straining, or
 225 to use abdominal massage to either initiate, maintain or improve defecation (7) (16) (17).

226 **1.3.3 Manual defaecatory assistance:**

227 **1.3.3.1 Splinting:** Support perineum or buttocks manually (usually with thumb or fingers) to assist in
 228 evacuation of stool content (9,18).

229 **1.3.3.2 Splinting / digitation:** Complaint of the need to digitally manipulate the vaginal wall or to otherwise
 230 apply manual pressure e.g. to the vagina or perineum (splinting), or to the vagina or rectum (digitation) to
 231 assist defecation.(NEW) (8,14)_{FN1.2}.

232 **1.3.4 Faecal (rectal) urgency:** Complaint of a sudden compelling desire to defecate that is difficult to defer
 233 (9,18).

234 **1.3.5 Post-defecatory soiling:** Complaint of soiling (passing of stool into clothing) occurring after defecation
 235 (7).

237 **1.4 Pelvic organ prolapse symptoms**

238 **1.4.1 Vaginal bulging:** Complaint of a “bulge”, lump or “something coming down” or “falling out” through
 239 the vaginal introitus. The woman may state, or not, she can either feel the bulge by direct palpation or see
 240 it, perhaps aided with a mirror (8).

241 **1.4.2 Pelvic pressure:** Complaint of increased heaviness or dragging (pain or discomfort) in the suprapubic
 242 area and/or pelvis (8) (CHANGED).

243 **1.4.3 Splinting / Digitation due to POP:** Complaint of the need to digitally replace the prolapse or to
 244 otherwise apply manual pressure, e.g. to the vagina or perineum (splinting), or to the vagina or rectum
 245 (digitation) to assist voiding or defecation (8).

246 **1.4.4 Urethral Prolapse:** Complaint of “lump” at the external urethral meatus (8).

247 **1.4.5 Anorectal Prolapse:** Complaint of a “bulge” or “something coming down” towards or through the
 248 anus/rectum. The woman may state she can either feel the bulge by direct palpation or see it perhaps aided
 249 with a mirror (9,18).

250
 251 **1.5 Obstetric pelvic floor trauma related pelvic symptoms:** Obstetric pelvic floor trauma may cause
 252 anatomical changes to pelvic floor musculature, connective tissue, nerves and vulvo-vaginal surrounding
 253 organs, bladder and rectum most commonly. This can lead to abnormal function, most commonly storage
 254 and voiding symptoms affecting the bladder and bowel.

255 **1.6. Obstetric pelvic floor trauma related urinary tract symptoms** FN1.3

256 **1.6.1 Pregnancy and postpartum storage symptoms**

257 **1.6.1.1 Pregnancy associated urinary incontinence:** Complaint of involuntary loss of urine during
 258 pregnancy (NEW)FN1.4.

259 **1.6.1.2 Postpartum urinary incontinence (PPUI):** Complaint of involuntary loss of urine experienced during
 260 the postpartum period and up to 12 months after delivery (NEW)(7)FN1.5.

261 **1.6.1.2.1 Postpartum stress urinary incontinence (PPSUI) (symptom):** Complaint of involuntary loss of urine
 262 on effort or physical exertion including sporting activities, or on sneezing or coughing experienced for the
 263 first time during the postpartum period and up to 12 months after delivery (NEW)(7).

264 **1.6.1.2.2 Postpartum urgency urinary incontinence (PPUUI):** Complaint of involuntary loss of urine
 265 associated with the sensation of a sudden, compelling desire to pass urine which is difficult to defer
 266 experienced for the first time during the postpartum period and up to 12 months after delivery (NEW).

267 **1.6.1.2.3 Postpartum mixed urinary incontinence (PPMUI):** Complaints of both stress and urgency urinary
 268 incontinence, i.e. involuntary loss of urine associated with urgency and also with effort or physical exertion
 269 including sporting activities or on sneezing or coughing experienced for the first time during the
 270 postpartum period and up to 12 months after delivery (NEW)(7).
 271

272 **1.6.1.2.4 Postpartum coital urinary incontinence:**

273 Complaint of involuntary urine loss during or after coitus experienced for the first time during the
 274 postpartum period and up to 12 months after delivery. This symptom might be further divided into that
 275 occurring with penetration and that occurring at orgasm (NEW)(12).

276 **1.6.1.2.5 Postpartum daytime urinary frequency:** Complaint that voiding occurs more frequently during
 277 waking hours than previously deemed normal by the woman during the postpartum period and up to 12
 278 months after delivery (NEW)(7).

279 **1.6.2 Postpartum voiding symptoms:** Lower urinary tract symptoms related to the voiding phase that
 280 appeared during the postpartum period and up to 12 months after delivery (7) (NEW).

281 - Complaint of inability to empty the bladder as before (to distinguish from predelivery/pre-
 282 pregnancy difficulties), despite the ability to pass some urine ^{FN1.6} during the postpartum period and up to
 283 12 months after delivery.

284 - Complaint of inability to initiate micturition during the postpartum period and up to 12 months
 285 after delivery - urinary retention.

286 - Complaint of inability to empty the bladder (regardless of whether emptying is complete or not)^{FN1.7}
 287 in relation to:

288 - characteristics of urination flow (spraying, slow stream etc...)

289 - how urination takes place (for example regarding the position to be maintained during
 290 micturition, whether or not external pressure on the abdominal or vaginal walls is applied,
 291 use of a catheter, etc.) and

292 - increased or reduced voiding interval (NEW) ^{FN1.8}.

293 **1.6.2.1 Postpartum incomplete (bladder) emptying:** Complaint that the bladder does not feel empty, after
 294 voiding has ceased, during the postpartum period and up to 12 months after delivery (NEW)(7).

295 **1.6.2.2 Postpartum splinting to micturate:** Complaint of the need to digitally support perineum or buttocks
 296 manually (usually with thumb or fingers) to assist voiding (micturition), eventually manually reducing the
 297 prolapse, first experienced during postpartum period and up to 12 months after delivery (NEW).

298
 299 **1.7 Pregnancy and postpartum associated defecatory or post-defecatory symptoms:** Symptoms
 300 experienced during or following the act of defecation during pregnancy, the postpartum period and up to
 301 12 months after delivery (7) (NEW).

302 **1.7.1 Postpartum constipation:** Complaint that bowel movements are infrequent and/or incomplete and/or
 303 there is a need for frequent straining or manual assistance to defecate (Rome IV criteria (19):(20)) during the
 304 postpartum period and up to 12 months after delivery (NEW) ^{FN1.9, FN1.10}.

305 **1.7.2 Postpartum post-defaecatory pain:** Complaint of pain occurring during or after defecation during
306 the postpartum period and up to 12 months after delivery (NEW).

307 **1.7.3 Postpartum post-defaecatory rectal bleeding:** Complaint of rectal bleeding occurring after defecation
308 during the postpartum period and up to 12 months after delivery (NEW).

309 **1.7.4 Postpartum anal incontinence (symptom).** Complaint of involuntary loss of flatus or feces during the
310 postpartum period and up to 12 months after delivery (NEW).

311 **1.7.4.1 Postpartum faecal incontinence:** Complaint of involuntary loss of feces (solid and/or liquid) during
312 the postpartum period and up to 12 months after delivery (7) (NEW).

313 **1.7.4.2 Postpartum flatal incontinence:** Complaint of involuntary loss of flatus (gas) during the postpartum
314 period and up to 12 months after delivery (9,18) (NEW).

315 **1.7.4.3 Postpartum coital anal incontinence:** Faecal or flatal incontinence occurring with vaginal intercourse
316 during the postpartum period and up to 12 months after delivery (12) (NEW).

317 **1.7.4.4 Postpartum passive faecal (insensible) incontinence:** Faecal soiling without sensation or warning or
318 difficulty wiping clean during the postpartum period and up to 12 months after delivery (9) (NEW).

319 **1.7.4.5 Postpartum overflow faecal incontinence:** Complaint of involuntary loss of stool due to an overfull
320 rectum or faecal impaction during the postpartum period and up to 12 months after delivery (9) (18) (NEW).

321 **1.7.4.6 Postpartum faecal urgency incontinence:** Complaint of involuntary loss of faeces associated with the
322 sensation of a sudden, compelling desire to pass faeces which is difficult to defer experienced for the first
323 time during the postpartum period and up to 12 months after delivery (NEW).

324 **1.7.4.7 Postpartum double incontinence:** Complaint of both anal incontinence and urinary incontinence
325 during the postpartum period and up to 12 months after delivery (NEW).

326
327 **1.8 Ante/Postpartum prolapse symptoms:** A departure from normal sensation, structure or function,
328 experienced by the woman about the position of her pelvic organs during pregnancy or in the postpartum
329 period and up to 12 months after delivery (NEW)^{FN 1.1}.

330
331 **1.9 Postpartum bleeding, discharge, infection:** Complaint of abnormal vaginal and/or vulvo-perineal
332 bleeding, mucus/pus discharge during the postpartum period and up to 12 months after delivery (NEW).

333
334 **1.10. Obstetric pelvic floor trauma related sexual dysfunction symptoms:** (6) (12) (21)

335 **1.10.1 Postpartum dyspareunia:** Complaint of persistent or recurrent pain or discomfort associated with
336 attempted or complete vaginal penetration during the postpartum period and up to 12 months after delivery
337 (NEW).

338 **1.10.2 Postpartum vaginal laxity:** Feeling of vaginal looseness during the postpartum period and up to 12

339 months after delivery (12) (NEW).

340 **1.10.3 Postpartum obstructed intercourse:** New onset difficulty or obstruction of vaginal intercourse that
341 occurs during the postpartum period and within 12 months after delivery (NEW).

342 **1.10.4 Postpartum anorgasmia or difficulty in achieving orgasm:** Complaint of lack of orgasm during the
343 postpartum period and within 12 months after delivery; the persistent or recurrent difficulty, delay in or
344 absence of attaining orgasm following sufficient sexual stimulation and arousal, which causes personal
345 distress (NEW).

346 **1.10.5 Postpartum decreased arousal:** Persistent or recurrent inability to achieve or maintain sexual
347 excitement during the postpartum period and within 12 months after delivery. This may be expressed as
348 lack of excitement, lack of lubrication, lack of vaginal and clitoral engorgement, or lack of expression of other
349 somatic responses (NEW).

350 **1.10.6 Postpartum decreased libido or sexual desire:** Absent or diminished feelings of sexual interest or
351 desire, absent sexual thoughts or fantasies, and a lack of responsive desire during the postpartum period
352 and up to 12 months after delivery. Motivations (here defined as reasons/incentives) for attempting to
353 become sexually aroused are scarce or absent. The lack of interest is considered to be beyond the
354 normative lessening with lifecycle and relationship duration (NEW).

355 **1.11 Obstetric pelvic floor trauma related pain symptoms**

356 **1.11.1 Postpartum perineal pain:** Complaint of pain felt between the posterior fourchette (posterior lip of
357 the vaginal introitus) and the anus during the postpartum period and up to 12 months after delivery (NEW).

358 **1.11.2 Postpartum vulval pain / vulvodynia.** Complaint of pain felt between the posterior fourchette
359 (posterior lip of the vaginal introitus) and the mons pubis limited by the inner thigh fold and including labial,
360 clitoral and periurethral pain during the postpartum period and up to 12 months after delivery (NEW).

361 **1.11.3 Postpartum pudendal pain (neuralgia).** Complaint of pain, pressure or discomfort referred to pubic
362 symphysis, labia majora and minora, inferior third of the vagina, urethral meatus, anus, perianal area, lower
363 third of the rectum and buttock (possible inflammation or entrapment of the pudendal nerve and involving
364 its dermatome) during the postpartum period and up to 12 months after delivery (7) (NEW).

365 **1.11.4 Postpartum pubic pain:** Complaint of pain in the symphysis pubic area during the postpartum period
366 and up to 12 months after delivery (NEW).

367 **1.11.5 Postpartum coccygeal pain:** Complaint of pain, pressure or discomfort felt in the coccygeal region
368 during the postpartum period and up to 12 months after delivery (7) (NEW).

369 **1.11.6 Postpartum chronic pelvic joint, ligament or bone pain syndrome:** Complaint of joint and/or bony
370 pain described at level of pelvic and perineal area during the postpartum period and up to 12 months after
371 delivery (NEW).

373 **1.11.7 Obstetric pelvic girdle syndrome:** A symptom syndrome which involves pain in all three pelvic
374 joints or unilateral/bilateral sacroiliac joint pain, which may also occur before or after childbirth (22) (NEW).
375

376 **Footnotes for Section 1**

377 **1.1:** Symptoms are generally worse in situations when gravity might make the prolapse worse (e.g. after long
378 periods of standing or exercise) and better when gravity is not a factor e.g. lying supine. Symptoms may also
379 be more noticeable at times of abdominal straining e.g. defecation or bearing down.(6) Straining is a
380 different manoeuvre to Valsalva and results in different effects on pelvic floor activity and pelvic organ
381 descent. (16) It has been proposed that Valsalva and straining have different PFM activation patterns. The
382 pelvic floor is stiffer with Valsalva resulting in better bladder neck (BN) support whereas straining leads to
383 more puborectalis and bladder neck descent (17).

384 Postpartum prolapse, urinary and in general pelvic floor symptoms are often self-limiting and may resolve
385 after the postpartum period, however in some cases they may persist (23) (24,25).

386 We acknowledge that definitions of pelvic floor symptoms are presented extensively in other relevant
387 terminology reports. In order to provide a comprehensive inventory of commonly encountered pelvic floor
388 symptoms in pregnancy and postpartum period, we provide a selected list of generic pelvic floor definitions
389 in addition to symptoms and their definitions that have specific characteristics in pregnancy and postpartum
390 period for comprehensiveness and ease of reference. As health care providers outside the area of pelvic
391 floor (urogynaecology, female urology) such as obstetricians, midwives etc may find this report useful
392 without necessarily having access to other terminology reports, we decided to allow such overlaps.

393 **1.2:** Manipulation of the vaginal wall also includes manual repositioning, if prolapsed.

394 **1.3:** In the postpartum period, voiding symptoms or other LUTS can be secondary to regional anaesthesia,
395 indwelling transurethral catheterisation or overdistention bladder injury.

396 **1.4:** It was decided not to change the definition of the urinary symptoms experienced by women during
397 pregnancy, considering their incidence, duration and, last but not least, the possibility of hindering
398 documentation and reporting in clinical practice.

399 **1.5:** Pregnancy and childbirth cause temporary and sometimes permanent changes to the anatomical
400 structures of the pelvic floor. Sequelae on pelvic organ function can be unpredictable both in the short and
401 long term. Epidemiological and comparative anatomy studies suggest that postpartum pelvic floor
402 dysfunction (for example urinary incontinence) could have a different aetiopathogenesis than those
403 experienced in a more advanced age (26).

404 **1.6:** If the woman experiences voiding difficulties and/or small frequent voids during the first hours post
405 childbirth, the post-void residual volume should always be investigated. This should be performed even in

the absence of specific symptoms if voiding interval is longer than 3-4 hours, especially after epidural / regional anaesthesia.

1.7: Voiding difficulty has been defined as an abnormally slow or incomplete voiding (27).

Voiding dysfunction is defined by symptoms and urodynamic investigations as abnormally slow and/or incomplete micturition, based on abnormally slow urine flow rates and or abnormally high post-void residuals, ideally on repeated measurement to confirm abnormality. Pressure-flow studies can be required to determine the cause of voiding dysfunction (8).

1.8: Postpartum urinary retention (PPUR) is the complaint of inability to empty the bladder completely or adequately, during the postpartum period and up to 12 months after delivery (7).

PPUR is usually:

- an acute condition due to trauma or inflammatory/infection changes associated with spontaneous or operative (vaginal or abdominal) delivery;
- characterized by absent or reduced woman's perceived bladder sensation;
- may be associated with acute pain in the initial phase of retention;
- may also be associated with small frequent voids that do not sufficiently empty the bladder;
- resolves, if properly recognized and treated, in a few hours or days.

For the management of PPUR, optimal management of bladder emptying is essential both during labour and in the postpartum period. Timed voiding and, possibly, evaluation of postvoid bladder residual is useful even if the woman does not report symptoms of incomplete emptying if the voiding interval is abnormally prolonged. Long labour, peridural analgesia, delivery trauma, prolonged surgical procedures under anaesthesia and sequelae of surgical repair (oedema and tissue inflammation) can be the cause, mechanical and / or functional, of diminished perception of the sensation of bladder filling and further secondary damage of the bladder innervation by overdistension.

Overt PPUR (oPPUR) is inability to void spontaneously within 6 hours after vaginal delivery or within 6 hours after removal of an indwelling bladder catheter after cesarean section, requiring catheterization (28).

Covert PPUR (cPPUR) refers to post void residual volume >150 mL with voided volume of at least 150ml (29) with no symptoms of retention.

1.9: Rome IV Criteria for Constipation (1.2.3.1): Complaint that bowel movements are

- (i) infrequent (<3 /wk);
- (ii) need to strain;
- (iii) lumpy or hard stool bloating;
- (iv) sensation of incomplete evacuation;
- (v) sensation of anorectal obstruction or blockage abdominal pain,
- (vi) need for manual assistance, in more than one quarter of all defecation.

440 **1.10:** During pregnancy and in the postpartum period, constipation may be secondary to hormone related
441 slow transit, or other changes associated with anatomical or physiological alteration of the pelvic floor
442 function.

444 **3 SECTION 2: SIGNS**

446 **2.1 Sign:** Any abnormality indicative of disease or a health problem, discoverable on examination of the
447 patient; an objective indication of disease (11) or a health problem.

448 **2.1.2 Vaginal signs of obstetric pelvic floor trauma**

449 **2.1.2.1 Vulvovaginal and perineal obstetric trauma:** Trauma (injury) occurring at the vulva, vagina or
450 perineum at the time of vaginal childbirth (30).

451 **2.1.2.2 Postpartum discharge:** Vaginal clear, bloody or mucus discharge in the postpartum period and up to
452 12 months after delivery. (NEW)

453 **2.1.2.3 Obstetric cervical trauma:** Trauma occurring to the cervix during the process of cervical dilatation or
454 at the time of childbirth. (NEW)

455 **2.1.2.4 Postpartum vulvovaginal and perineal oedema:** swelling of the vulvovaginal and perineal area
456 characterized by watery fluid collection. (NEW)

457 **2.1.2.5 Postpartum vulvovaginal haematoma:** Haematoma in the vulva and/or vagina caused during
458 childbirth. (NEW)

459 **2.1.2.6 Vaginal burst trauma:** Multiple generalized multidirectional vaginal tears, usually superficial, that
460 occur during vaginal delivery. (NEW)

461 **2.1.2.7 Superficial /cutaneous perineal / vaginal trauma (also known as first degree tear):** Laceration of the
462 vaginal epithelium or perineal skin only. On inspection there is cutaneous laceration of the perineal and / or
463 vaginal epithelium. (CHANGED)

464 **2.1.2.8 Postpartum vaginal skin tag:** Excess vaginal skin resulting in skin growth at the introitus diagnosed
465 after vaginal childbirth. (NEW)

466 **2.1.2.9 Vaginal mucosa avulsion/scalp:** Vaginal tear occurring by detachment of the vaginal mucosa from
467 the underlying muscle during vaginal childbirth, resulting in a superficial but wide raw bleeding surface in
468 the vagina. (NEW)

469 **2.1.2.10 Postpartum vaginal granuloma:** Small mass composed of granulation tissue on the surface of a
470 previous wound often secondary to retained suture material or other causes provoking localized foreign
471 body inflammatory reaction following vaginal childbirth and vaginal epithelial injury. (NEW)

473 **2.1.3 Postpartum lower urinary tract signs**

474 **2.1.3.1 Obstetric bladder injury:** Trauma or injury to the bladder during childbirth. (NEW)

475 **2.1.3.2 Postpartum urinary stress incontinence:** Urinary stress incontinence occurring after childbirth, that
476 was not present before or during pregnancy, observed on clinical examination during cough test, Valsalva
477 or physical exertion. (NEW)

478 **2.1.3.3 Postpartum voiding dysfunction:** a painfully distended and readily palpable or percussible bladder
479 due to difficulty emptying the bladder, causing high post-void residuals, during the postpartum period and
480 up to 12 months after delivery. (NEW)

481 **2.1.4 Postpartum perineal and anorectal signs**

482 **2.1.4.1 Obstetric perineal muscle trauma** (also known as **second degree**): Trauma (injury) of the perineal
483 muscles but not the anal sphincter following vaginal childbirth. (CHANGED)

484 **2.1.4.2 Obstetric anal sphincter trauma (injury)** (also known as **third and fourth degree**): Disruption of the
485 anal sphincter muscles following vaginal childbirth. (CHANGED)

486 The different types and classification of obstetric anal sphincter trauma are discussed in the “Diagnoses”
487 Section.

488 **2.1.4.3 Perineal scar:** Cutaneous scar resulting from trauma to the perineum.

489 **2.1.4.4 Deficient perineum:** Reduced perineal body measuring less than 2.5 cm and often associated with
490 introital gaping (31) (NEW).

491 **2.1.4.5 Perineal ridge (PR):** Measurement performed at the hymenal ring that describes the distance in
492 centimeters from the midline of the mid-hymenal ring to the commencement of the posterior vaginal skin
493 on the vaginal side of the PR as distinct from the perineal side (perineal body) (31) (NEW).

494 **2.1.4.6 Cloacal-like defect:** A spectrum of tissue loss from the perineal body and rectovaginal septum with
495 variable appearance. This may consist of a common cavity made up of the anterior vagina and posterior
496 anorectal walls or just an extremely thin septum between the anorectum and vagina (12).

497 **2.1.5 Postpartum vulval signs**

498 **2.1.5.1 Vulval and perineal ecchymosis (bruising):** Vulval and perineal skin discoloration secondary to
499 subcutaneous blood leakage into surrounding tissue from a broken capillary under the skin. (NEW)

500 **2.1.5.2 Vulval gaping, enlarged (widened) genital hiatus:** Non-coaptation of vulva at rest, commonly
501 associated with increased size of genital hiatus.(12)_{FN2.1}

502 **2.1.5.3 Obstetric paraurethral trauma:** injury of the vaginal epithelium around the urethral meatus at the
503 time of vaginal childbirth. (NEW)

504 **2.1.5.4 Obstetric paraclitoral/clitoral trauma:** injury close to or of the clitoris at the time of vaginal
505 childbirth. It may or may not involve clitoral tissues. (NEW)

2.1.6.1 Levator ani muscle trauma

2.1.6.1.1 Levator avulsion: The detachment of the levator ani muscle (LAM) from its insertion on the inferior pubic ramus (8) (14) (NEW). It can be ascertained by per-vaginam palpation, especially during pelvic floor muscles contraction and can be:

- partial
- complete (32)
- unilateral
- bilateral

2.1.7 Obstetric pelvic floor nerve trauma

2.1.7.1 Obstetric neuropathy: Decreased or absent sensation or tone during examination of the vagina, vulva or perineal structures, following childbirth

2.1.7.2 Obstetric pudendal nerve injury: Decreased or absent sensation or tone during examination, in the distribution of the pudendal nerve, secondary to injury to the pudendal nerve or its branches during vaginal childbirth. (NEW)

2.1.8 Obstetric pelvic floor musculoskeletal/connective tissue trauma

2.1.8.1 Pelvic organ prolapse (sign): The descent of one or more of the anterior vaginal wall, posterior vaginal wall, the uterus (cervix) or the apex of the vagina. The presence of any such sign should be correlated with relevant POP symptoms i.e. patient report of symptoms with maximal prolapse. More commonly, this correlation would occur with descent to the level of the hymen or beyond (8) (14) (33) (34) (35) (36) FN2.2.

2.1.9 Bone trauma / effects of pregnancy and childbirth on bones and joints

2.1.9.1 Postpartum symphysis pubis diastasis: separation of the symphysis pubis, without fracture, which allows excess lateral or anterior movement of the symphysis pubis and can result in symphysis pubis dysfunction during the postpartum period and up to 12 months after delivery. (NEW)

2.1.9.2 Postpartum coccygeal dislocation / fracture: The coccyx slips anteriorly or posteriorly with respect to the sacrum during labour and/or postpartum period and up to 12 months after delivery (NEW)

2.1.10 Obstetric fistula: Is an abnormal communication from the urinary (bladder, ureter and/or urethral lumen) and/or anorectal tract to the vagina or perineal area respectively characterized by the observation of urine leakage through channels other than the urethral meatus (extra-urethral incontinence)(7) and of faeces leakage through channels other than the anal canal observed during postpartum period and up to 12 months after delivery. (NEW)FN2.3

2.1.10.1 Extra-urethral incontinence: Observation of urine leakage through channels other than the urethral meatus, for example, fistula. The fistula may be described anatomically from one structure to another. Below

are anatomical descriptions of pelvic floor fistula (PFF). The PFF defects may occur between 2 or more structures (10). FN2.4

2.1.10.2 Lower urinary tract pelvic floor fistula (PFF) signs: Observation of a defect between the lower urinary tract structure (urethra, bladder) and vagina (vesicovaginal fistula, figure 1) and/or uterus (and/or cervix) that may occur across a spectrum of tissue loss (figure 2), with variable appearance and with or without observation of a

- probe passing through the lumen of the two or more affected structures (10)

- a dyed irrigant fluid passing per defect at the time of retrograde fill test of the bladder through a bladder catheter (positive blue test) (10)

- retrograde blue test after filling to the urethral lumen by a Trattner catheter without filling the bladder (10). FN2.5

2.1.10.3 Upper urinary tract pelvic floor fistula (PFF) signs:

Observation of a defect between the ureter(s) and vagina and/or uterus (and/or cervix) that may occur across a spectrum of tissue loss, with variable appearance and with or without observation of

- a probe passing through the lumen of the two or more affected structures (10).

- urine pooling in the posterior vaginal fornix directly or passing through the cervix.

- urine pooling in the posterior vaginal fornix at the time of retrograde dyed irrigation fill test of the bladder through a bladder catheter (negative dye test, positive urine) (10).

- urine passing per cervical os; with or without pooling in the posterior vaginal fornix at the time of retrograde dyed irrigant fill test of the bladder through a bladder catheter (negative blue test, positive clear urine) (10).

FN2.5

2.1.10.4 Anorecto – vaginal fistula signs: Excoriation dermatitis at level of inner thighs, external genitalia, perineum or vagina with or without skin rashes, crusting or scabbing, soiling, discharge, scars, sinus, deformities, hematoma.(10)

2.1.10.5 Recto – vaginal fistula signs: Abnormal connection between the rectum to the vagina with or without observation of vaginal flatus/faeces. With or without the observation of:

- anorectal fluid per vagina (10),

- probe or examination finger passing per vagina through anus or per anus through vagina (10),

- anorectal tract fluid per vagina, or with bubbles passing through the abnormal connection through vaginal irrigant fluid after retrograde injection of air per rectum (10). FN2.5



Figure 1: Obstetric vesico-vaginal fistula during repair (37). Reprinted by permission from Springer Nature.

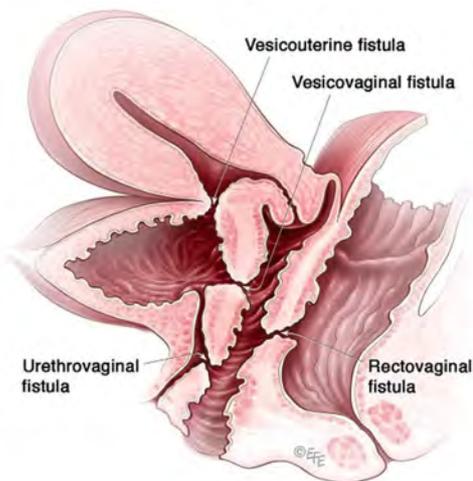


Figure 2: Pelvic floor fistula anatomy.(10)

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2.2 Clinical Examination

Clinical examination immediately after childbirth or in the postpartum period is guided by parameters of labour, mode of delivery and associated / suspected injuries. Often, acute interventions including emergency measures to arrest postpartum haemorrhage or surgical repair of complex trauma require a thorough clinical examination and accurate diagnosis as well as optimization of analgesia, adequate exposure (positioning, lighting), co-operation and consent of the patient and availability of equipment and assistance. FN2.6

2.2.1 Postpartum digital vaginal-anorectal examination: An examination in which a doctor or midwife

594 inserts a lubricated, gloved finger into the rectum and a thumb in the vagina. The examiner observes to
 595 identify injured structures and palpates the sphincter from 9-o'clock to 3 o'clock to detect lacerations or
 596 other injuries to the vaginal or rectal epithelium, perineal muscles and anal sphincter muscles. Anal sphincter
 597 tone may be altered by the effects of regional anaesthesia. Following a repair, an anorectal exam is
 598 performed to detect palpable sutures that have been unintentionally perforated the anorectal epithelium.
 599 (NEW)

600 **2.2.2 Vaginal examination:** Examination for vaginal length and mobility, presence of scarring and/or pain,
 601 and estrogenization. The location of any vaginal pain should be noted (6).^{FN2.7}

602 **2.2.3 Examination for levator defects/trauma:** Per-vaginam palpation for levator injury/defect/ "avulsion"
 603 (8) (14).

604 **2.2.4 Postpartum rectal examination:** Examination of the rectum in the immediate postpartum period and
 605 up to 12 months after delivery. The gloved finger should be placed in the centre of the anus with the finger
 606 parallel to the skin of the perineum in the midline. The finger should then be pressed gently into the anal
 607 canal but at the same time pressed backwards against the skin of the posterior wall of the anal canal and
 608 underlying sling of the puborectalis muscle. This overcomes most of the tone of anal sphincter and allows
 609 the finger to straighten and slip into the rectum (9) (18) (NEW). ^{FN2.8}

610 **2.2.5 Postpartum anorectal examination.** A comprehensive anorectal examination undertaken
 611 immediately after birth or during postpartum and up to 12 months after delivery. The patient lies in the
 612 left lateral position with hips flexed and ankles away from the examiner. Dorsal lithotomy position is also
 613 commonly used. An anorectal examination is essential to exclude/confirm obstetric anal sphincter or
 614 anorectal injury (9) (18) (NEW).

615 **2.2.6 Postpartum perianal and perineal examination:** Examination of the perineal and perianal area is
 616 conducted around introital-vulvar area, perineum and anus.

617 Exposure of the vaginal introitus is performed by gently parting the labia majora and minora with
 618 inspection and palpation of the external genitalia, the bulbocavernosus and transverse perineal muscles
 619 and the vulvar and vaginal epithelium (NEW). ^{FN2.9}

620 **2.2.6.1 Perianal sensation/reflex:** In patients with possible neurogenic pelvic floor dysfunction there should
 621 be particular note of those neurological signs related to S2-4 but these should be complimented by a more
 622 general neurological examination as indicated. Specific to anorectal dysfunction, assessment of anal reflex,
 623 and perianal sensation should be performed (9) (18).

624 **2.2.6.2 Sacral reflex testing:** This measures the reflex arc of the spinal cord and the sacral plexus including
 625 the pudendal nerve. Bulbocavernosus and anal reflex are the most commonly evaluated.

2.1: An enlarged hiatus has long been considered both a possible cause and an effect of pelvic organ prolapse(38). A large epidemiological study (39) conducted for 10 years on a sample of 1198 women, although not clarifying the causality or not, seems to correlate a larger hiatus and its faster increase with the development of prolapse. A genital hiatus larger than 3.16 cm increasing in the size at a mean rate of more than 0.56 cm per 5-year period could identify women at highest risk for developing prolapse.

2.2: For a more detailed definition see IUGA/ICS joint report on the terminology for female pelvic organ prolapse(8)

2.3: Obstetric fistulas is a rare condition and is usually secondary to mechanical obstetric pelvic floor trauma provoked by a prolonged or obstructed labour in women who do not have access to health care facilities.

2.4: Basic categories of Pelvic Floor Fistula are classified defining each in relation to the hollow organ system component involved in the fistula defect (figure 2). These are localizing/descriptive terms and not a classification system as such. The following acronyms will be used: F (fistula); V (bladder/vesico); U (urethra); Va (vaginal); Vt (vaginal vault); Ut(uterine); Cx (cervical); Ur (ureteric); R (rectal); Co (colon);Pe (perineal); AC (ano-cutaneous).

- UVaF: Abnormal connection between the urethra and the vagina.(10)

- Vesico-vaginal fistula (VVaF): Abnormal connection between the bladder and the vagina.(10)

- Vesico-uterine fistula (VUtF): Abnormal connection between the bladder and the uterus. (10)

- Uretero-vaginal fistula (UrVaF): Abnormal connection between the ureter and the vagina. (10)

- (Colo)-recto-vaginal fistula (RVaF): Abnormal connection between the rectum (colon) and the vagina. (10) (figure 3)

- (Colo)-rectal to urinary tract: Any abnormal connection between the rectum (colon) and any part of the urinary tract, without vaginal involvement. (10)

- Partial UVaF: Urethral structure is evident, with a demonstrable fistula defect (Figure 2). (10)

- Total UVaF: Urethral structure is not evident (Figure 3). (10)

- Circumferential fistula (genito-urinary): An entire segment (anterior, posterior, lateral urethra) from the anterior vaginal wall to the posterior aspect of the pubic symphysis is absent and destroyed.^{23,24} The circumferential fistula almost always involves the urethra and the fistula totally separates the proximal urethra/bladder from the distal portion. Bladder involvement with a circumferential fistula is common (10).

- VVaF: Fistula affecting anterior vaginal wall and posterior bladder wall with or without involvement of the ureteric orifices

- Circumferential fistula (genito-urinary): It almost always involves the urethra (10).

- Vesico-vaginal vault fistula (VVtF): VVaF located at vaginal vault (cuff) following hysterectomy (10).

- 661 - Vesico-cervical fistula (VCx F): Abnormal connection between the bladder and the cervix. May occur
 662 after cesarean section, procedures to the cervix, supra-cervical hysterectomy (10).
- 663 - VUt F: Abnormal connection between the bladder and the body of the uterus (10).
- 664 - UrVa F: Abnormal connection between the ureter and the vagina (10).
- 665 - UrVa F may be congenital (ectopic ureter) (10) or
 666 - Acquired (e.g., following surgery or obstructed labor) (10)
- 667 - Uretero-vesical-vaginal fistula (UrVVa F): Fistula involving the ureter(s), bladder, and vagina. This may be
 668 seen with a large obstetric fistula and the ureter is outside the VVa F (10).
- 669 - Uretero-uterine (cervical) fistula (UrUt F/UrCx F): Abnormal connection between the ureter and the uterus
 670 (cervix). Predominantly post-cesarean or postsupracervical hysterectomy (10).
- 671 - Fourth-degree tears: Obstetric anal sphincter injury with disruption of the perineal body, connecting the
 672 vagina to the anorectum. The internal and external anal sphincters are disrupted (10).
- 673 - Acute fourth degree tear—Occurs at time of childbirth or other trauma (10).
- 674 - Chronic fourth degree tear—Unrepaired or dehiscence following repair at time of childbirth or other
 675 trauma, resulting in an absent perineal body with a total perineal defect (10).
- 676 - RVa F: Abnormal connection between the rectum and the vagina (10).
- 677 - Non-circumferential RVa F: Involves the posterior vaginal wall and anterior rectum (10).
- 678 - Circumferential RVa F: Involves an entire segment of the rectum, involving the posterior vaginal
 679 wall, anterior and posterior rectum. The proximal rectal part of the fistula is completely separated from the
 680 distal portion (10).
- 681 - Rectal/vaginal/perineal fistula (RVaPe F): An abnormal communication from the anorectum to the vagina
 682 or perineal area (10).
- 683 - Recto-uterine/cervical fistula (RUt F/RCx F): An abnormal connection from the rectum to the uterus or
 684 cervix (10).
- 685 - Fistula in ano (FIA)/ano-cutaneous fistula (ACF): An abnormal connection between the anal canal
 686 epithelium and the skin epithelium.
- 687 - Colo-vesical fistula (CoVF): Abnormal connection between the rectum (colon) and the bladder. (10)
- 688 - Recto (colo)-ureteric fistula (RUr F/CoUr F): Abnormal connection between the rectum (colon) and the
 689 ureter. (10)
- 690 **2.5:** For a more detailed definition see ICS report on the terminology for female pelvic organ fistulas (10).
- 691 **2.6:** Training on postpartum management is an essential part of obstetric and gynaecological training
 692 curriculum (40). In some countries, childbirth assistance is carried out by doctors who are not specialized in
 693 gynecology and few countries provide a specific training in urogynecology during a general obstetrics and
 694 gynecology residency (41) (42).

695 **2.7:** A full vaginal examination should be performed to examine the perineum and vaginal tissues and
 696 evaluate the extent of any vaginal tear. Although parting the labia and vaginal walls by the fingers is usually
 697 adequate, deep tears may necessitate the use of a Kristeller, Kallmorgen or Sims Vaginal Specula. Evaluation
 698 for cervical tear with the sponge-holding forceps gently grasping the cervix to systematically inspect for any
 699 disruption is important. A digital rectal examination should be performed to evaluate the anal sphincter
 700 complex and to exclude buttonhole tears. The woman can be asked to contract her anal sphincter around
 701 the examiners finger.

702 **2.8: Postpartum rectal examination allows assessment of:**

703 (a) Resting anal tone, voluntary squeeze of the anal sphincter as well as the levator muscles, sustained
 704 squeeze over 5 sec and involuntary contraction elicited during a cough. Immediately after delivery, especially
 705 in cases with epidural analgesia, clinicians may not be able to adequately assess the integrity of the sphincter
 706 and its tone, which may only to be determined through direct visual examination and its palpation.

707 (b) Obvious haemorrhoids can be palpated but grade II and grade III haemorrhoids are better assessed by
 708 proctoscopy. Painful examination may be associated with fistula in ano, fissure in ano, infection or pilonidal
 709 abscess.

710 (c) Palpable anal sphincter gap. An assessment can be made of a palpable anal sphincter gap to assess if
 711 there has been recent or previous obstetric or surgical damage. The perineal body can be assessed for
 712 deficiency.

713 (d) Rectal contents. The contents of the rectum can be assessed. The feces may be hard or soft, the rectum
 714 may be empty or collapsed and sometimes ballooned out. This allows assessment of fecal impaction.

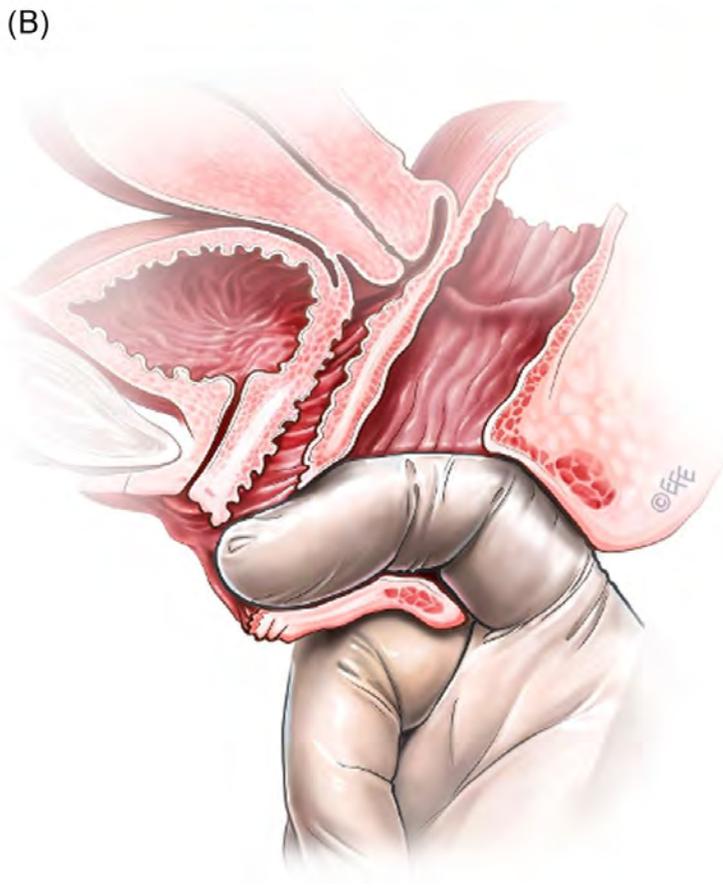
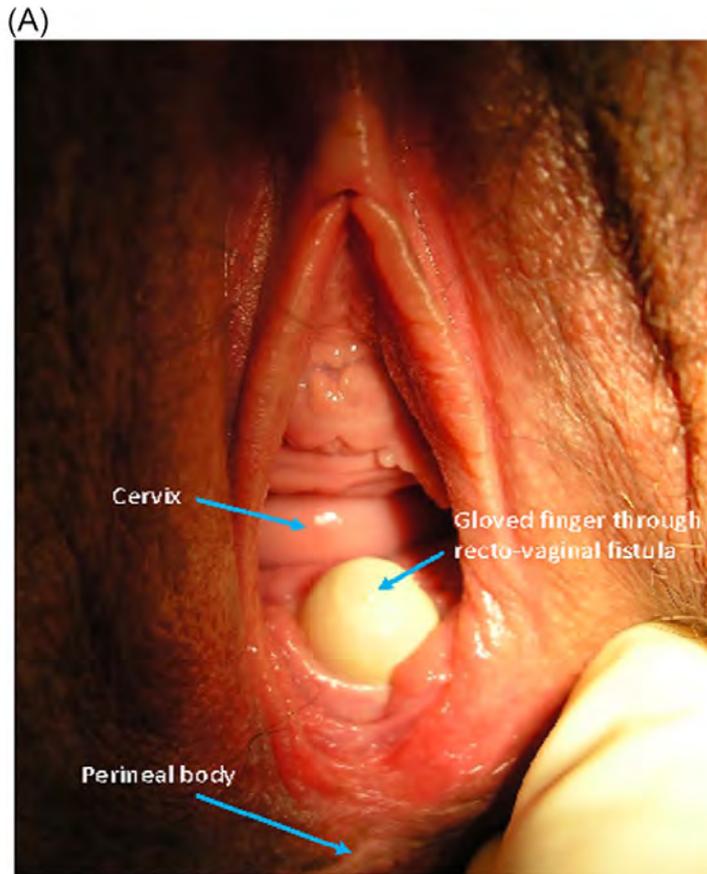
715 (e) Confirmation of presence of rectocele, enterocele, or perineocele. Use of POP-Q for staging of prolapse.

716 (f) Bidigital examination is defined as a concurrent digital examination of the vagina and rectum and may be
 717 carried out with the patient supine in a gynecological examining position. The index finger is inserted in the
 718 vagina and the middle finger in the rectum, in order to identify fascial rectovaginal defects, exclude a
 719 rectovaginal perforation (buttonhole injury) and differentiate a rectocele from an enterocele, during an
 720 abdominal straining manoeuvre (9) (18).

721 **2.9: Perianal and perineal examination aim to assess:**

- 722 (i) Perineal body and superficial perineal musculature integrity, consistence and lacerations
- 723 (ii) Excoriation: perianal excoriation, skin rashes (9) (18)
- 724 (iii) Soiling: perianal faecal soiling or vaginal faecal soiling (9) (18)
- 725 (iv) Discharge: perianal or vaginal bloody or mucus discharge (9) (18)
- 726 (v) Gaping anus: non-coaptation of anal mucosa at rest (9) (18)
- 727 (vi) Scars, sinuses, deformities, condylomata, papillomata, haematoma

- 728 (vii) “Dovetail” sign: where the anterior perianal folds are absent, indicating a defect in the
729 external anal sphincter (23)
- 730 (viii) Others described individually: anal fissure, haemorrhoids, anorectal prolapse, fistula-in-ano,
731 recto-vaginal fistula, anorectal/ vaginal/perineal fistula (9) (18) (figure 3)



732
733 **Figure 3:** Rectovaginal fistula (10).

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735 Clearance Center, Inc)

4 SECTION 3: INVESTIGATIONS

3.1 Assessment of possible impact of obstetric trauma on voiding function

Labour, regional anaesthesia and delivery and specifically obstetric pelvic floor trauma can have a negative impact on voiding function, screening for which involves a bladder postvoid residual volume measurement and ideally uroflowmetry. Voiding cystometry may clarify the cause of any voiding dysfunction.

However, invasive urodynamic investigations in the postpartum period are usually delayed and non-invasive assessment (post void residual measurement) is the common investigation of choice for first line assessment of voiding symptoms. (NEW)

3.1.1 Postpartum urodynamic investigations: Measurement of physiological parameters relevant to the function of the lower urinary tract (7).

These usually take place in a special clinical room and involve post void residual urine volume (PVR) measurement after a spontaneous micturition flow. Uroflowmetry, filling cystometry with (artificial) bladder filling with a specified liquid (ICS recommends physiological saline solution or X-ray contrast if video studies) at a specified rate and pressure-flow studies are unnecessary in the most,(43) if not, in almost all cases during postpartum period and up 12 months after delivery.FN3.1 (NEW)

3.1.1.1 Postpartum post void residual (PPVR) measurement: Volume of urine left in the bladder at the completion of voiding in the post-partum period, that may be measured by catheter or ultrasound (6) (7) (15) (44) (NEW). FN3.2

3.1.1.2 Postpartum free (no catheter) uroflowmetry: Measurement of urine flow rates during micturition. A test that measures the flow rate of the external urinary stream as voided volume per unit time in millilitres per second (mL/s) (45)(figure 4). FN3.3

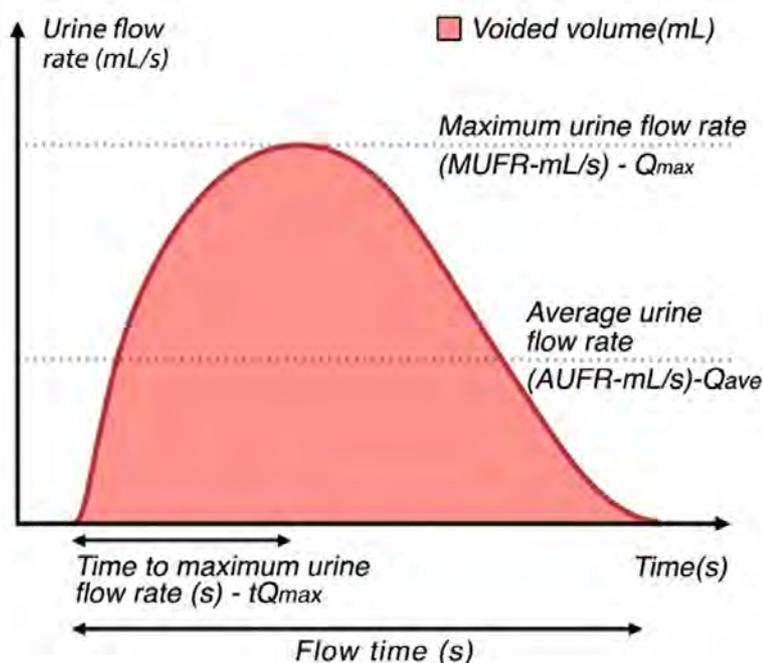


Figure 4: Uroflowmetry(10)

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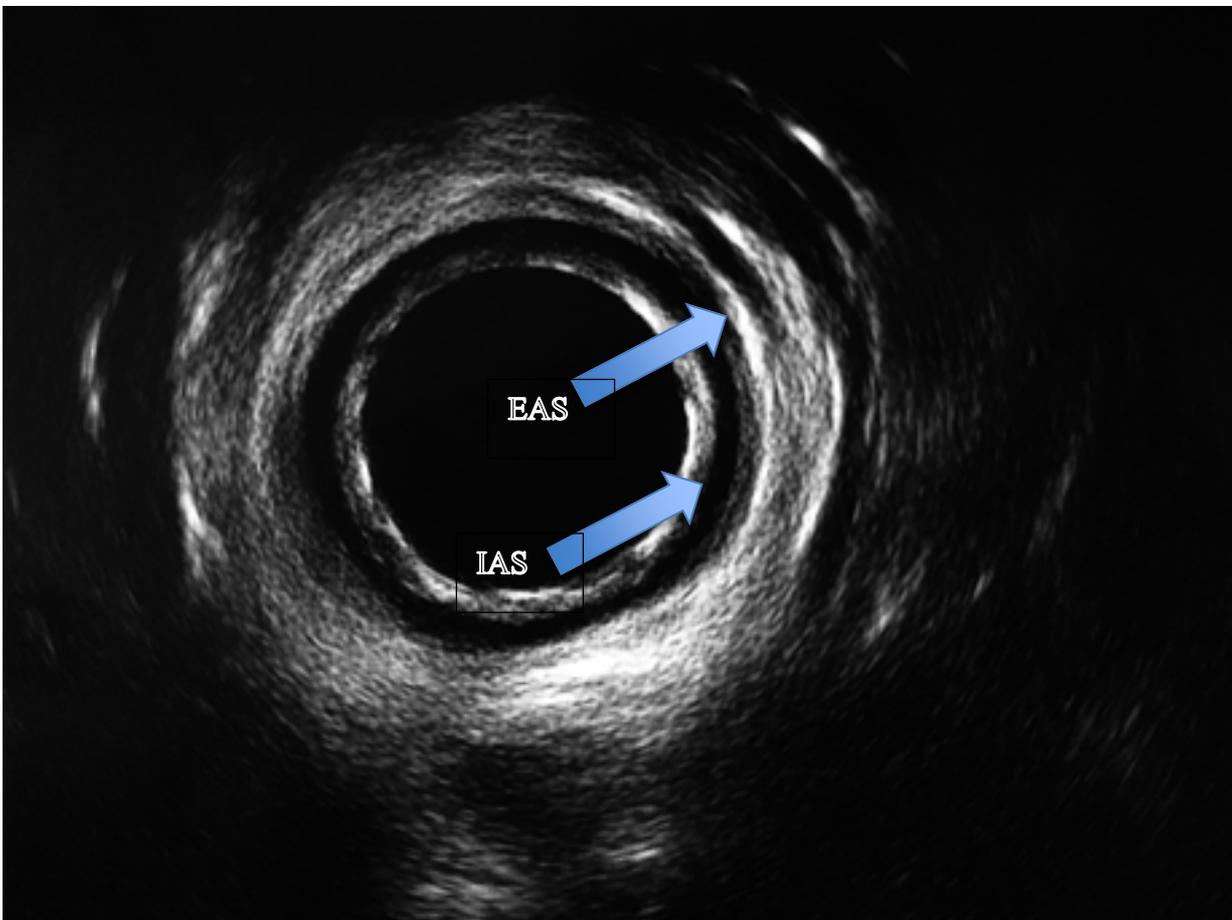
3.2 Assessment of possible impact of obstetric trauma on defecatory and anorectal function

3.2.1 Anorectal manometry: Assessment of resting, squeeze pressures as measured with air or water charged or solid state pressure manometer. As normal values can differ substantially between laboratories according to the style of catheter used, each unit is encouraged to generate its own normal data (9,18).

3.3 Imaging

794 **3.3.1 Ultrasound 3D and 4D:** The potential of 3D ultrasound in urogynaecology and female urology is
 795 currently being researched with validated applications likely to be included in future updates of this report
 796 and/or separate ultrasound reports. Applications with the most current research include: (i) major
 797 morphological abnormalities such as levator defects, (ii) excessive distensibility of the puborectalis muscle
 798 and levator hiatus (“ballooning”) and anal sphincter integrity. The additional diagnostic potential of 4D (i.e.,
 799 the addition of movement) ultrasound awaits clarification by further research (6).

800 **3.3.2 Endoanal ultrasound (EAUS) or anal endosonography (AES):** Ultrasound of the anal canal performed
 801 with a pole-like ultrasound probe placed in the anal canal giving a 360 degree image of the anal canal (Figure)
 802 . It is usually performed with the patient placed in the lithotomy, prone position or sometime left lateral.
 803 Two dimensional AES; three dimensional AES – three-dimensional reconstruction of the anal canal is
 804 performed using either axial or sagittal images (7) (Figure 5). FN3.4



805 **Figure 5:** Endoanal ultrasound images showing normal appearance of the internal (IAS) and external
 806 (EAS) anal sphincters.(46) Reprinted by permission from Springer Nature.

808
 809
 810
 811
 812 **3.3.3 Ultrasound imaging modalities(6):** The practice parameters for terminology and the practice
 813 parameters for performance of urogynaecological examinations were established by the American Institute

814 of Ultrasound in Medicine (AIUM) and IUGA in collaboration with the AUGS, AUA, ACR, and SRU in 2019
815 (47).

816

817 **3.3.3.1 Perineal:** Curved array probe applied to the perineum. This term incorporates transperineal and
818 translabial ultrasound.

819 **3.3.3.2 Introital:** Sector probe applied to the vaginal introitus.

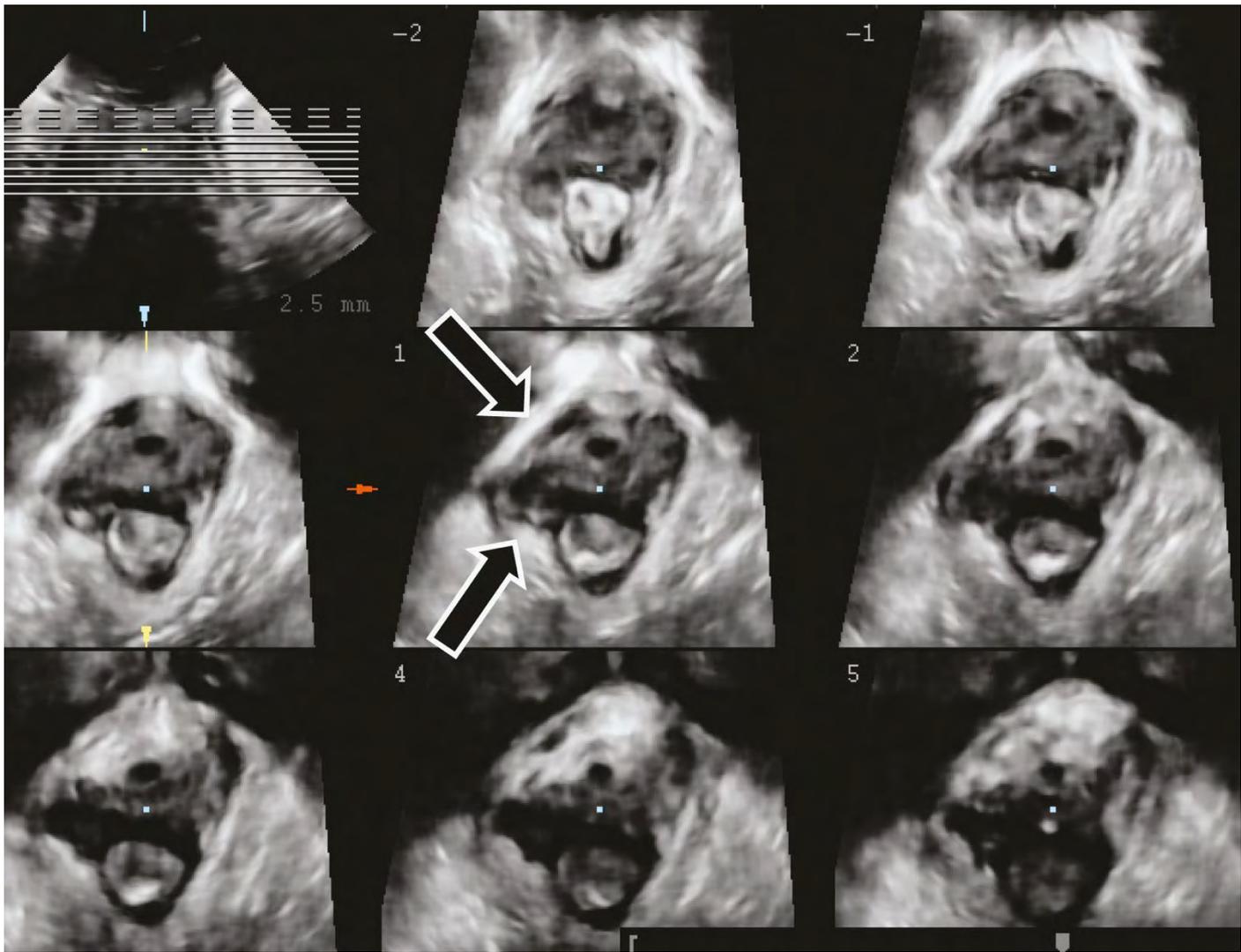
820 **3.3.3.3 Transvaginal (T-V):** Intravaginal curvilinear, linear array or sector scanning. An endocavitary
821 transducer is inserted into the vagina.

822 **3.3.3.4 Transabdominal (T-A):** Curvilinear scanning applied to the abdomen.

823 **3.3.3.5 Ultrasound 3D imaging of levator ani trauma:** The presence of levator ani trauma has been
824 postulated to be associated with an increased risk of pelvic organ prolapse. This can be evaluated using a
825 tomographic ultrasound imaging assessment of the levator ani muscles (8).

826 **3.3.3.5.1 Transperineal ultrasound imaging criteria** for levator ani avulsion are defined as:

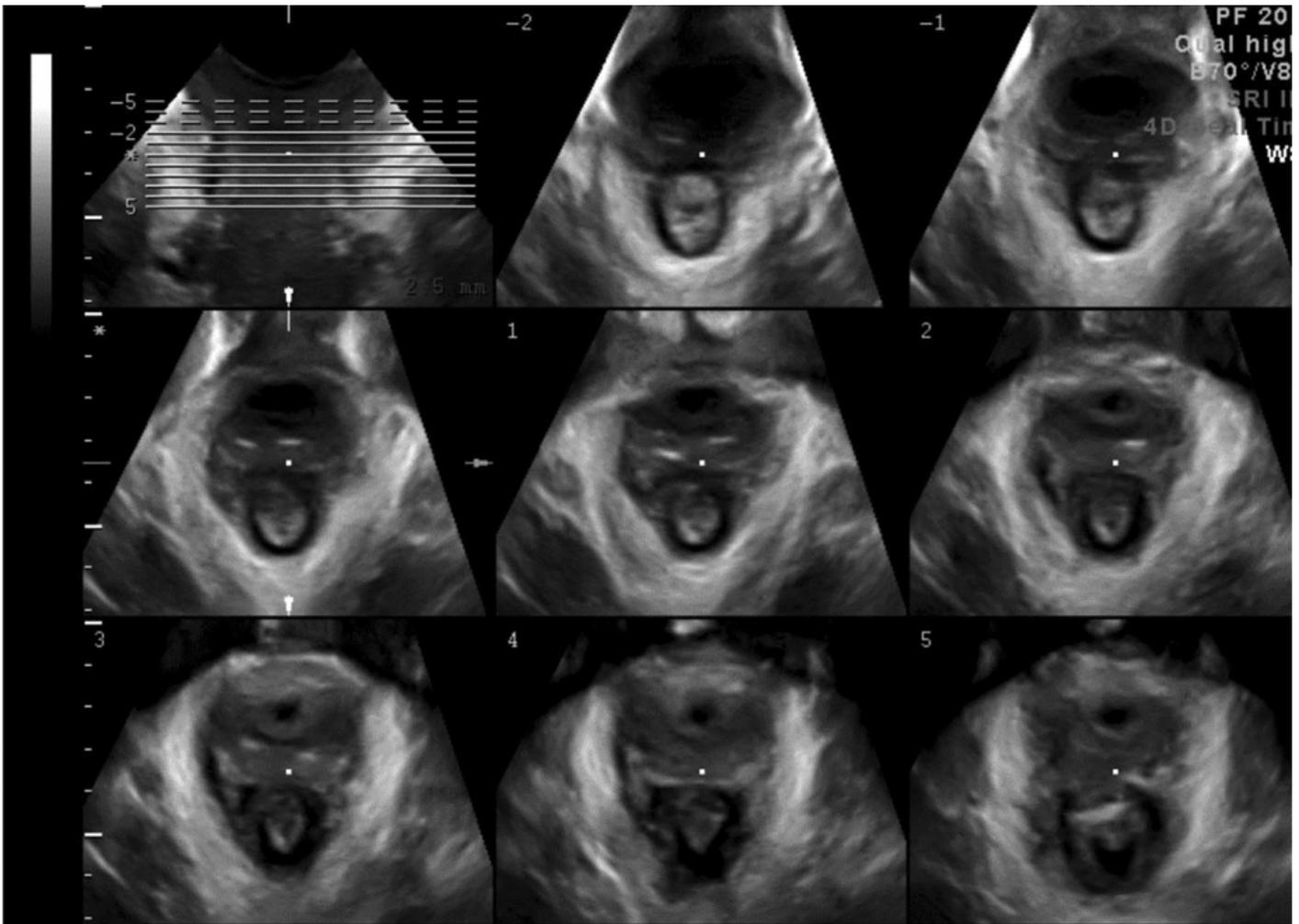
827 **3.3.3.5.2. Levator avulsion complete:** A defect in 3 central slices as identified on transperineal imaging
828 (figure 6) (NEW).



830 **Figure 6:** Ultrasound image of the pelvic floor in a woman following forceps vaginal delivery, showing
 831 avulsion of the levator plate from the right pubic ramus. Courtesy of Professor HP Dietz (48).
 832 Reproduced with permission of the Licensor through PLSclear.
 833

834 **3.3.3.5.3 Levator avulsion partial:** Defect in 1-2/3 central slices as identified on transperineal imaging (NEW)

835 **3.3.3.5.4 Tomographic ultrasound imaging (TUI):** Can be used for assessment for puborectalis avulsion
 836 should be performed on volumes obtained during a pelvic floor muscle contraction at 2.5-mm slice
 837 intervals, from 5 mm below to 12.5 mm above the plane of minimal hiatal dimensions (49) (Figure 7).



839 **Figure 7:** Tomographic ultrasound imaging assessment of the levator ani muscles Intact LAM(8)-(14)
 840 (Republished with permission of John Wiley & Sons - Books, permission conveyed through Copyright
 841 Clearance Center, Inc)
 842

843 **3.3.3.5.5 3D ultrasound imaging of ballooning of the genital hiatus:** The presence of ballooning of the
 844 genital hiatus (= excessive distensibility of the levator hiatus) on straining manoeuvre has also been
 845 associated to the severity of urogenital prolapse. An area of more than 25 cm², 30 cm², 35 cm² and 40 cm²
 846 has been defined as mild, moderate, marked and severe ballooning respectively (Figure 8) (8) (14) (50).

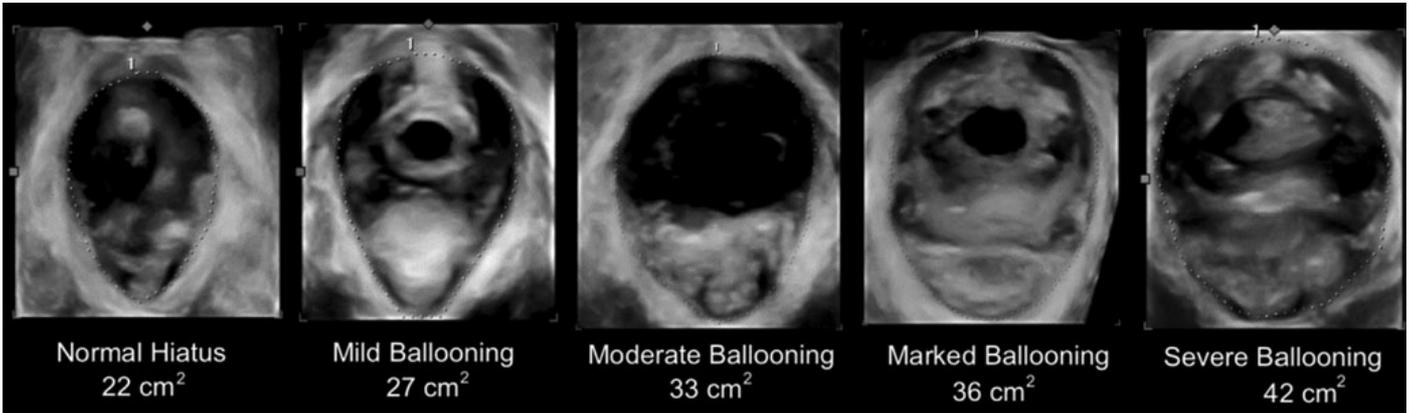


Figure 8: Ballooning of the genital hiatus on straining manoeuvre – levator defect(8)(14) (Republished with permission of John Wiley & Sons - Books, permission conveyed through Copyright Clearance Center, Inc)

3.3.3.5.6 Clinical applications of pelvic floor Ultrasound

- Bladder neck descent/mobility. The position of the bladder neck at rest and on straining.
- Urethral funnelling: i.e., opening of the proximal third of the urethra during coughing or on straining.^{FN 3.5}
- Post void residual: Several formulas have been described in the literature to measure the bladder volume by ultrasound
- Rectal intussusception
- EAS, IAS injury
- Degree of anal mucosa coaptation(51)

3.3.3.5.7 Postpartum ultrasound imaging modalities limitations and benefits: endovaginal, transanal, and translabial/transperineal

- Endovaginal ultrasound imaging may inadvertently compress tissues thus distorting the anatomy.
- Transanal ultrasound approach requires an expensive and dedicated transducer, and it is a more uncomfortable and embarrassing test for the woman. Its most common clinical indication is the assessment of sphincter integrity following obstetric trauma. It is the reference standard for imaging of the anal sphincters and diagnosis of sphincter defects, and correlates with symptoms and histological diagnosis (52).
- Translabial/transperineal approach overcomes the limitations of endovaginal and transrectal techniques providing minimal pressure on local structures and it is least likely to alter surrounding anatomy. There is ongoing research validating this against the transanal approach for diagnosis of sphincter integrity and correlation with symptoms.

3.3.3.5.8 Postpartum imaging evaluations:

The following pelvic floor abnormalities can be evaluated following childbirth:

- 874 • trauma (injury/damage) of the levator ani muscle (LAM)
- 875 • excessive distensibility of the puborectalis muscle and levator hiatus (“ballooning”)
- 876 • pathologies of the anterior vaginal compartment like urethral diverticula.
- 877 • anal sphincter integrity
- 878 • haematomas
- 879 • voiding symptoms
- 880 • defaecatory symptoms
- 881 • excessive pain or pressure

882

883 **3.3.4 Magnetic resonance imaging (MRI) of the pelvic floor:** MRI allows the detection of ligamentous and

884 muscular pelvic floor structures in fine detail. Although it does not use ionising radiation, it is a high cost

885 technique, may not be suitable for all patients and, in most centres, is not a dynamic study. ^{FN3,6}

886 **3.3.4.1 Static MRI** relies on static sequences and high spatial resolution images, to delineate the passive and

887 active elements of the pelvic organ support system. Most commonly, images are acquired in axial, sagittal

888 and coronal planes. MRI has been proposed to be a useful method for diagnosing and staging POP. Several

889 lines and levels of reference have been described in the literature. The most commonly used ones are either

890 a line drawn from the inferior margin of the symphysis pubis to the last coccygeal joint (pubococcygeal line—

891 PCL), in the sagittal plane, noted as midpubic line (MPL). Other applications of MRI are the assessment of

892 the LAM morphology (size, thickness volume) and detection of LAM injuries/ defects/ (“avulsion”).

893 **3.3.4.1.1 Levator trauma MRI based diagnosis**

894 **3.3.4.1.2 Levator avulsion unilateral:** The disruption of the levator ani on only one side visualized on MRI.

895 (NEW)

896 **3.3.4.1.3 Levator Avulsion Bilateral:** The disruption of the levator ani on both sides visualized on MRI (53)

897 (NEW).

898 **3.3.4.2 Dynamic MRI** is a technique that enables imaging of the mobility of the pelvic floor structures on

899 straining. (NEW)

900 **3.3.5 Computed tomography (CT) of the pelvic floor:** Computed tomography (CT) may offer an accurate

901 visualization of the pelvic floor soft and bony structures by reconstruction of axial images using 1 mm thick

902 slices without gaps thus increasing the diagnostic accuracy of pelvic floor anatomical disorders (ie. LAM

903 trauma). However, multiplanar spiral CT is not routinely recommended for imaging the pelvic floor, in the

904 postpartum period or during the breastfeeding period, mainly due to irradiation and poor soft tissue

905 contrast. (NEW)

906 **3.4 Electrophysiologic Testing**

907 **3.4.1 Electromyography (EMG)** is the recording of electrical potentials generated by the depolarization
 908 of muscle fibres. Electromyographic diagnosis is made by evaluating the state of the muscle (muscle
 909 pathology) by recording and analysing the electrical activity generated by the muscle. 1. Intramuscular EMG:
 910 insertion of a wire or needle electrode into the muscle to record motor unit action potentials. 2. Surface
 911 electromyography: electrodes placed on the skin of the perineum or inside the urethra, vaginal or rectum
 912 (54).

913 **3.4.2 Pudendal nerve terminal motor latency testing** is a measurement of time from stimulation of the
 914 pudendal nerve to muscular contraction of the bulbocavernosus or external anal sphincter. The St. Mark's
 915 pudendal electrode (Medtronic functional diagnostics A/S) can be used to stimulate the nerve via the
 916 rectum or vagina.

917 **3.4.3 Transvaginal pudendal nerve terminal motor latency testing:** The St. Mark's pudendal electrode
 918 (Medtronic functional diagnostics A/S) may be used to measure time from stimulation of the pudendal
 919 nerve to muscular contraction of the bulbocavernosus or external anal sphincter (NEW).

920 **3.4.4 Transient pudendal nerve terminal motor latency:** Increased pudendal nerve terminal motor latency
 921 identified postpartum that resolves in a short time interval within 8 weeks (55) (NEW).

923 **3.5 Associated radiological modalities:**

924 **Defecography** demonstrates normal anatomy of the anorectum as well as disorders of rectal evacuation.
 925 Barium paste is inserted rectally prior to defecation over a translucent commode. Measurement of the
 926 anorectal angle is allowed with evidence of the presence, size or emptying of any rectocele. Enterocoele,
 927 rectal intussusception and mucosal prolapse might be diagnosed as well as a spastic pelvic floor (anismus)
 928 (6). (Unchanged)

930 **3.6 Dye and bubble tests for pelvic floor fistulas:** Dye tests may be used to detect small or unusual fistulas
 931 (less useful for large or multiple fistulas), such as utero-vaginal or cervico-vaginal fistulas and to differentiate
 932 ureteric fistula (clear or yellow urine in vault, "negative dye test with urine in vault") from bladder fistula
 933 ("positive dye test") or to detect small or distorted anorectal fistula (positive vaginal bubble or rectal dye
 934 test) (10).

935 **3.6.1 Simple dye test for urinary tract fistulas:** The bladder is filled retrograde through a urethral catheter
 936 using a dye to change the colour of the irrigation fluid, for example, methylene blue or indigo carmine to
 937 turn the irrigation fluid blue (Figure 10). Observation may begin with or without retractor(s) in the vagina,
 938 depending on digital and visual exam signs and patient symptoms, or following careful dissection. Blue fluid
 939 leakage per genital tract or per anus indicates a bladder or urethral fistula. Lack of blue fluid leakage

940 combined with visualization of extra-meatal clear urine leakage increases suspicion of an upper urinary
 941 tract ureteric fistula (10).

942 **3.6.2 Triple swab test for urinary tract fistula:** Three separate sponge swabs, one above the other, are
 943 placed in the upper, middle, and lower vagina. The bladder is then filled with a pigmented irrigant such as
 944 diluted methylene blue, and the swabs are removed after 10 min (it can take up to 30 min for urine to come
 945 through a tiny tortuous fistula especially if it is in the cervix or uterus). Discoloration of only the lowest swab
 946 supports diagnosis of a low urethral fistula or urethral leakage. Diagnosis of a uretero-genital fistula is
 947 supported when the uppermost swab is wet but not discoloured. A VVaF fistula diagnosis is supported when
 948 the upper swabs are wet with blue irrigant. Careful observation for backflow of blue irrigant per meatus
 949 must be ongoing to avoid false-positive test reporting (10).^{FN3.7}

950 Complex of multiple urinary tract fistulas concurrent between the ureter and uterus/cervix and between
 951 the bladder and uterus/cervix are often diagnosed by hysterosalpingogram (HSG) or contrast-enhanced
 952 MRI (10).

954 **Footnotes for Section 3**

955 **3.1:** During pregnancy significant changes in the anatomy (macro and microscopic) and physiology of the
 956 lower urinary tract due to mechanical and hormonal factors that together with the expansion of the uterus
 957 and the weight of the foetus, especially in predisposed women, can result in the occurrence of UI (56).

958 The prevalence of UI goes from 26% of the prepregnant state to 58% in the third trimester of pregnancy
 959 even if it is mainly a mild SUI characterized by only droplet losses, less than once a week (57).

960 The prevalence and incidence of urinary incontinence in pregnancy are always less than 54% and 67%
 961 respectively, in the postpartum decreasing respectively below 21% and 45% with the multiparous women
 962 reaching values higher than about 10% compared to primiparous in pregnancy and vice versa in the
 963 puerperium (58). More than half of women who experience any type of urinary loss during pregnancy,
 964 whether the symptom was present before pregnancy (55%) or who experience it for the first time in
 965 pregnancy (60%), consider it a minor problem or ignore it (59). Lifestyle changes, including pelvic floor
 966 muscle training, before and / or during pregnancy and in the postpartum period could be effective (reaching
 967 a grade of recommendation A or B) in preventing UI (60) and urodynamic investigations are not necessary
 968 before rehabilitation treatment. This, together with lifestyle modification represents the first therapeutic
 969 choice in pregnancy and in the postpartum period (61). In the first six months after childbirth there is a slow
 970 recovery of the pre-gravid anatomical-functional conditions even if some of these will never return as before
 971 pregnancy(62). Breastfeeding itself may delay the reestablishment of a regular hormonal cycle. In pregnancy
 972 and postpartum, more invasive, pharmacological or surgical interventions should not be carried out (56) (61)
 973 (62).

974 **3.2: Conditions for PVR measurement:** PVR reading is erroneously elevated by delayed measurement due
975 to additional urine production (1-14mL/min). Ultrasonic techniques (transvaginal, translabial most
976 accurately) allow immediate (within 60 seconds of micturition) measurement and possible repeat
977 measurement. A short plastic female catheter provides the most effective bladder drainage for PVR
978 measurement by catheterization (8).

979 Assessment of normality of PVR: Quoted upper limits of normal may reflect the accuracy of measurement.
980 Studies using "immediate" PVR measurement (e.g., transvaginal ultrasound) suggest an upper limit of
981 normal of 30 mL. Studies using urethral catheterization (up to 10 min delay) quote higher upper limits of
982 normal of 50 or 100 mL. An isolated finding of a raised PVR requires confirmation before being considered
983 significant (6).

984 In the postpartum period the PVR measurements using a bladder scanner may be inaccurate due to the
985 volume of the uterus (63) (64).

986 **3.3:** For a more detailed definition see ICS report on the terminology for female pelvic organ fistulas (10).

987 **3.4:** EAUS can be used in the assessment of sphincter integrity following obstetric trauma. Although, clinical
988 assessment remains the most commonly used modality to diagnose perineal trauma in the immediate
989 postpartum period, ultrasound has been also used. Postpartum ultrasound examination can be associated
990 with an improvement in diagnosis of anal sphincter tears (65).

991 **3.5:** A deep urethral funnelling $\geq 50\%$ of the urethra is a sign of SUI or occult SUI (66).

992 **3.6: Clinical applications of MRI:**

993 **Faecal incontinence:** Endoanal ultrasound and endoanal magnetic resonance imaging (MRI) have been
994 demonstrated to be comparable in the detection of external sphincter defects. External phased array coil
995 MRI can replace endoluminal MRI with comparable results.

996 **Levator ani injuries:** Abnormalities of the LAM are identified on MRI as present or absent. Defect severity is
997 further scored in each muscle from 0 (no defect) to 3 (complete loss). A summed score for the two sides (0–
998 6) is assigned and grouped as minor (0–3) or major (4–6).

999 **Obstructed defecation:** During maximal straining manoeuvre, dynamic MRI may be used to demonstrate:

000 **Rectocele:** measured as the depth of wall protrusion beyond the expected margin of the normal anorectal
001 wall. Based on sagittal MR-sections through mid of pelvis, rectoceles are graded as small (<2cm), moderate
002 (from 2 to 4cm), and large (>4cm).

003 **Rectal intussusception:** The infolding of the rectal mucosa occurring during defecation. Depending on the
004 location, an intrarectal intussusception, limited to the rectum, is distinguished from an intra-anal
005 intussusception extending into the anal canal. The location of the intussusception may be anteriorly,
006 posteriorly, or circumferentially. The intussusception either involves only the mucosa or the full thickness of
007 the rectal wall.

Enterocoele: Defined as a herniation of the peritoneal sac, which contains omental fat (peritoneocoele), small bowel (enterocoele) or sigmoid (sigmoidocoele), into the rectovaginal or rectovesical space below the PCL. The largest distance between the PCL and the most inferior point of the enterocoele is measured with a perpendicular line. Depending on this distance, small (<3cm), moderate (3–6cm), and large (>6cm) enterocoeles are distinguished.

Dyssynergic defecation: Different structural imaging findings can be seen on dynamic pelvic MRI, including prominent impression of the puborectal sling, narrow anal canal, prolonged evacuation, a lack of descent of the pelvic floor and thus a failure to increase the ARA.

The anorectal angle is the angle created by a line drawn through the central axis of the anal canal and a line drawn through either the central axis of the distal rectum or a line drawn parallel to the posterior wall of the distal rectum (67).

In comparison with clinical examination (POP-Q), dynamic MRI has no additional value in the prediction of symptoms with increasing degree of POP.

Perianal abscesses and fistulas (9).

Bladder neck and cervical descent / mobility:

- Position of bladder neck and cervix at rest and on straining
- Pubo-coccygeal line: A line extending from the inferior border of the pubic symphysis to last coccygeal joint (pubococcygeal line—PCL) Bladder neck or cervical descent > 2 cm below this line with straining indicates weakness of the pelvic floor. If alternative landmarks are used in scientific papers they should be clearly described (68).
- PICS line (Pelvic Inclination Correction System line): this line takes into account the pelvic inclination during straining or Valsalva. The use of this line is recommended for dynamic MRI. For measurements outside the midsagittal plane, the 3D PICS is the most advanced measurement system for any kind of pelvic floor disorders (69,70).

3.7: Other dye and bubble tests for Pelvic Floor Fistulas are:

- **Double dye test for urinary tract fistula:** This includes oral intake of phenazopyridine (pyridium) 200 mg three times a day for one to two days until urine is bright orange, followed by retrograde bladder filling with blue irrigant through a bladder catheter. Diagnosis of a bladder or urethral fistula to the vagina (VVaF, UVaF) is supported if the vaginal swab turns blue. Diagnosis of a ureteric fistula to the vagina is supported if the swab turns orange, combination upper and lower urinary tract fistula to the vagina is supported if the swab turns both blue and orange. Careful observation for backflow of blue irrigant per meatus must be ongoing to avoid false-positive test reporting (10).

042 - **Trattner double balloon catheter test for urethral fistula:** The Trattner catheter has two balloons, one
 043 sits intravesically and the other inflates outside of the meatus to block efflux from the urethra. The irrigant
 044 flows out through a lumen that sits between the balloons, isolating fill to the urethra (10).

045 - **Posterior wall irrigant/fluid per rectum for anorectal tract fistula:** As with bladder dye testing, dye
 046 irrigation fluid may be instilled per rectal catheter. If colored irrigant passes per vagina, an anorectal fistula
 047 to the genital tract is confirmed (10).

048 - **Posterior wall “bubble test” for anorectal tract fistula:** With anterior vaginal wall retraction permitting
 049 visualization of the posterior vaginal wall, a Foley catheter is inserted into the rectum, the balloon inflated,
 050 and held under gentle traction against the anus. Irrigant fluid is placed per vagina. A catheter-tipped, air-
 051 filled syringe is inserted into the catheter and slowly decompressed to insert air into the rectum. Vaginal
 052 inspection allows visualization of bubbles emanating per vagina through a fistula defect (10).

054 **5 SECTION 4: DIAGNOSES (including complications)**

056 This Report highlights the need to base diagnoses for the different types of obstetric pelvic floor trauma on
 057 the correlation between a woman’s symptoms, signs and any relevant assessment based on clinical
 058 examination and diagnostic investigations.

060 **4.1 Pelvic floor, vaginal and perineal diagnoses**

062 **4.1.1 Obstetric perineal injury:** Injury to perineum occurring at the time of vaginal childbirth(30) and usually
 063 classified using the RCOG criteria. FN4.1

064 This is further subdivided into:

065 **4.1.1.1 First-degree tear:** Injury to perineal skin and/or vaginal mucosa.

066 **4.1.1.2 Second-degree tear:** Injury to perineum involving perineal muscles but not involving the anal
 067 sphincter.

068 **4.1.1.3 Third-degree tear:** Injury to perineum involving the anal sphincter complex (figure 9). Tears involving
 069 the external anal sphincter can be:

- 070 • **Partial EAS tears**
- 071 • **Complete EAS tears**



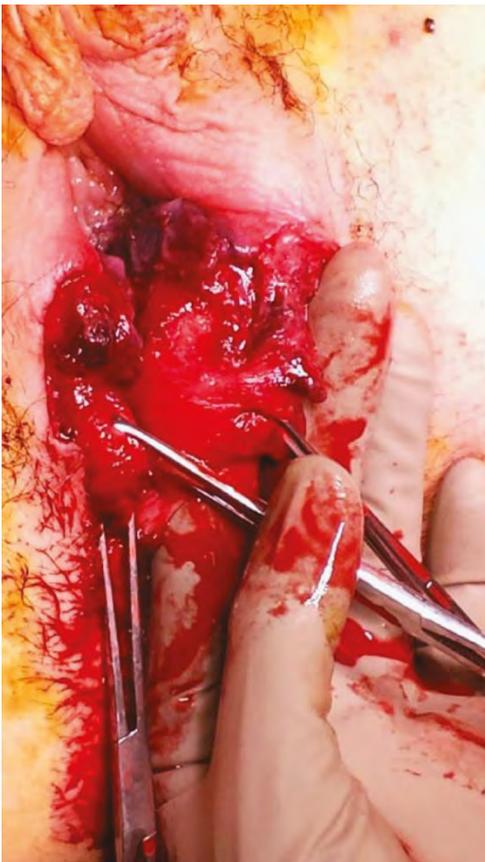
074 **Figure 9.** External appearance of a third degree tear.(46) Reprinted by permission from Springer Nature.

075
076 **4.1.1.3.1 Grade 3A tear:** <50% thickness of external anal sphincter torn.

077 **4.1.1.3.2 Grade 3B tear** >50% thickness of external anal sphincter torn.

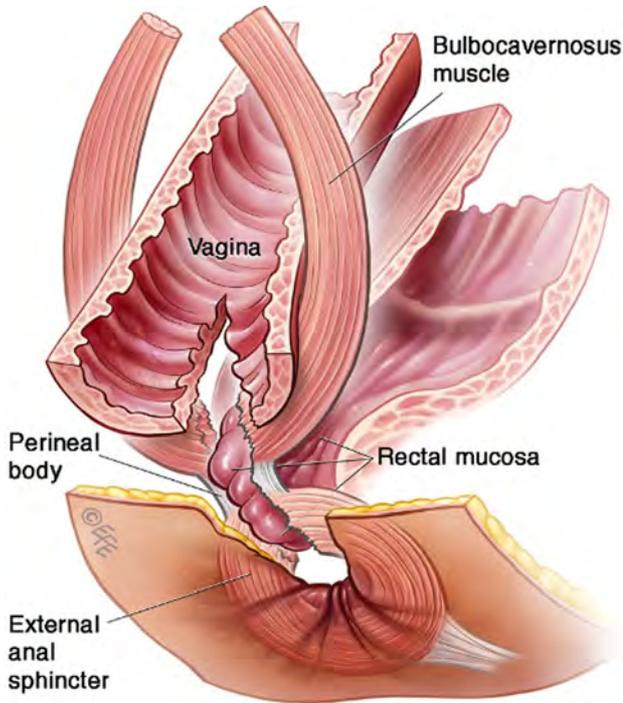
078 **4.1.1.3.3 Grade 3C tear:** External and internal sphincters torn (figure 10).

079 **4.1.1.4 Fourth degree tear:** Injury to perineum involving the anal sphincter complex (EAS and IAS) and
080 anorectal mucosa. (Figures 11, 12)

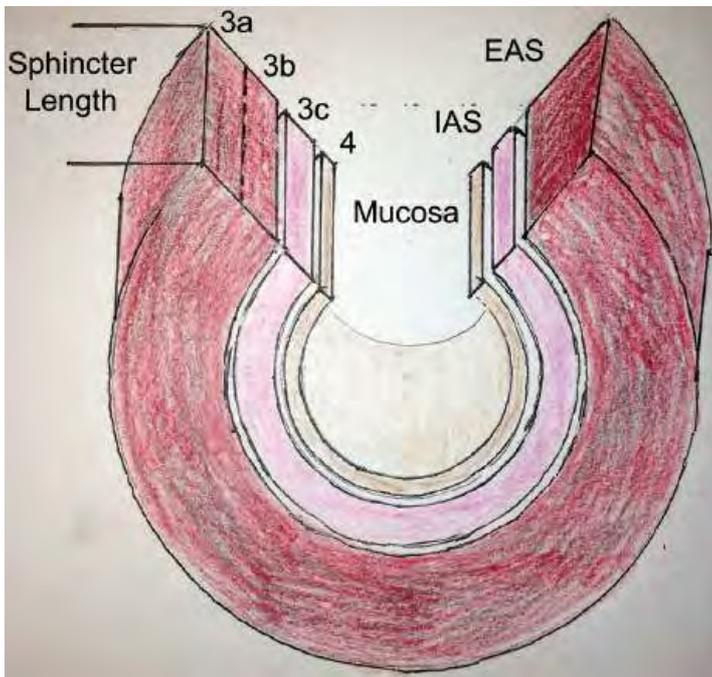


082 **Figure 10:** Third- degree perineal tear, with complete division of the internal and external anal sphincters
083 (48).

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087 Figure 11: Fourth degree vaginal tear (10).
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 090



092
 093 **Figure 12:** Classification of anal sphincter injuries (71). Reproduced with kind permission.
 094

095 **4.1.1.5 Obstetric rectovaginal perforation** (also known as “**buttonhole**” tear): Trauma (injury) of the anal
 096 mucosa and the vaginal epithelium without involvement of the anal sphincters. (NEW)

097 **4.1.1.6 Cloacal defect:** A confluence of the anus and vagina with no perineum to divide the vagina and anus,

098 leaving one large opening.

099 **4.1.1.7 Obstetric fistula (OF):** De novo fistula due to prolonged obstructed labour causing pressure necrosis
 100 of soft pelvic tissues between the impacted fetal presenting part and the bony maternal pelvis caused by
 101 ischemia and necrosis resulting in an abnormal communication between the urinary/colorectal tract and the
 102 vagina or perineal area during the postpartum period and up to 12 months after delivery. (NEW) ^{FN4.2}

103 **4.1.1.7.1 Iatrogenic childbirth-related fistula (ICRF):** Fistula is directly due to inadvertent injury to urinary
 104 /colorectal tract during operative delivery (caesarean section/caesarean hysterectomy or instrumental
 105 delivery including episiotomy) (10).

106 **4.1.1.7.2 Mixed obstetric and iatrogenic fistula (MOIF):** Fistula related to operative delivery for prolonged
 107 obstructed labour (10). Tissue integrity already compromised by obstructed labour prior to operative
 108 delivery.

109 **4.1.1.7.3 Obstetric genitourinary fistula:** An abnormal connection between the genital tract and urinary
 110 tract (10).

111 **4.1.1.7.4 Genito-anorectal tract fistula:** An abnormal connection between the genital tract
 112 (vagina/uterus/cervix) and the anorectum (10).

113 **4.1.1.8 Fistula in-ano:** An anal fistula is an abnormal connection between the anal canal epithelium (or rarely
 114 rectal epithelium) and the skin epithelium. Patients may complain of pain, swelling, intermittent discharge
 115 of blood or pus from the fistula and recurrent abscesses formation (9).

116 **4.1.1.9 Anal fissures:** Longitudinal split in the skin of the anal canal, exposing the internal anal sphincter
 117 muscle and causing anal spasm. Often associated with pain, a tearing sensation and fresh blood with
 118 defecation. Most fissures are found in the mid-line posteriorly and there may be a skin tag associated with
 119 them. The second most common gastrointestinal complication after haemorrhoids (9).

120 **4.1.1.10 Haemorrhoids:** Dilated and engorged blood vessels in swollen tissue internally in the anal canal or
 121 externally around the anus, that may be characterised by bleeding, pain, or itching. Internal haemorrhoids
 122 may protrude through the anus (72). (NEW) ^{FN4.3}

123 **4.1.1.11 Vulvovaginal complications in the postpartum period**

124 **4.1.1.11.1 Postpartum vaginal fusion (agglutination):** Where the walls of the vagina are stuck together
 125 during the postpartum period and up to 12 months after delivery (12). (NEW)

126 **4.1.1.11.2 Vaginal narrowing:** Decreased vaginal calibre.

127 **4.1.1.12. Postpartum scarred vagina:** Self-perception or perception by the partner of a “stiff” vagina or a
 128 foreign body in the vagina in the postpartum period and up to 12 months after delivery. (NEW)

129 **4.1.1.13. Postpartum vulvo-vaginal hyperaesthesia:** Increased vulvo-vaginal sensitivity to touch, pressure,
 130 vibration or temperature during the postpartum period and up to 12 months after delivery. (NEW)

131 **4.1.1.14. Postpartum vulvo-vaginal hypoaesthesia:** Reduced vulvo-vaginal sensitivity to touch, pressure,

vibration or temperature during the postpartum period and up to 12 months after delivery. (NEW)

4.1.1.15 Postpartum perineal wound infection: A surgical infection of the perineal wound, associated with bleeding, pain, offensive discharge and signs of Redness, Edema, Ecchymosis, Discharge and disruption of wound edge Approximation (REEDA)(73) (figure 13). (NEW)



Figure 13: Necrotizing perineal infection (74). Reprinted by permission from Springer Nature.

4.1.1.16 Perineal / vulval cellulitis: Bacterial infection involving the inner layers of the perineal and vulval skin. (NEW)

4.1.1.17 Necrotizing fasciitis: A severe soft tissue infection that is caused by bacteria, and is marked by oedema and necrosis of subcutaneous tissues with involvement of adjacent fascia and by painful red swollen skin over affected areas. It is associated with sepsis and the associated systemic inflammatory response syndrome causing changes in biochemical or haematologic parameters, but may be difficult to distinguish from cellulitis, abscess or other soft tissue infection, in the early stages. Risk scoring tools such as the Laboratory Risk Indicator for Necrotizing Fasciitis score indicating systemic toxicity, may assist in identifying those at intermediate (score 6-7) or high (≥ 8) risk which warrant urgent surgical evaluation and debridement (75) (figure 14).



Figure 14: Debridement of necrotizing perineal infection. (74) Reprinted by permission from Springer Nature.

4.1.1.18 Postpartum perineal wound dehiscence (breakdown): A breakdown of the suture line resulting in a dehiscence of a perineal wound during the postpartum period and up to 12 months after delivery. (NEW)_{FN4.4}

4.1.2 Vulval Complications

4.1.2.1 Labial scarring and defects: Labial tissues are scarred, distorted or asymmetrical following obstetric trauma and repair. (NEW)

4.1.2.3 Vulval fusion (agglutination): Labial lips fused. Vulval / labial fusion is a spontaneous approximation of lacerations of the labia resulting in distorted anatomical healing, dyspareunia or obliteration of the introitus.

4.1.2.4 Introital narrowing: Vaginal entry is difficult or impossible (penis or sexual device).

168 **4.1.3 Levator ani muscle injuries**

169 **4.1.3.1 Levator avulsion:** The disconnection of the muscle from its insertion on the inferior pubic ramus and
 170 the pelvic sidewall, and may be complete, partial, unilateral or bilateral. Avulsion is a common consequence
 171 of overstretching of the levator ani during the second stage of labour and is detectable on palpation.
 172 Complete and partial defects may be diagnosed on tomographic TVUS pr TPUS modalities using the criteria
 173 defined in the imaging section or on MRI. Defects are usually visualized most clearly on maximal PFMC (76).
 174 Levator ani injuries affect the size of the levator hiatus and are associated with the development of
 175 anatomical and symptomatic prolapse (9).

176 Levator avulsions can be:

177 **4.1.3.1.1 Complete levator avulsion:** Complete detachment of the levator ani muscle from its insertion to
 178 the inferior pubic ramus (Type II defect).. This may be suspected on signs. (NEW)

179 **4.1.3.1.2 Partial levator avulsion:** Partial detachment of the levator ani muscle from its insertion to the
 180 inferior pubic ramus (Type I defect) (77). (NEW)

181 **4.1.4 Hiatal ballooning:** Excessive distensibility of the levator hiatus. Levator ani injuries affect the size of
 182 the levator hiatus, with a hiatal enlargement to over 25cm² on straining manoeuvre defined as “ballooning,”
 183 and are related to symptoms and signs of prolapse.(8). (NEW)

184 **4.1.5 Pelvic organ prolapse:** The diagnosis by symptoms and clinical examination (POP-Q), assisted **or not**
 185 by any relevant imaging, of descent of one or more of the anterior vaginal wall (central, paravaginal or
 186 combination cystocele), posterior vaginal wall (rectocele), the uterus (cervix) or the apex of the vagina
 187 (vaginal vault or cuff scar after hysterectomy). The presence of any such sign should correlate with relevant
 188 POP symptoms (6). (CHANGED)_{FN4.5}

189 **4.1.6. Postpartum vaginismus:** Recurrent or persistent spasm of vaginal musculature that interferes with
 190 vaginal penetration in the postpartum period and up to 12 months after delivery. (NEW)

192 **4.2 Urinary tract diagnoses (78)**

193 **4.2.1. Voiding dysfunction:** A diagnosis by symptoms and investigations, including urodynamics, is defined
 194 as abnormally slow and/or incomplete micturition, based on abnormally slow urine flow rates and or
 195 abnormally high post-void residuals, ideally on repeated measurement to confirm abnormality. Pressure-
 196 flow studies can be required to determine the cause of the voiding dysfunction (8) (14). _{FN4.6}

197 **4.2.1.1 Postpartum urinary retention (PPUR):** Inability to empty the bladder completely during the
 198 postpartum period and up to 12 months after delivery characterized by high PVR accompanied or not by
 199 symptoms of bladder distension. There is a generally (but not always) evidence of painless and palpable or
 200 percussible bladder in the postpartum period and up to 12 months after delivery, suggestive of a chronic
 201 high PVR. The patient experiences slow flow and incomplete bladder emptying. (NEW)

202 **4.2.1.2 Acute Postpartum urinary retention (APPUR):** A patient, with or without symptoms of bladder
 203 distension, is unable to pass any urine despite having full bladder, which on examination is painfully
 204 distended and readily palpable or percussible and on catheterization is characterized by high PVR during
 205 the postpartum period and up to 12 months after delivery (7). (NEW)

206 **4.2.1.3 Voiding dysfunction - Retention with overflow:** Involuntary loss of urine directly related to an
 207 excessively full bladder in retention (7).

208 **4.2.1.4 Chronic urinary retention:** Complaint of chronic or repeated inability to empty the bladder, despite
 209 the ability to pass some urine. This may result in the frequent passage of small amounts of urine or urinary
 210 incontinence and a distended bladder (7). FN4.7

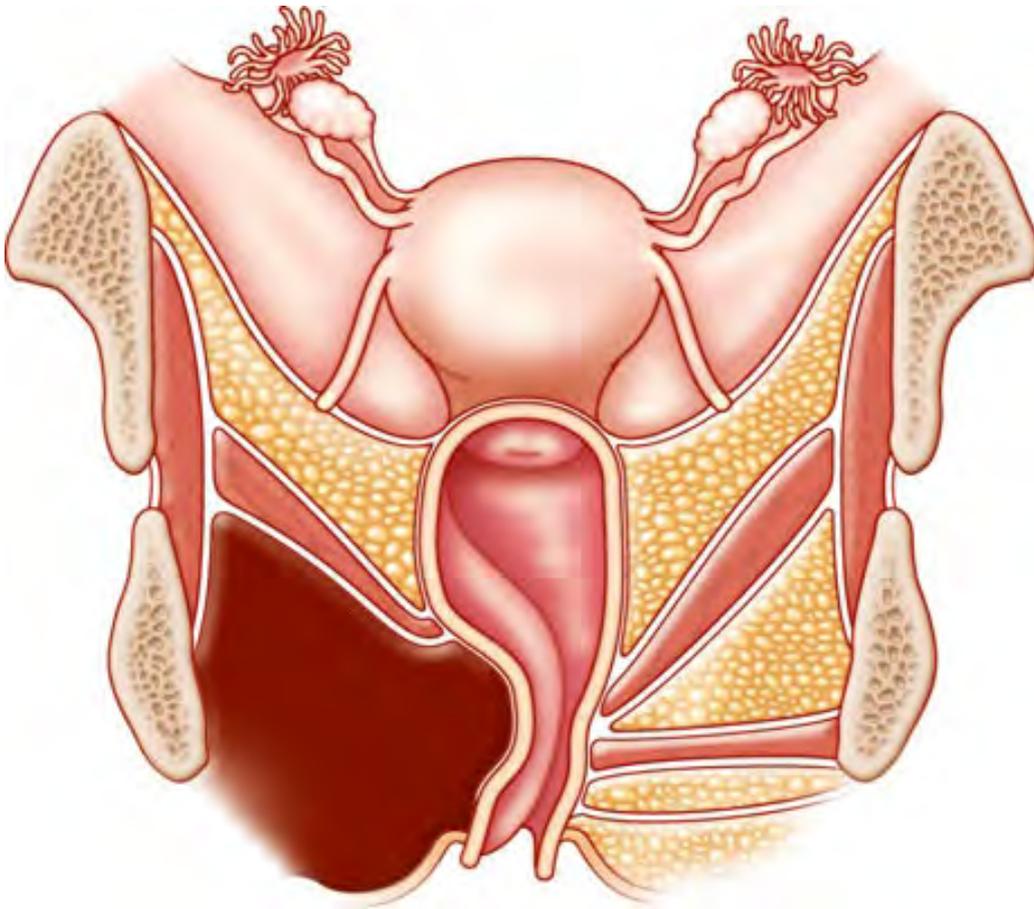
211 **4.2.1.5 Acute on chronic retention:** An individual with chronic retention goes into acute retention and is
 212 unable to void (7).

213 **4.2.1.6 Covert postpartum urinary retention:** Diagnosis of high PVR with no or minimal voiding symptoms
 214 and a postvoid residual volume greater than 150ml, in the postpartum period (28). (NEW)

215
 216 **4.3 Postpartum sexual dysfunction:** A de novo postdelivery (in the postpartum period and up to 12 months
 217 after delivery) diagnosis of an abnormality or difficulty with sexual intercourse, experienced by the woman
 218 or partner, confirmed by clinical history and/or signs. The diagnosis may be associated with vaginal, urinary,
 219 anorectal, prolapse, pain symptoms, and may include decreased libido, arousal or anorgasmia. This diagnosis
 220 may persist or develop to meet DSM V criteria of Female Sexual Interest/Arousal Disorder (FSIAD) and/or
 221 DSM IV criteria of genito-pelvic pain/ penetration disorder (GPPPD), and/or Female Orgasmic Disorder (8)
 222 (12) (79). (NEW)

223
 224 **4.4. Postpartum vaginal haematomas:** These diagnoses can be confirmed using imaging modalities.

225 **4.4.1 Postpartum infralevator haematomas** are defined as haematomas (blood collections) in the
 226 infralevator space occurring following childbirth and associated with massive swelling and ecchymosis of the
 227 labia, perineum, and lower vagina with severe vulval and perineal pain. Anorectal tenesmus may result from
 228 extension into the ischiorectal fossa, while urinary retention may result from spread ventrally into the
 229 paravesical space (figure 15). (NEW)



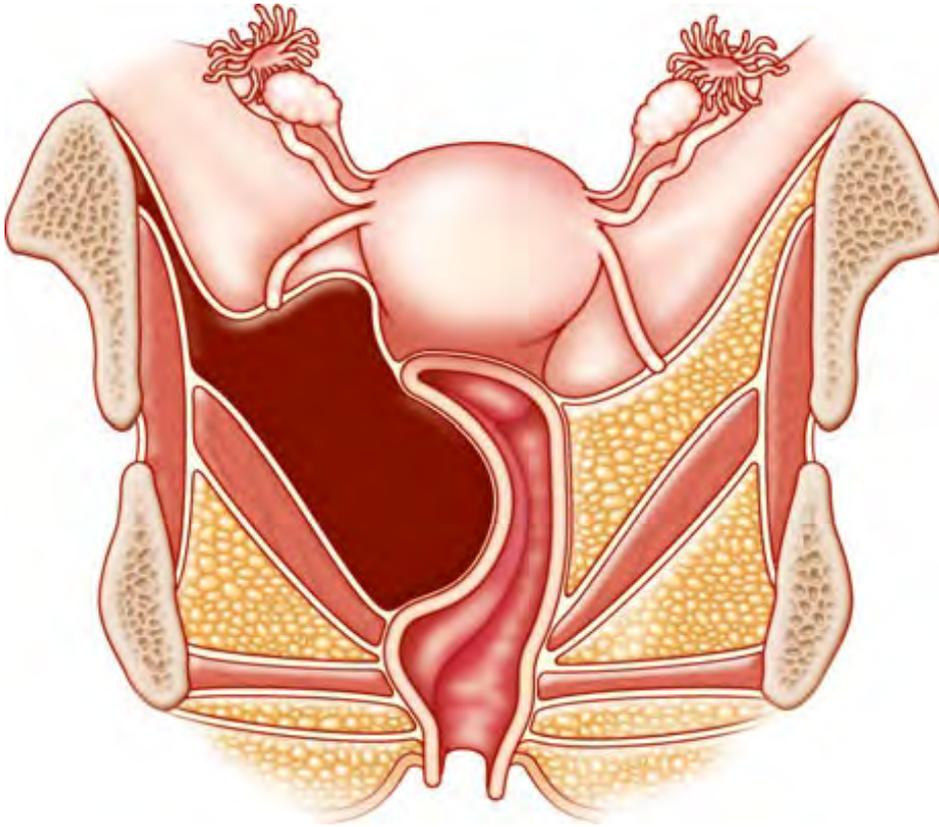
231

232 **Figure 15:** Infralevator haematoma(74). Reprinted by permission from Springer Nature.

233

234 **4.4.2 Postpartum supralelevator haematoma**, is a haematoma in the supralelevator space occurring following
 235 childbirth. It can be palpable as a rubbery mass protruding into the vaginal wall and potentially occluding
 236 the vaginal and causing pain and pressure symptoms (figure 16). (NEW)

237



239 **Figure 16:** Supralelevator haematoma (74). Reprinted by permission from Springer Nature.
 240

241 **4.4.3 Vulval haematoma** is a blood collection subcutaneously in the vulval area and usually results from
 242 injuries to the pudendal artery or its branches during childbirth. (NEW)
 243

244 **4.5 Postpartum pain**

245 **4.5.1 Postpartum vaginal pain syndrome:** The occurrence of persistent or recurrent episodic vaginal pain
 246 following childbirth, during the postpartum period and up to 12 months after delivery. There is no proven
 247 vaginal infection or other obvious pathology (15) (80). (NEW)

248 **4.5.1.1 Chronic (or persistent) vaginal pain:** Chronic pelvic pain during the postpartum period and up to 12
 249 months after delivery, characterized by persistent pain lasting longer than 6 months or recurrent episodes
 250 of abdominal/pelvic pain, hypersensitivity or discomfort often associated with elimination changes, and
 251 sexual dysfunction often in the absence of organic aetiology. (NEW)

252 **4.5.1.2 Postpartum somatic nerve pain:** Nerve injury (stretching, blunt trauma, compression, entrapment,
 253 suture ligation) during the postpartum period and up to 12 months after delivery. (NEW)

254 **4.5.1.3 Postpartum pudendal neuralgia:** Pudendal neuralgia is a disabling form of pelvic pain during the
 255 postpartum period and up to 12 months after delivery. It is related to a ligamentous nerve compression
 256 mechanism. This pain is associated with the second stage of labour, vaginal injuries and repairs.

257 1. Unilateral or bilateral.

258 2. Lancing burning pain in the clitoris, urethra, labia, perineum and/or anus.

259 3. Worse with sitting.

260 4. Relieved by standing or supine position. (NEW)

261 **4.5.2 Postpartum chronic pelvic joint, ligament or bone pain syndrome:** Complaint of: 1. Joint pain: i.
262 Sacroiliac or pubic symphysis joint. 2. Ligament pain: i. Sacrospinous or sacrotuberous ligament. 3. Bony pain:
263 i. Pain described in or along the margins of the pubic ramus, ilium, ischial spine or ischial tuberosity during
264 the postpartum period and up to 12 months after delivery. (NEW)

265 **4.6. Postpartum anorectal complications**

266 **4.6.1 Postpartum anal incontinence:** involuntary loss of flatus and/or solid or liquid stool during the
267 postpartum period and up to 12 months after delivery. (NEW) FN4.8, FN4.9

268 **4.7 Obstetric pelvic floor nerve trauma**

269 **4.7.1 Obstetric neuropathy:** disease or dysfunction of one or more peripheral nerves, secondary to
270 childbirth. (NEW)

271 **4.7.2 Obstetric pudendal nerve injury:** injury to the pudendal nerve or its branches during vaginal childbirth.
272 (NEW)

274 **Footnotes for Section 4:**

275 **4.1 RCOG classification for perineal and anal sphincter injuries:**

276 Define perineal or genital trauma caused by either tearing or episiotomy as follows:

- 277 • first degree – cutaneous trauma to the vaginal epithelium or perineal skin only
- 278 • second degree – injury to the perineal muscles but not the anal sphincter
- 279 • third degree – injury to the perineum involving the anal sphincter complex:
 - 280 ○ 3a – less than 50% of external anal sphincter thickness torn
 - 281 ○ 3b – 50% or more of the external anal sphincter thickness torn
 - 282 ○ 3c – internal anal sphincter torn.
- 283 • fourth degree – injury to the perineum involving the anal sphincter complex (external and
284 internal anal sphincter) and anal epithelium.

285 **4.2:** For a more detailed definition see ICS report on the terminology for female pelvic organ fistulas (10).

286 The past two commonly used classification systems have been the Waaldijk and Goh classifications (81).

287 **4.3:** Haemorrhoids: Abnormality of the normal cushion of specialized, highly vascular tissue in the anal canal
288 in the submucosal space. Haemorrhoids can be divided into those originating above the dentate line which
289 are termed internal and those originating below the dentate line which are termed external. Internal
290 haemorrhoids are graded as follows:

291 Grade I - bleeding without prolapse.

292 Grade II - prolapse with spontaneous reduction.

293 Grade III - prolapse with manual reduction.

294 Grade IV - incarcerated, irreducible prolapse.

295 Grade II and Grade III haemorrhoids will become evident on asking the patient to bear down and grade IV
296 haemorrhoids are obvious at the time of the examination. A proctoscopy is essential in examining for
297 haemorrhoids unless they are completely prolapsed.

298 **4.4: Wound dehiscence:** A bursting open, splitting or gaping along natural or sutured lines.(82)

299 **4.5:** For a more detailed definition see IUGA/ICS joint report on the terminology for Female Pelvic Organ
300 Prolapse (8).

301 **4.6:** for a more detailed definition see IUGA/ICS joint report on the Terminology for Female Pelvic Floor
302 Dysfunction (6).

303 **4.7:** Persistent postpartum urinary retention has been defined as the inability to void spontaneously by the
304 third day postpartum despite the use of intermittent catheterisation (83).

305 Non-neurogenic chronic urinary retention (CUR) has been proposed to refer to elevated post-void residual
306 volumes of greater than 300 mL that has persisted for at least 6 months and is documented on two or more
307 separate occasions (84).

308 **4.8:** Postpartum anal incontinence could be due to:

309 1: Anal sphincter disruption of the external anal sphincter, internal anal sphincter or both;

310 2: Hypocontractile/acontractile sphincter due to pudendal nerve neuropathy;

311 3: Combined anal sphincter disruption and hypocontractile/acontractile sphincter;

312 4: Rectal overactivity due to exaggerated smooth muscle contraction of the rectum could also be associated
313 with hypersensitivity;

314 5: Overflow incontinence seepage of stool due to faecal impaction (9).

315 **4.9:** Anal incontinence is usually most prevalent after one month postpartum and resolving almost
316 completely by 1 year (85). Overall prevalence decreases further in the next 6 years so that only a small
317 percentage of women, especially with a history of operative delivery and / or anal sphincter injury, will
318 complain of persistent anal incontinence 6 years later (86).

319

320

321

6 SECTION 5: PREDICTION OF OBSTETRIC PELVIC FLOOR DISORDERS AND PREVENTION

5.1 Prediction of obstetric pelvic floor disorders: A process of prospectively evaluating the risk of sustaining pelvic floor trauma at childbirth. (NEW)_{FN5.1}

5.1.1 Antenatal predictors: Pre-existing risk factors for the development of significant obstetric pelvic floor trauma, such as maternal age, BMI and bladder neck descent (87) (88). (NEW)

5.1.2 Intrapartum predictors: Intrapartum risk factors for the development of significant obstetric pelvic floor trauma, such as the use of forceps and a prolonged second stage (89) (90) (91) (92). (NEW)

5.2 Obstetric variable: A characteristic, quantity or attribute relating to childbirth that can be measured in research (93). (NEW)

5.2.1 Obstetric risk factors: Obstetric variables associated with an increased risk of obstetric pelvic floor disorders (94) (NEW) _{FN5.2}

5.3 Primary prevention of obstetric pelvic floor trauma: Measures to prevent the occurrence of obstetric perineal trauma or postpartum pelvic floor dysfunction by avoiding or modifying the risk factors:

- before pregnancy: Lifestyle modifications; controlling diabetes mellitus, controlling body mass index
- during pregnancy: Lifestyle modifications, screening for gestational diabetes, ultrasound screening for fetal macrosomia, controlling weight gain, perineal massage, pelvic floor muscle training (controversial), induction labour for suspected macrosomia (controversial), elective caesarean section
- during labour/delivery: Maternal position, manual rotation of posterior position, avoidance of instrumental deliveries, preference for ventouse rather than forceps, performing a 60° mediolateral episiotomy (controversial), slowing the descent of the foetal head, manual perineal protection (controversial), warm compresses, perineal massage, bladder emptying before pushing, pushing without Valsalva (controversial), manual perineal support; or bundle of two or more of these measures
- after delivery: Avoiding urinary retention, lifestyle modifications, pelvic floor muscle training. (NEW)

5.3.1 Elective caesarean delivery: Delivery of the foetus via a caesarean (lower abdominal) incision prior to the onset of labour. It has been advocated as the only true primary prevention of perineal trauma strategy. Caesarean delivery after the onset of labour is not protective of trauma to the pelvic floor.

5.3.2 Antenatal pelvic floor muscle training: Pelvic floor muscle exercises during the antenatal period. (NEW)

5.3.3 Perineal massage, antenatally or during second stage: A digital technique involving the insertion of one or two fingers inserted into the vagina to a depth of 3–4 cm to massage the posterior vaginal wall in a U-shaped movement (95) to stretch the perineum and surrounding structures.

5.3.4 Warm compresses in second stage: Application of a compress (pack) soaked in warm (38-44 degrees centigrade) water at the commencement of perineal stretching (96). (NEW)

5.3.5 Maternal position during delivery: The position adopted by women in the second stage of labour and may be associated with the risk of perineal trauma. These may be defined as:

- Upright: sitting, standing, semi-recumbent at >45 degrees to the horizontal, kneeling, squatting, all fours, walking.
- Recumbent: supine, semi-recumbent at <45 degrees to the horizontal, lateral, Trendelenburg, lithotomy, knee-elbow (97).

5.3.6 Water immersion during labour and birth: Immersion in water by a pregnant woman during any stage of labour (first, second, third) where the woman's abdomen is completely submerged. 'Waterbirth' refers to where the fetus is born under the water (98).

5.3.7 Avoidance of use of forceps: A primary or secondary preventive measure of reducing the risk of levator injury,(99) obstetric anal sphincter injury (4) and pelvic floor dysfunction when compared with other modes of delivery.

5.3.8 Manual Perineal support (protection) at birth: A bimanual technique that requires support of the posterior fourchette with one hand and cupping of the foetal head with the other to prevent the head coming out with great force as it progresses at crowning. (Figures 17-19)

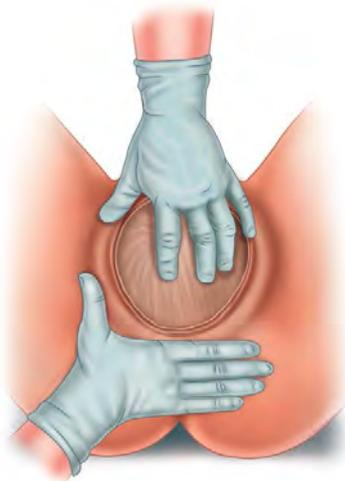
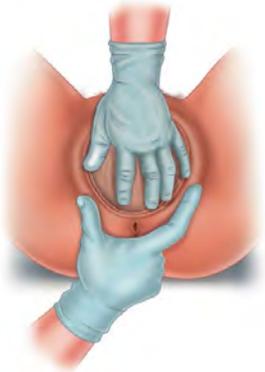


Figure 17: Central palmar support_Reprinted/adapted by permission from Springer Nature Customer Service Centre GmbH Springer Nature: Perineal Mapping. in Perineal Trauma at Childbirth (KMK Ismail) [COPYRIGHT] (2017) (100).



381 **Figure 18:** Viennese method. Reprinted/adapted by permission from Springer Nature Customer Service
382 Centre GmbH Springer Nature: Perineal Mapping. in Perineal Trauma at Childbirth (KMK Ismail)
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385





389 **Figure 19:** Finnish method. (a) Finnish method – application of the accoucheur’s hands on the fetal
 390 head and perineum; (b) Finnish method – accoucheur’s dominant hand, view from above; (c)
 391 Finnish method – accoucheur’s dominant hand, view from the front Reprinted/adapted by permission
 392 from Springer Nature Customer Service Centre GmbH Springer Nature: Perineal Mapping. in Perineal
 393 Trauma at Childbirth (KMK Ismail)
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395
 396 **5.3.9 Bearing down in labour:** A common technique during second stage involving closed-glottis pushing
 397 (holding breath while pushing) duration of 10 seconds or more. This is contrasted with other spontaneous
 398 breathing techniques while pushing (101).

399 **5.3.10 Delayed pushing in second stage:** Once fully dilated, a delay in the onset of pushing would allow
 400 spontaneous descent and rotation of the foetal head to increase efficiency of pushing efforts and reducing
 401 the risk of the parturient fatigue and instrumental delivery (101).

402 **5.3.11 Perineal hyaluronidase injection in second stage:** The injection of hyaluronidase to the perineum to
 403 relax the connective tissue around the skin or subcutaneous muscles and render them less vulnerable to
 404 mechanical stress or extension during the passage of the fetus through the vaginal canal (102).

405
 406 **5.4 Secondary prevention of obstetric pelvic floor trauma:** measures to reduce severity of obstetric perineal
 407 trauma or postpartum pelvic floor dysfunction on patients with known risk factors or with mild to moderate
 408 symptoms. (NEW)

409 - Before pregnancy: lifestyle modifications controlling diabetes mellitus, controlling body mass index

410 FN5.3
 411 - During pregnancy: lifestyle modifications, screening for gestational diabetes, ultrasound screening
 412 for fetal macrosomia, controlling weight gain, perineal massage, pelvic floor muscle training
 413 (controversial), induction of labour for suspected macrosomia (controversial) (103).

414 - During labour/delivery: maternal position, manual rotation of turn posterior position, avoidance of
 415 instrumental deliveries, preference for ventouse rather than forceps, performing a 60° mediolateral
 416 episiotomy (controversial), slowing the descent of the foetal head, manual perineal protection

(controversial), warm compresses, perineal massage, bladder emptying before pushing, pushing without Valsalva (controversial), manual perineal support, or bundle of two or more of these measures

- After delivery: avoiding urinary retention, lifestyle modifications.

5.4.1 Episiotomy: Episiotomy is a surgical enlargement of the vaginal orifice by an incision to the perineum during the last part of the second stage of labour during vaginal delivery.(104) (NEW)

5.4.1.1 Types of episiotomy:

Main types of episiotomy include median, modified median, J shaped, mediolateral, lateral, radical lateral, and anterior (Figure 20).

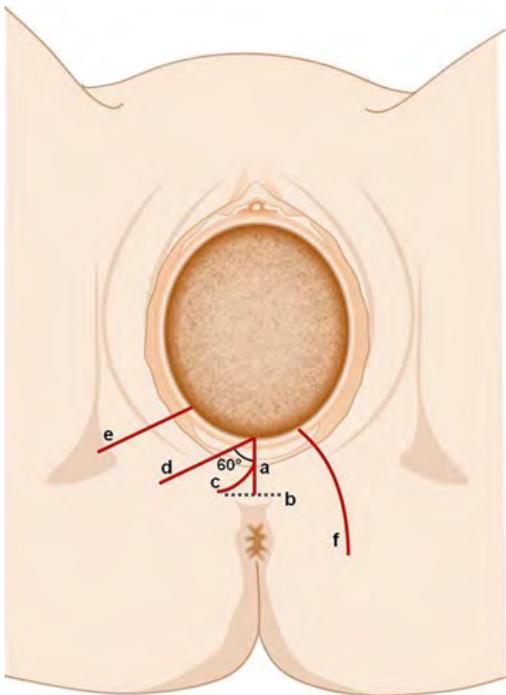


Figure 20: Types of episiotomy (105). Key: a midline episiotomy; b modified median episiotomy; c J-shaped episiotomy; d mediolateral episiotomy; e lateral episiotomy; f radical lateral (Schuchardt incision).

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5.4.1.1.1 Median (midline, medial) episiotomy: Median episiotomy starts at the posterior fourchette and runs along the midline through the central tendon of the perineal body *. The origin of the initial incision is within 3mm of the midline in the posterior fourchette and the direction of the cut is between 0° and 25° of the sagittal plane (106). The extension of the incision is half of the length of the perineum.(107). (NEW)

5.4.1.1.2 Modified median episiotomy: This is a modification of median episiotomy. It involves extending the median episiotomy by adding two transverse incisions bilaterally just above the anal sphincter (108). The transverse incisions are perpendicular to the midline, 2-5 cm in total length. This type of episiotomy aims to increase the diameter of the vaginal outlet by 83% compared with a standard median episiotomy, possibly

440 by separation of the perineal membrane and sphincter attachments (109). The origin of the initial incision
441 is within 3mm of the midline in the posterior fourchette and the direction of the cut is between 0° and 25°
442 of the sagittal plane, with two transverse cuts on each side added (106). (NEW)

443
444 **5.4.1.1.3 'J'-shaped episiotomy:** This type starts with a midline incision and is then curved laterally to avoid
445 the anus. In this technique curved scissors are used starting in the midline of the vagina until the incision is
446 2-5 cm from the anus. Then the 'J' is made by directing the incision towards the ischial tuberosity away from
447 the anal sphincter. The origin of the initial incision is within 3mm of the midline in the posterior fourchette
448 and the direction of the cut is at first midline, then 'J' is directed towards the ischial tuberosity (106). (NEW)

449
450 **5.4.1.1.4 Mediolateral episiotomy:** This type of episiotomy involves an incision beginning in the midline and
451 directed laterally and downwards avoiding the anal sphincter (110). The origin of the initial incision is within
452 3mm of the midline in the posterior fourchette and the direction of the cut is laterally at an angle of at least
453 60° from the midline towards the ischial tuberosity (106). (NEW)

454
455 **5.4.1.1.5 Lateral episiotomy:** This type of episiotomy begins laterally to the vaginal introitus and is directed
456 towards the ischial tuberosity (107). The origin of the initial incision is more than 10mm from the midline in
457 the posterior fourchette and the direction of the cut is laterally towards the ischial tuberosity (106). (NEW)

458 **5.4.1.1.6 Radical lateral (Schuchardt incision):** Radical lateral episiotomy is often considered to be a non-
459 obstetrical incision. It is a fully extended episiotomy, deep into one vaginal sulcus and is curved downwards
460 and laterally part way around the rectum. It may be performed at the beginning of radical vaginal
461 hysterectomy or trachelectomy to permit easy access to the parametrium, or rarely to facilitate complicated
462 deliveries (large head, difficult breech or for management of shoulder dystocia). The origin of the initial
463 incision is more than 10mm from the midline and the direction of the cut is laterally towards the ischial
464 tuberosity and around the rectum (106). (NEW)

465 **5.4.1.1.6 Anterior episiotomy (deinfibulation):** The anterior episiotomy or deinfibulation is defined as a
466 surgical incision usually performed during delivery in women who previously had infibulation(111). Fused
467 labia minora are incised in the midline anteriorly until the level of the external urethral meatus. The clitoris
468 and surrounding tissues or clitoral remnants should not be incised. The origin of the initial incision is midline
469 and the direction of the cut is midline, directed towards the pubis (106). (NEW)

470 **5.5 Tertiary prevention of obstetric pelvic floor trauma:** measures to manage women with previous
471 obstetric trauma or severe pelvic floor dysfunction and attempt to treat or prevent further complications.

472 - Lifestyle modifications

473 - Mode of delivery in subsequent pregnancies for women with previous obstetric trauma or severe
474 pelvic floor dysfunction (i.e. fecal incontinence). (NEW)
475
476
477
478
479
480

481 **Footnotes for Section 5**

482 **5.1 Risk prediction model:** a mathematical equation that uses a number of predictors to estimate the
483 probability of obstetric pelvic floor trauma. It can assist in clinical decision making for clinicians and patients.
484 Before being used in clinical practice, risk prediction models should be validated.

485 Recent risk prediction models for obstetric pelvic floor trauma include OSIRIS and UR-CHOICE (112) (113)
486 (114) (115). (NEW)

487 **5.2 Instrumental delivery,** especially forceps, midline episiotomy, and a persistent occiput posterior position,
488 have been associated with the highest risk of developing severe perineal trauma (94).
489

490 **5.3 Lifestyle modifications:** Interventions that intentionally change the way a person lives in order to improve
491 health status to prevent or avoid deterioration of any pelvic floor disorders (weight loss, avoid heavy lifting
492 or coughing, cease tobacco smoking, avoid or treat constipation, modify occupational health parameters,
493 avoid physical straining or heavy weight lifting at work).
494
495

7 SECTION 6: MANAGEMENT OF OBSTETRIC PELVIC FLOOR TRAUMA

6.1. Conservative treatments: Restricted to non-surgical and non-pharmacological treatment.

6.1.1. Conservative treatment of vaginal / perineal tears: The non-surgical treatments that allow spontaneous healing of surgical trauma, including topical hygiene measures (avoiding irritant soaps, detergents, and douches) and expectant management.^{FN6.1}

6.1.1.1 Vulval hygiene: Involves maintaining a clean perineum by means of washing the area on a regular basis and wearing cotton underwear. To avoid vulval irritation, shampoo, perfumed creams, or soap should be avoided.

6.1.1.2 Anal hygiene: Involves keeping the perianal region clean, which is especially important when fecal seepage is present. Advice includes using soft toilet paper or moist wipes (avoiding any with an alcohol base), always wiping from front to back, washing after a bowel movement, then gently patting dry.

6.1.1.3 Perineal cryotherapy: The application of substances that remove body heat and reduce the temperature of the tissues as a treatment approach (116). (NEW)

6.1.1.4 Sitz baths: Warm bath to which salt has been added (117). (NEW)

6.1.1.5 Pelvic brace/belt: Tubigrip or trochanteric belts worn over the lower abdomen and pelvic area, just cranial to the greater trochanters. Exerts a small amount of force and aids in restoration and stability of the pelvic ring (118). (NEW)

6.1.2. Pudendal Nerve Infiltration: infiltration of local anaesthetic like bupivacaine and corticosteroid around the pudendal nerve to provide symptom relief in cases of pudendal neuralgia (119).

6.1.3. Physical Therapies

6.1.3.1. Pelvic physiotherapy: Assessment, prevention and/or treatment of pelvic floor dysfunction, performed by a pelvic physiotherapist. The therapy aims at reducing pelvic floor symptoms and related bother as well as improvement of pelvic floor function. Pelvic physiotherapy covers many specialised therapies that can be used to train the pelvic floor: physical activity, cognitive behavioural therapy, bladder training, bowel habit training, muscle training (endurance, power), coordination training, biofeedback, and electrical muscle stimulation. The physiotherapist can use adjuvant treatments such as soft tissue therapies.^{FN6.2} For the treatment of obstetric trauma associated POP it may be useful to associate the use of devices^{FN6.3} with physiotherapy.

6.2 Surgical Management

6.2.1 Surgical repair of vaginal and perineal trauma: Surgical treatment of a tear by suturing and closure of the anatomical defect. (NEW) ^{FN6.4} (See appendix)

530 **6.2.2 Levator ani repair:** Dissection from the ischial spine to the pubic bone and suturing of the various
531 divisions of the levator ani muscle to recreate a functioning levator plate (120). (NEW)

532 **6.2.3 Perineoplasty:** Surgical procedure intended to narrow genital hiatus, reduce introital gap and
533 increase perineal body. It can be performed as a stand-alone procedure or in combination with other
534 perineal or vaginal repairs (121). (NEW)

535 **6.2.4 Perineal scar revision:** Surgical excision of symptomatic perineal scar. It will usually include
536 resuturing to create a new scar. (NEW)

537 **6.2.5 Fenton's procedure:** Surgical procedure to increase genital hiatus and widen the introitus by excising
538 scar tissue and/or an area of constriction at the entrance of the vagina. (NEW)

539 **6.2.6 Z-plasty procedure to treat introital stenosis:** Involves a central incision along the length of the
540 constriction and 2 lateral incisions at an angle of 60° to form a Z as shown in the video. The lengths of the
541 three limbs and the angles formed between the central and lateral limbs are equal. This creates two
542 triangular tissue flaps which when transposed change the length as well as orientation of the scar. This is
543 associated with a 40% gain in functional length along the central incision once the flaps are transposed. FN6.5
544

545

546 **Footnotes for Section 6**

547 **6.1** Whilst most practitioners tend to suture vaginal and perineal tears, the debate of whether to leave the
548 skin unsutured has been longstanding. Overall, there does not seem to be enough consistent evidence to
549 support a change in practice of leaving perineal cutaneous trauma unsutured.

550 **6.2 Soft Tissue Therapies consist of:**

551 **Touch desensitisation:** The manipulation of the soft tissues of the body for the purpose of affecting the
552 nervous, muscular, respiratory, and circulatory systems.

553 **Massage:** The manipulation of the soft tissues of the body for the purpose of affecting the nervous, muscular,
554 respiratory, and circulatory systems.

555 **Abdominal massage:** Therapist or self-directed massage of the abdominal wall with the aim of stimulating
556 peristalsis and relieving the symptoms of constipation. Generally, the technique follows the ascending,
557 transverse, and descending colon to aid emptying. The effect may be mechanical or sensory.

558 **Myofascial release techniques:** The use of deep friction and stroking of the fascia of the body to improve
559 the ability of the fascia to deform and move within the body.

560 **Skin rolling:** A manual technique in which skin is pulled away from the underlying structures and elongated
561 in various directions.

562 **Scar massage:** A specific application of soft-tissue mobilization to an adherent scar.

Perineal massage: intravaginal massage by the woman, her partner, or the clinician. Technique includes alternating downward and sideward pressure, using thumb and forefinger and a natural oil, with the aim of stretching and elongating the tissue in preparation for vaginal childbirth, or for treatment of adherent scarring in the perineum.

Transverse friction: the operator's fingertip is placed on the exact site of the lesion and rubbed firmly across the direction of the fibers of the affected tissue.

Thiele's massage: per-rectal digital massage of the levator ani, sweeping lengthwise along the muscle fibers. Massage is begun lightly, and pressure is increased as tenderness decreases.

TrP treatment: (sometimes called myofascial trigger point treatment): Soft-tissue mobilization specifically targeting trigger points and may include ischemic pressure, massage, myofascial release, electrotherapy, ultrasound, laser, spray and-stretch, injection (a variety of chemicals including local anaesthetic, botulinum toxin or steroids), dry needling (insertion of a solid needle into the TrP), and stretching (54).

6.3 Devices for the treatment of obstetric trauma associated POP fundamentally are vaginal pessaries defined as a device that is inserted into the vagina to provide structural support to one or more of descending vaginal compartments, i.e., the uterus, anterior vaginal wall (and bladder), posterior vaginal wall (and rectum) (122).

Vaginal pessaries can be broadly divided into two types:

- **support pessaries** Ring pessary with or without central support; Gehrung, Hodge pessaries.
- **space filling pessaries** Doughnut; cuboid; Gellhorn; inflatable; shelf (similar to a Gellhorn but asymmetric).

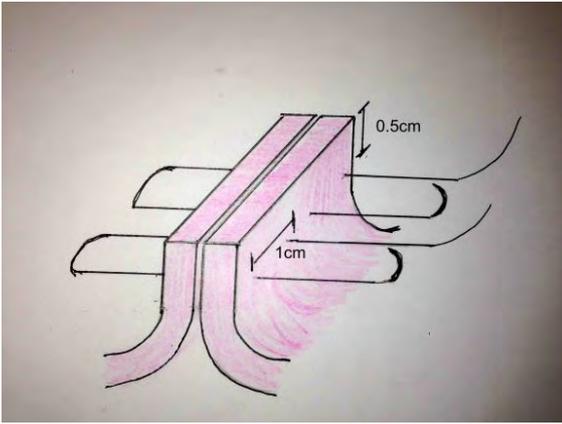
The most frequently used pessaries are (122):

- a. Ring pessary with or without central support
- b. Gellhorn pessary; round solid pessary with a central stem
- c. Donut pessary
- d. Cuboid pessary
- e. Shelf pessary: Similar to a Gellhorn but asymmetric

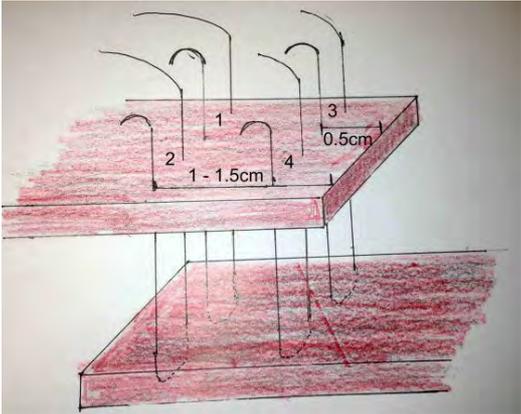
6.4 Surgical repair of the anal sphincter: Re-apposition of the injured external and/or internal anal sphincter. An incomplete external sphincter or internal sphincter injury may be repaired with an end-to-end technique, while a complete external sphincter injury may use an end-to-end or overlapping technique (123).

An end-to-end technique involves apposition of the injured ends of the sphincter with interrupted horizontal mattress sutures. The overlapping technique involves using vertical mattress sutures to overlap one edge of the injured sphincter over the other (Figures 21-22).

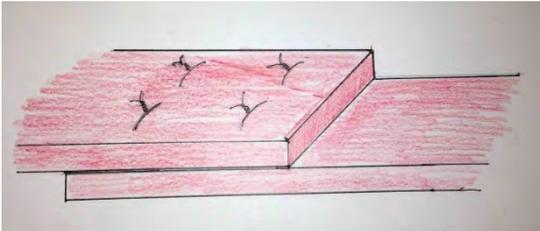
Surgical repair of anal sphincter



598 Internal anal sphincter – end-to-end technique



600 Complete external anal sphincter: Overlapping technique

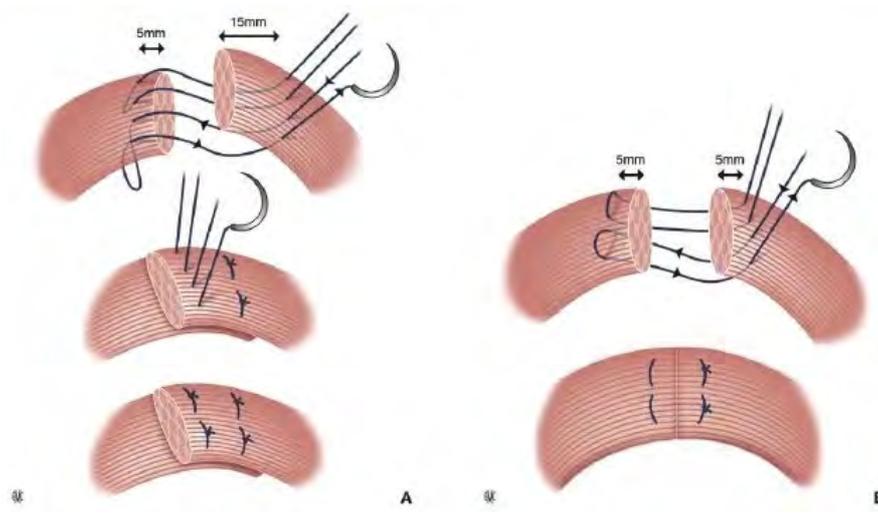


602 Complete external anal sphincter repair: End result

603

604 **Figure 21:** Repair of obstetric anal sphincter injuries (71). Reproduced with kind permission.

605



607 **Figure 22:** The two different methods of external anal sphincter repair. A Overlapping technique. B End-
608 to-end technique. Extract from: V. Letouzey, E. Mousty, B. Fatton, J.-F. Bourgaux, M. Bertrand,
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- 985

986 **APPENDIX**

987
988 **1 Methodological criteria for the selection of definitions**

989
990 Potentially eligible terms for inclusion were identified and included into a term inventory. Subsequently each
991 member of the WG completed a Delphi survey in order to prioritise the most relevant terms with a Likert
992 type scale (1-7) from 1 (least relevant) to 7 (most relevant).

993
994 The terms with the highest scores were the subject of group discussion in order to decide a cut-off of
995 relevance, with regards to pelvic floor anatomy and function changes during pregnancy, the puerperium and
996 / or up to 12 months postpartum. Their definitions were reviewed and those already existing in other
997 documents were considered for inclusion based on relevance to pregnancy, puerperium and postpartum
998 period of 12 months. Some definitions were modified and new definitions were introduced where no
999 previous definitions existed.

000
001 The following criteria were used to inform the inclusion and detail required to define each term:

- 002 1. Is this term childbirth trauma related?
- 003 2. Is this a separate entity to other PFD types (eg Postpartum stress urinary Incontinence vs generic
004 SUI)?
- 005 3. Is this term covered by other Terminology documents?
- 006 4. Is this term covered or described in other literature?
- 007 5. Does this term need to be modified?
- 008 6. Is this term important or relevant enough to be repeated in this document if it features in other
009 reports?
- 010 7. Is a footnote or appendix indicated / warranted for this term?
- 011 8. Does this term require an illustration?
- 012 9. Does this term require a video link?

013
014 The Working Group convened in multiple online Conference calls and face-to-face meetings during the ICS
015 or IUGA Congresses: ICS2018 (Philadelphia), ICS 2019 (Gothenburg), IUGA 2019 (Nashville).

016
017 Working Group members:

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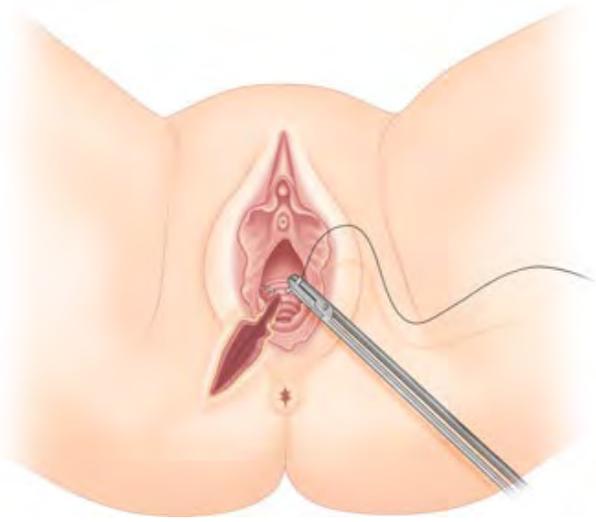
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051 **Appendix 2.**

052 **Repair of episiotomy**

053



055 **a**



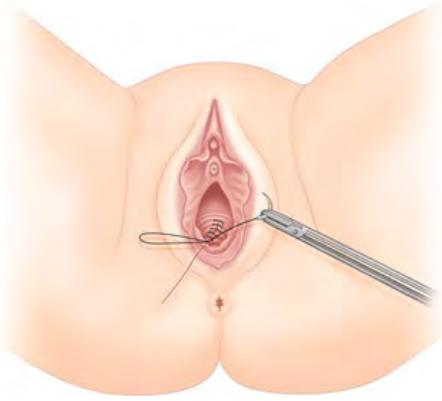
057 **b**

058



060 **c**

061



D
Figure 23: Episiotomy repair using continuous non-locking suture (all layers) (105).

(a) Episiotomy repair, suturing of vaginal wall. Insert first stitch to the vagina above the apex of episiotomy cut and tie a knot.

(b) Episiotomy repair, suturing of perineal muscles.

(c) Episiotomy repair, suturing of perineal skin. Starting from the bottom edge of the episiotomy cut, close perineal skin in the opposite direction towards the vaginal orifice using subcuticular continuous suture.

(d) Episiotomy repair, knotting of the stitch. Place the subcuticular stitch in the vagina just above the level of the hymen and tie a knot.

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Surgical repair of vaginal and perineal trauma

1 Repair of perineal and vaginal tears

- Following informed consent and adequate pain relief, the position of the woman should allow visualisation of the vaginal and perineal tear. This usually involves lithotomy position.
- The first suture is applied above the apex of the vaginal component of the tear to ensure haemostasis.
- The vaginal part of the wound is sutured with a continuous, non-locking technique. This is associated with less pain and dyspareunia compared to interrupted sutures.
- The perineal muscles should be apposed and sutured with the same continuous suture, aiming to approximate the muscle such that the skin edges can be closed without tension. Two layers of continuous sutures may be required in deep tears.
- The perineal skin is usually closed with a continuous subcuticular suture.
- Following repair, a vaginal and rectal examination will ensure the repair is complete and there is no other trauma.

2. Repair of anal sphincter injuries (4)

- Repair of anal sphincter injuries should be undertaken by a clinician who is competent and ideally following formal training.
- Ideally these injuries should be repaired immediately after birth however there is no difference in functional outcome if the repair is delayed by a few hours e.g. because of lack of trained practitioner.
- The repair should take place in an operating theatre environment under regional or general anaesthesia for more complete examination and easier identification of the anatomy.
- A rectovaginal perforation (buttonhole tear) this should be repaired using two layers of interrupted polyglactin sutures.
- In the case of a fourth-degree tear, trauma to the anal epithelium should be repaired with interrupted 3/0 polyglactin sutures with the knots tied in the anal lumen.
- Any trauma to the internal anal sphincter should be repaired separately with interrupted horizontal mattress sutures using a fine suture such as 3/0 polydioxanone (PDS) or 2/0 polyglactin (figure 21). Separate identification and repair of the internal anal sphincter is associated with better continence outcomes.
- The torn ends of the external anal sphincter are held with Allis tissue forceps and sutured using either an overlap (if the muscle is completely torn, i.e. 3B/3C) or end-to end approximation, using 3/0 polydioxanone (PDS) or 2/0 polyglactin. When an overlapping technique is used, one or both sphincter ends may need to be dissected from surrounding tissue to provide sufficient length for the overlap. There is no difference in perineal pain, dyspareunia, faecal incontinence or flatal incontinence between the two techniques, although there is some evidence of a lower incidence of faecal urgency and lower anal incontinence symptom scores in the overlap group.
- Following repair of the sphincter, it is important to perform perineal reconstruction for support of the sphincter muscles.
- Repair of the vagina and perineum should proceed as for a second-degree tear.
- A rectal examination should be carried out to ensure that the repair is complete and that no sutures have been placed inadvertently through the rectal mucosa.
- An indwelling catheter should be left in the bladder for 12 to 24 hours.

- 120 • Broad spectrum antibiotics at the time of the repair, plus oral antibiotics for 5 to 7 days after are
121 recommended.
- 122 • Laxatives are recommended in the post-natal period to avoid constipation.
- 123
- 124