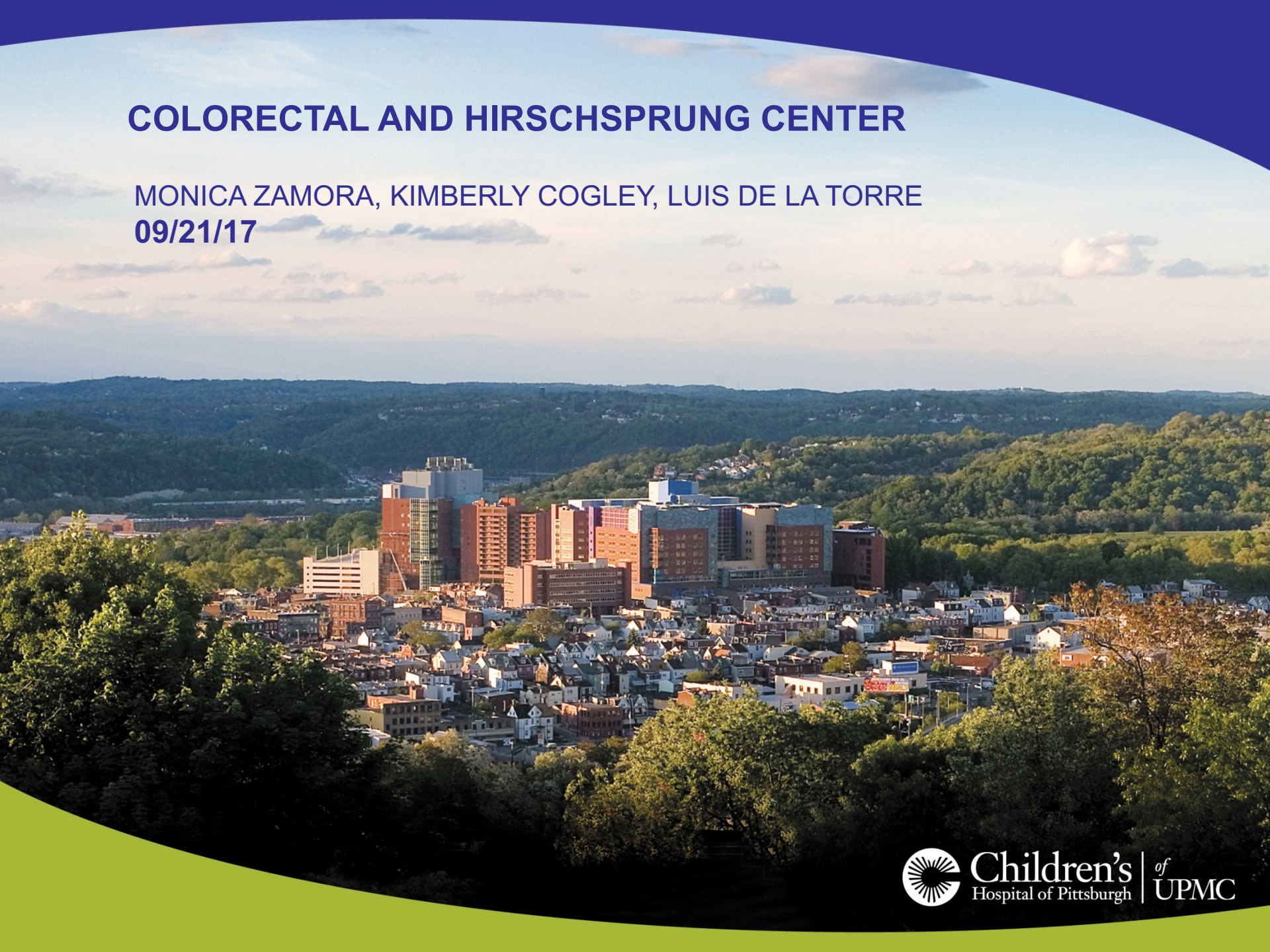


# COLORECTAL AND HIRSCHSPRUNG CENTER

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# History

**Male**

**3.7 kg**

**39 weeks**

**C-section**

**Mom history: gestational diabetes**

**Transferred to Children's: Day of life 5**

- Delayed passage of meconium**
- Bilious emesis**
- Abdominal distention**

# With this history, what would you do?

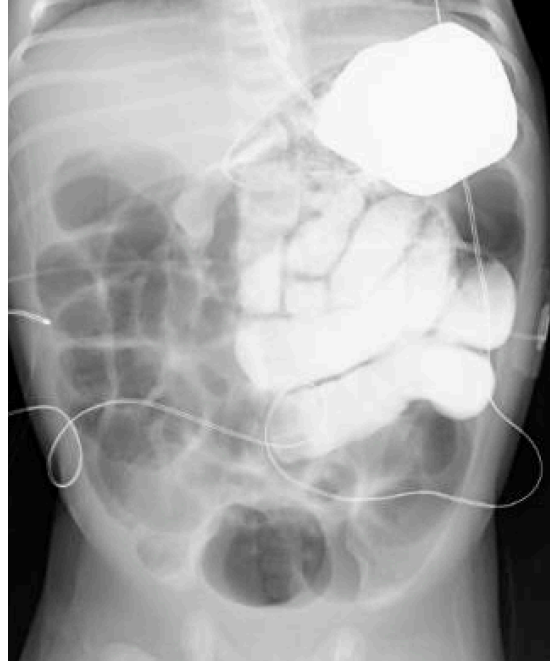
- A. Abdominal X-ray
- B. Abdominal ultrasound
- C. Upper GI
- D. Contrast enema
- E. CT scan
- F. Nasogastric tube
- G. All of the above



# Based on this image, what would your treatment be?

- A. Irrigations
- B. Rectal biopsy
- C. Upper GI
- D. Contrast enema
- E. Option A and B
- F. All of the above

# Upper GI Was Performed



**Is this UGI normal?**

# Suction Rectal Biopsy

## FINAL DIAGNOSIS:

Suction rectal biopsy, 1 cm and 2 cm

NERVE HYPERTROPHY AND AGANGLIONIC NERVE PLEXUS

ACETYLCHOLINESTERASE STAINING PATTERN IS ABNORMAL.

## TRANSANAL ENDORECTAL PULL-THROUGH

“...the dissection was continued proximally until we identified a transition zone based upon the muscular hypertrophy. The biopsy was taken at this point, approximately 15-cm from the dentate line, and the frozen section report returned the diagnosis of ganglion cells present” ...

Patient was discharged on Day 3 Post-op.



# PATHOLOGY

## Rectosigmoid colon, seromuscular biopsy (#1):

GANGLION CELLS PRESENT IN A MYENTERIC PLEXUS.

## Colon/rectum, pull through (14 cm) (#2):

HIRSCHSPRUNG DISEASE, 4.0 CM AGANGLIONIC DISTAL SEGMENT  
PARTIALLY GANGLIONATED TRANSITION ZONE (1.5 CM).  
PROXIMAL SEGMENT (8.5 CM) WITH GANGLION CELLS IN A  
MYENTERIC PLEXUS.

# Colorectal and Hirschsprung Center

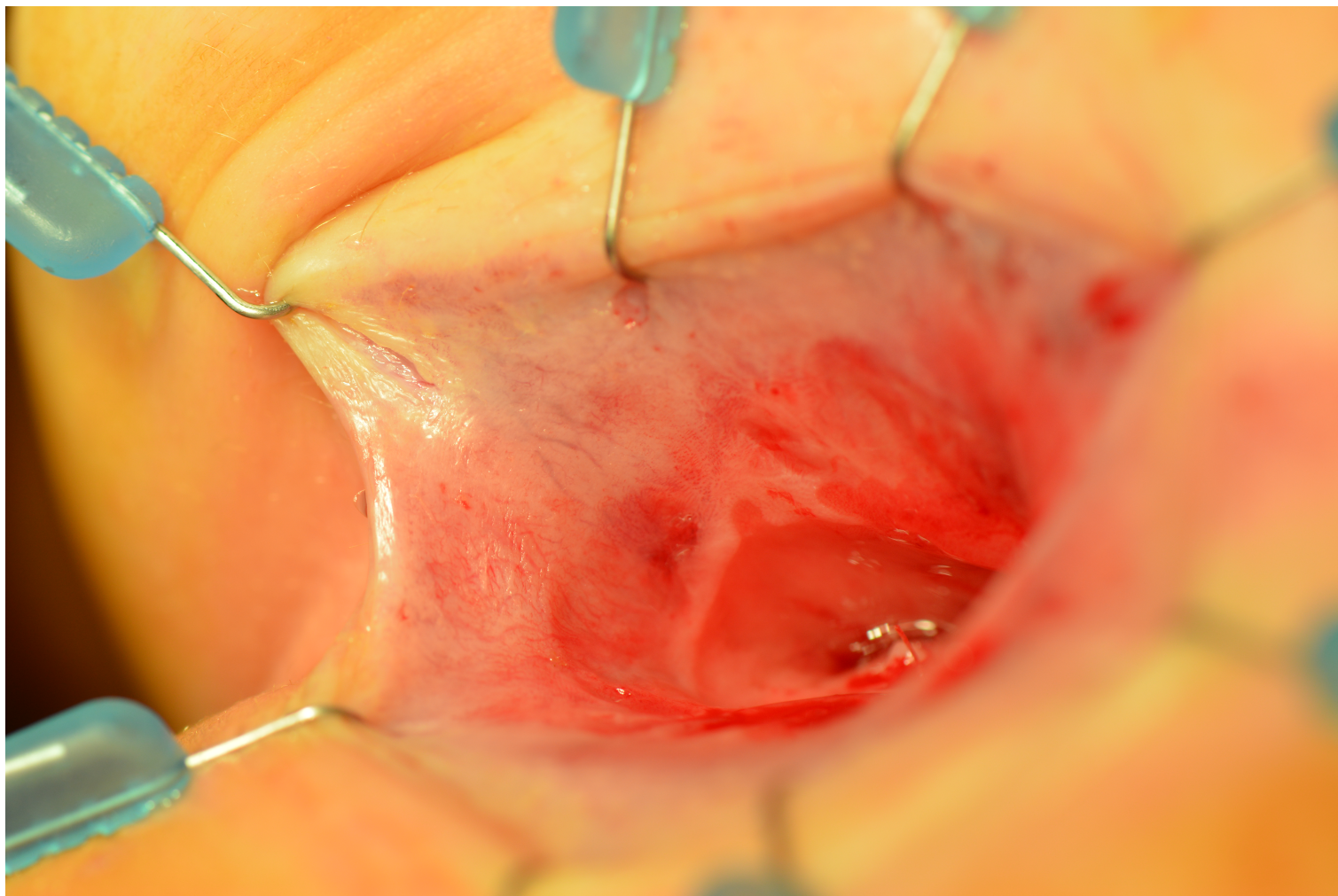
## Initial evaluation

- 6 years
- 14 to 20 bowel movements/day first 4 years of life
- 3 to 4 bowel movements day 4 – 6 years of life
- Most of them are involuntary bowel movements
- MTx Miralax® - prescribed by pediatric surgeon
- Never had colitis
- Physicians have affirmed that is because he is lazy

## With this information, what would you do?

- A. Abdominal X-ray
- B. Rectal biopsy
- C. Contrast enema
- D. Start laxatives
- E. Enemas
- F. Anorectal examination under anesthesia
- G. Option A, B, C, F

# Damage of the anal canal in 70% of its circumference



# CE: Pre- and Postevacuation



# Damage of the anal canal in 70% of its circumference

We placed a LoneStar retractor with 8 hooks in a symmetrical way. We were able to identify the anal canal.

- 12 to 3 o'clock-wise sewn - The anastomosis was done in the anoderm and over the pectinate line
- 3 and 6, anastomosis was done in the anoderm
- 6 and 9, anastomosis was done in the anoderm
- 9 and 12, anastomosis was done in the anoderm and pectinate line.

Then, we obtained a full-thickness rectal biopsy from the lateral wall.

With this information, what would your management be?

- A. Laxative trial
- B. Imodium
- C. Redo pull through
- D. Colostomy
- E. Appendicostomy

# Successful Bowel Management

- Family attended Bowel Management Workshop
- Colorectal enema 150-10-0-0 (4pm)
- Loperamide 8mg (Q12 – am dosing)
- Lomotil 10mg (Q12 – pm dosing)
- He was “accidents free for few weeks”

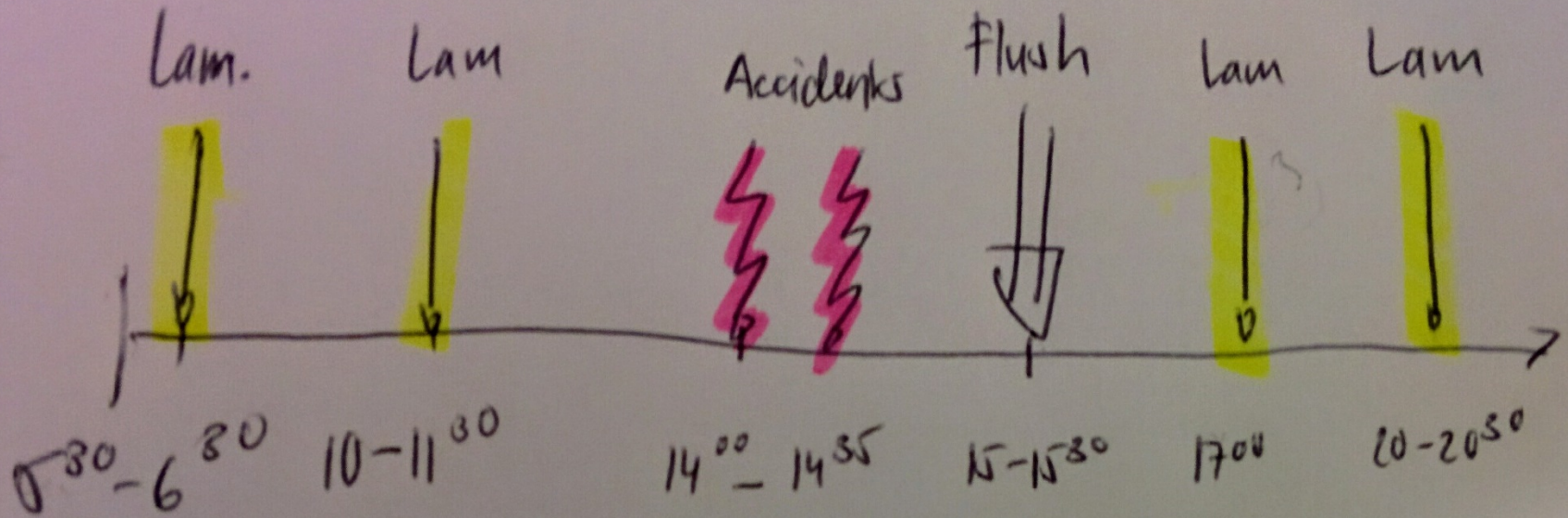


# Successful Bowel Management

Because mom noticed better response with Lomotil

- Lomotil 5tabs Q6 (50mg)
- Enema: 150-10-0
- “Miserable” diet: rice, chicken, banana, apple, toast, meat, no milk.

Patient accident free (30 days) but unhappy with food choices



Flush 150/10

Lam (2.5mg Tbs) 5Tbs 4x/day

# Unsuccessful Bowel Management

- **Additional foods added Q48 hours**
- **Patient started with accidents**
- **Slowly decreased food/fluid intake to starvation**
- **Admitted to hospital for dehydration**
- **Loss of 7 kg**
- **Poor body image**
- **Angers easily**

**\*Restarted enemas, miserable diet, behavioral health consult  
Lomotil 40 mg Q6 and added Loperamide 2 mg every day.**