

# Rates of obstetric anal sphincter injuries among immigrant women

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Linked article: This is a mini commentary on Sorbye et al.

The Norwegian-wide cohort study by Sorbye et al addresses the question of whether the maternal region of origin and birthplace have an influence on the risk of obstetric anal sphincter injury (BJOG 2021).

Obstetric anal sphincter injuries (OASI), as a complication of vaginal delivery, are associated with potential long-term complications such as anal and fecal incontinence, perineal pain, sexual dysfunction and increased rates of caesarean section in subsequent deliveries. Established risk factors for OASI are high birthweight, operative vaginal delivery and prolonged second stage of labor.

When it comes to ethnicity as a risk factor, retrospective studies suggest Asian women are at increased risk for OASI (Brown J et al. Aust N Z J Obstet Gynaecol. 2018;58(1):79-85.). However, it has remained unclear whether the biological or the migration factor is the cause.

Maternal origin, immigrant status and duration of residence have been the subject of many studies, in order to identify risks of various adverse obstetric outcomes, with known increased risk of both giving birth to small for gestational age fetuses, and preterm delivery (Urquia et al. BJOG 2010 Apr;117(5):591-601.)

The present study analyzed a 9-year comprehensive data set from birth registries, and concluded that, compared to Norwegian women, women from South Asia were most likely to experience OASI, with an aOR of 2.24, followed by women from Southeast/East Asian/Pacific and Sub-Saharan Africa. Furthermore, the authors found newly arrived migrant women to be at highest risk for OASI.

Migrant women are exposed to a new physical and social environment, with limited language competence a significant factor in preventing social integration, resulting in limited health literacy and sub-optimal care after migration.

Language skills are particularly significant in OASI cases, being important for collaboration between the woman and birth attendant during delivery. Interestingly, a difference was found regarding whether the partner was Norwegian-born or foreign-born, indicating that good communication at giving birth was important. The inference is that an understanding of the birth process and an explanation of the difficulties that might arise is an advantage. Undoubtedly educating women during pregnancy itself about OASI risks is of value.

Sorbye et al do not address the topic of perineal laceration protection techniques, experience of birth attendants or birth position. As studies have identified certain positions, such as the lithotomy position, to be a risk factor for OASI, whilst others, such as the lateral position, are considered to be protective, this information would have been interesting.

In other nationwide studies the incidence of OASI is shown to have increased, explained by improved awareness, diagnostic recognition and documentation (Andrews V et al. BJOG. 2006;113:195-200.). However, in this and another recent study, the incidence has decreased in Norway and Sweden, possibly due to implemented perineal protection programs for midwives/physicians (Gyhagen et al. Acta Obstet Gynecol Scand. 2021 Aug 25).

Sorbye and colleagues highlight the influence of environmental factors on OASI, which in theory could be preventable, and confirm that there are migration specific factors. Hence, the vulnerable group of migrant women need special attention and care in order to reduce morbidity.