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Pediatric Colostomy: Indications, Types, Care, Complications and Closure

Thesis

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To

A lovely

MOTHER

&

A dedicated

FATHER

And a little brother

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CHAPTER I

INTRODUCTION

INTRODUCTION

Colostomy as we know it today is the result of maturation in several areas of acceptance, technical modifications and clarification of indications. Although much of the history concerns all age groups, certain portions are related specifically to the infants.[1]

Historical review

M. Littre,[2] a French surgeon, has been credited with the conception , based on his brief suggestion in 1710 that an artificial abdominal anus can be used to relieve the obstruction of imperforate anus.[2] The idea materialized sixty six years later, when M. Pillore performed a cecostomy on an adult with rectal carcinoma.[1] The second colostomy was performed on an infant with imperforate anus in 1783.[2] In 10 years the third colostomy on a moribund infant with imperforate anus was performed and produced the first long term survivor, the child was 3 days old and he lived for 45 years after the operation.[2]

Amussat[3] in 1839 introduced the extraperitoneal lumbar approach to the colon. It has the advantage of not opening the peritoneal cavity, but it has serious drawbacks:

1- It was a blind procedure and often the surgeon had little or no idea what the underlying pathology causing the obstruction was.

2- It was placed in the flank so was difficult to manage.

3- There was no established continuity of bowel epithelium to the skin so the stoma had a great tendency to stricture and stenosis.[3,4]

By 1860 Bodenhamer[5] was able to collect from the literature 32 accounts of the operation for imperforate anus. In 1861 A.C.Post[6] performed the first infant colostomy done in the United States. The operation was slow in gaining professional as well as social acceptance, especially in this country. Thus although its value in management was gradually recognized, many continued to avoid it on an emotional basis.[1,6]

In 1887 the abdominal colostomy was flourished again by Allingham[7] due to the complications of the lumbar colostomy, Allingham[7] recommended bringing the loop of the bowel to the skin surface, suturing the seromuscular layer to the skin to prevent retraction, and then excising the antimesenteric surface of the bowel to give a double-lumen colostomy.[4,7]

The initial colostomies served simply to vent the colon and as a result, incompletely diverted the fecal stream to the anterior abdominal wall. And to completely divert the stream, methods of forming a spur with the proximal and distal components of the colon were divised. Maydl, in 1888 did this by elevating the posterior colon wall above the abdominal wall and simply passing a vulcanite rod through a rent in the mesocolon. With the single modification of a glass for the vulcanite rod, this sutureless technique has remained popular to 1960s, while successful in preventing gross retraction, it did little toward avoiding prolapse and evisceration (originally the colon edges were tacked to the skin edges).[1,4]

Many efforts have since been made to secure a more reliable union between bowel and abdominal wall and eliminate the frequency of complications, particularly in infants. Donovan[8] and Stanley Brown[8] described a sutureless method of obtaining this bond. Iodoform gauze

temporarily placed in the potential space between the colon and the raw abdominal incision resulted in inflammatory response, which led to a stabile union of the exposed surface.[6]

The initial abdominal ani during infancy were for gravely ill patients with imperforate anus, often following previous perineal exploration.[5] Deaths were common; a survivor justified a case report. The selection of patients and anomalies associated with anorectal disease no doubt influenced the mortality rate.[9] Although there has been a broadening of colostomy use for imperforate anus, the procedure was seldom used for other lesions until Swenson[10] described a definitive operation for aganglionic megacolon in the late 1940s.[8]

Gradually the mortality figures have improved and focus has been placed on the nonlethal, but too frequent complications.[1]