Comparison of the outcomes of overlapping and direct apposition sphincteroplasty techniques in anal sphincter repair

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ABSTRACT
Objective: Sphincteroplasty is of great importance in the repair of anal sphincter damage. In the present study, we compared the results of overlapping sphincteroplasty and direct apposition techniques used in anal sphincter repair.

Material and Methods: Between 2011 and 2021, 36 patients underwent sphincteroplasty for anal sphincter injury and were analysed retrospectively. Sex, age, etiologic factors, repair technique, degree of laceration, postoperative complications, length of hospital stay, time between injury and repair, follow-up time and postoperative Cleveland Clinic Incontinence Score (CCIS) were recorded for analysis, and the two techniques were compared statistically using SPSS statistics, Version 17.0.

Results: Of the sample, 31 were females and five were males, with a mean age of 31.50 ± 6.7 years. The etiologic factors were obstetric trauma in 25 patients, perianal interventions in seven patients and other traumas in four patients. The overlapping technique was applied to 14 patients and the direct apposition technique was applied to 22 patients. Mean postoperative CCIS of all cases was 5.53 ± 2.59, and was significantly lower in those who underwent overlapping sphincteroplasty technique than those who underwent apposition repair (p= 0.006). It was observed that postoperative CCIS decreased as the time between sphincter injury and repair decreased (p< 0.001; r= 0.625).

Conclusion: It is vital to repair anal sphincter damage as early as possible. The overlapping sphincteroplasty and direct apposition methods can both be considered safe for anal sphincter repair although in terms of faecal incontinence, the outcomes of overlapping sphincteroplasty are better than those of the direct apposition technique.

Keywords: Anal sphincter injury, direct apposition, fecal incontinence, overlapping sphincteroplasty

INTRODUCTION
Most anal sphincter injuries are obstetric and iatrogenic. Sphincter damage identified in postpartum ultrasonographic examinations occurs in 30% of women after first vaginal delivery (1). A study of sphincter damage via transanal ultrasonography following anorectal surgery has revealed 76% and 24% cases of internal and external anal sphincter damage, respectively (2). Perianal fistula surgeries are the most common cause of postoperative faecal incontinence, with the risk of incontinence following fistula surgery reported to be in the 10-20% range, increasing proportionally with the amount of the muscle cut (3). Anorectal traumas are other aetiological factors that usually result from sexual abuse, anal rape, falling on a sharp foreign body and vehicle accidents (4).

Faecal incontinence (FI) is the uncontrolled outflow of liquid or solid faecal matter from the anus, the extent of which depends on the degree of anal sphincter or nerve damage (5). It is a condition that can cause perineal pain and dyspareunia and a reduction in quality of life, which can lead to social withdrawal and postpartum depression and has very high treatment costs (6).

The available surgical approaches to anal sphincter repair include overlapping, direct apposition, post-anal repair, graciloplasty and total pelvic floor repair. Aside from the surgical methods available for the treatment of anal sphincter damage, medical treatments, stem cell treatments, artificial intestinal sphincters, elastomer implants, biofeedback method, rectal balloon, pelvic muscle exercises, digital rectal feedback method, transcutaneous posterior tibial nerve stimulation, sacral nerve
stimulation, radiofrequency stimulation, etc. have also been described as treatment approaches. Despite the wealth of available information, a standard treatment algorithm for all patients is still lacking (5).

The present study compares the results of the overlapping and direct apposition techniques for the repair of anal sphincter damage resulting from anorectal trauma.

MATERIAL and METHODS

A retrospective analysis was made for 36 patients who underwent direct apposition or overlapping sphincteroplasty for the treatment of anal sphincter injury between January 2011 and June 2021. Ethics committee approval was obtained for the study (approval number: 2021/S14/205/5), and the study was conducted following the ethical standards defined in the Declaration of Helsinki, as revised in 2013. In order to determine the sample power, power analysis was performed through the G*Power 3.1.9.4 program. When the margin of error $\alpha=0.05$ was accepted and it was assumed that the evaluations made would have a large effect size ($d=0.93$), the power of the test was calculated as 0.83 (7). Included in the study were those over 18 years of age with obstetric traumas, perianal interventions and anal sphincter injuries secondary to trauma. Except for direct apposition and overlapping techniques, other sphincteroplasty cases ($n=3$, graciloplasty) and patients under 18 years of age were excluded from the study. Patients who underwent sphincteroplasty for such reasons as congenital anomaly, advanced age, rectal prolapse and diabetes mellitus, as other aetiological causes of faecal incontinence, were also excluded from the study.

Age, sex, aetiological factor, degree of perineal laceration, surgical repair technique, presence of ostomy, time between sphincter injury and repair, postoperative complications, hospitalization period (days) and follow-up period (months) were obtained from the patients’ epicrisis records and surgery reports. The Postoperative Cleveland Clinic Incontinence Score (CCIS) of the patients was ascertained via telephone or face-to-face interviews. The CCIS scoring system used to evaluate anal incontinence produces a score in the range of 0-20, and is based on such parameters as solid-liquid-gas incontinence, daily pad use and lifestyle change (8) (Table 1). Perineal lacerations are divided into four basic categories in the literature (Grade 1,2,3A-B-C and 4), (9,10).

In the overlapping sphincteroplasty technique, after the existing scar tissue is divided, the two free ends are superimposed and fixed with separate sutures to form a new sphincter complex (11). In the direct apposition technique, the end-to-end suturing of the muscle is carried out, one by one, with the sphincter ends facing each other (12). In the present study, following surgery, the postoperative CCIS, length of hospital stay and rate of postoperative complications of the groups that underwent overlapping and apposition repair surgeries were compared, and the relationship between the time between sphincter injury and sphincteroplasty and postoperative CCIS was analysed.

Statistical Analysis

The statistical analyses were performed using SPSS Statistics (Version 17.0. Chicago: SPSS Inc.). The conformity of the variables to normal distribution was evaluated with histogram graphs and Kolmogorov-Smirnov test. Mean, standard deviation and median values were used for descriptive analyses. Categorical variables were compared with Pearson Chi-square test, and a Mann-Whitney U test was used for the evaluation of non-normally distributed (nonparametric) variables in two groups. Spearman correlation test was used for the comparative analysis of the measurement data. A p-value of <0.05 was considered statistically significant.

RESULTS

Of the 36 patients included in the study, 31 were females and five were males, with a mean age of 31.5 ± 6.7 years. The aetiological factors were obstetric trauma in 25 patients, perianal surgical interventions in seven patients and trauma in four patients. There were four patients with perineal laceration Grade 3a, 10 patients with 3b, 11 patients with 3c, and 11 patients with 4. Repairs were made using the direct apposition technique in 22 patients and the overlapping technique in 14 patients. Mean time between sphincter injury and repair was 11.2 ± 18.1 days. A diversion colostomy was performed in a case with grade 4 perineal laceration resulting from trauma. A perianal fistula was developed in two patients and wound infection in one patient as postoperative complications. Mean hospital stay was 2.00 ± 1.1 days; mean postoperative CCIS score of all cases was 5.5 ± 2.6; and mean follow-up period was 9.3 ± 5.2 months (Table 2).

<table>
<thead>
<tr>
<th>Table 1. Cleveland clinic incontinence score (8)</th>
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<tbody>
<tr>
<td><strong>Type of incontinence</strong></td>
</tr>
<tr>
<td>Solid</td>
</tr>
<tr>
<td>Liquid</td>
</tr>
<tr>
<td>Gas</td>
</tr>
<tr>
<td>Wears pad</td>
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<tr>
<td>Lifestyle alteration</td>
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</table>
There was no significant difference between the overlapping and apposition repair groups in terms of age, sex, aetiological factors, perineal laceration degree, postoperative complications, length of hospital stay, and follow-up (p > 0.05), (Table 3). In contrast, the postoperative CCIS mean of the overlapping group was significantly lower than that of the apposition repair group (p = 0.006).

The relationship between sphincter injury-sphincteroplasty interval and postoperative CCIS was evaluated with Spearman correlation test, revealing that postoperative CCIS increased as the time between sphincter injury and repair increased (p < 0.001; r = 0.625), (Figure 1).

**DISCUSSION**

There can be many causes of anal and perineum trauma, including sexual trauma, pelvic trauma and iatrogenic injuries, with the potential to lead to sphincter damage. In women, vaginal delivery is the most common cause of perineal trauma (13). Labour and vaginal deliveries can lead to the rupture of the perineal striated muscles and damage the pelvic nerves.

Obstetric anal sphincter injuries (OASIS) are referred to also as third-and fourth-degree spontaneous perineal tears (14). The incidence of OASIS has been reported to be between 0.5% and 17% in the literature (15-20). Primiparous women (5.7%) are at greater risk than multiparous women (1.5%) with no previous OASIS (21). Prolonged second labour stage (> 1 hour), advanced maternal age, high birth weight (> 4 kg), instrumental vaginal delivery, nulliparity, shoulder dystocia, permanent occiput posterior position, Asian ethnicity, labour induction, epidural analgesia, and midline episiotomy have all been identified as independent risk factors for OASIS (22,23). The incidence of mediolateral episiotomy during vaginal deliveries has been reported to be 45-68%, and has been associated with third-or fourth-degree lacerations in approximately 25% of women (24).

In the present study, obstetric trauma was the most common aetiological factor (69%) in anal sphincter injury.

Imaging methods such as anal manometry, magnetic resonance imaging, endoanal ultrasound, electromyography and defecography can be used for the evaluation of sphincter damage secondary to trauma, among which endoanal ultrasound is currently considered the optimum approach to the management of anal incontinence (25).

Sphincter repair aims to restore the anal canal to dimensions of at least 3 cm long and 2 cm thick (6). Lacerations involving the internal anal sphincter (Grade 3c, 4) must be identified and properly repaired to prevent the development of faecal incontinence. The two most common approaches to the repair of damaged external anal sphincter (EAS) are the direct apposition and overlapping techniques. Since the overlap of grade 3a and 3b partial thickness EAS tears will impose excessive stress on the repair, the direct apposition approach should be applied.
in such cases. In this technique, the free ends of the damaged EAS are approximated and sutured. The overlapping technique can be used only for full-thickness lacerations, as two free ends of anal sphincter muscle are required for a tension-free overlapping repair. The torn ends of the EAS are brought together, and 1-1.5 cm of the muscle ends are overlapped and sutured (15). In a meta-analysis, no significant difference has been found between the direct apposition and overlapping repair techniques in terms of flatus incontinence, dyspareunia and perineal pain, although those undergoing overlapping surgery have been shown to have lower faecal urgency and anal incontinence scores than those treated with the direct apposition technique (26). A randomized study comparing the two techniques has revealed the overlapping technique to be associated with worse functional outcomes (7).

For the best results in the treatment of sphincter injury, the repair procedure should be performed as early as possible—immediately after the damage occurs, if possible, but within 24 hours at the latest—and in a centre experienced in anal reconstruction surgeries (4). If sphincter damage is diagnosed after vaginal delivery, surgical repair is recommended within the first 12 hours (27).

Secondary surgical repair refers to surgery performed several months or years after anal sphincter injury. Sphincter repairs should be considered only after failed primary reconstructive surgery when other treatment modalities have been ineffective or there is an identifiable factor responsible for the failure. Sacral nerve modulation (SNM) is a minimally invasive, effective and sustainable treatment option for the treatment of faecal incontinence that improves impaired sphincter function through the continuous, electrical stimulation of the sacral nerves (28). Regardless of the aetiology of faecal incontinence, studies have shown SNM to be effective in the improvement of the continence mechanism (5). In patients with faecal incontinence with low quality of life, faecal referral involving the creation of a colostomy is a treatment alternative in cases where other treatments fail or cannot be applied (29).

Consistent with the literature, obstetric trauma (69.4%) was found to be the main aetiological factor in the patients in our study group. The postoperative quality of life and incontinence scores were higher in the group that underwent overlapping sphincteroplasty than in the group that underwent direct apposition surgery. There have been few studies to date investigating the effect of timing on CCIS. In the present study, a correlation analysis of the time between sphincter injury and surgery with CCIS revealed that early sphincteroplasty resulted in a better quality of life. The limitations of our study are its retrospective design, the fact that the postoperative results were not

Table 3. Comparison of the overlapping and direct apposition repair groups

<table>
<thead>
<tr>
<th></th>
<th>Overlapping</th>
<th>Direct Apposition</th>
<th>p</th>
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<tbody>
<tr>
<td></td>
<td>n/mean ± sd</td>
<td>n/mean ± sd</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>29.8 ± 5.5</td>
<td>32.6 ± 7.2</td>
<td>0.490²</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>4</td>
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<tr>
<td>Female</td>
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<td></td>
</tr>
<tr>
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<tr>
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<td>13</td>
<td>0.225</td>
</tr>
<tr>
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</tr>
<tr>
<td>Trauma</td>
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<td>3</td>
<td></td>
</tr>
<tr>
<td>Perineal laceration grade</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>2</td>
<td>2</td>
<td>0.550</td>
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<tr>
<td>3b</td>
<td>2</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>3c</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Postoperative complication</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Perianal fistula</td>
<td>1</td>
<td>1</td>
<td>0.689</td>
</tr>
<tr>
<td>Wound infection</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Length of hospital stay (days)</td>
<td>2.00 ± 1.1</td>
<td>2.00 ± 1.1</td>
<td>0.962²</td>
</tr>
<tr>
<td>Postoperative CCIS score</td>
<td>4.1 ± 1.9</td>
<td>6.4 ± 2.6</td>
<td>0.006²*</td>
</tr>
<tr>
<td>Follow-up time (months)</td>
<td>7.9 ± 3.3</td>
<td>10.3 ± 5.9</td>
<td>0.296²</td>
</tr>
</tbody>
</table>

¹Chi-square test ²Mann-Whitney U test.

CCIS: Cleveland Clinic Incontinence Score.
Overlapping and direct apposition sphincteroplasty

supported by such diagnostic methods as endoanal ultrasound and anal manometry.

CONCLUSION

The early repair of anal sphincter injuries is vital. Both the overlapping and direct apposition sphincteroplasty techniques can be considered reliable for anal sphincter repair, although in terms of faecal incontinence, the outcomes of overlapping sphincteroplasty are better than those of the direct apposition technique. Further studies are needed to develop algorithms to steer the repair of sphincter damage secondary to trauma.

REFERENCES

Anal sfinkter onarımında overlapping ve direkt apozisyon sfinkteroplasti tekniklerinin sonuçlarının karşılaştırılması

Ozan Akıncı, Zehra Zeynep Keklikkıran, Yasin Tosun
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ÖZET


Gereç ve Yöntem: 2011-2021 yılları arasında anal sfinkter yaralanması nedeniyle sfinkteroplasti uygulanan 36 hasta retrospektif olarak analiz edildi. Yaş, cinsiyet, etyolojik faktör, laserasyon derecesi, onarım tekniği, postoperatif komplikasyonlar, yaralanma ile onarım arasında geçen süre, hastanede yatış süresi, takip süresi, postoperatif Cleveland Kliniği Inkontinans Skoru (CKİS) değerlendirildi. İki teknik SPSS versiyon 17,0 ile istatistiksel olarak karşılaştırıldı.

Bulgular: Hastaların 31'i kadın, beşi erkekti ve yaş ortalaması 31,50 ± 6,7 yıl idi. Yırmı beş hastada obstetrik travma, yedi hastada perianal girişim, diğer dört hastada ise travma etyolojik faktörüdür. Overlapping teknigi 14 hastaya, direkt apozisyon teknigi ise 22 hastaya uygulanmıştır. Tüm oğulların ortalaması postoperatif CKİS 5,53 ± 2,59 idi. Overlapping sfinkteroplastide CKİS, apozisyon onarımına göre anlamlı ölçüde daha düşüktü (p= 0,006). Sfinkter hasari ile onarım arasında geçen süre azalıca postoperatif CKİS'nin de düştüğü gözlemdi (p< 0,001; r= 0,625).


Anahtar Kelimeler: Anal sfinkter hasarı, direkt apozisyon, fekal inkontinans, overlapping sfinkteroplasti

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