ETHIOPIAN INTERNATIONAL JOURNAL OF MULTIDISCIPLINARY RESEARCH

eISSN: 2349-5715 pISSN: 2349-5707

Volume: 11, Issue 02, Fev-2024 SJIF 2019: 4.702 2020: 4.737 2021: 5.071 2022: 4.919 2023: 6.980

UDK: 616.348 - 089.86 - 053

COLOSTOMY IN COMPLICATIONS OF SURGICAL CORRECTION ANORECTAL MALFORMATION IN CHILDREN

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Annotation: Anorectal malformations in children are still one of the most difficult problems in pediatric coloproctology. Most pediatric surgeons continue to adhere to the opinion that preliminary colostomy and delayed proctoplasty are expedient, motivating this tactic by the possibility of creating the optimal conditions for performing a complex intervention, reducing the anesthetic risk, and avoiding technical errors. The work is based on the results of treatment of 154 children with anorectal malformation, with a preliminary colostomy. The use of colostomy in children with anorectal malformation made it possible to carry out the necessary surgical tactics in a timely and differentiated manner, reduce the frequency and nature of complications and early disability, improve the quality of life and social adaptation of patients.

Keywords: Anorectal malformations, colostomy, surgical treatment.

Relevance of the problem: Anorectal malformations in children is a special chapter of pediatric coloproctology. In the specialized literature, you can find different judgments about the level of imposition of a colostomy. Some authors recommend choosing the sigmoid colon for this purpose, others prefer the transverse colon, others prefer the blind and ascending colon. This question cannot be answered unambiguously. First of all, a colostomy should correspond to the main idea of treatment, and also not create special difficulties in subsequent operations [1, 2, 3]. Recent years have been marked by the possibility of anorectal defect correction without the use of a protective colostomy. At the same time, in most publications, preliminary stoma is considered correct. At the same time, one cannot agree with the widespread replication of operations without an ostomy, since this will increase the risk of complications [4, 5, 6, 7].

Clinical studies have shown a high rate of complications associated with neonatal colostomy, in particular transversostomy has a higher complication rate than sigmostoma. However, controversy continues over the type of split colostomy. This study compares the clinical outcomes of loop and split colostomy for ARM. [8, 9, 10, 11]. There is always a temptation to correct anorectal anomalies without a protective colostomy, but complications associated both directly with the colostomy and its formation and further closure pose a serious threat to the normal functioning of both the intestine itself and the sphincter apparatus of the anus [12, 13, 14] . The technique of performing an operative technique is very important - the imposition of an intestinal stoma in order to prevent colostomy complications. There is no disagreement that in children with high variants of malformations and cloaca, as well as before re-correcting operations, it is necessary to perform first a colostomy, and after 2-3 months, a radical correction of the defect [15, 16, 17]. Most pediatric surgeons continue to

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be of the opinion that preliminary colostomy and delayed proctoplasty at the age of 6-18 months or after the child reaches a certain body weight (usually about 8-10 kg.), Motivating this tactic by the possibility of creating an optimal condition for performing a complex intervention, avoiding technical errors and excessive traumatization of the muscular structures of the pelvic floor, pelvic organs, blood vessels and nerves of the rectum [18,19].

Purpose. To improve the results of treatment of anorectal malformations in children with prior colostomy.

Material and research methods. In our work, we analyzed the use of 154 (100%) colostomies. In the departments of pediatric surgery of the clinic of the Andijan State Medical Institute for the period from 2005 to 2021, 117 (76%) children with and without fistulous, as well as with high fistulous forms of anorectal malformation with an already formed preliminary colostomy, applied to Perinatal centers or clinics at the place of residence . The age of the children ranged from 2 months to 14 years.

Results and discussion. In 37 (24%) children, the formation of a colostomy (ileostomy) was performed directly by us. Of these, 9 (5.8%) children as the first stage before primary radical correction with a high form of defect and 10 (6.5%) children previously operated on once or several times with the development of gross anatomical and functional disorders of the small intestine and perineum, requiring repeated - corrective surgeries, 5 (3.2%) patients underwent colostomy after the development of complications in the early postoperative period, in 13 (8.5%) cases, colostomy was formed with associated anomalies and defects that clinically "dominated" anorectal malformation. The distribution of patients according to indications and type of colostomy is presented in Table 1.

Table 1. Distribution of patients according to indications and type of colostomy formation

Type of colostomy / Indications	Suspended (ileostomy)	Cecostomies	double sigmastoma	Distal single-barreled sigmastoma	Hartmann's type (corrugation method)	Total
As the first stage before the primary radical correction	-	-	2(5,4%)	2(5,4%)	5(13,5%)	9 (24,3%)
Before re-corrective operations	2(5,4%)	-	1(2,7%)	3(8,1%)	4(10,8%)	10 (27%)
With complications in the early postoperative period	2(5,4%)	2(5,4%)	1(2,7%)	-	-	5 (13,5%)
With concomitant anomalies and malformations	3(8,1%)	3(8,1%)	-	2(5,4%)	5(13,5%)	13 (35,1%)

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Total n=37	7(18,9%)	5(13,5%)	4(10,8%)	7(18,9%)	14(37,8%)	37(100%)

P ≥0,5

Out Of 9 (24.3%) children, we formed colostomies as the first stage before the primary radical correction; in 2 (5.4%) children, a double sigmastoma was imposed; in 2 (5.4%), a distal single-barrel sigmastoma; in 5 (13.5%) %) terminal sigmastoma according to the Hartmann type (corrugation rule).

Out of 10 (27%) children who had colostomies formed before re-correcting operations, previously operated on once or several times with the development of gross anatomical and functional disorders of the small intestine and perineum, 2 (5.4%) children had suspension (ileostomy), 1(2.7%) double sigmastoma;

Out of 5 (13.5%) children in whom colostomies were formed due to complications in the early postoperative period (retraction of the small intestine, necrosis of the stump, early adhesive obstruction, etc.), in 2 (5.4%) suspended (ileostomies) were imposed, 2 (5.4%) cecostomas and 1 (2.7%) double sigmastoma

Of the 13 (35.1%) children who had colostomies formed with concomitant anomalies and malformations that did not allow one-stage radical surgery, 3 (8.1%) children had suspension (ileostomies), 3 (8.1%) had cecostomies, 2 (5.4%) distal single-barrel sigmastoma, terminal sigmastoma of the Hartmann type (corrugation rule) in 5 (13.5%).

Staged corrective operations were performed depending on the "clinical dominant" of one or another pathology. In a number of cases, in relation to the identified lesions of the urinary tract, it was necessary to adhere to expectant tactics. This was done if information about a specific nosological unit made it possible to predict the outcome of the operation in general terms, and there were also aggravating moments.

Expectant management is required for rectourethral and rectovaginal fistulas, neurogenic bladder. For example, only after elimination of the intestinal anastomosis, intervention for megaureter, vesicoureteral reflux, hydronephrosis, etc. is permissible. Only with further examination for atresia of the anus and rectum, with high fistulous forms with an anastomosis in the bladder and urethra in boys in 11 patients the distal end of the atrezated intestine opened into the bladder in the projection of Lieutaut's triangle, it should be noted that 2 of them were female patients with rectovesical fistula, which, according to the literature, is a very rare variant of malformations. 4 children had a rectourethral fistula.

In repeated visits of primary operated children with retraction of the small intestine, with gross cicatricial changes in the obturator apparatus of the rectum, relapse of the disease, as well as in the formation of complete pararectal fistulas, the first stage of re-corrective surgical treatment was always the imposition of a colostomy.

In three patients with rectovaginal fistula, an attempt at perineal correction of the defect led to the development of retraction of the reduced intestine, anastomosis failure, and cicatricial deformity of the anus. Subsequently, a preliminary formation of a single-barrel terminal sigmostoma was performed, followed by a repeated radical operation. When analyzing the advantages of any type of colostomy, I would like to note that often a colostomy is the only way to create conditions for bowel emptying against the background of intestinal obstruction. It is possible to work without infection of surgical wounds, which prevents the development of postoperative complications in the form of retraction, prolapse of the rectal mucosa, stenosis of the anus and incontinence phenomena.

Overall, our results support the fact that sigmostoma placement is more favorable than transverse colon stoma placement. Also, our studies show the presence of greater complications from loop stomas than from separate ones; in particular, this applies to prolapse. It should be noted that

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insufficient information among pediatric surgeons about other colostomy techniques also plays a huge role and more often the stoma surgeon mainly uses the technique that he knows best. When forming a colostomy, it is necessary not only to create an adequate emptying of the intestine, but also to plan the further stage of the operation anatomically and physiologically in order to avoid complications associated with an incorrect determination of the type and level of the colostomy.

Conclusions.

1) Re-corrective operations in all cases of complications should be performed only under the cover of a "protective" colostomy.

2) Preferably the formation of a single-barrel end colostomy (sigmostoma);

3) Colostomy is necessary in case of identified concomitant anomalies and malformations that clinically “dominate” anorectal malformation

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