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The deficient perineum: oblique presentation of a clinically obvious anomaly

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Summary

The deficient perineum is a recognized anatomical defect attributable essentially to the trauma of vaginal delivery. We studied, retrospectively, 64 women with the deficient perineum who presented in our unit for other reasons. All were parous and had previous vaginal delivery. Eighty-four percent delivered recently outside a hospital. Presumed marital disharmony occurred in 45% and may have been profound. Perineorrhaphy in the women seen, had salutary effects.

Keywords: Birth trauma; perineal injury; coital satisfaction; perineorrhaphy; deficient perineum.

Résumé

Le perineum deficient est un défaut anatomiquement reconnu attribué essentiellement à un trauma de la délivrance vaginale. Nous étudions rétrospectivement 64 femmes avec un perineum deficient qui se sont présentées dans notre unité pour d'autres raisons. Toutes étaient parvenues et avaient eu au paravent une délivrance vaginale. 84% d'accouchement récemment hors de l'hôpital. La désaccorde présumée dans les ménages a été la cause dans 45% des cas. La perineorrhaphie chez les femmes consultées avait des effets salutaires.

Introduction

Lower genital tract trauma complicating vaginal delivery could be a significant aetiology of perineal deficiency and/or coital dissatisfaction in the pre-menopausal woman.

Many women who deliver vaginally in the hospital have an episiotomy while the majority of those who deliver outside the hospital end up with trauma or laceration of the perineum and/or vagina [1]. In Nigeria, where a good number of deliveries occur outside hospital settings, lower genital tract trauma or lacerations may be quite common. If obstetric lacerations of the introitus are neglected, or break down from sepsis, the perineal body may become deficient, with or without distressing incontinence of flatus or loose faeces. The perineal body is frequently torn during childbirth [2], and this may cause the urogenital hiatus to gape. Such perineum may have a normal appearance, but on palpation is felt to consist of skin only, the so-called "dash board" perineum.

The deficient perineum is a clinical entity that we had to reconstruct in our practice over 7 years (1992-1998). We have highlighted this gynaecological problem because of a few striking features in its symptomatology, and the uniform satisfaction that appeared to have accrued from the procedure of perineorrhaphy.

Patients and methods

Sixty-four (64) parous women were found to have striking deficiency of the perineal body during the course of routine

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pelvic examinations between March 1992 and July 1998 at the gynaecology clinic of the University College Hospital, Ibadan, and were enrolled in the study. None of the women had complained initially about sexual dissatisfaction or any problem whatsoever at the introital or anorectal region.

When offered surgery to "restore the private part to normalcy", all the 64 women readily gave consent. All perineorrhaphies were performed within two weeks of the offer for repair.

Operative Procedure

The patients were placed in lithotomy position after administration of general anaesthetic technique. The perineum, vulva, and vagina were cleaned with cetrimide solution and sterile drapes were applied.

The tissue plane between the vaginal wall and the remnants of the perineal body as well as the rectal wall posteriorly was infiltrated with 20 ml of 1:100,000 solution of adrenaline. This was extended anteriorly between the vaginal wall and the bladder for those patients with associated cystocele.

A flap of vaginal wall was dissected off the rectal wall and reflected to expose the fibres of the 'torn' perineal muscles. The muscle fibres were then apposed from the apex down to the base formed by the perineal body in an interrupted fashion with size 0 polyglactin (Vicryl-Ethicon) sutures. The redundant vaginal skin was excised and the edges apposed. The perineal skin was then apposed over the reconstructed perineal body.

In those patients with associated cystocele, a flap of the anterior vaginal wall was dissected off the bladder and its attachment to the cervix after infiltration. The bladder was reflected upwards. Kelly's stitches were used to buttress the bladder base and the redundant vaginal skin was excised the edges apposed using the same suture materials.

The two patients with associated Bartholin's cysts had marsupialisation of the glands done and haemostasis was achieved. An in-dwelling urethral catheter as well as vaginal packs were left in-situ. All the patients recovered uneventfully from anaesthesia. The catheter and the packs were removed on the first post-operative day and they were discharged on the third day.

Coital abstinence was advised for 3 weeks post-repair, and K-Y Jelly (Johnson and Johnson) prescribed for the first few acts thereafter.

The patients and their spouses were then seen, 6 weeks after the procedure, in the follow-up gynaecology clinic. Data were obtained from their case records on age, parity and place of delivery. Other information on marital disharmony attributable to sexual dissatisfaction, and presence or absence of faecal incontinence was obtained by direct questioning.

Results

The age of the patients ranged between 24 and 41 years with the mean age of 35.5 years \pm 8.2 (Fig. 1). The parity distribution is

as shown in figure 2.

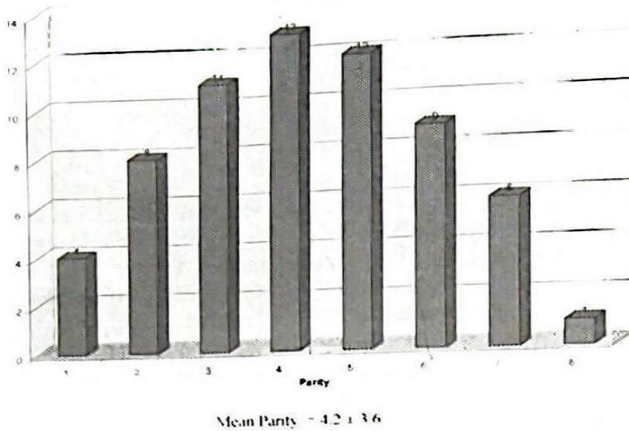


Fig. 1: Age distribution.

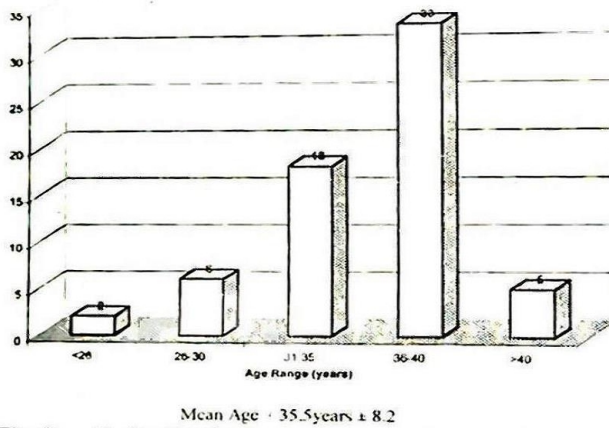


Fig. 2: Parity distribution

Fifty-two (81.3%) patients had had 3 or more vaginal deliveries, while 54 (84.4%) had with the last delivery outside a hospital setting. Twenty-nine (45.3%) patients admitted to some form of marital disharmony attributable to sexual dissatisfaction. There was no faecal incontinence.

Table 1 is a summary of operative findings. All patients had loss of levator ani grip. The post-operative course was uneventful in all patients. All had been discharged home on the third post-operative day.

Table 1: Frequency of intra-operative findings

Intra-operative findings	No.	%
Loss of levator grip	64	100
Associated cystocele	19	29.7
Associated rectocele	18	28.1
Weak anal sphincter grip	14	21.9
Old skin sutures	12	18.8
Bartholin gland cyst	2	3.1

All spouses (interviewed in absence of their wives) admitted to a "noticeable" change in coital satisfaction. Three women complained of some dyspareunia but did not believe analgesic was necessary.

Discussion

Coital satisfaction is rarely routinely enquired about by the busy, practicing gynaecologist. The "defective perineum" is usually symptomless, but the occasional patient may complain of vaginal flatus, or that water enters the vaginal whilst bathing or that coitus is less satisfactory than before vaginal delivery.

In this series, not one patient initially had complaints that had any bearing to any introital or coital problem. Women, probably because of embarrassment, volunteer sexual dysfunction infrequently. Plouffe had suggested a simple questionnaire to screen for sexual problems in basically educated females although this was not used for any of our patients [3]. That a majority of these women had had home deliveries may suggest the fact that trauma is common and/or that genital lacerations are never sutured. It is the profuse, life threatening haemorrhage that usually brings home-delivered women to hospital.

For hospital delivered women, who constituted about a third of our patients, faulty techniques of perineal repair may have contributed to the development of a deficient perineum. A recent UK study [4] showed that doctors and midwives who had been confidently repairing episiotomies and perineal lacerations did not actually have a good grasp of the basic anatomy of the perineum. Long-term results of these injuries and their repairs are not difficult to identify [5,6].

Apart from our presumed impressions about the deficient perineum and coital satisfaction, it is to be remembered that, more importantly, an intact perineal body supports the pelvic viscera. The chronic denervation of the pelvic musculature, which complicates repeated childbirth, superimposed on the deficient perineum, might result in genital prolapse much earlier before the oestrogen lack of the climacteric or post menopause [7].

In concluding, it is worth reasoning that as our women are not well supervised during childbirth significant perineal injuries or lacerations will continue to occur. And, if such lacerations (or extended episiotomies) are not well repaired by trained personnel, we should expect a disturbing increase in the number of women with deficient perineal bodies.

As clinicians who see parous women at virtually all phases of life, we suggest that the perineum be deliberately evaluated during routine examinations. There is also a need to develop a locally applicable screening tool for sexual dysfunction in our women who may not, as a culture, complain.

It is also important to encourage our women to embrace the practice of hospital-supervised delivery. This will ultimately result in improved intrapartum care and reduction in injuries associated with poorly supervised delivery.

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