THE VERY WORST TEAR DOWN THERE

Yes, it's possible to tear straight through your anal sphincter during childbirth. It sounds scary (and it is) but here's what you can do.

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WOMEN PHOTO: **STOCKSY** PAPER TEAR PHOTO: **ERIK PUTZ**

When first-time mom Sophia Black* was pregnant with her daughter, she knew she had a tight pelvic floor and expected some degree of tearing. But nothing could have prepared her for what happened when she delivered her daughter. Her baby's heart rate wasn't normal, so the doctor recommended she be delivered with the assistance of a vacuum. After her baby arrived safely, Black was told she needed stitches. "Did I tear very badly?" she asked, having felt no pain thanks to an epidural.

Black soon found out that she had torn straight through her perineum and anal sphincter into her rectal mucosa (the inner lining)—the most severe type of tear possible with a vaginal delivery. She was stitched up in the delivery room and then spent an agonizing 24 hours in the hospital. "I just assumed that giving birth felt pretty bad," she says. "There was a heaviness, and I really couldn't stand." She bled profusely, had to change her adult diapers every two hours and experienced torturous bowel movements.

Things didn't get easier when she got home. She had trouble walking up and down stairs for the first week and had to lie down to breastfeed because it hurt to sit. For the next three months, she had to sit on a foam pillow made for people with broken tailbones to ease the pain. Now, more than eight months postpartum, she still has vaginal and anal nerve pain, as well as anal fissures and a pulling sensation when she goes to the bathroom. Her proctologist told her she was sewn too tightly, so her rectum is too narrow, which causes the fissures. "It's hard to know what it would be like if I wasn't breastfeeding, because it really compounds things," says Black. Since women who breastfeed have high prolactin levels, which can temporarily decrease estrogen production, side effects such as vaginal dryness and irritation can occur—even in women who have not experienced tearing. "I've got a lot of tenderness in my vagina and anus," she says.

Because fourth-degree tears are uncommon and a little scary to contemplate, many mothers have trouble getting adequate information before delivery and feel unprepared and unsupported during recovery. Those who experience further complications or excessive pain many months postpartum—rarer still—often feel very alone. Here's what you need to know.

THE RISK OF A FOURTH-DEGREE TEAR

Obstetric lacerations, ranging from first to fourth degree, are common and occur in 53 to 79 percent of vaginal births, according to the American Congress of Obstetricians and Gynecologists. (There is less data available in Canada.) Most of these tears are first and second degree, though. The exact number varies by source, but third- and fourth-degree tears typically affect about three percent of women who have vaginal births, with the number increasing to six percent for first vaginal births and decreasing to two percent for women who have had one or more vaginal births. The prevalence of fourth-degree tears specifically is quite low.

> "MY FIRST BOWEL MOVEMENT CAME THROUGH THE VAGINA, SO I KNEW THERE WAS A MAJOR PROBLEM."

You're more at risk for a third- or fourth-degree tear if it's your first vaginal birth; you have a forceps- or vacuum-assisted vaginal delivery; your baby is large (over eight pounds, 13 ounces, or four kilograms); you're induced; you experience a prolonged second stage of labour (the time between when the cervix is fully dilated and delivery); you deliver a child whose shoulder gets stuck behind your pubic bone; or your baby is in the persistent occiput posterior position (where the head is down and the child is facing your belly).

But even if you have all of those risk factors, you might not tear at all. And if you have none of them, you could still tear to your bum. "Can I tell you why some women get tears and some women don't?" asks Ellen Giesbrecht, an OB/GYN and senior medical director of the maternal newborn

THE FOUR DEGREES OF TEARING

There are four types of tearing that can occur during a vaginal birth.

FIRST DEGREE: The least severe type of tear, it involves the skin around the vagina and entering the perineum. These tears usually heal on their own without stitches.
SECOND DEGREE: The next level of tear builds on a first-degree tear but also affects the perineal muscle.
THIRD DEGREE: A third-degree tear extends even further, into the anal sphincter, which is the muscle that controls the anus.
FOURTH DEGREE: The most severe type, a fourth-degree tear passes through the anal sphincter and into the mucous membrane that lines the rectum, known as the rectal mucosa.

According to Ellen Giesbrecht, an OB/GYN and senior medical director of the maternal newborn program at BC Women's Hospital and Health Centre, third- and fourth-degree tears are "different from each other from a repair perspective but indistinguishable in recovery from a patient's perspective." An anal sphincter disruption causes the most symptoms and difficulty for patients, and that muscle is affected in both third- and fourth-degree tears.

program at BC Women's Hospital and Health Centre. "No, because we don't always know. Part of it is the patient's anatomy, which is what the body looks like, and another part is the physiology, or the stretchability, of the skin and muscles. It's very individual."

That said, Kirstyn Richards, a pelvic health physiotherapist at Moss Postpartum House in Calgary, notes that many women have a hypertonic pelvic floor, which means the muscles are too tight and unable to relax, which could increase the risk of tearing. Pain during intercourse or when inserting a tampon, or chronic lower back pain, could be a sign of a tight pelvic floor. Urge incontinence, which is the sudden and strong need to urinate, is another common indicator.

There's nothing you can do to prevent third- and fourth-degree tearing. "If your anatomy is such that you're going to end up with a fourth-degree tear, even if you do perineal massaging, it's not going to prevent it," says Giesbrecht. Still, there is evidence that seeing a pelvic health physiotherapist during pregnancy can help by providing useful exercises to reduce the chances of first- and second-degree tears in women at risk of only low-severity tearing. It will also improve recovery after delivery, no matter how severe the tear. As well, Giesbrecht recommends being active during pregnancy, getting at least 30 minutes of exercise, such as vigorous walking, five times a week, and doing regular Kegel exercises. "There's a significant amount of physical exertion during labour and there's a lot of mobility required in the immediate postpartum," she says. "If you go into that in a better state of health, you're going to perform better. With Kegels, the benefit has to do with muscle memory. If you go to the gym and work out, it builds your muscles. Then if you take a break and go back, it takes less time to build your muscles again. The same thing happens with your pelvic floor."

ESTROGEN IS CRITICAL TO PELVIC FLOOR HEALTH, SO YOU MIGHT NOT SEE A FULL IMPROVEMENT UNTIL YOU STOP BREASTFEEDING.

SIGNS, SYMPTOMS AND SOLUTIONS

In an ideal situation, your healthcare provider will accurately identify the severity of your injury and request a surgical repair by an obstetrician who has experience with third- and fourth-degree tears. It is not an easy surgery and requires someone with experience and skill, because all kinds of secondary problems can occur if you aren't stitched fully or correctly.

In rare cases, a fourth-degree tear is misdiagnosed, which is what happened to Nicki Miller* during the delivery of her third child. "I had a postpartum hemorrhage, so that became the focus," she says. "I needed a blood transfusion, and everything else was overlooked." Her doctor misdiagnosed her tear as only second degree and stitched it up accordingly. "Eight or nine days later, I discovered I had torn really badly and also had a rectovaginal fistula [a canal that passes between the rectum and vagina]. My first bowel movement came through the vagina, so I knew there was a major problem." Miller headed straight to the emergency room, where she was referred to a colorectal surgeon and another OB/GYN.

Pain, including pain during intercourse, and urinary incontinence are common side effects of any vaginal delivery, especially in the first four to six weeks postpartum. Women who experience third- and fourth-degree tears also have trouble holding in gas. "However, stool incontinence is quite rare," says Giesbrecht. If you notice stool leakage or stool exiting through your vagina, it's important to notify your doctor immediately. You could require the repair of a rectovaginal fistula or additional surgery if your muscles are severely damaged.

Richards also notes that she sees vaginal and rectal prolapses after fourth-degree tears because support to the bowels is decreased when a tear goes all the way to the anus. A posterior vaginal prolapse is where the front wall of the rectum bulges into the back wall of the vagina. If it's small, there are usually no symptoms, but it can create difficulties when trying to empty the bowels.

First-time mom Chey Jefferson's* tear became more problematic over time because it wasn't repaired properly and her anal sphincter muscles weren't properly reattached. Since she wasn't given any information about the severity of fourth-degree tears or what to expect, she believed her fecal incontinence was a typical result of childbirth. By the three-month mark, Jefferson started to realize something was wrong when she hadn't healed yet. "I had trouble leaving the house with my daughter because I was having accidents," she says. "It was giving me a lot of anxiety." After doing some online research, she realized she had a fistula and immediately went to a colorectal surgeon. The surgeon recommended a sphincteroplasty and fistula repair to fix her damaged anal sphincter muscles.

HEALING FROM A FOURTH-DEGREE TEAR

Proper care during the six-month period after childbirth is key to a good recovery. Your doctor will likely recommend pain medicines, including ibuprofen (Advil), naproxen (Aleve) or acetaminophen (Tylenol), or a morphine derivative if required, but never codeine. "A lot of women are scared to take pain medications because they're breastfeeding, but these medications are completely safe unless you have another medical reason for not taking them," says Giesbrecht. "It's best to take your meds regularly and stay mobile, because it improves your recovery." Your doctor will also prescribe stool softeners and plenty of fluids, which can help prevent the pain of passing hard stools. Breastfeeding women are already at risk for constipation because they have to take in a couple of extra ounces of fluid for every ounce of breastmilk they produce, says Giesbrecht. Even if you hate constantly getting up to go to the bathroom or find it painful, do not restrict your fluids.

Another way to improve recovery is to work with a pelvic health physiotherapist, says Giesbrecht. Though Richards doesn't see her patients until six weeks after childbirth (whether they've torn or not), if they've visited her before delivery, she'll give them a postpartum recovery program. The program involves deep-core activation and breathing exercises that mobilize the site of the tear from the beginning. Then, at six weeks, she continues to teach her patients how to connect with their pelvic floor and strengthen their muscles. Richards also works on massaging scar tissue so patients get full mobility and their muscles can contract and act like they should.

Be sure to attend your follow-up appointments as scheduled and report any issues, including fecal incontinence, as soon as they arise. The sooner you mention them to your doctor, the better your chances of getting timely care. Don't be scared to push to have your questions answered or your voice heard.

Over the first six months after delivery you should continue to see improvements in your muscle strength and a reduction in symptoms. However, you probably won't see a full improvement until you stop breastfeeding (if you're nursing) and your estrogen is therefore no longer suppressed. "Estrogen is critical to your pelvic floor, especially the tone and tissues there," says Giesbrecht. While their cases are extreme, both Miller and Jefferson required reparative surgeries: a sphincteroplasty and perineoplasty for Miller, and a fistula repair and sphincteroplasty for Jefferson. The processes were long and painful but have improved the women's fecal incontinence. "I can go outside and resume my normal life," says Jefferson. "I don't have to run to the bathroom—I can hold it now. I'm still seeing a pelvic health physiotherapist because I continue to experience frequent urinary incontinence."

Though her doctors say her tear has healed well, Black still has a buildup of scar tissue and continues to see a pelvic health physiotherapist and an acupuncturist. She has also met with a proctologist, who prescribed Diltiazem (a drug that relaxes a tight sphincter), as well as a gynaecologist, who gave her estrogen cream to see if it would help with the overtightness and rawness she experiences. "I don't have time for these things," Black says. "It makes me want to cry when I think of how much easier it is for other people. My daughter really loves breastfeeding, so I do it even though I'm in pain. I probably won't go past a year, though, because of how much discomfort it brings me."

While it's true that you will never be exactly the same down there, most women do recover well after a tear—even a fourth-degree one. "Everyone looks different after they've had a baby vaginally," says Giesbrecht. "But with good care and dedication to pelvic physiotherapy, the vast majority of women will go back to having a very good quality of life." **TP**

* NAMES HAVE BEEN CHANGED

TEARING VS. EPISIOTOMY: IS ONE BETTER?

An episiotomy, in which a doctor makes an incision in the perineum, was once a routine part of delivery, but now most doctors will only intervene if it's absolutely necessary—say, if the baby needs to be delivered immediately because their heart rate is dropping. "Some doctors think it's better to tear than to cut, but that's not universal," says Ellen Giesbrecht, an OB/GYN at BC Women's Hospital and Health Centre. "Depending on the anatomy and flexibility of the tissue, some doctors will make a small episiotomy to guide the tear rather than have multiple tears occur. It's done at the discretion of the healthcare provider in consultation with the patient." An episiotomy will not prevent tearing to, and through, the anal sphincter.

PRE-LABOUR PREP

Seeing a pelvic health physiotherapist during pregnancy won't prevent a tear, but there are some benefits.

YOU'LL STRENGTHEN YOUR CORE, PELVIC FLOOR AND HIPS "I always try to encourage patients to come in during their first trimester," says Kirstyn Richards, a pelvic health physiotherapist at Moss Postpartum House in Calgary. "Our goal in the beginning is to build stability and strength in their core, pelvic floor and hips to give them support and start connecting them to those muscles."

YOU'LL LEARN TO LET GO "Once a patient reaches 35 or 36 weeks, it's all about connecting to those muscles and learning how to let go using their breath," says Richards.

YOU'LL LEARN ABOUT IDEAL BIRTHING POSITIONS Certain positions close off the pelvic inlet and make it harder for the baby to come out. "How we typically give birth, with legs out wide and on our backs, shuts off the pelvic inlet," says Richards. "Something as simple as rotating your knees inward opens it up."

YOU'LL PRACTISE PERINEAL MASSAGE AND STRETCHING "Our clients actually massage the perineal area and the muscles between the vagina and anus to make those tissues move and become as pliable as possible," says Richards. She suggests avoiding any oils and creams for this type of massage, because it's key for "friction and warmth to come into that tissue and mobilize it that much more effectively."