Overview of surgical cause of constipation & Incontinence

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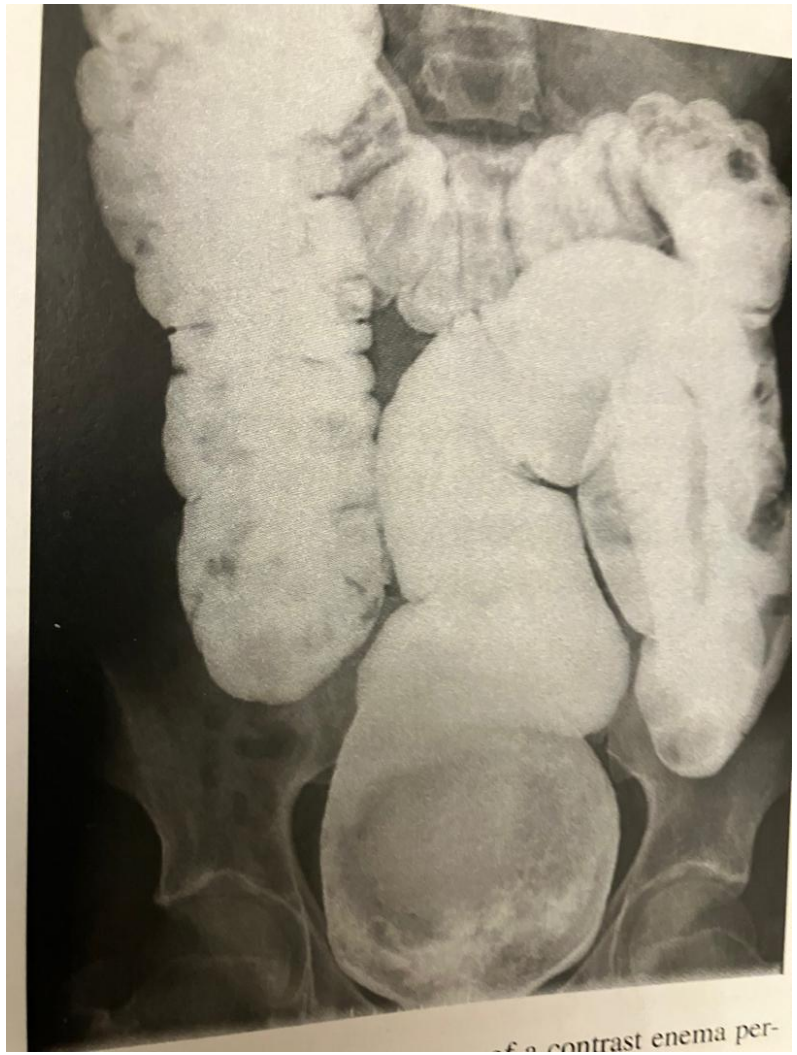
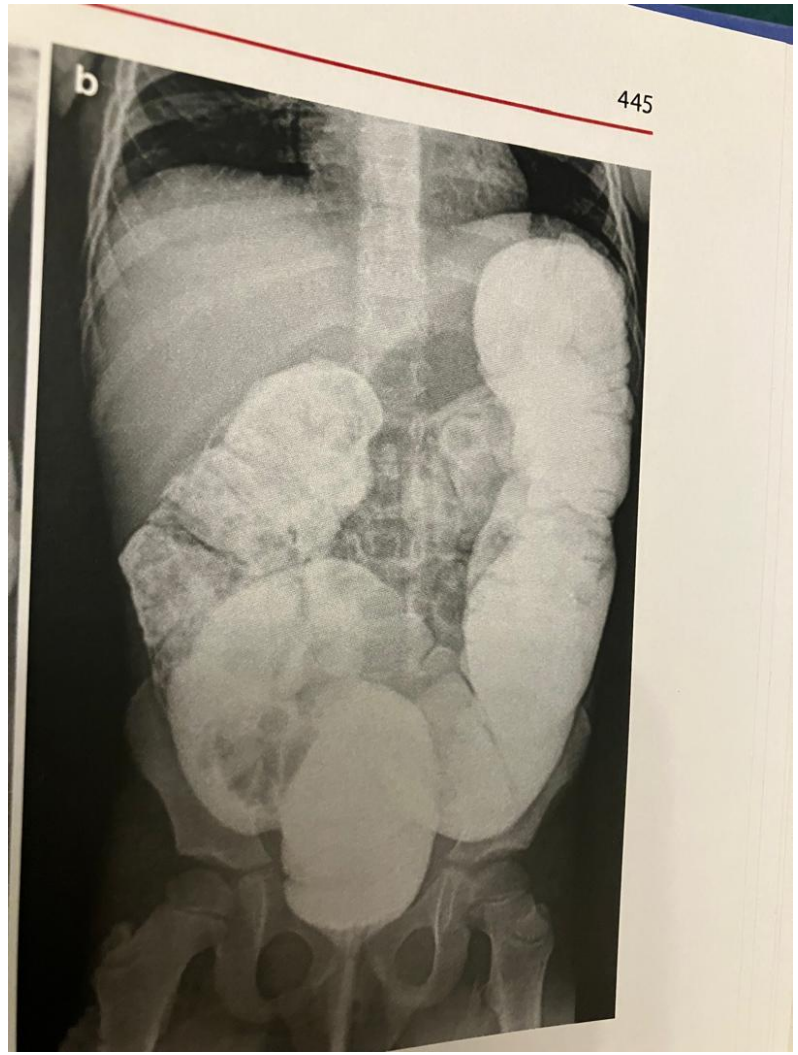
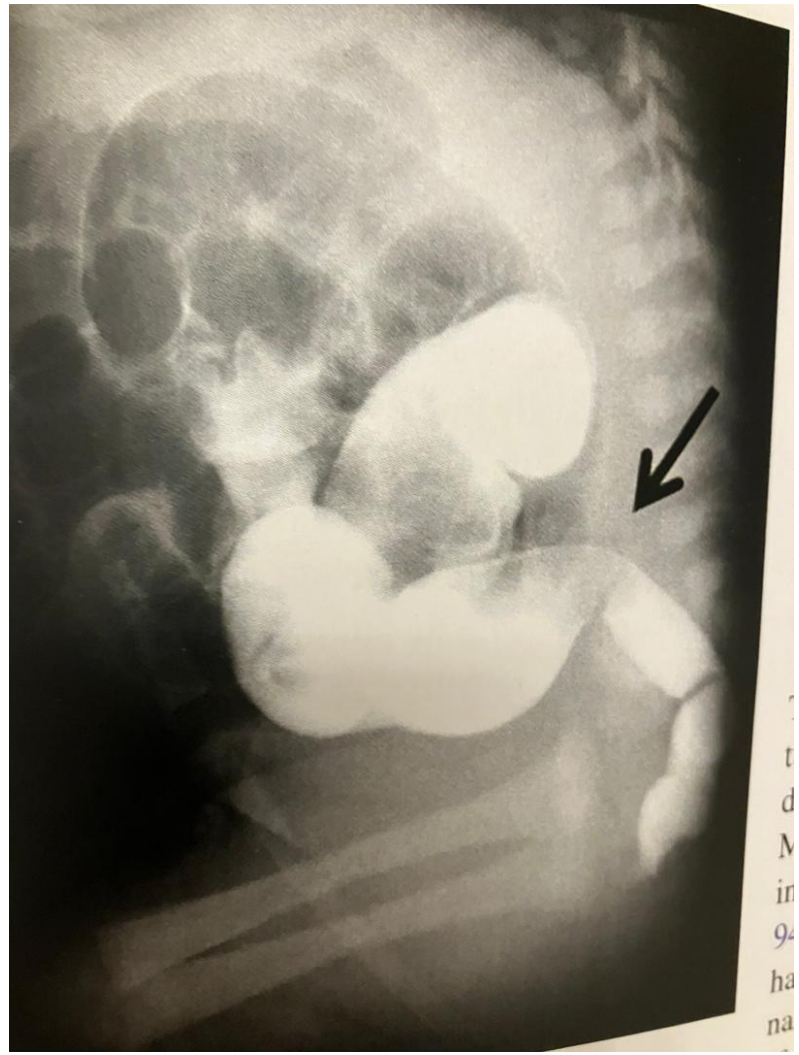
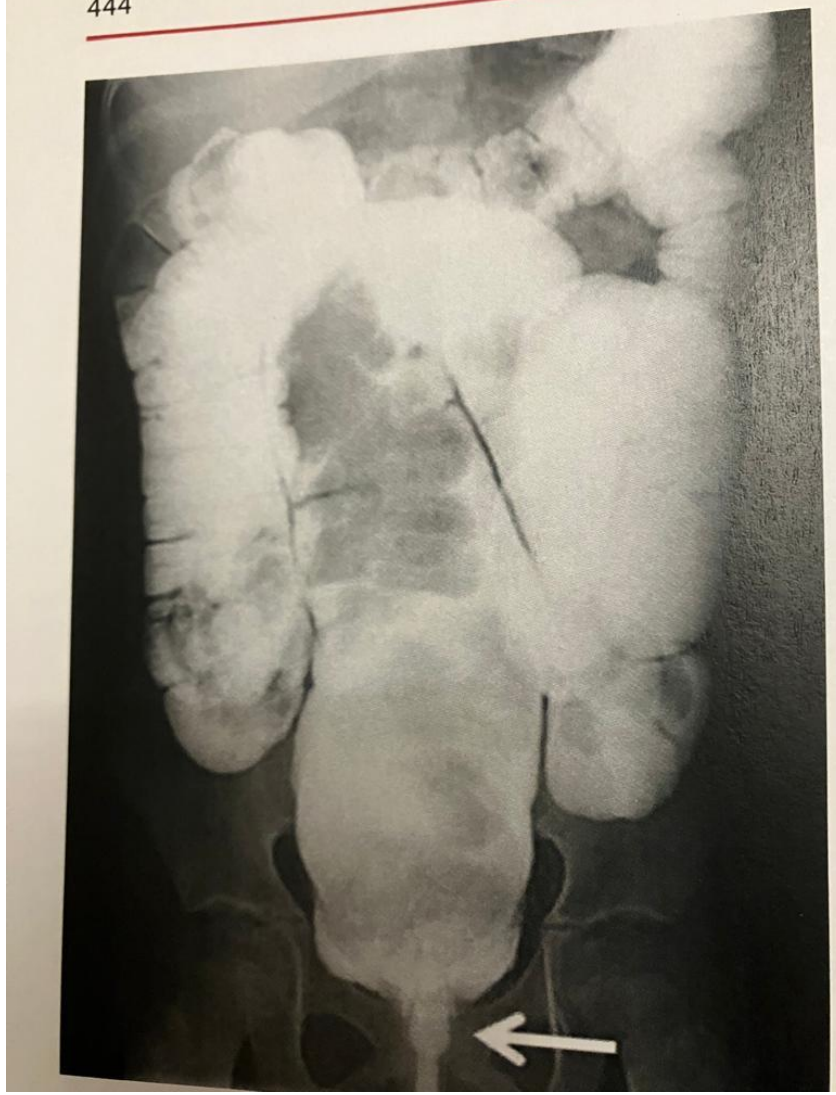
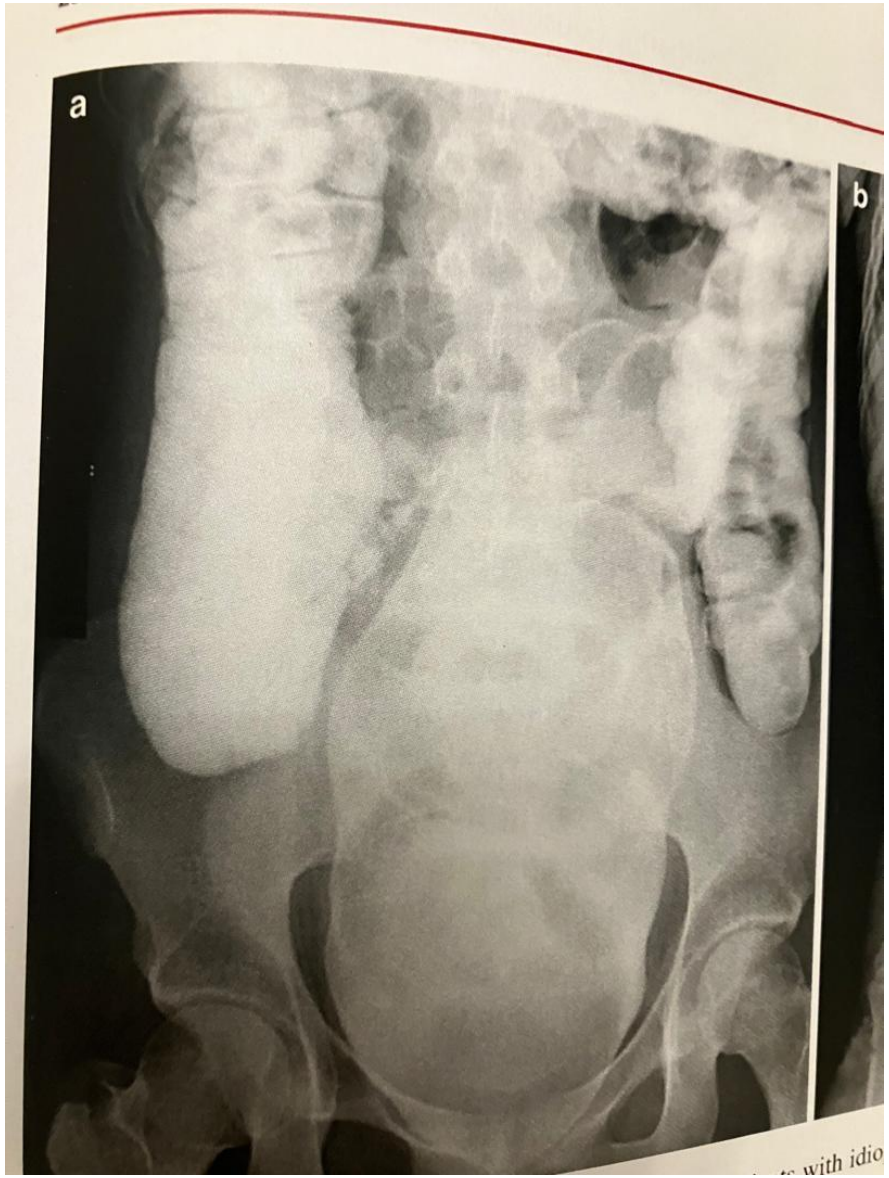


of a contrast enema per-





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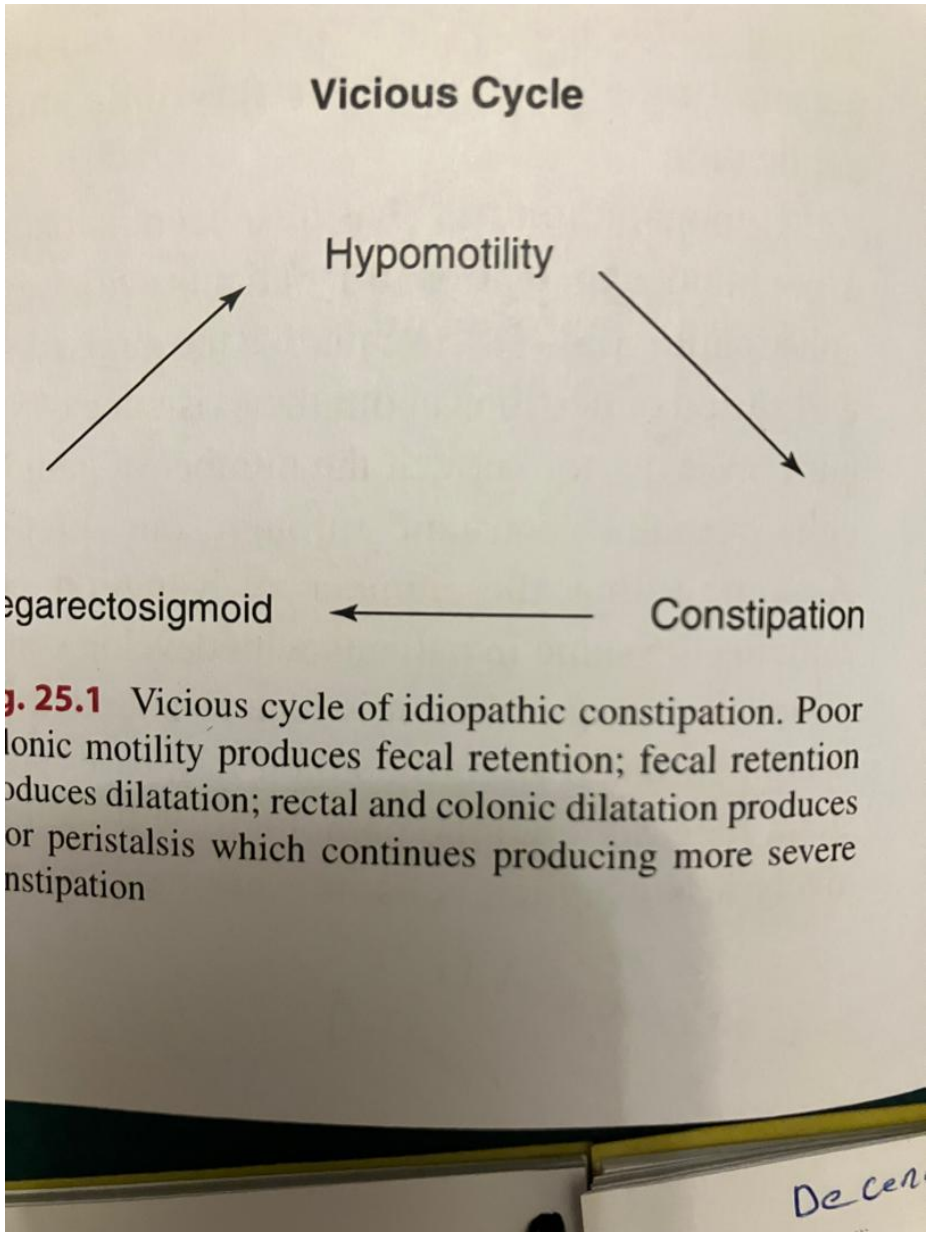


g. 25.1 Vicious cycle of idiopathic constipation. Poor lonic motility produces fecal retention; fecal retention oduces dilatation; rectal and colonic dilatation produces or peristalsis which continues producing more severe nstipation

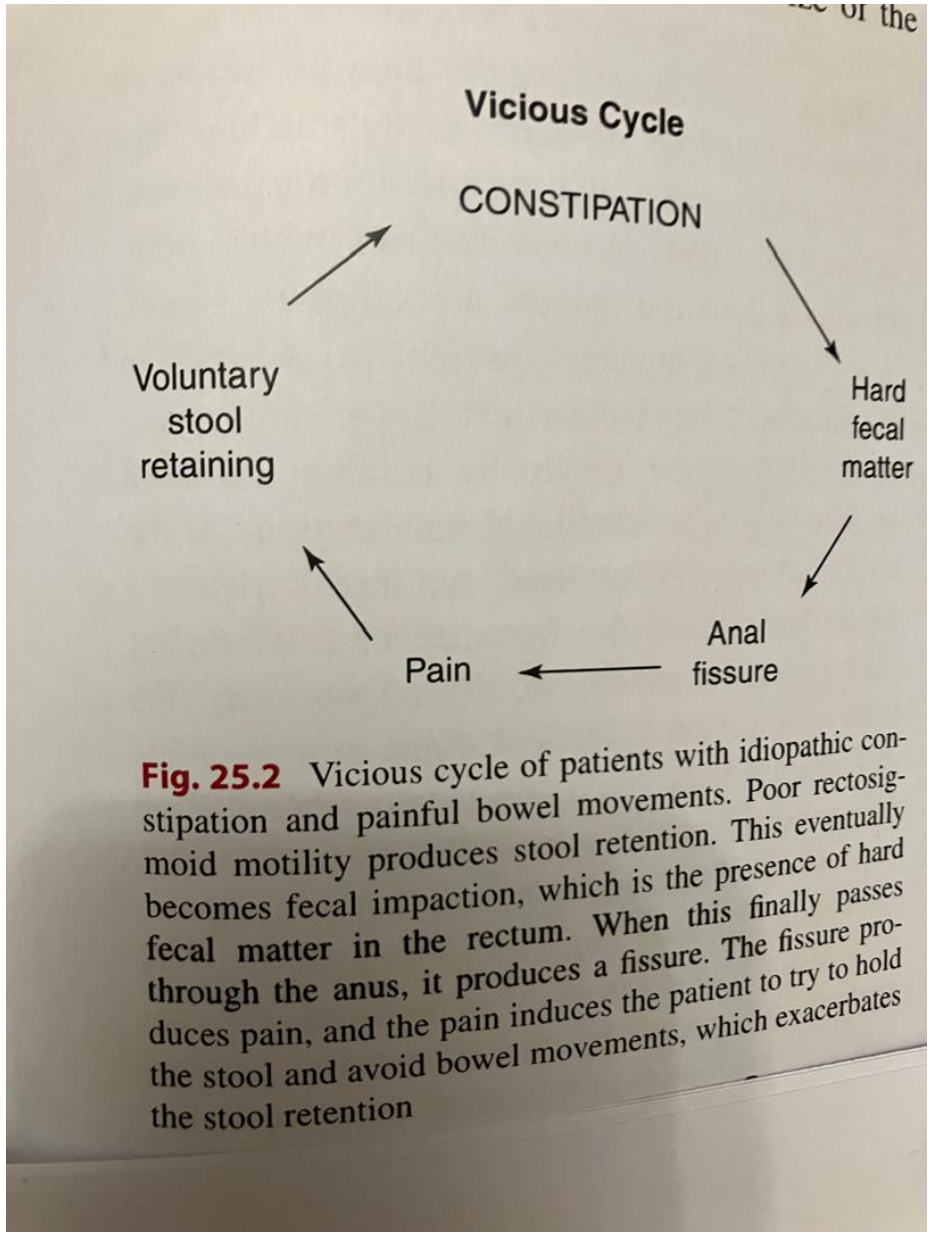


Fig. 25.2 Vicious cycle of patients with idiopathic constipation and painful bowel movements. Poor rectosigmoid motility produces stool retention. This eventually becomes fecal impaction, which is the presence of hard fecal matter in the rectum. When this finally passes through the anus, it produces a fissure. The fissure produces pain, and the pain induces the patient to try to hold the stool and avoid bowel movements, which exacerbates the stool retention

Definition:

1-Any child who has a hard stool less frequently than once every third day should be considered to have constipation

2- Children with true fecal incontinence include some surgical patients with ARM, those with HD, and those with spinal problems, either congenital or acquired, because they lack a key anatomic element required for voluntary bowel movements

Etiology:

Congenital

Acquired

Congenital Constipation & Incontinence

1- Neurologic disorders in which colonic dysmotility is present

2- Hirschsprung's disease, in which there is a deficiency of the intrinsic neural plexus

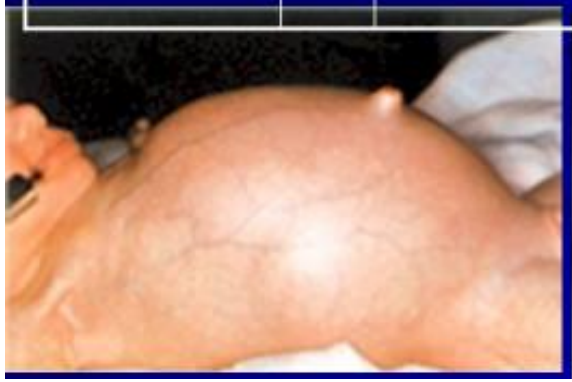
3- Hypothyroidism

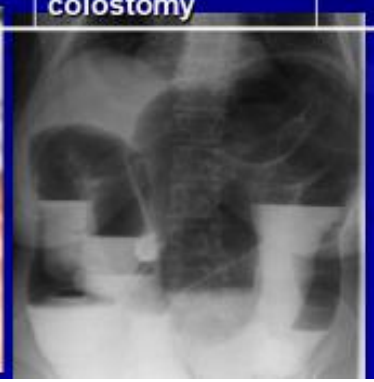
4- Intestinal pseudo-obstraction

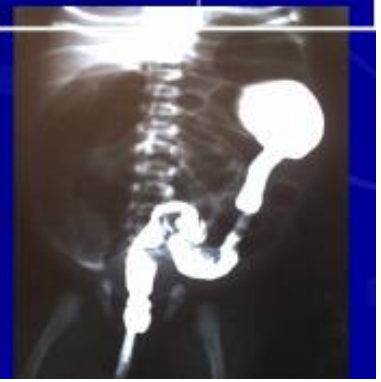
5- Variants of low imperforate anus for constipation (anal stenosis, rectoperineal fistula or anterior anus) and high imperforate anus for incontinence

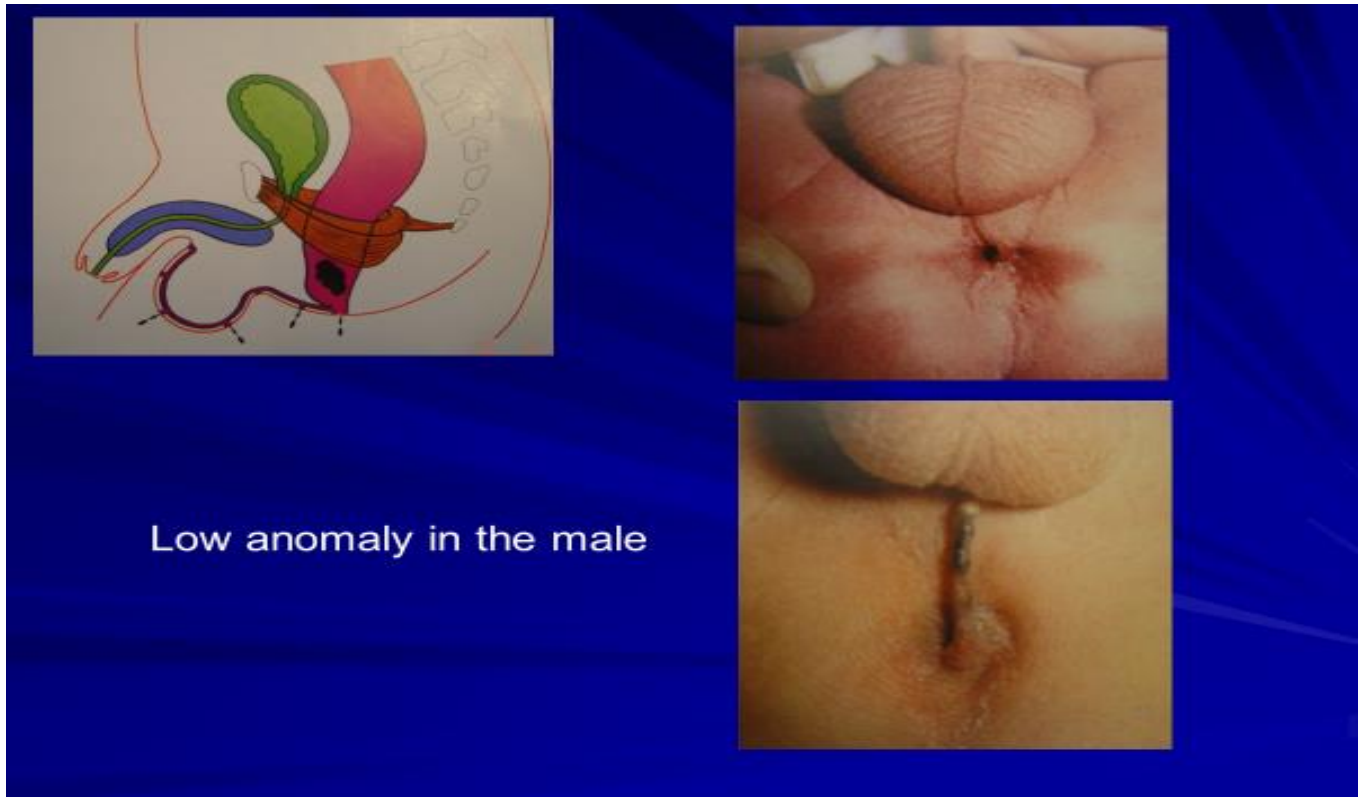
I-c. Immediate Group

Anomalies	*M/F*	*Estimated Incidence*	*Usual Operation/ Treatment*	*Optimum Age For Operation*	*Usual Stay in hospital*
Hirschsprung's disease (causing neonatal intestinal obstruction)	4/1	1 in 4400 – 7000	One stage abdominal or transanal Colostomy Rectosigmoidecty & pull through closure of colostomy	Soon after diagnosis. 6–10 months 2–5 weeks later	7 - 10 days

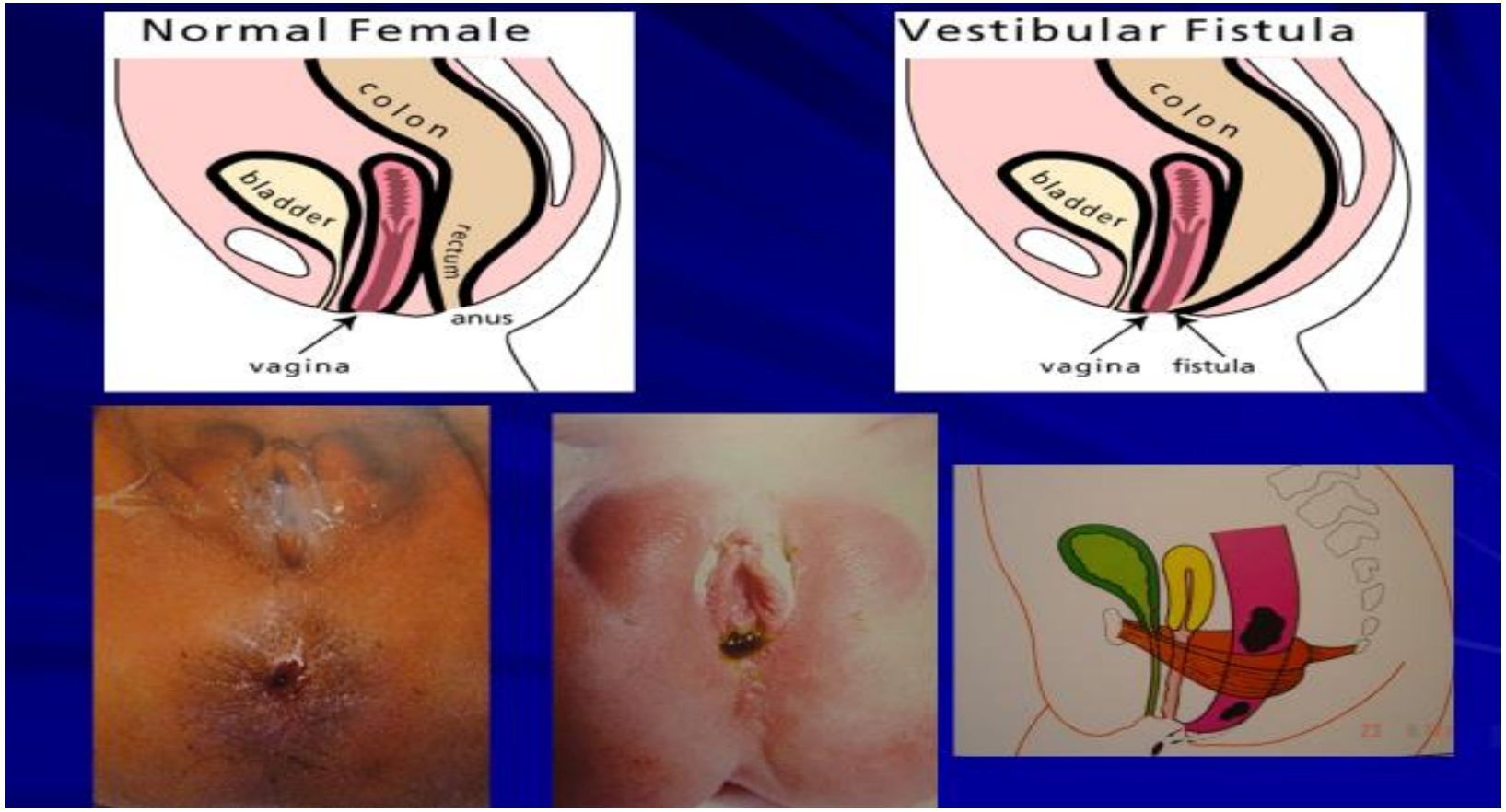







Low anomaly in the male

Low Anorectal Anomalies in female



Acquired Constipation & Incontinence

- Habitual or functional constipation (Pseudo incontinence)
- Chronic dehydration
- Use of opiates and anticholinergics drugs
- Metabolic disorders (hypothyroidism)
- Disorder of calcium metabolism
- Lead poisoning
- Cystic fibrosis

Diagnosis

- History
- Physical examination
- Imaging
- Barium enema
- Anorectal manometry
- Rectal biopsy
- Diagnostic tests for underline diseases

Treatment

1-Anatomic repair (anal stenosis, anterior anus or rectoperineal fistula)

2-Proctosigmoidectomy and pull through operation

3-Dietary manipulation

4-Stool softeners (mineral oil, polyethylene glycol)

5-Enema (saline)

6-Suppositories (glycerin, bisacodyl)

7-Manual evacuation

8-Biofeedback therapy

9-Surgical intervention (redo surgery, Ace operation)

Treatment

10- Butax injection

11-Malone Procedure (Appendicocecostomy, Antegrade Colonic, Enema)

12-Percutaneous sigmoidostomy tube (isolated rectosigmoid constipation)

13-Partial Lt Colectomy

14-Partial Colectomy with ACE

15-Total colectomy and ileorectal anastomosis

Thank you for your attention