



Under Pressure: Our Experience Introducing Anal Manometry to an NHS Perineal Service

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Introduction

Following obstetric anal sphincter injury (OASI), counselling on future mode of delivery (MOD) should incorporate objective assessment of sphincter function and symptoms to mitigate the risk of recurrent trauma or worsening function.

While endoanal ultrasound evaluates anatomical defects, anal manometry provides complementary information on physiological function.

Our perineal service is multidisciplinary, led by specialist midwives and physiotherapists, and supported by consultant obstetricians.

We describe the integration of manometry into routine care and reflect on the challenges of translating quantitative data into clinical decision-making.



THD® Anopress is a portable, user-friendly device used for anorectal pressures **Figure:** THD® Anopress device. Image courtesy of THD Lab. Available from: <https://www.thdlab.co.uk/healthcare-professionals/products/thd-anopress> [Accessed 24 May 2025].

Objective

We assessed the role of anal manometry in shaping delivery mode decisions for women with prior obstetric anal sphincter injury (OASI). This evaluation explored how closely clinical advice matched guideline-based thresholds derived from manometry and ultrasound results.

Design

This was a service evaluation reviewing outcomes since anal manometry was incorporated into our perineal clinic from February 2024. The aim was to embed evidence-based parameters into delivery planning.

Method

We analysed data from 60 women with a history of OASI who underwent anal manometry, including maximal resting pressure (MRP, reference range: 40–103 mmHg), maximal squeeze pressure (MSP, 41–121 mmHg), and incremental MSP (iMSP).

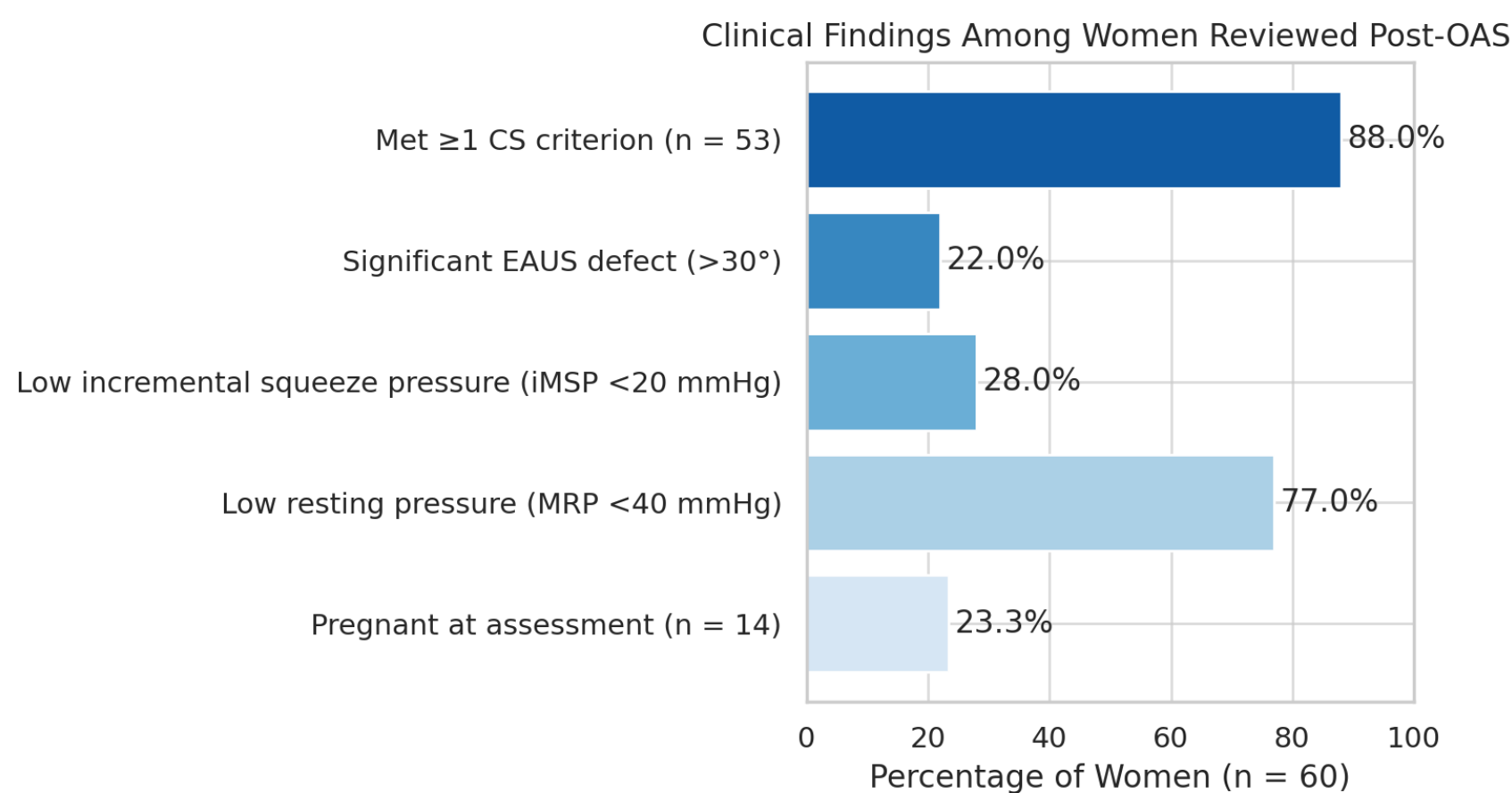
Sphincter integrity was assessed using endoanal ultrasound, and symptoms were evaluated using the Wexner score.

Based on published evidence (Jordan et al., 2018), we developed local criteria to guide delivery counselling. Vaginal delivery was considered appropriate for women who were asymptomatic, had ultrasound defects $\leq 30^\circ$, and iMSP >20 mmHg. Caesarean section was recommended for those with symptomatic incontinence, defects $>30^\circ$, iMSP <20 mmHg, or MRP <40 mmHg.

Results

Variable	Mean (Range)
Age	39.5 (24.0–69.0)
BMI	23.9 (18.0–34.0)
Parity	1.7 (0.0–4.0)

Table summarising patient demographics with mean age, BMI, and parity (ranges in parentheses), reflecting the characteristics of our study cohort.



This figure demonstrates the proportion of women (n = 60) with key clinical features. Of the 88% of women met at least one objective criterion supporting caesarean section, 35% had a caesarean formally recommended, reflecting the nuanced and individualised nature of delivery counselling.

As expected larger defects correlated with lower pressure measurements.

Women with previous instrumental deliveries showed a trend towards lower mean resting and incremental squeeze pressures compared to those without.

All women received individualised counselling which included discussion of recurrence risk and symptom progression associated with different modes of birth.

Conclusions

Introducing anal manometry into our post-OASI care pathway has enhanced our ability to offer objective, tailored recommendations. Despite frequent findings supporting caesarean delivery, decisions also reflected psychological aspects and patient values. **Our experience highlights the value of structured protocols while acknowledging that shared decision-making often extends beyond purely numerical thresholds.** Medico-legal factors may also influence final decisions, reinforcing the need for thorough documentation and patient engagement.