Conclusions: The choice of peritoneal commissures disease treatment in children depends on patient severity, process intensity and complications (including chronic intestinal obstruction, recurrent enterocutaneous fistula and abdominal wall eventration).

13:00 CLOSING REMARKS

FREE AFTERNOON / EVENING

TUESDAY, JUNE 4TH, 2013

Free bus transfer from Frankfurt to Leipzig for the 14th Congress of the European Paediatric Surgeon's Association (EUPSA): June 5th-8th, 2013

Please refer for further details (time of departure, number of requested seats, etc.) to: udo.rolle@kgu.de

For further details on the EUPSA Meeting, please visit the following website: www.eupsa2013.org

20th International Pediatric Colorectal Club Meeting

Frankfurt, June 1st- 3rd, 2013

Lecture Hall 23-4

University Hospital Frankfurt
Campus Niederrad
Theodor-Stern-Kai 7

www.colorectalclub2013.com

UNIVERSITY HOSPITAL FRANKFURT
GOETHE UNIVERSITY

INTERNATIONAL SCIENTIFIC COMMITTEE

- Arnold Coran (Ann Abor, USA)
- Michael Höllwarth (Graz, Austria)
- Alberto Peña (Cincinnati, USA)
- Prem Puri (Dublin, Ireland)
- Risto Rintala (Helsinki, Finland)
- Massimo Rivosecchi (Rome, Italy)
- Tomas Wester (Stockholm, Sweden)

LOCAL ORGANIZING COMMITTEE

- Udo Rolle
- Stefan Gfrörer
- Henning Fiegel
- Secretary Frau Kerstin Petri

GENERAL INFORMATION

MEETING TIME

- Saturday, 1st June 2013, Get Together, 19:00
- Sunday, 2nd June 2013, 08.45 - 18.00
- Monday, 3rd June 2013, 09.00 - 13.00

MEETING VENUE

- Lecture Hall 23-4, University Hospital Frankfurt, Goethe-University Frankfurt, Campus Niederrad, Theodor-Stern-Kai 7
- The University Hospital Frankfurt is very close to the Main River and about 10 minutes walking distance from the city and the main railway station.

LANGUAGE

The official language will be English.

SECRETARY DESK AND REGISTRATION

All participants are requested to register. Payment modalities and the official registration form can be found under the following link: www.colorectalclub2013.com

On-site registration will be provided. The secretary desk will be located at the meeting venue and will be open from:

- Saturday, June 1st 16:00 - 19:00
- Sunday, June 2nd 08:30 - 18:00
- Monday, June 3rd 08:30 - 13:00

Registration fee for delegates includes

- Attendance to all scientific sessions
- Congress bag, including name badge and scientific brochures
- Attendance certificate
- Coffee breaks and lunch on June 2nd and 3rd, 2013
- Get together on the June 1st, 2013
- Social dinner at the June 2nd, 2013

CONTACT

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Department of Pediatric Surgery, Nicolaus Copernicus University, Ludwik Rydygier Collegium Medicum, Bydgoszcz, Poland

Background: Congenital rectal atresia comprise only 1% of all anorectal malformations. Many operative approaches for the management of this rare entity exists. Patients with Down syndrome have higher risk of poor outcome after correction of anorectal anomaly, thus the search for the most appropriate operative management is indicated.

Methods: We describe a case of patient with Down Syndrome and rectal atresia. In the newborn period an initial colostomy was performed along with an evaluation for associated anomalies. At the age of 7 months definitive operation of rectal atresia was performed. We implemented operative technique proposed by Hamrick and colleagues which uses posterior saggital approach with preservation of an anterior dentate line of native anal canal. Previous reports concerned cases where proximal rectal pouch was immediately adjacent to the distal anal canal. In our case despite the 3,5 cm distance, proximal rectal pouch was adequately mobilized and anastomosed to the posteriorly opened anal canal.

Results: Postoperative course was uneventful. Only few control dilatation of the neo-anus were performed. Patient is doing well 4 months after completion of surgical treatment, regular bowel movements are observed. Further assessment of patients bowel control will be carried out in the long-term observation.

Conclusions: Technique of definitive reconstruction of rectal atresia with preservation of anterior dentate line in presented case was safe and easy. Advantages of this technique is preservation of very sensitive anorectum, what could improve prognosis in terms of bowel control, especially in patient with Down Syndrome. We believe also that elliptically fashioned anastomosis prevents for stricture formation and obviates the need of serial anal dilatation.

11:00-11:30 COFFEE BREAK

11:30-13:00 SCIENTIFIC SESSION VI

CHAIRS: G.D.H. Croaker (Canberra, Australia), I. de Blaauw (Nijemegen, The Netherlands)

52. MODERN TECHNOLOGIES IN THE TREATMENT OF FECAL INCONTINENCE IN CHILDREN (6 mins)

I. Komissarov, N. Kolesnikova, V. Glushkova

Saint-Petersburg State Pediatric Medical University, Saint-Petersburg, Russia

Background: Fecal incontinence in children is an actual problem that has not only medical influence, but serious impact on social life. Three physiological and anatomical factors, as intestinal motility, rectal sensation and healthy anal sphincters are responsible for ideal fecal continence. Patients with fecal incontinence after surgical corrections of anorectal malformations, Hirschsprung disease and patients with fecal incontinence due to neurogenic disfunction of pelvic floor are the most difficult group of patients.

Methods: Since 2004 for 2013 at the State Pediatric Medical University have been treated 186 patients with fecal incontinence, that included 126 patients with fecal incontinence after surgical correction of anorectal malformations, 30 patients after surgical correction Hirschsprung disease and 30 patients after operative management myelomeningocele. All patients were examined and treated with conservative means, such as constipation diet, rectal enemas or laxatives, biofeedback therapy.

Some patients in case of failure to response on conservative treatment were operated for improvement fecal continence.

Results: In recent years for surgical correction of fecal incontinence, we have used modern technologies and materials. Patients, having overflow incontinence and megarectum, operating in one stage resection of megarectum and transanal pull-through without abdominal approach. 4 patients (3,2%) after surgical correction of anorectal malformations underwent this type of surgical management. At serious damage of anatomical foundations of the anal sphincters with absence of function of a puborectal muscle, impossibility of reconstruction of an external sphincter and levator, we make prosthetics of a puborectal muscle with application of allogenic materials, polypropylene synthetic sling (Uretex TO, Bard) or porcin dermal sling (Pelvicol implant, Bard). 20 patients (15,9%) after surgical correction of anorectal malformations, 10 patients (30%) after surgical correction myelomeningocele were operated for reconstruction of anorectal angle with allogenic materials. In some cases, fecal incontinence in children caused by insufficient internal sphincter, incompletely closed anus and low resting pressure. In that reasons of fecal incontinence, can be used injections of bulking agent «DAM+» into the submucosal layer of anal channel. In our hospital, 26 patients (20,6%) after surgical correction of anorectal malformations were treated with injections of «DAM+» with good result. However, in most cases it should be necessary to combine different type of operations.

Conclusions: In complex management of the patients with organic fecal incontinence, its very important to begin with meticulous conservative treatment and it is necessary to choose the right type of surgical intervention for everyone patients, if the conservative management were failed.

53. PAINLESS RECTAL BLEEDING AND ANEMIA IN CHILDREN DUE TO COLORECTAL HEMANGIOMAS AND VASCULAR MALFORMATIONS (6 mins)

A. Khaleghnejad Tabari, L. Mohajerzadeh, M. Rouzrokh, A.R. Mirshemirani, P. Ghaffari

Pediatric Surgery Research Center, Shaheed Beheshti University of Medical Sciences, Tehran, Iran

Background: Hemangiomas and vascular malformations of the GI tract are rare entity. The small bowel is the most frequent site. Colonic and anorectal hemangiomas and vascular malformations are even rarer and account only 38% of this problem of which 50% are located in the rectum.

Case 1: Female neonate with classic triad of Klipple-Trenaunay-Weber Syndrome (right limb hypertrophy, cutaneous hemangiomas of right limb and perianal area and right pelvic and rectal hemangiomatous mass that confirmed by pelvic CT , at age 2 years developed massive rectal bleeding that treated by high dose steroid therapy and blood transfusion and followed with oral propranolol and her cutaneous and perianal hemangiomas and limb hypertrophy was managed by local steroid ointment and elastic bandage. Now she is at age 8 years and is stable.

Case 2&3: Tow brothers with confirmed diagnosis of Hereditary Hemorrhagic Telangiectasia (Osler-Weber-Rendu syndrome) of left colon that presented with repeated attack of fresh rectal bleeding and chronic iron deficiency anemia at age 4 years and 3 years, RBC scan and colonoscopy identified the site of bleeding. Investigation for other component of this syndrome was negative. Both patients underwent segmental colectomy of affected part of colon and histology confirmed the vascular malformation.

Case 4: 4-year-old female with repeated fresh rectal bleeding and anemia from age 1year. Several upper and lower GI endoscopies was not conclusive. She has been under medical treatment for three years with ferrous sulfate and PPI. Her technetium-99m scan was suspected to Meckel's diverticulum. Explorative laparotomy was performed that confirmed the hemangiomas of terminal ileum and cecum. Resection of terminal ileum and cecum with ileocolic anastomosis was done. She had uneventful post-operative course and her bleeding completely stopped during one year follow up.

Conclusions: 1- Hemangiomas and vascular malformations of the distal GI tract should be considered as one of the causes of painless rectal bleeding and chronic anemia in childhood or early