

**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 4<sup>TH</sup>, 2013**

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

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

For further details on the EUPSA Meeting, please visit the following website: [www.eupsa2013.org](http://www.eupsa2013.org)

# 20<sup>th</sup> International Pediatric Colorectal Club Meeting

**Frankfurt, June 1<sup>st</sup> - 3<sup>rd</sup>, 2013**

**Lecture Hall 23-4**

**University Hospital Frankfurt  
Campus Niederrad  
Theodor-Stern-Kai 7**



[www.colorectalclub2013.com](http://www.colorectalclub2013.com)

## INTERNATIONAL SCIENTIFIC COMMITTEE

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

## LOCAL ORGANIZING COMMITTEE

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

## GENERAL INFORMATION

### MEETING TIME

- Saturday, 1<sup>st</sup> June 2013, Get Together, 19:00
- Sunday, 2<sup>nd</sup> June 2013, 08.45 - 18.00
- Monday, 3<sup>rd</sup> 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](http://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 1<sup>st</sup> 16:00 - 19:00
- Sunday, June 2<sup>nd</sup> 08:30 - 18:00
- Monday, June 3<sup>rd</sup> 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 2<sup>nd</sup> and 3<sup>rd</sup>, 2013
- Get together on the June 1<sup>st</sup>, 2013
- Social dinner at the June 2<sup>nd</sup>, 2013

## CONTACT

Department of Pediatric Surgery  
Office Hs. 23  
University Hospital Frankfurt  
Theodor-Stern-Kai 7  
60590 Frankfurt am Main  
Germany

Tel: +49- (0)1577- 6400442  
Fax: +49- (0)69- 630- 17936  
E-Mail: [udo.rolle@kqu.de](mailto:udo.rolle@kqu.de)



### 33. THE "RESCUE" OPERATION FOR PATIENTS WITH CLOACAL EXSTROPHY AND ITS VARIANTS (6 mins)

A. Bischoff, G. Brisighelli, M.A. Levitt, A. Peña

*Colorectal Center for Children, Division of Pediatric Surgery, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, USA*

**Background:** Patients with cloacal exstrophy have variable colonic length that ranges from normal to an almost absent colon. A common error in the initial operative management is to create an ileostomy leaving the colon defunctionalized, and often still connected to the urinary tract. The negative implications of this are: a) the colon does not grow and b) the patient may suffer from hyperchloremic acidosis due to colonic absorption of urine. An absent or a very short colon results in the incapacity to form solid stool due to lack of water absorption capacity and it disqualifies a patient from having a pullthrough. Therefore, every effort must be made to preserve and use the available colon. Small colonic pieces will grow and improve their water absorption capacity, provided they are incorporated into the fecal stream. These patients benefit from a "rescue" operation.

**Methods:** A search in our database was performed, looking for patients with cloacal exstrophy and its variants that underwent an inadequate diversion during the newborn period and required a "rescue" operation. 19 patients were identified. A retrospective review of the medical records of these patients was performed looking for gender, time of the "rescue" operation, colonic length rescued, symptoms present before the operation that improved after it, and follow up.

**Results:** In all patients a piece of colon was rescued from the pelvis and incorporated into the fecal stream, the original stoma was closed and an end colostomy was created. 15 patients were female and 4 males. 13 had exstrophy variants and 6 had classic cloacal exstrophy. 18 patients received an ileostomy at birth, and 1 patient had a loop colostomy. The "rescue" operation was performed on average 26.9 months after birth (range 1 month – 12 years). The length of rescued colon ranged from 5.5 cm to 20 cm. 8 patients had symptoms that were present before and improved after the operation: acidosis (3), failure to thrive (2), sepsis (1), multiple urinary tract infection (1), and dehydration (1). On follow up, 10 patients still have their colostomies as we are waiting for continued colonic growth, 6 patients had a pullthrough after responding to our bowel management program through the stoma, 2 patients have a permanent stoma, and one patient expired.

**Conclusions:** When patients with cloacal exstrophy or its variants incorrectly receive an ileostomy at birth, a rescue operation should be attempted in order to incorporate the colon into the fecal stream giving the colon the opportunity to grow enough to absorb water and form solid stool, which improves symptoms and makes the patient a candidate for a future colonic pullthrough.

### 34. TREATMENT FECAL INCONTINENCE IN CHILDREN WITH BULKING AGENT "DAM+" (6 mins)

I. Komissarov, V. Glushkova, N. Kolesnikova

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

**Background:** In recent years some authors have been reported about treatment fecal incontinence in adult with various bulking agent and contradicting results. However, the ideal bulking agent are still not found out and there are isolated reports about using this type of treatment for improvement fecal continence in children with organic and neurogenic fecal incontinence. Aim: To evaluate results of using bulking agent «DAM+» (Russian Federation) in children with organic and neurogenic fecal incontinence.

**Methods:** The study has been performed during 5 years, since 2007 for 2013. In total, 35 patients with organic or neurogenic fecal incontinence after surgical correction of anorectal malformations, Hirschsprung disease or myelomeningocele underwent 57 procedure of introduction polyacrylamid gel «DAM+». «DAM+» was injected into submucosal layer of rectum, above dentate line at the 3, 6, 9 12 o'clock positions. We have used from 20 to 50 ml of bulk agent. The injection was carried out under

the direct control of a finger inserted in the anus. Before treatment, through 1 month and 1 year all patients were assessed clinical examination and anal manometry.

**Results:** The average quantity of resting pressure in the anal canal before operation is formed  $20.98 \pm 5.17$  cm. (H<sub>2</sub>O), after operation  $32.62 \pm 6.63$  cm. (H<sub>2</sub>O), in long-term period  $28.07 \pm 6.65$  cm. (H<sub>2</sub>O). 17 patients (51%) had marked improvement after first procedure, fecal incontinence were fully reduced. 11 patients (31%) received second injection in one year in case of increasing episodes of fecal incontinence and decreasing of resting pressure. 4 patients (31%) have underwent 3 procedures and 3 patients (9%) have underwent 4 procedures (one procedure a year), for the same reason. In last two groups of patients basal resting pressure before operations was significantly lower than in groups of patient with better result after treatment. We have not seen any incidents of close or distance migration of this bulking agent.

**Conclusion:** The clinical efficiency of procedure correlates with values of resting pressure in the anal canal before and after treatment. Injections of «DAM+» can be used for improvement fecal continence in children.

### 35. CLINICAL AND MANOMETRIC EVALUATIONS OF ANORECTAL MALFORMATIONS WITH GOOD PROGNOSIS (6 mins)

R. Arnoldi<sup>1</sup>, A. Morandi<sup>1</sup>, G. Farris<sup>1</sup>, F. Macchini<sup>1</sup>, A. Zanini<sup>1</sup> and E. Leva<sup>1</sup>

*<sup>1</sup> Department of Pediatric Surgery, Fondazione IRCCS "Ca' Granda" - Ospedale Maggiore Policlinico, Milano, Italy*

**Background:** This study was undertaken to investigate the outcome of a group of patients operated for anorectal malformations (ARMs) with good prognosis (defined as some types of ARMs with prominent midline groove and normal sacrum) through a clinical and manometric evaluation.

**Methods:** Among 200 ARM patients followed-up at the Colorectal Center of our Institution, 84 were affected by ARM with good prognosis. Thirty patients, who had completed toilette training, were included in the present study and underwent clinical evaluation by Rintala score and anorectal manometry to record anal resting pressure (ARP), rectoanal inhibitory reflex (RAIR) and rectal volume (RV). Clinical and manometric results were analyzed with regard to sex, type of ARMs, surgical timing of PSARP, neurospinal cord dysraphism (ND), neonatal colostomy and institution where they underwent surgery.

**Results:** Seventeen out of 30 (57%) patients who underwent clinical evaluation had a normal Rintala score while 13 (43%) had a good score. Clinical data showed a significant correlation between normal score and the absence of ND and of neonatal colostomy. Manometric results showed how ARP in patients with ND was lower than in patients with normal spine ( $23,5 \pm 7,2$  mmHg vs  $32 \pm 7,9$  mmHg,  $p < 0,023$ ). ARP in patients with neonatal colostomy was also significantly lower than in patients without it ( $25,22 \pm 10,24$  mmHg vs  $32,57 \pm 6,68$  mmHg,  $p < 0,026$ ). Positive RAIR was demonstrated in 23 (77%) out of 30 patients. Six (20%) out of 30 patients with ND had RAIR, while RAIR was found in 24 (80%) without ND ( $p < 0,015$ ). Nine (30%) out of 30 patients with colostomy had RAIR, while 21 (70%) out of 30 without colostomy had RAIR ( $p < 0,014$ ). No significant differences were observed for RV.

**Conclusion:** Clinical and manometric results suggest that this group of patients showed a satisfactory outcome even if non comparable to that of healthy children. Neurospinal cord dysraphism and neonatal colostomy seem to worsen the outcome in the examined population.