

## Pull-Through / PSARP

The posterior sagittal anorectoplasty is more commonly referred to as the PSARP, or the "Peña procedure," named after **Alberto Peña, MD**. It's also referred to as the Pull-Through procedure.

### Pre-PSARP Care

Nursing care and assessment are essential during the preoperative stage. A distal colostogram is obtained from the PSARP to determine the location of the most distal part of the bowel and document the presence and location of a fistula between the bowel and the urogenital tract. This test is obtained in an outpatient setting.

Preoperative preparation may occur in the hospital or home setting. Visiting nurses may assist the family in the home setting. Bowel preparation includes irrigation of the distal stoma (nonfunctional, mucous fistula) with warm normal saline solution with the aid of a Foley catheter.

The purpose of this irrigation is to remove all the fecal matter left in the colon distal to the colostomy to avoid contamination at the time of the pull-through. Irrigations are continued until the return is clear.

### PSARP / Pull-Through

Generally, this second stage of the surgical repair is performed in patients older than one month of age, provided the infant is growing and developing normally. Some surgeons, however, prefer to wait until the baby is six to 12 months old. The operation is performed in the prone position (face down) with a Foley catheter inserted in the bladder. It entails a midline posterior sagittal incision running from the middle portion of the sacrum to the anterior edge of the external sphincter.

The sphincter mechanism is divided in a midline incision, thereby preserving the nerve fibers and decreasing the amount of postoperative pain. The back of the child's buttocks is opened like a book, and all internal structures are exposed.

The rectum is then meticulously separated from the genitourinary tract, dissected, and freed enough to reach its normal site without tension. The fistula site is then closed.

With the use of an electrical muscle stimulator, the limits of the sphincter mechanism are determined and the rectum is placed in its optimal location to achieve the best functional results.

If the child is known to have a very high defect or the child's rectum is not able to be reached with this approach, the abdomen must also be entered and is ideally approached using laparoscopy.

The postoperative course for this surgical procedure is relatively benign. If a laparotomy was not needed, the child may drink fluids after the surgery and have a regular diet the next day.

The intravenous line must be preserved for the administration of antibiotics for two to three days, such as:

- Ampicillin
- Gentamicin
- Clindamycin

Some surgeons continue antibiotics for several more days.

In males and in females with [cloaca](#), the Foley catheter remains in place five to 10 days. This protects the suture line in the urethra, where the communication between the bowel and urethra is located.

The surgeon should be notified if the catheter comes out inadvertently. If the infant is unable to void, a suprapubic tube is inserted.

The children do not need to be positioned in any particular way; they may simply find the best position for themselves.

Parents should apply antibiotic ointment to the perineum with every diaper change to prevent local infection.

Continue the antibiotic ointment for two weeks until the child's first postoperative visit. The expected length of stay is two to three days.



## Contact the Colorectal Center at Cincinnati Children's

For more information or to request an appointment for the Colorectal Center at Cincinnati Children's Hospital Medical Center, please [contact us](#).