Maternal birth trauma and its consequences: time to raise awareness

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This editorial is an introduction to the Themed Edition on obstetric pelvic floor trauma and its consequences.

The rate of obstetric pelvic floor trauma and the consequences of urinary and faecal incontinence and pelvic organ prolapse have increased in recent years. Although one can understand that preventing these might not be a priority for many obstetricians and midwives compared with preventing stillbirth, pre-term labour or pre-eclampsia, pelvic organ prolapse and incontinence are nonetheless a significant public health burden. This involves considerable personal and financial costs for the patient, healthcare providers and society.

The understanding of the pathophysiology of obstetric pelvic floor trauma has grown in recent years, with evidence from imaging techniques well described in the paper in this edition by H.P. Dietz [1] and modelling studies of the pelvic floor during labour and head expulsion in a paper by Cechova H [2].

Levator avulsion, a high-risk factor for short and long-term pelvic floor dysfunction, has been seen in ultrasound and MRI studies [3]. One of the main risk factors is instrumental delivery, particularly forceps, and this is well described in the paper by de Leeuw and Daly [4].

Unsurprisingly, the consequences of such trauma have significant physical and psychological consequences for young women that can last a lifetime.

It appears they are not routinely informed of these risks, despite several legal rulings, and their right to make informed choices is well described in the paper written by a legal expert, L. Sutherland [5].

Qualitative studies suggest that women want to know their risk of developing pelvic floor dysfunction to help make

decisions about childbirth. They also report that knowing their risk would motivate them to undertake preventative strategies such pelvic floor muscle training (PFMT) [6]. This desire for information is further supported in the paper by M. Jurczuk [7], as part of a “care bundle” that has been shown to reduce the rate of obstetric anal sphincter injury (OASI), with no increase in caesarean section rate.

Providing women with their individual risk has the potential to reassure the majority at a lower risk and reduce caesarean section requests, while advising the smaller number at a higher risk about preventative strategies. The UR-CHOICE risk calculator has been developed for that purpose and is described by E. Jelovsek in this edition [8].

This highlights the need for antenatal risk assessment and providing women with information on which to make informed choices.

For example, although planned caesarean section can be protective for pelvic organ prolapse and urinary incontinence [9], potential risks require explanation, as in the paper by J. King [10].

Pelvic floor muscle training is arguably less controversial and should be offered to all women during and after pregnancy as it can prevent urinary incontinence in late pregnancy and postpartum, and also reduce prolapse symptoms and the need for further treatment [11].

S. Woodley and E. Hay-Smith provide the important evidence base and advice on PFMT implementation in a paper in this edition [12].

Hopefully, this Themed Edition will raise awareness of the consequences and effects of obstetric pelvic floor trauma, not just amongst readers of the IUJ but for midwives, obstetricians and especially women either during pregnancy, or during the planning of one, who can then be risk assessed, informed and empowered to make informed choices.

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