

Are Women Aware of the High Prevalence Rates of Anorectal Dysfunction After Childbirth?

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Abstract

Urinary and fecal incontinence are common and successful indications for pelvic floor muscle training (PFMT) in the first year postpartum, but it is often not addressed by healthcare providers. Only a minority of the women that suffer from pelvic floor dysfunction (PFD) receives a routine inquiry about PFD and is advised to seek for help. This brief communication highlights the need for healthcare providers to discuss postpartum incontinence symptoms with women.

Keywords: Anal incontinence; Childbirth; Episiotomy; Fecal urgency; Vaginal delivery; Knowledge; Pelvic floor muscle training

Discussion

Pregnancy and childbirth are the most important risk factors that contribute to PFD. Disorders of defecation are undoubtedly the most severe adverse events of PFD associated with childbirth. Anal incontinence (AI), the involuntary loss of flatus, liquid, or solid stool, is a distressing and debilitating condition with considerable impact on occupational, social, and sexual quality of life. Rusavy et al. investigated AI following mediolateral (n=300) or lateral (n=360) episiotomy during a first vaginal delivery [1].

Their study showed AI among 7 and 3% of patients who underwent mediolateral and 7 and 6% of who underwent lateral episiotomy, at

respectively 3 and 6 months postpartum. They concluded that AI was comparable between both groups and that the association between lateral episiotomy and fecal urgency merits further scientific interest. Next to the high prevalence of AI after childbirth in primiparous women.

Previous research has showed that nulliparous (n=212) and primigravid (n=221) women have a significant lack of knowledge about the pelvic floor and the risk of PFD postpartum [2,3].

Table 1 shows that the risk of urinary incontinence after delivery is known by most women; but disorders of defecation and flatulence were only known by a minority. The majority of the nulliparous and primigravid women never receive any information about PFD. But almost all women confirm that they are interested to receive more information (Table 1) [2,3].

How much do you know about the pelvic floor muscles on a scale from zero to ten, whereas zero is absolutely nothing and ten is expert in the domain?				
NP (212)	2.4 to 10 (SD 2.01)			
PG (221)	3.7 to 10 (SD 2.59)			
Does a healthy woman occasionally lose stool, immediately after delivery, 1 month after delivery and 6 months after delivery?				
1-5 d PP	NP (212)	51 (24%) Yes; 85 (40%) I don't know	PG (221)	34 (15%) Yes; 63 (29%) I don't know
1 m PP	NP (212)	52 (25%) Yes; 156 (74%) I don't know	PG (221)	2 (1%) Yes; 61 (28%) I don't know
6 m PP	NP (212)	45 (21%) Yes; 165 (78%) I don't know	PG (221)	1 (1%) Yes; 55 (25%) I don't know
Which consequences can you expect after delivery?				
UI	NP (184)	147 (80%)	PG (221)	162 (73%)
Stool problems, AI	NP (185)	26 (14%)	PG (221)	35 (16%)
Flatulence	NP (182)	18 (9%)	PG (221)	16 (7%)

Experience with education and gathering of information on this topic				
Ever received information?	NP (208)	40 (19%) Yes	PG (219)	62 (28%) Yes
Sufficiently informed?	NP (205)	15 (7%) Yes	PG (221)	178 (81%) Yes
Interested in more information?	NP (206)	191 (93%) Yes	PG (221)	195 (88%) Yes

Table 1: Pelvic floor Knowledge of nulliparous women (nulliparous and primigravid group) [d: Days; m: Months; PP: Postpartum; SD: Standard Deviation; UI: Urinary Incontinence; AI: Anal Incontinence; NP: Nulliparous Women; PG: Primigravid Women].

The research about postpartum AI performed and the latest IUGA consensus about anorectal dysfunction in women are a significant aid to clinical practice and a stimulus for research. While the taboo about these PFD is clearly diminishing in scientific research, the performed research highlights the taboo and ignorance that prevails among women about AI [2,3]. Therefore, we emphasize the need of a good education about the pelvic floor and PFD in young women, before they are exposed to the greatest risk factors such as pregnancy and delivery. Education might offer the first way to reduce dysfunction by promoting help seeking behavior, prevention and treatment.

Conflict of Interest

The authors of this brief communication report no conflicts of interest.

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