

Specific obstetrical risk factors for urinary versus anal incontinence 4years after first delivery.

Xavier Fritel, Babak Khoshnood, Arnaud Fauconnier

▶ **To cite this version:**

Xavier Fritel, Babak Khoshnood, Arnaud Fauconnier. Specific obstetrical risk factors for urinary versus anal incontinence 4years after first delivery.. Progrès en Urologie, 2013, 23 (11), pp.911-6. 10.1016/j.purol.2013.06.009 . inserm-00870500

HAL Id: inserm-00870500

https://inserm.hal.science/inserm-00870500

Submitted on 7 Oct 2013

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

Specific obstetrical risk factors for urinary versus anal incontinence four years after first delivery.

Abstract

Aim: delivery can be complicated by urinary or anal incontinence (UI or AI). We hypothesized that the mechanisms of injury may differ for UI and AI. Hence, obstetrical risk factors may be specific for different types of incontinence.

Design: Data on maternal characteristics were collected at first delivery. Data on incontinence were obtained by a questionnaire completed by 627 women four years after first delivery. UI was defined by "Do you have involuntary loss of urine" and AI by "Do you have involuntary loss of flatus or stool". A multinomial logistic regression analysis was conducted to assess risk factors for UI only, AI only, and UI + AI.

Results: 22% of women reported UI only, 6.5% AI only, and 6.5% both. Risk factors associated with UI only were age (at 1st delivery) ≥ 30 (OR 2.27 [95% CI 1.47-3.49]), pre-existing UI (6.44 [2.19-19.0]) and pregnancy UI (3.64 [2.25-5.91]). Risk factors associated with AI only were length of the second active stage > 20 minutes (2.86 [1.15-7.13]) and third degree perineal tear (20.9 [1.73-252]). Significant predictors of UI+AI were age ≥ 30 (2.65 [1.29-5.46]), no epidural (4.29 [1.65-11.1]), third degree perineal tear (20.0 [1.28-314]), and UI before pregnancy (32.9 [9.00-120]). Cesarean delivery was not significantly associated with UI, AI, or UI+AI, although for all three outcomes, the adjusted odds ratios were substantially less than one.

Conclusion: We found specific associations between obstetrical risk factors and urinary versus anal incontinence four years after first delivery. Our results are consistent with the hypothesis that the underlying mechanisms of injury differ for UI and AI.

Key-words: urinary incontinence; anal incontinence; delivery

Word count: abstract 261; text 1996.

Facteurs de risque obstétricaux spécifiques de l'incontinence urinaire ou de l'incontinence anale quatre ans après le premier accouchement.

Résumé

Objectif : L'accouchement peut se compliquer par une incontinence urinaire ou anale (IU ou IA). Notre hypothèse est que si les mécanismes lésionnels sont différents pour chaque incontinence, les facteurs de risque obstétricaux devraient être spécifiques à chaque type d'incontinence.

Méthodes : Les données sur la mère ont été recueillies à la première naissance. Les données sur l'incontinence ont été obtenues par un questionnaire rempli par 627 femmes, quatre ans après le premier accouchement. L'IU était définie par « Avez-vous des fuites involontaires d'urine » et l'IA par « Avez-vous des pertes involontaires de gaz ou de selles ». Une régression logistique multinomiale a été conduite afin d'estimer les facteurs de risque pour l'IU isolée, l'IA isolée, et IU+IA.

Résultats : 22% des femmes avaient une IU isolée, 6,5% une IA isolée, et 6,5% les deux à la fois. Les facteurs de risque associés à l'IU isolée étaient un âge (au 1er accouchement) ≥ 30 ans (OR 2,27 [IC 95% 1,47-3,49]), une IU préexistante (6,44 [2,19-19,0]), et une IU de la grossesse (3,64 [2,25-5,91]). Les facteurs de risque associés à l'IA isolée étaient une durée des efforts expulsifs > 20 minutes (2,86 [1,15-7,13]) et un périnée complet (20,0 [1,28-314]). Les facteurs de risques pour IU+IA étaient un âge ≥ 30 ans (2,65 [1,29-5,46]), l'absence de péridurale (4,29 [1,65-11,1]), un périnée complet (20,0 [1,28-314]), et une IU préexistante à la grossesse (32,9 [9,00-120]). L'accouchement par césarienne n'était pas significativement associée à l'IU isolée, à IA isolée, ou IU+IA, bien que pour les trois, les OR ajustés étaient sensiblement inférieur à un.

Conclusion : Nous avons trouvé des associations spécifiques entre des facteurs obstétricaux et l'incontinence urinaire ou anale quatre ans après le premier accouchement. Nos résultats sont compatibles avec l'hypothèse que les mécanismes lésionnels diffèrent pour l'IU et l'IA.

Mots-clés: incontinence urinaire ; incontinence anale ; accouchement

Introduction

First childbirth may become complicated by urinary or anal incontinence (UI or AI). The exact pathophysiology of postnatal incontinence is not well understood. Observable lesions such as third degree perineal tears can explain anal incontinence but this occurs in only a minority of deliveries. Other occult injury to the pelvic floor, e.g., pudendal neuropathy or levator ani muscle avulsion could affect urinary or anal continence.[1] The pudendal nerve innervates striated muscles of the pelvic floor, including levator ani, urethral sphincter and anal sphincter. Risk factors for pudendal nerve damage during childbirth are birth weight > 4 kg and a second active stage longer than 30 minutes.[2] The levator ani muscle which is involved in the maintenance of the urinary and anal continence can also be injured at the time of childbirth. Using MRI findings, DeLancey reported injuries of the levator ani in 20% of primiparous women and Dietz found lesions in 36% of women using sonography.[3,4] Risk factors for the lesions of the levator ani during childbirth are advanced maternal age, forceps delivery and the duration of the second stage.[5] The two sphincteric (urinary and anal) complexes are also bound by crossed reflex like the vesico-anal reflex.[6]

Previous literature has not elucidated to what extent postnatal urinary incontinence and postnatal anal incontinence result from the same underlying mechanisms of injury. The analysis of risk factors associated with postnatal incontinence suggests that certain risk factors such as advanced maternal age and parity may be common to both UI and AI.[7,8] Other risk factors may be more specifically associated with one type of incontinence. For example, UI during pregnancy has been found to be a specific risk factor for postnatal UI and instrumental vaginal childbirth for postnatal AI.[9,10]

We hypothesized that pregnancy and delivery-associated traumatic mechanisms at the origin of postnatal incontinence differ at least to some extent for UI and AI. Therefore, specific obstetrical risk factors are likely to be associated with different types of incontinence. The analysis of risk factors related to stress UI was published previously for a portion of the population.[11] To complete this objective we performed a secondary analysis in the whole sample of primiparous to identify both risk factors that may be common to UI and AI, and those that may be specifically associated with different types of postnatal incontinence, four years after a 1st delivery.

Materials and Methods

Our data were initially collected for a study aimed at comparing the risk of incontinence for women delivering in two maternity units.[12] One maternity had a policy of systematic episiotomy and the other a restrictive policy for episiotomy. The study population includes nulliparous women who delivered a live-born singleton at 37-41 weeks in cephalic presentation in 1996. Mothers whose current mailing address was not known (and those deceased) were excluded. Data on maternal characteristics (age, height, weight), pregnancy (gestational age, epidural, second active stage duration, delivery mode, newborns' birthweight) were collected at the time of childbirth. Women were asked to provide information about pelvic floor disorders using a postal questionnaire, which was sent four years after childbirth. In the absence of response to the first mail, a second and if necessary a third mail was sent. The questionnaire collected data about profession and education level of the mother, interventions on the pelvic floor since childbirth, new pregnancies and pelvic floor symptoms. Urinary incontinence was defined by a positive response (Yes) to the question "Do you have involuntary loss of urine?" and anal incontinence was defined by the answer "Yes" to "Do you have involuntary loss of flatus or stool?" The type of UI was defined using a validated questionnaire (Bristol Female Lower Urinary Tract Symptoms questionnaire),[13] severity of UI was measured with Sandvik's score,[14] and AI was assessed using Pescatori's score,[15] as detailed in a previous publication.[12] The complete questionnaire used for the study is available online. The choice of cut-off values for continuous variables (maternal age < 30, BMI < 25 kg/m², gestational age < 40 weeks, active second stage length > 20 minutes, newborn weight < 4000g) was done a priori. We found no evidence of a difference in the risk of urinary incontinence four years after 1st childbirth for women delivering in the two maternity units. However, the risk of anal incontinence was slightly higher for women who delivered in the maternity with a policy of systematic episiotomy.[12] Using data from this enquiry, we first examined risk factors associated with each type of incontinence (UI or AI) using two separate logistic regression models adjusted on maternity. All significant risk factors for UI or AI were then included in a multinomial logit analysis to assess specific risk factors for the following outcomes: UI only, AI only, and UI + AI. Variables for mode of delivery, third degree perineal tear and maternity unit were forced in the model irrespective of their statistical significance in the logistic models. We used estimates of the odds ratios in the multinomial model for each risk factor and outcome in

order to examine the extent to which specific risk factors may be associated with different types of incontinence.

We complied with French laws on data confidentiality, and restrictions on type of data collected (e.g. no religious or racial data). Informed consent was obtained from all study participants.

Results

Among the 1323 primiparous women who met inclusion criteria, postal address was no longer valid for 548 (41%) and one had died, 774 (59%) women received the postal questionnaire and 627 (81 %) completed it. The first delivery was spontaneous vaginal in 368 cases, instrumental in 209 cases (95 by vacuum) and by cesarean section for 50 women. Continence disorders four years after 1st childbirth of the 627 women who responded are summarized in Table 1. The prevalence of UI was 29% (N=181) and that of AI 13% (82), 22% of women (140) reported UI only, 6.5% (41) AI only, and 6.5% (41) both UI and AI.

Risk factors for UI (with or without AI) were maternal age ≥ 30 at 1st delivery (adjusted OR, 2.3 [95% CI 1.5-3.4]), UI before 1st pregnancy (10.2 [3.7-28.1]), and UI during 1st pregnancy (3.3 [2.1-5.1]). Risk factors for AI (with or without UI) were UI before 1st pregnancy (adjusted OR 5.2 [95% CI 2.3-11.8]), no epidural (versus yes) during 1st delivery (2.4 [1.2-4.8]), second active stage > 20 min (2.5 [1.2-5.1]), and occurrence of 3rd degree perineal tear during 1st delivery (13.3 [2.1-83.0]). Other factors tested and non-significant were: education level, a BMI greater than 25 kg/m², gestational age at first delivery, a first newborn over 4000g, pelvic floor exercises after first delivery, episiotomy at first delivery, a second delivery (this concerns 381 women), and an ongoing pregnancy (see online additional tables S1 and S2).

Table 2 presents the results of the multinomial logistic regression analysis to assess specific risk factors associated with UI only, AI only, and UI+AI. Estimates suggested that different risk factors were associated with the three outcomes. Risk factors associated with UI only were maternal age at delivery ≥ 30 (adjusted OR 2.3 [95% CI 1.5-3.5]), pre-existing UI (6.4 [2.2-19.0]) and UI during pregnancy (3.6 [2.2-5.9]), whereas risk factors for AI only were duration of the second active stage > 20 min (2.9 [1.1-7.1]), and 3rd degree perineal tear (20.9 [1.7-252]). Risk factors significantly associated with UI + AI were maternal age > 30 years (2.6 [1.3-5.5]), UI before pregnancy (32.9 [9.0-120]), no epidural (4.3 [1.6-11.1]) and 3rd degree perineal tear (20.0 [1.3-314]).

Discussion

To our knowledge, this is one of the few studies that evaluated specific risk factors associated with UI and AI four years after 1st delivery. One previous study, which looked at specific risk factors for UI and AI, was based on data collected six months after first childbirth.[16] This study found that risk factors were different for postnatal UI (shoulder dystocia and vaginal delivery) vs. postnatal AI (age over 35 years, smoking, duration of the second stage of labor more than an hour and third degree perineal tear).

We found that different risk factors were associated with UI only (i.e., without AI), AI only, and UI + AI four years after 1st delivery. Risk factors for UI only were maternal age at 1st delivery ≥ 30, pre-existing UI and pregnancy UI. Risk factors associated with AI only were length of the second active stage > 20 min and 3rd degree perineal tear. Risk factors associated with UI + AI were age ≥ 30, no epidural, 3rd degree perineal tear, and UI before pregnancy.

The relatively long period of follow-up in our study (four years after 1st delivery) is an important advantage as the prevalence of postpartum UI tends to decrease spontaneously in the 1st postpartum year.[17] Nevertheless, our study has certain limitations. The sample size of the study was based on the number of subjects needed to have sufficient power for showing a difference in the outcomes between the two maternities that had different policies for episiotomy in our initial study.[12] The study was not specifically designed to have sufficient power to explore the specific effects associated with different risk factors. Indeed, the confidence intervals for the estimates of the effects for several risk factors were wide and lack of sufficient power may explain the absence of statistically significant results for some of the risk factors in the present study. In particular, the lack of statistical significance for the associations between mode of delivery and outcomes (different types of incontinence) is likely to be due to insufficient power. It is worth noting that the point estimates (odds ratios) suggested a lower, albeit not statistically significant, risk for all three outcomes (UI only, AI only and UI+AI) for women who delivered following a cesarean section. For reasons of statistical power we also renounced conduct an analysis based on the type of instrument used for delivery (forceps or vacuum).

Our findings of specific associations between obstetric risk factors and prevalence of UI only, AI only and UI+AI may be due to differences in the underlying mechanisms of injury for different types of incontinence. The two main mechanisms proposed to explain postnatal AI are sphincter injury and pudendal neuropathy. In our study, the specific risk factors for AI

(third degree perineal tear and prolonged second active stage) are compatible with these mechanisms. Prolonged active second stage is associated with pudendal nerve damage.[2] Even following repair, 3rd degree perineal tear is associated with anal incontinence years after delivery.[18]

Concerning postnatal stress urinary incontinence, the mechanisms of injury are still largely unknown.[17] Vaginal birth is likely to increase the mobility of the urethra or to be accompanied by lesions of the levator ani.[3,4] However, urethra mobility returns to prenatal values a few months after delivery.[19] Wijma *et al.* found no relation between urethra mobility and postnatal UI.[20] Dietz and Lanzarone found no link between levator ani avulsion and postnatal stress UI.[4] DeLancey *et al.* reported that only 16% of postnatal stress UI could be explained by urethra mobility, whereas urethra closing pressure could account for 25% of postnatal de novo stress UI.[21] The relation between urethra closure pressure and pregnancy remains unclear. Iosif *et al*. found closure pressure to increase during pregnancy and to decrease after delivery, while Le Coutour *et al.* reported opposite findings.[22,23] In our study, the finding of an association between maternal age and UI could be explained by a lower urethra closure pressure as the latter is known to decrease with increasing maternal age.[24] We are not aware of any studies that have examined the link between pregnancy UI and urethra closure pressure or urethral mobility.[17]

In conclusion, our results suggest that urinary incontinence and anal incontinence four years after 1st delivery do not share the same set of risk factors. These results are consistent with the hypothesis that the underlying mechanisms of postnatal incontinence differ for urinary versus anal incontinence. This implies in turn that different strategies may be needed for prevention of urinary and anal incontinence.

210 ***References***

1 Billecocq S, Morel MP, Fritel X. Traumatisme du levator ani après l'accouchement, de l'étirement à l'avulsion : revue de la littérature [levator ani trauma after childbirth, from stretch injury to avulsion: review of the literature]. Prog Urol 2013;23:511-8.

2 Sultan AH, Kamm MA, Hudson CN. Pudendal nerve damage during labour: prospective study before and after childbirth. BJOG 1994;101:22-8.

3 DeLancey JO, Kearney R, Chou Q, Speights S, Binno S. The appearance of levator ani muscle abnormalities in magnetic resonance images after vaginal delivery. Obstet Gynecol 2003;101:46-53.

4 Dietz HP, Lanzarone V. Levator trauma after vaginal delivery. Obstet Gynecol 2005;106:707-12.

5 Kearney R, Miller JM, Ashton-Miller JA, DeLancey JOL. Obstetric factors associated with levator ani muscle injury after vaginal birth. Obstet Gynecol 2006;107:144-9.

6 Basinski C, Fuller E, Brizendine EJ, Benson JT. Bladder-anal reflex. Neurourol Urodyn 2003;22:683-6.

7 Rortveit G, Hannestad YS, Daltveit AK, Hunskaar S. Age- and type-dependent effects of parity on urinary incontinence: The Norwegian EPINCONT Study. Obstet Gynecol 2001;98:1004-10.

8 Abramov Y, Sand PK, Botros SM, Gandhi S, Miller JJR, Nickolov A, Goldberg RP. Risk factors for female anal incontinence: new insight through the Evanston-Northwestern twin sisters study. Obstet Gynecol 2005;106:726-32.

9 van Brummen HJ, Bruinse HW, van de Pol G, Heintz AP, van der Vaart CH. The effect of vaginal and cesarean delivery on lower urinary tract symptoms: what makes the difference? Int Urogynecol J 2007;18: 133-9.

10 MacArthur C, Bick DE, Keighley MRB. Faecal incontinence after childbirth. BJOG 1997;104:46-50.

11 Fritel X, Fauconnier A, Levet C, Bénifla JL. Stress urinary incontinence four years after the first delivery: a retrospective cohort study. Acta Obstet Gynecol Scand 2004;83:941-5.

12 Fritel X, Schaal JP, Fauconnier A, Bertrand V, Levet C, Pigné A. Pelvic floor disorders 4 years after first delivery, a comparative study of restrictive versus systematic episiotomy. BJOG 2008;115:247-52.

13 Jackson S, Donovan J, Brookes S, Eckford S, Swithinbank L, Abrams P. The Bristol Female Lower Urinary Tract Symptoms questionnaire: development and psychometric testing. Br J Urol 1996;77:805–12.

14 Sandvik H, Seim A, Vanvik A, Hunskaar S, Sandvik A. Severity index for epidemiological surveys of female urinary incontinence: comparison with 48-hour pad-weighing tests. Neurourol Urodyn 2000;19:137–45.

15 Pescatori M, Anastasio G, Bottini C, Mentasti A. New grading and scoring for anal incontinence, evaluation of 335 patients. Dis Colon Rectum 1992;35:482–7

16 Hatem M, Pasquier JC, Fraser W, Lepire E. Factors associated with postpartum urinary/anal incontinence in primiparous women in Quebec. J Obstet Gynaecol Can 2007;29:232–9.

17 Fritel X, Ringa V, Quiboeuf E, Fauconnier A. Female urinary incontinence, from pregnancy to menopause, a review of epidemiologic and pathophysiologic findings. Acta Obstet Gynecol Scand 2012;91:901-10.

18 Mous M, Muller SA, de Leeuw JW. Lonf-term effects of anal sphincter rupture during vaginal delivery: faecal incontinence and sexual complaints. BJOG 2008;115:234-8.

19 Toozs-Hobson P, Balmforth J, Cardozo L, Khullar V, Athanasiou S. The effect of mode of delivery on pelvic floor functional anatomy. Int Urogynecol J Pelvic Floor Dysfunct 2008;19:407-16.

20 Wijma J, Potters AE, de Wolf BT, Tinga DJ, Aarnoudse JG. Anatomical and functional changes in the lower urinary tract following spontaneous vaginal delivery. BJOG 2003;110:658-63.

21 DeLancey JO, Miller JM, Kearney R, Howard D, Reddy P, Umek W, Guire KE, Margulies RU, Ashton-Miller JA. Vaginal birth and de novo stress incontinence: relative contributions of urethral dysfunction and mobility. Obstet Gynecol 2007;110:354-62.

22 Iosif S, Ingemarsson I, Ulmsten U. Urodynamic studies in normal pregnancy and in puerperium. Am J Obstet Gynecol 1980;137:696-700.

23 Le Coutour X, Jouffroy C, Beuscart R, Renaud R. Influence de la grossesse et de l'accouchement sur la fonction de clôture cervico-urétrale [Effect of pregnancy and delivery on the function of the cervico-urethral closure]. J Gynecol Obstet Biol Reprod 1984;13:771-4.

24 Edwards L, Malvern J. The urethral pressure profile: Theoretical considerations and clinical application. Br J Urol 1974;46:325-36.

Table 1

Continence complaints 4 years after 1st childbirth. Where percentages do not add to 100%, there were some missing data (from 0 to 3.3%).

Troubles de la continence 4 ans après le premier accouchement. Quand la somme des pourcentages est inférieure à 100% c'est le signe de quelques données manquantes (de 0 à 3,3%).

Continence troubles 4 years after 1st childbirth		
	N = 627	n (%)
Urinary Incontinence (UI)	no	438 (71)
	yes	181 (29)
Severity of UI	no UI	438 (71)
(Sandvik score)	slight	110 (18)
	Moderate	42 (7)
	Severe	16 (3)
Type of UI	stress	55 (30)
(% among women with UI)	urgency	12 (7)
	mixed	109 (60)
UI bothersome	*Not a problem*	24 (13)
(% among women with UI)	*A bit of a problem*	107 (59)
	Quite a problem	27 (15)
	A serious problem	17 (9)
Anal Incontinence (AI)	no	525 (84)
	yes	82 (13)
Type of AI	Flatus only	64 (78)
(% among women with AI)	Stool	18 (22)
AI bothersome	*Not a problem*	1 (1)
(% among women with AI)	*A bit of a problem*	36 (44)
	Quite a problem	13 (16)
	A serious problem	30 (37)

Table 2

Risk factors for urinary incontinence (UI) only, anal incontinence (AI) only, and UI+AI. Multinomial logistic regression adjusted on maternity. Other factors tested and non-significant were: education level, a BMI greater than 25 kg/m², gestational age at first delivery, a first newborn over 4000g, pelvic floor exercises after first delivery, episiotomy at first delivery, a second delivery, and an ongoing pregnancy. Case numbers may not add up because of some missing data for given risk factors (from 0 to 4.6%).

Facteurs de risque d'incontinence urinaire (IU) isolée, d'incontinence anale (IA) isolée, et d'IU+IA. Régression logistique multinomiale ajusté sur la maternité. Les autres facteurs testés et non-significatifs sont les suivants : le niveau scolaire, un BMI supérieur à 25 kg/m², l'âge gestationnel au premier accouchement, un premier enfant de plus de 4000g, une rééducation périnéale après le premier accouchement, un nouvel accouchement, et une grossesse en cours. Le nombre de sujet peut être inférieur à ce qui est attendu en raison de données manquantes pour certains facteurs de risque (de 0 à 4,6%).

Variable		(N)	UI only adjusted OR (CI 95%)	AI only adjusted OR (CI 95%)	IU+IA adjusted OR (CI 95%)
Age at 1st childbirth	< 30 years	(415)	**1**	1	**1**
	≥ 30 years	(212)	**2.27 (1.47-3.49)**	1.34 (0.65-2.73)	**2.65 (1.29-5.46)**
UI before pregnancy	no	(565)	**1**	1	**1**
	yes	(33)	**6.44 (2.19-19.0)**	2.02 (0.21-18.9)	**32.9 (9.00-120)**
UI during pregnancy	no	(468)	**1**	1	1
	yes	(133)	**3.64 (2.25-5.91)**	1.57 (0.64-3.90)	1.87 (0.77-4.55)
Epidural	no	(101)	0.96 (0.51-1.78)	1.52 (0.59-3.92)	**4.29 (1.65-11.1)**
	yes	(526)	1	1	**1**
Second active stage	≤ 20 minutes	(561)	1	**1**	1
	> 20 minutes	(59)	1.26 (0,62-2,57)	**2.86 (1.15-7.13)**	2.29 (0.73-7.15)
Mode of delivery	spontaneous	(368)	1	1	1
	instrumental	(209)	1.16 (0.74-1.81)	1.11 (0.54-2.31)	0.96 (0.43-2.11)
	cesarean	(50)	0.54 (0.22-1.31)	0.61 (0.14-2.79)	0.28 (0.05-1.70)
Third degree perineal tear	no	(621)	1	**1**	**1**
	yes	(6)	3.67 (0.22-61.3)	**20.9 (1.73-252)**	**20.0 (1.28-314)**