Volume 13 No 6 DECEMBER 1999

Bowel Management

Fecal incontinence (FI) could be the outcome after surgery for anorectal malformations (imperforate anus) or Hirschsprung's disease. FI can be further subdivided by history and contrast studies into those with a tendency to constipation (megasigmoid) or diarrhea (a non-dilatated colon running straight from the splenic flexure to the anus). Bowel management aims to improve the personal and social burden inherent to this problem promoting independence in the affected child. The most effective regimen consists of regular and complete emptying of the colon limiting the episodes of fecal soilage. This is accomplished with the use of a daily enema program, dietary manipulation, laxatives and drugs. The enema is administered while the child sits in the toilet at a rate of 10-20 cc/kg of weight. To avoid spillage the silastic tube must have a balloon to seal the distal rectum. After enema administration the balloon is deflated and the child allowed to evacuate the colonic content. Leaving the balloon partially inflated encourages the child to expel it as a biofeedback mechanism allowing some patients to realize they have some minimal control to be exploited. If the enema program is effective in a 3 to 6 month period, the child can become a candidate for a Malone procedure (appendicostomy). Children with constipation and megasigmoid needs large volume enemas. Likewise, the large megasigmoid can cause overflow pseudo incontinence that is only helped with sigmoid resection. Those with diarrhea may need constipating diet and anti-motility drugs. A few children that continue with incontinence in spite adequate therapy might benefit from a permanent colostomy.

References

1- Shandling B, Gilmour RF: The Enema Continence Catheter in Spina Bifida: Successful Bowel Management. J Pediatr Surg 22(3): 271-273, 1987

2- Blair GK, Djonlic K, Fraser GC, Arnold WD, Murohy JJ, Irwin B: The Bowel Management Tube: An Effective Means for Controlling Fecal Incontinence. J Pediatr Surg 27(10): 1269-1272, 1992

3- Peña A, Guardino K, Tovilla JM, Levitt MA, Rodriguez G, Torres R: Bowel Management for Fecal Incontinence in Patients with Anorectal malformations. J Pediatr Surg 33(1): 133-137, 1998

4- Levitt MA, Soffer SZ, Pena A: Continent appendicostomy in the bowel management of fecally incontinent children. J Pediatr Surg 32(11):1630-3, 1997

5- Paidas CN: Fecal incontinence in children with anorectal malformations. Semin Pediatr Surg 6(4):228-34, 1997

6- Gleeson RM: Bowel continence for the child with a neurogenic bowel. Rehabil Nurs 15(6):319-21, 1990