

Instructions For Parents Of Children After A Colostomy Closure For The Management Of Anorectal Malformations

Most patients born with [anorectal malformations](#) receive a [colostomy](#) at birth. A colostomy creates an artificial anus (stoma) to allow feces to pass out of the body and into a stoma bag. After the anorectal malformation is repaired, the colostomy can be closed and with a proper [bowel management program](#), the child can have a very good quality of life.

After a colostomy is closed, the patient must have nothing by mouth for usually 24 to 48 hours. Babies usually start passing stool through the new rectum in 24 to 48 hours, but occasionally it takes 72 hours. By the third or occasionally the fourth day after surgery to close the colostomy, babies are discharged from the hospital.

The closure of the wound in the abdomen is performed with a suture that is mostly invisible. The purpose of this is to achieve the best possible cosmetic result in the wound closure. Only two big suture knots can be seen in the extreme ends of the suture.

The wound is then covered with a plastic material called collodion, which is waterproof, transparent, and water soluble, dissolving by itself by 8 to 10 days after surgery.

Using collodion avoids the use of dressings in little babies. While routine in adults, the use of dressings is not recommended in babies because they still use diapers and the stool can make the dressings dirty and contaminate the wound. The collodion material also allows parents to give the baby a bath from day 1 after surgery, to be able to see the wound through the transparent material, and to not have to bother the baby with dressing changes.

That suture can be removed two weeks after surgery. The pediatrician, surgeon, or parents themselves can cut the two little knots visible above the skin on the extreme ends of the wound. That can be done with a small scissors. The rest of the suture remains under the skin and is totally absorbable.

Dealing with Diaper Rash

When the baby starts passing stool, the fecal matter is usually liquid. The baby may have many liquid bowel movements, because the colon was not used for this purpose before and because during treatment, the baby receives strong antibiotics that produce diarrhea in many children. The baby may have so many bowel movements that the parents get concerned. It is important to remember it is a temporary situation.

Because the baby's skin in this area was not in contact with stool before, the skin is particularly sensitive. As a consequence, the baby usually develops a severe diaper rash. Preventing stool from touching the skin is the best way to prevent diaper rash. The best way to combat this rash is to change the diapers as often as possible. As soon as you notice stool in the diaper, remove the diaper and sit the baby in soap and water followed by irrigation with clean water. Do not rub the skin, because that can make the diaper rash worse.

Sometimes it is even better to keep the baby without a diaper so that exposure to air will keep the skin dry. By keeping the baby's bottom open to the air without a diaper, the parents also can see exactly when stool is in contact with the skin, wash the baby's skin, and protect it with an ointment provided by the Colorectal Center to create an isolation barrier between the skin and the stool.

The Switch to Constipation

After a few days, sometimes weeks, the number of bowel movements will start to decrease. Then the baby switches to what will be the major problem in the following months and years—constipation. Parents must keep in mind that constipation is a serious enemy of children with anorectal malformations for the rest of their lives.

Constipation is often misunderstood and its significance underestimated. While most parents understand that a baby that does not have a bowel movement in more than 24 hours has constipation, many parents do not realize that constipation also may be manifested by frequent episodes of passing stool, but in very small amounts, so that the rectum does not empty.

By looking at the stools, the parents eventually become experts in detecting constipation. If a baby keeps passing stool, but the stool is dark and sticky, and it seems like the baby never stops passing the stool and never empties the rectum, the parents should assume that the baby is constipated. At that point, we recommend that the parents give the child laxative type foods. We

provide the parents a list of laxative type foods and advise that these foods be given as much as possible.

Many times, however, laxative food is not enough to combat constipation and parents need to give the baby a laxative medication. Nurses at the Colorectal Center can recommend a specific type of laxative, but generally there is not much difference in laxatives. The amount of laxative, however, must be adjusted to the specific response of the child so the child is not constipated, but does not have diarrhea either.

It is often said that babies with anorectal malformations have two enemies. One is constipation. The other one is diarrhea. Even with the most successful surgery to correct an anorectal malformation and even if the baby is going to have bowel control, it is very unlikely that a child with an anorectal malformation can have bowel control when subjected to an episode of diarrhea.

Overflow Pseudoincontinence

Constipation can also produce a condition called overflow pseudoincontinence. In this case, a child born with an anorectal malformation but with a good prognosis for functional bowel control and a successful operation, may develop severe constipation because of an incapacity to empty the rectum.

The child accumulates a lot of stool in the colon and develops fecal impaction that produces overflow of stool. As a result, the child soils day and night, behaving as if totally incontinent, when actually the child is continent, but severely constipated. This phenomenon of overflow pseudoincontinence also may happen in a normal child with no anorectal malformation, but suffering from severe constipation.

It is impossible to determine the degree of constipation that a specific baby will have with after the colostomy is closed. In general, however, anorectal malformations associated with better chances of achieving bowel control also increase the chance of constipation.

Responsibilities of Parents

From the moment the colostomy is closed until the age of 2-1/2 or 3, the parents have two main responsibilities. One responsibility is to be sure that the child empties the rectum every day.

Many pediatricians will tell the parents that there are many babies who empty the colon every three or four days for the rest of their lives and they are normal. That is true for other children, but it is not true for children with anorectal malformations.

If the baby goes the entire day without a bowel movement or the aspect of the stool suggests the presence of constipation, parents should assume that the baby is constipated and give laxatives. Even if parents are not sure the child is constipated, it is better to give the baby and laxatives than to wait and take the chance that the baby will develop fecal impaction.

If the baby develops diarrhea as a result of a laxative, all the parents have to do is decrease the amount of laxative. If fecal impaction is detected too late, retention of stool results in severe dilatation of the colon, which means more constipation and more impaction, creating a vicious cycle. Parents are responsible for avoiding that problem.

At the Colorectal Center at Cincinnati Children's, we treat children from all over the world, making it impossible for us to personally see our patients whenever they have constipation and advise their parents. We encourage parents who need help in dealing with their child's constipation to call the nurses at the Colorectal Center. Whenever in doubt about whether the child is constipated, the parents must be ready to give laxatives.

Many parents do not want to give laxatives, because they think that by doing that they are going to make the child laxative dependent. But most babies born with an anorectal malformation are born laxative dependent. Only occasionally do we have patients who do not need laxatives.

The other responsibility that the parents have after the colostomy is closed and after the baby is 1 year of age, is to try to provoke regularity in bowel movements. If the baby has one, two or three bowel movements at a predictable time of the day, this will make it much easier to toilet train the baby. If the baby has five bowel movements one day, constipation the next day, and diarrhea the next day, toilet training it is going to be very difficult.

Parents do not control the motion of their child's colon, but can influence colon motility (the movement of food through the colon) by the kind of food they give the child to eat and the frequency of meals.

We recommend that after the child is 1 year of age, parents try to give the child more or less the same types of foods and give the child only three meals and no snacks per day. Following that



recommendation should hopefully provoke one, two or three bowel movements per day, at the same times, by the age of 2-1/2 or 3, and that will make the child more likely to be toilet trained.

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](#).