



by ANDREW I. KAPLAN, ESQ

Was this fourth-degree laceration properly repaired?

Case

A patient received prenatal care for the pregnancy at issue at Defendant Clinic. This was the patient's first pregnancy and it proceeded without issue. Defendant Obstetrician (Defendant OB) did not see the patient for any pre- or postnatal visits.

The patient was at 41 weeks, 4 days' gestation when she was admitted to the Labor and Delivery Department at the Codefendant Hospital on August 11, 2013. Her labor was managed by a nonparty obstetrician until the morning of August 13, when Defendant OB took over service. External fetal monitoring throughout this time was category 1, but with irregular contractions. Defendant OB's initial exam was at 7:27 AM on August 13, at which time the patient was still 3 cm dilated (no change since approximately 5:00 AM), 90% effaced, and still at -2 station above the spine.

She was started on oxytocin after

verbal consent at 9:50 AM, as she continued to have category 1 tracings but irregular contractions and no progression of dilation. At 12:12 PM, she was 6 cm dilated, 100% effaced,



and -1 cm above the spine with category 1 tracings. The patient was fully dilated at 10 cm with the head 2 cm below the spine when Defendant OB examined her at 3:09 PM, which ended the first stage of labor (16 hours, 44 minutes). The plan was for a normal vaginal delivery.

Pushing was effectively initiated at 3:56 PM, and at 4:00 PM, fetal tracings were category 2 with a single prolonged deceleration to 70 beats per minute for 2 minutes. The patient denied a strong urge to push, so she was told to rest. Oxytocin was continued (at a lower rate) and Defendant OB requested that her epidural be topped off. After pushing began again at 6:10 PM, at 6:18 PM, Defendant OB observed episodes of fetal bradycardia on the fetal monitoring strips.

Considering the strips, maternal exhaustion, and ineffective pushing, Defendant OB recommended a vacuum-assisted delivery and received verbal consent from the patient by showing her the vacuum and explaining the risks, benefits, and complications, including the risk of perineal tears. In anticipation of delivery, Defendant OB placed a straight catheter at 6:20 PM to empty the patient's bladder. The records document the

Andrew I Kaplan, Esq is a partner at Aaronson, Rappaport, Feinstein & Deutsch, LLP in New York City, specializing in medical malpractice defense and healthcare litigation. This case was handled by one of his partners.

patient's second stage of labor as 3 hours, 26 minutes (with pushing for less than 1.5 hours and rest for approximately 2 hours).

Defendant OB testified that the patient had a normal-sized perineum that was very swollen and edematous from labor. He placed the vacuum between the anterior and posterior fontanel, approximately 5 cm to 6 cm from the posterior and 2 cm to 3 cm from the anterior. He used a Kiwi vacuum, which includes a standard 4-mm cup and a hand pump. He pumped it up to 100 mm Hg and, in the direction of the plane of delivery, he pulled the vacuum out. The first application resulted in a "pop off" of the vacuum, whereas the second application resulted in the extraction of the infant without difficulty at 6:35 PM. Also, Defendant OB did not perform an episiotomy.

Defendant OB did see the perineum tearing during the extraction. Once the infant's head was out, he paused the procedure to reduce the cord from around the infant's neck before resuming the delivery. After delivery of the infant, during his postdelivery exam, Defendant OB observed a fourth-degree laceration. He testified that he informed the patient of the tear before repairing it, at which time he also discussed the risks of the laceration and repair, including the possibility of repair breakdown and fistula development.

Defendant OB's delivery note documents that, after the administration of cefazolin (Ancef, GlaxoSmith-Kline; Kefzol, Pfizer), he repaired the fourth-degree perineal laceration, noting "rectal mucosa 2 layers of run-

ning 3-0 Vicryl episiotomy in usual fashion, antibiotics given, betadine wash during procedure." He testified that the entire rectum was torn open, and that rectal tissue appeared healthy and normal. He placed a self-retaining Gelpi (a retraction device) for good exposure and then poured povidone-iodine (betadine) over the entire area. After finding the apex of the tear, he used 4-0 Vicryl

A perineal exam on the day of discharge indicated no redness, discharge, vulvar edema, or external hemorrhoids.

sutures (he later stated 3-0), which are long-acting and self-absorbing sutures, to sew the rectal mucosa in 2 layers. As he placed the running sutures in the mucosa, he released the Gelpi to put less tension on the tissue. He tied the first suture and left it long at the apex and then sewed all the way down to the anal verge, where he left another suture. The 2 long sutures were guidelines for where he started and stopped.

Defendant OB then repeated the same procedure with the second layer of mucosa. He cut the 2 sutures and identified the rectal sphincter. He placed Allis clamps on each side of the sphincter and repaired the internal rectal sphincter with 3 individual 2-0 Vicryl sutures before closing the external sphincter with the muscle

capsule using 2-0 Vicryl. Finally, he closed the perineal tear. Defendant OB did not extend the perineal tear during the delivery or repair. With each layer of the repair, povidone-iodine was poured over the surgical site. Once the repair was complete, Defendant OB performed a rectal exam, finding that the rectal mucosa and sphincters were intact, there were no sutures in the rectum, and the vagina was put together properly. The repair was uncomplicated and took approximately 30 minutes. After the repair, Defendant OB ordered routine pain medication, including topical sprays for the perineum, and advised the patient to keep the area clean, take sitz baths, and use witch hazel and a stool softener, but take nothing per rectum.

Over the next few days, the patient reported low levels of pain (4-5/10) and received pain medication. A perineal exam on the day of discharge, August 14, 2013, indicated no redness, discharge, vulvar edema, or external hemorrhoids. It was also noted that the patient was voiding independently with no issues. The records were not clear on whether the patient had a bowel movement or flatus prior to discharge (the notes are written to state "no abdominal tenderness, bowel movement, passage of flatus, no vomiting/drainage, no external hemorrhoids"). However, there is nothing to suggest that the patient advised that anything other than urine was coming through her urethra (she testified to passing gas through her vagina prior to discharge but did not tell anyone). She was instructed to take sitz baths

A Kelly probe was used to identify the fistula before Dr Q transformed the connection “into a fourth-degree laceration” and placed Vicryl sutures on the 2 ends of the sphincter with a “0” Vicryl.

3 times per day and was advised on perineum care and demonstrated her understanding of these instructions.

The patient was seen for 3 postpartum visits at Defendant Clinic. At the first visit, on August 20, 2013, she complained of “odorous discharge like feces for 2 days and some discomfort.” A Defendant Clinic physician noted a small rectovaginal fistula near the introitus, started her on an antibiotic, and asked her to return in 2 weeks.

Instead, she returned 1 week later, on August 26, at which time a small rectovaginal separation was noted, and she was referred to Dr Q. The patient saw Dr Q that same day and reported that she experienced gas passing through her vagina prior to discharge and then feces passing through her vagina after she went home. She did not report any issues with fecal incontinence.

On exam, Dr Q recorded the location of the fistula as “1 cm in diameter, and approximately 2 cm from the hymenal ring” and confirmed the presence of the fistula on rectal exam. Unspecified treatment was discussed, and the patient was asked to return, which she did on September 4. At that visit, Dr Q reported that the patient’s vagina was less inflamed and that the defect was well delineated. Notably, while the patient continued to report feces passing through her vagina,

there were no complaints of fecal incontinence.

Preoperative assessment was performed on October 2, 2013, and the patient reported no issues with fecal incontinence. She also did not report any issues of fecal incontinence on October 7, when she presented to Codefendant Hospital in anticipation of the fistula repair performed by Dr Q later that day. Dr Q’s Operative Report noted the indication for the rectovaginal fistula repair as the failed repair of a fourth-degree laceration following vacuum delivery.

A Kelly probe was used to identify the fistula before Dr Q transformed the connection “into a fourth-degree laceration” and placed Vicryl sutures on the 2 ends of the “cut” sphincter. Dr Q then dissected the vaginal mucosa away from the rectal mucosa and excised scar tissue to ensure a well-vascularized rectal mucosal edge. The rectal opening was then closed by placing interrupted 4-0 Vicryl sutures on the prerectal fascia, “thus imbricating the rectal mucosa,” but taking care to avoid suturing the rectal mucosa. Dr Q then placed a second layer of prerectal fascia to decrease the tension from the first layer of sutures before approximating the 2 ends of the sphincter with “0” Vicryl. Following this, Dr Q addressed the vaginal mucosa, placed levator stitches, and

completed the perineorrhaphy. Dr Q performed a rectal exam that revealed no sutures in the rectal mucosa and well-approximated edges.

Per the Operative Report, Dr Q concluded the procedure by performing a “contra coup sphincterotomy to relieve the tension on the sphincters and to avoid rectal stricture.” The repair was uncomplicated. Patient complained of rectal pain (5-8/10) postoperatively. She was passing flatus on postoperative days 2 and 3 and had 2 bowel movements by postoperative day 4. She was discharged home on October 11, 2013, on docusate sodium (Colace), ibuprofen (Advil), and oxycodone/acetaminophen (Percocet). Six weeks of pelvic rest was recommended to the patient and she later presented to Dr Q on October 30 for a single postoperative follow-up, at which time she reported external hemorrhoids. No review of systems was recorded, and Dr Q noted a well-healed perineum and “no fecal incontinence.”

In April 2014, the patient complained that she was possibly passing gas through her vagina. In July 2014, a dye test ruled out a rectovaginal fistula. Instead, her complaints were due to a weak anal muscle/sphincter. Dr Q recommended a change in diet, Kegel exercises, and biofeedback physical therapy, which she did with improvement (able to hold stool for

10 seconds, an improvement from 1 second). However, she could still not control flatus and had post-bowel movement leakage due to issues with rectal emptying, so the patient started seeing a new doctor in January 2015.

Anorectal manometry showed normal involuntary resting tone of the internal anal sphincter, normal voluntary squeeze pressures of the external anal sphincter, and normal sensation. A pudendal nerve test was not performed because the assessment showed that the external anal sphincter was functioning. She underwent an endoscopic ultrasound in March 2015 that showed the “anterior portion of [the] anal sphincter [was] missing.” As such, continued biofeedback therapy and a sphincteroplasty if improvement plateaued were suggested.

The patient did improve to being able to hold her stool for 40 seconds but was still having accidents. In December 2016, she tried a Solesta injection that was unsuccessful. As such, the patient agreed to the recommended sphincteroplasty, which was performed on February 6, 2018. Significantly, “after repair of sphincters at the delivery, the rectovaginal fistula was repaired; however, no attempt was made to repair the sphincter deficit that was associated with it.” The new physician then went on to state that “at the time of this operation, [the patient] had [a] markedly attenuated external sphincter with marked scarring in the perineum, all making repair of sphincter quite difficult.”

In November 2018, the patient testified that she was doing pelvic

floor therapy and using a rented biofeedback machine at home. Her fecal incontinence had improved, but she continued to have 2 to 3 “accidents” per month and leakage 3 to 4 times a week (down from daily). The accidents made it difficult for her to go out.

The patient testified that she was

Patient claimed damage to the anal sphincter, including decreased tone and weakness, perineal laceration, and nerve and muscle damage.

afraid of vaginal intercourse but confirmed that her sexual relationship with her husband returned to normal after the placement of an intrauterine device in September 2015. At the patient’s further deposition on January 12, 2021, she testified that she had stopped doing pelvic floor exercises and no longer used a biofeedback machine as she was not seeing any new results. The patient continued to experience fecal incontinence every other week and post-bowel movement leakage almost daily, for which she wears pads. She believed her condition had worsened since November 2018 because her pelvic floor was weakening with age.

Allegations

Plaintiff claimed damage to the anal sphincter, including decreased tone and weakness, perineal laceration,

nerve and muscle damage, fecal incontinence, flatulence, numbness, hypotonia, anxiety over public soiling, depression, inability to care for her child, and inability to engage in sexual and recreational activities, secondary to improper repair of a fourth-degree laceration resulting in the formation of a rectovaginal fistula. Plaintiff alleged that she would require cesarean sections for all future deliveries. She also included the rectovaginal fistula repair surgery, the overlapping sphincteroplasty, and the need for potential future surgeries as part of her injuries.

Discovery

The defense’s obstetrics expert was supportive of the decision to perform a vacuum-assisted delivery, the decision to not perform an episiotomy, and the repair of the fourth-degree laceration that occurred during the delivery.

He agreed that a mediolateral episiotomy is more painful for the mother and the repair has a greater risk of breaking down, even though it is associated with a decreased risk of third- and fourth-degree perineal lacerations (although lacerations can still occur with episiotomy). The development of a rectovaginal fistula is a known and accepted risk of a fourth-degree laceration and can occur absent a negligent repair. However, it is possible that Defendant OB placed 2 sutures too far apart allowing the hole to persist and a fistula to form given Plaintiff’s report of passing gas through her vagina while still in the hospital after delivery.

If this is the case, Defendant

OB's repair would be below the standard of care. However, based on Defendant OB's testimony and his experience, it is more likely that the fistula formed naturally from the normal pressure of postrepair bowel movements and/or Plaintiff straining too much with the first postpartum bowel movement. The expert also commented that even if Defendant OB's repair was subpar and allowed the fistula to develop, his layered repair of the anal sphincters was within the standard of care and was shown to be a good repair as Plaintiff had no complaints of fecal continence in the 2 months that followed the repair.

Our expert opined that the appropriateness of Dr Q's decision to re-create the fourth-degree laceration to address the rectovaginal fistula depended on where the fistula was located and whether it was visible during the surgery, but neither was described in Dr Q's Operative Report. The expert also indicated that the Operative Report did not clearly describe how Dr Q closed and repaired the sphincters after opening them back up. Nevertheless, given that no fistula remained with subsequent testing, the expert confirmed that Dr Q's fistula repair was successful. It was unusual for a sphincterotomy to be performed following a fistula repair and, given that Plaintiff had no complaints of fecal incontinence prior to Dr Q's repair, the expert believed that Dr Q's decision to cut the sphincter was the cause of Plaintiff's subsequently developed incontinence.

The colorectal surgery expert opined that Defendant OB's repair of

Plaintiff's fourth-degree laceration was appropriately performed and that the breakdown and development of a rectovaginal fistula is a known and accepted complication of same. He also opined that the breakdown of the laceration repair had nothing to do with Defendant OB's "layered" repair of the anal sphincters, as fistula development is a known and accepted complication regardless of whether the anal sphincters are comingled or repaired in layers.

Although it is unclear what Dr Q did to the anal sphincters during the October 2013 surgery, the expert opined that Dr Q's performance of a sphincterotomy was not indicated and is below the standard of colorectal surgery care. He explained that a sphincterotomy is only performed by colorectal surgeons to treat anal fissure, which the plaintiff did not have. Although the expert speculated that Dr Q performed the sphincterotomy because he thought the repair made the sphincters too tight, the expert opined that the sphincter can always be dilated, whereas a sphincterotomy cannot be repaired without another surgery. He also pointed out that Plaintiff did not have complaints of fecal incontinence prior to Dr Q's October 2013 surgery and that impairment of control with leakage of feces/gas and soiling of undergarments, as Plaintiff described at deposition, is a known complication of sphincterotomy in 5% of patients. ■

Result

Codefendant Hospital moved for dismissal and was discontinued from the case as this was Defendant OB's patient and there were no direct allegations of negligence against them. Defendant Clinic was ultimately discontinued from the case as well. Although Defendant OB's care could be defended, Plaintiff focused on his repair of the external and internal sphincters and contended that in his repair he had "bunched" them together rather than repairing them separately and then bringing them together, resulting in breakdown and the patient's eventual fistula formation, incontinence, and need for subsequent surgeries.

Given the significant exposure in a case involving a young mother who underwent multiple corrective procedures without success, resulting in continued incontinence and the documented need to have all future deliveries performed by caesarean section, the decision was made to resolve the case reasonably rather than defend through trial. By depicting the ability to potentially apportion a significant percentage of responsibility for the injuries to the subsequent treating surgeon's repair, the defense lawyers were able to negotiate a more favorable result.

