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# RESULTS OF SURGICAL TREATMENT OF ANORECTAL DEFECTS IN CHILDREN

Ollanazarov J. O.
Tashkent Medical Academy Republican Scientific and Practical Center for Minimally Invasive and Endoscopic Surgery of Children. Tashkent, Uzbekistan
Ollanazarov19860@gmail.com

**Abstract**
Anorectal malformations (ARM) are the main group of children's coloproctology diseases, accounting for 85% of the total number of colorectal malformations. The average incidence of MRC in children is 1 in 5,000 newborns.According to statistics, it is more common in boys than in girls. Today, surgeons have at their disposal more than 20 methods of surgical correction of anorectal defects. According to statistics, unsatisfactory results of treatment of anorectal defects range from 10 to 60%. This is related to a complex of factors: various anatomical variants of the defect, combination with other anomalies of development, complete preoperative diagnosis, highly traumatic nature of traditional methods of correction of anorectal defects, which determine the presence of unsatisfactory functional results against the background of good anatomical reconstruction. Rehabilitation measures are a necessary step in the further treatment of children with anorectal defects. In order to improve and improve the methods of diagnosis and treatment of ARP, about 40 classifications have been proposed, which are based on the clinical, embryogenetic and anatomical characteristics of the defects.The classification of Ladd and Gross was of the greatest importance. Murashova, A.M. Amineva, A.I. Lenyushkina, G.A. Bairova, Krikenberg, Melbourne classification, A. Peňa classification.

## Introduction

**The purpose of the work:** To analyze the results of operations performed on patients with congenital anorectal defects.

## Materials and Methods:

From 2019 to 2023, 56 children with anorectal defects were examined at the Republican Scientific and Practical Center of Minimally Invasive and Endovisual Surgery. 46 of them (82%) are boys, 10 (18%) are girls. 50 full-term (89%), 6 premature (11%).

All patients were classified according to Crickenberg.

1. Main clinical groups 53 (95%): including 3 recto-perineal skin fistulas (5.4), 7 recto-urethral fistulas (12.5%), 2 recto-vesical fistulas (3, 6%), rectus vestibular fistula 6 (10.7%, cloaca 1 (1.8%). Types without fistula: atresia ani 24 (42.7%), atresia ani et recti 10 (17.8%).

2. Rare types 3 (5.4%), of which "rectal bag" (Pouch Colon) - 2 (3.6%), H-type 1 (1.8%). In the diagnosis of all patients, laboratory examination and the following instrumental research methods are used: general radiography of the chest and abdominal organs, invertogram according to Vangentin-Rice, radiography using the Cross-table method, determination of the sacral index ,



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ultrasound. perineum and abdominal organs, fistulo-irrigography, bladder catheterization, distal colostography, neurosonography, Exo-CG.

**Results and Discussion:**

We performed the following surgical interventions: 24 perineal proctoplasty, 4 Stone-Benson operations, 25 primary colostomy (sigmastoma), followed by radical surgery (3 abdomino-perineal proctoplasty, 2 Stone-Benson operations, 16 video-assisted laparoscopy) abdominoperineal proctoplasty, 1 intussusception extirpation according to Lenyushkin, and in 3 patients radical surgery for a wide fistula was performed at the age of 3-6 months.

Perineal proctoplasty was performed in 24 (43%) patients with low forms of anorectal malformations. In the postoperative period, rehabilitation measures were carried out for all patients (bougieneage of the anus according to the scheme + treatment against local scars with Contratubex gel until the end of the course). The rehabilitation measures implemented have shown positive results in the prevention of slowing, stopping and scarring. As a result, not all patients who underwent perineal proctoplasty had cicatricial narrowing of the neoanus.Postoperative incontinence in these patients showed satisfactory and good examination results. No repeated operations were performed in all patients. In 3 patients, anorectal malformations occurred 3-6 months after birth in the form of recto-perineal, recto-vestibular fistulas with a wide fistula path.

Postoperatively, all patients underwent intestinal intubation with a gas tube through the neoanus for better healing of the primary wound.

In the case of high forms of anorectal malformations and fistula forms of the urinary tract, after birth, the patients were initially operated on sigmastoma and asendostomy.In addition, in some cases, distal colonoscopy was performed before radical surgical interventions. In 5 patients, the distal part of the stoma was located close to the atretic part and the fistula tract, and therefore, radical surgery was performed to eliminate the sigmoid and abdominoperineal proctoplasty in these patients.In 14 patients, the stomas were to determine the position of the sigmoid colon, so a laparoscopic video-assisted abdominal-perineal proctyoplasty was performed without removing the stoma, which contributed to the improvement of the primary development of the neoanus after the operation and was highly reduced. Working in complications mode. At the clinical stage, patients underwent an operation to remove the sigmoid.

The following complications were observed in patients after surgical treatment for upper anorectal malformations; 3 patients had rectal mucosal prolapse; 3 patients had stoma evagination; 1 patient with purulent orchiepididymitis; 2 patients with cicatricial narrowing of the neoanus; in one patient the neoanus was outside the sphincter; 5 patients had fecal incontinence.

**Conclusion:**

1. The results of surgical intervention for anorectal defects are closely related to diagnostic, tactical, technical errors, as well as the type of defect and associated developmental anomalies.

2.Step-by-step treatment of advanced forms of anorectal defects and the use of modern minimally invasive methods can significantly reduce postoperative complications.



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