

Isolated rectal tear after a vacuum delivery

Laceração rectal isolada após um parto distócico por ventosa

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Abstract

Obstetric injuries comprising tearing of the rectovaginal septum or rectal mucosa with intact anal sphincters are highly uncommon and few reports are published. Obstetric perineal tears have precise guidelines regarding their risk factors, classification and management, but they don't include isolated rectal mucosa injuries. We present a report of isolated rectovaginal tear detected after a vacuum delivery. The rectal laceration was promptly repaired, with optimum results and no complaints of flatus or stool incontinence at the follow-up visits.

Keywords: Obstetric Labor Complications; Rectum injuries; Anal sphincter; Vacuum delivery.

A 29-year-old primigravida was admitted to the labor room at 39 weeks and 2 days of gestation in spontaneous labor in vertex presentation. Pregnancy was uneventful. The first stage of labor progressed normally with low-dose oxytocin and epidural analgesia. Due to insufficient descent of fetal head, we decided to proceed to operative delivery. With effective analgesia, a left mediolateral episiotomy was performed and a vacuum delivery occurred, with one pull and moderate traction during 30 seconds. A baby boy of 3180 grams was born with an Apgar score of 8/9/9, without need to resuscitation and good evolution.

Immediately after delivery, perineal examination showed a normal length episiotomy and a midline longitudinal tear in the rectovaginal septum (in the distal third of the vagina) about 2 centimeters in length with regular edges, with apparently intact anal sphincters (Figure 1).

The laceration was repaired by the most experienced gynecologist surgeon in the team, after placental delivery, in the operative room under general anesthesia. Continuous nonlocking suture using absorbable monofilament (Monosyn®) 2/0 thread was used along



FIGURE 1. Perineal examination showing the rectal mucosa tear (arrow) and the left mediolateral episiotomy (star)

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the vaginal route to repair the rectal mucosa. The rectovaginal septum was sutured with continuous absorbable multifilament (Vycril®) 2/0 suture. Episiotomy was then repaired routinely. Intravenous antibiotics were given intraoperatively (Cefuroxime 1,5 grams and Metronidazole 500 milligrams), and continued for 3 days, according to our protocol. Postoperatively, she was on IV fluids for 48 hours, then a hydric (low fibre/high fluid) diet was started, followed by a low-residue diet for one month. Proper analgesia and lactulose were also prescribed. She was discharged home on the 6th day after birth, with restored bowel movement.

At review 3 weeks postnatally, the patient had no complaints of flatus/stool incontinence or pain. Rectovaginal examination showed a well-healed laceration and normal sphincter tone. At the follow-up visits after 6 and 12 weeks, she remained asymptomatic and resumed her sexual life with no setbacks.

Instrumental vaginal delivery, birth weight of more than 4 kilograms, persistent occipito-posterior presentation, nulliparity and prolonged second stage are recognized risk factors for severe perineal tears¹⁻⁴. These factors may also contribute to rectal isolated tearing, as some of them were present in our case. However, other explanations must be taken into consideration, such as vaginal tissue inclusion under the vacuum cup or tissue damage at the time the episiotomy was performed with the inner tip of the scissors. Other hypotheses include congenital abnormality of the connective tissue or rapid descent of the fetal head (with only one pull of the ventouse) with insufficient

time for the tissues to adapt^{3,4}.

This case merits reporting due to rarity of this situation and to raise awareness of such complication^{2,4}. Speed and traction control in instrumental delivery is essential, but careful rectovaginal examination afterwards in all women should not be underestimated^{3,5}. Early detection and adequate repair of this type of obstetric injury are the key points to a successful long-term evolution, minimizing complications as rectovaginal fistula and faecal incontinence^{1,5}.

REFERENCES

1. Simhan H, Krohn M, Heine R. Obstetric rectal injury: risk factors and the role of physician experience. *The Journal of Maternal-Fetal & Neonatal Medicine*. 2004;16(5):271-274.
2. B Thirumagal, S Bakour. Rectal tear during normal vaginal delivery with an intact anal sphincter: a case report. *J Reprod Med*. 2007; 52(7): 659-60.
3. Shaaban K. An isolated rectovaginal tear as a complication of vacuum delivery. *J Obstet Gynaecol (Lahore)*. 2008;28(1):106-106.
4. Vergers-Spooren H, de Leeuw J. A Rare Complication of a Vaginal Breech Delivery. *Case Rep Obstet Gynecol*. 2011;2011:1-2.
5. Athanasiou S, Mousiolis A, Grigoriadis T, Antsaklis A. Postpartum Traumatic Rectal Tear After Normal Vaginal Delivery with an Intact Anal Sphincter. *J Gynecol Surg*. 2012;28(2):176-178.

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