IMPERFORATE ANUS PASSPORT

Patient name: _____

Date of Birth: _____

GP : _____

Consultant: _____

Contact details

Colorectal/ Stoma CNS
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Introduction:

This booklet was compiled by the Colorectal/ Stoma Clinical Nurse Specialists (CNSp) in Our Ladys Children's Hospital, Crumlin to give parents and professionals a guide to the treatment of Imperforate Anus. This booklet should be retained by the parent and used to keep track of their child's treatment.

It is a guide and should be treated as such. Each patient is an individual and specific care will vary. Please discuss any concerns you have with your nurse specialist or doctor.

CONTENTS

DEFINTION

Imperforate Anus or Anorectal Malformation (ARM) is where your child's anus (back passage) is absent, very tiny or in the wrong place. Arm occurs in 1 in 4,360 live births.

There are several variations of this condition and the severity depends upon where the bowel ends within the body. ARM can be divided into two groups:

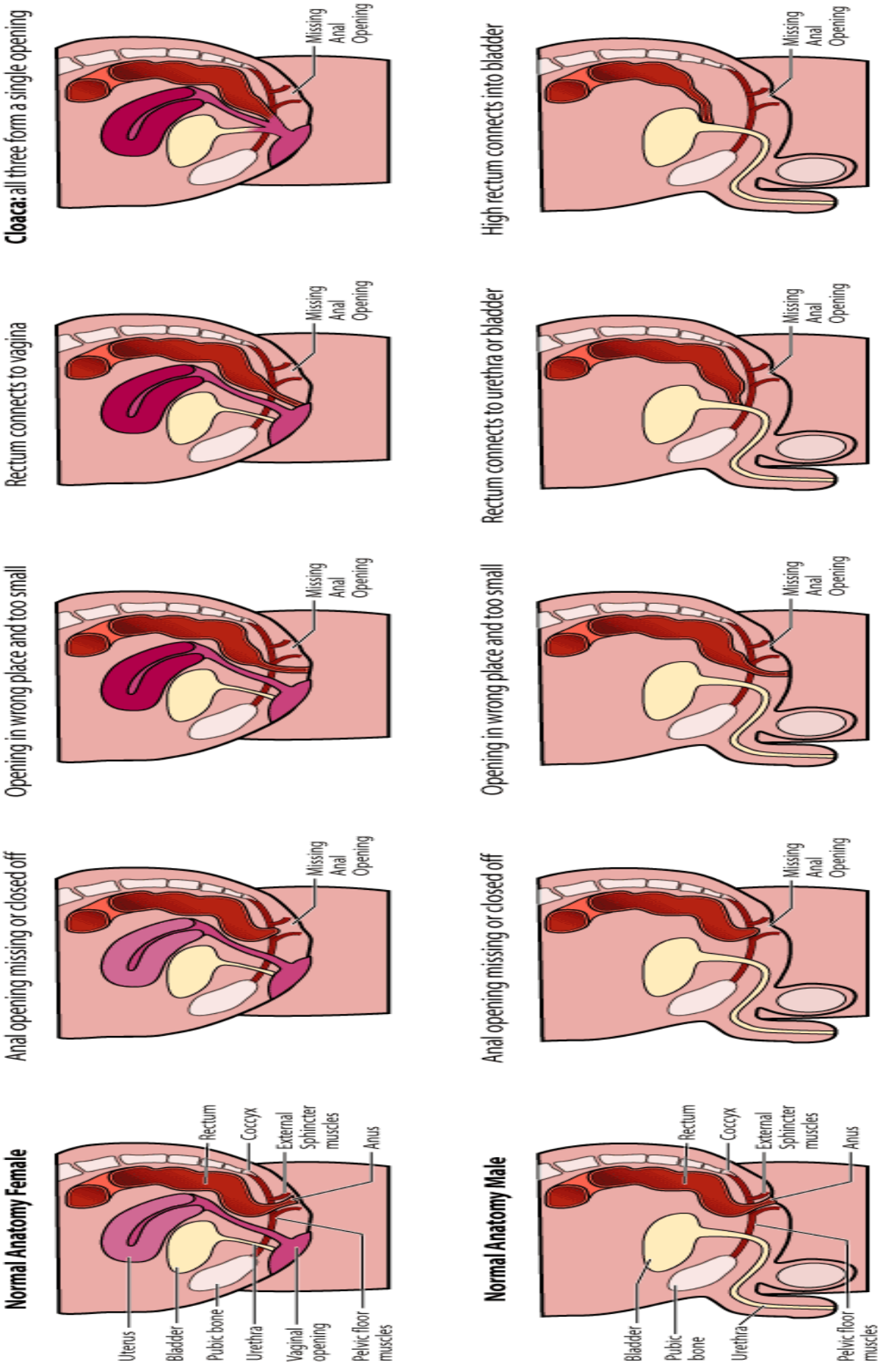
- Low ARM: This is where the bowel stops slightly short of where the anus should be, or the anus is present but small or in the wrong place. The corrective operation is called an 'anoplasty' or 'cut back' and may be performed soon after birth.

- High ARM: A high ARM may be more complex. The bowel ends with no opening (blind end) or there may be an abnormal tract (fistula) between the bowel and another part of the body. If a fistula is present it is usually between the bowel and the area just behind the vagina in girls and between the bowel and urethra or bladder in boys.

Associated problems:

40-50% of babies born with ARM have one or more associated problems involving:

- Genitourinary tract (renal tract)
- Vertebral (spine)
- Alimentary tract (gut)
- Cardiac (heart)
- Neural abnormalities which can affect the nerves to the bowel and bladder


Cloaca: all three form a single opening
Missing Anal Opening
Rectum connects to vagina
Missing Anal Opening
Opening in wrong place and too small
Missing Anal Opening
Anal opening missing or closed off
Missing Anal Opening
Normal Anatomy Female
Rectum
Coccyx
External Sphincter muscles
Anus
Uterus
Bladder
Pubic bone
Urethra
Vaginal opening
Pelvic floor muscles
High rectum connects into bladder
Missing Anal Opening
Rectum connects to urethra or bladder
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Anal opening missing or closed off
Missing Anal Opening
Normal Anatomy Male
Rectum
Coccyx
External Sphincter muscles
Anus
Bladder
Pubic bone
Urethra
Pelvic floor muscles

TREATMENT PATHWAY

Referral to OLCHC with? Imperforate Anus

↓

Decompress the bowel

↓

Stoma

↓

Posterior Sagittal Ano-Recto-Plasty (PSARP)

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Examination under Anaesthesia (EUA) 2-3 weeks post-surgery Dilatation (P) size determined

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Dilatations program 2-3 months

↓

Out Patients Department(OPD)

↓

Stoma closure

↓

Nappy care

↓

Wean dilatations

SURGERY

Correction of a high ARM may be done in three stages:

Stage One: at birth, your baby will need a colostomy to allow the stool out. Alongside the colostomy there will be a second opening called a mucous fistula. This is to connect the blind ended bowel that at the moment is not doing anything. Sometimes mucous will come out of this opening hence the name.

Stage Two: once your baby has gained weight and grown (approx. 3-6 months) a new anus will be made and the bowel will be pulled down and connected to this new anus. A couple of weeks after this procedure the anus will be checked and dilations commenced. You will be educated on how to do dilatations at home twice a day. Every 1-2 weeks you will go up a size until the desired size is reached. You will be given the set of dilators and linked in with the CNSp. The purpose of the dilatations is to ensure the new anus does not tighten (narrow down) and it is stretched to ensure it will be at the correct size for your child's age when the stoma is closed.

Stage Three: once the correct size has been reach with the dilator then the closure of the stoma and mucous fistula can be scheduled.

STOMA CARE

The word stoma comes from the Greek meaning mouth or opening. This allows the poo to come out and so will keep the bowel deflated**.**

There are 2 types of stomas:

1. **Colostomy**: A portion of the large bowel (colon) is brought out through the abdominal wall and is normally sited in the left lower side (iliac fossa). Any part of the large bowel (transverse, descending or sigmoid colon) may be used. A mucous fistula (passage) is also formed alongside or slightly away from the colostomy. This is the non-functioning part of the bowel, it will produce mucous, hence the name.
2. **Ileostomy**: A portion of small bowel (ileum) is brought out through the abdominal wall and is normally sited in the right lower side (iliac fossa).

Looking after the stoma:

It's important to remember that your child's stoma is painless. It may look red and sore but there are no nerve endings to pain in the stoma. Your nurse will teach you how to care for your child's stoma and with a little practise you will be able to change the stoma bag.

The stoma bag is an appliance made of special plastic designed to fit around the stoma to collect the poo and protect the skin around the stoma (peristomal skin). The bag will need to be changed every 2-3 days or sooner if it leaks. It will need to be emptied by the drainable end every 2-3 hours or when you change the wet nappy.

EQUIPMENT

- Warm water
- Gauze squares
- Remover spray & wipes
- Protective barrier spray or wipe
- Paste or seal if using
- Fresh bag cut to size (using template) & end closed

WHAT TO DO

- Wash hands
- Remove old bag using remover spray, gently pulling away from top end first
- Dispose of bag into a nappy sac
- Wipe off any residue or poo or glue with remover wipe
- Wash skin with warm water and gauze
- Dry skin with clean dry gauze
- Apply protective barrier
- Allow to dry
- Apply seal or paste if using right up against the stoma to protect the peristomal skin
- Check size of stoma bag hole before removing backing and if correct size remove backing and apply bag. Take your time making sure the bag is well adhered to the skin.
- Check that there are no creases in the base of the bag
- Dispose of nappy sac in domestic waste and wash your hands
- Apply nappy

Points to remember:

The stoma will change size in the first few weeks so the template for cutting the stoma bag will change.

The colour of the stoma will change when your child cries, it should return to a normal pink healthy colour when your child is settled.

If the bag leaks it needs to be changed. If this is a continual problem then your stoma nurse needs to review your child to overcome this problem.

If the skin around the stoma is getting sore you must contact your stoma nurse to prevent it getting any worse. It will initially be red when you take the bag off but this will disappear after a couple of minutes.

It is normal to see a small amount of blood on the gauze when you are cleaning the stoma. The stoma has a good blood supply and so this is a normal healthy sign.

Potential problems

Skin irritation:

When you remove the bag first you will notice the skin is red, this will calm down after a minute or two. This redness is from pulling the bag off the skin. However if the skin remains red and irritated looking there may be a reason why:

- The bag is leaking and poo is sitting on the skin causing the irritation.
- It could be due to an allergy to a product.
- Changing the bag too often or rubbing the skin too much to clean it can cause irritation.
- It the child is teething skin can become more delicate.
- Excess sweating.
- Fungal infection.

Call you CNS and arrange a review. These problems can be easily sorted.

Loose stool:

If you notice the poo is watery and has increased in volume please seek medical advice. Your child is at risk of dehydration and will need to be reviewed. Babies require a certain level of sodium (salt) in their body to utilise their feeds. If they have excess losses from their stoma they may be losing excess sodium and may have low sodium in their urine. They may show signs of poor or no weight gain. Your baby will need to have a blood and urine test to check sodium levels. Usually a supplement will solve the problem.

Prolapse:

This is when a bit more bowel comes out via the stoma. This can be alarming to see but as long as the bowel is pink and healthy looking and it continues to function it is not an emergency situation. This is a common problem.

The bag may need to be changed to a larger size to accommodate the larger stoma. Contact your Stoma CNS to arrange a review.

Retraction:

This is when the stoma is flush with the skin or sunken below skin level. Once the bowel is pink and healthy looking and it continues to function it is not an emergency situation. However, this can cause problems with bag leakages. Contact your Stoma CNS to arrange a review.

Pancaking:

This is when the stool collects around the top of the bag and does not drop down into the bag. It is caused by a negative vacuum in the bag itself. Try putting a few drops of baby oil into the bag or a piece of cotton wool. If there is a filter on the bag, partially cover it with the sticky tab supplied in the box.

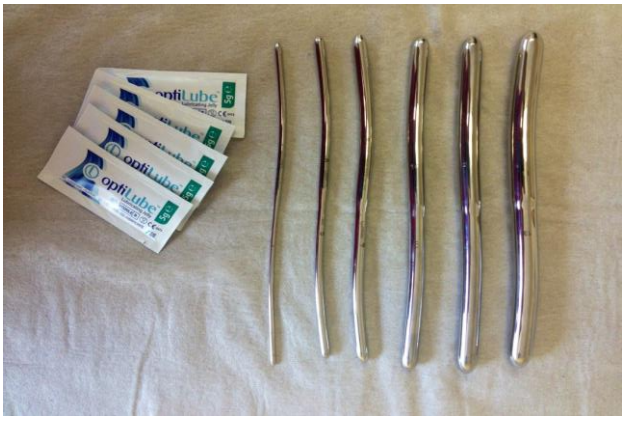
Ballooning:

This is when the bag blows up due to wind being passed into the bag and becoming trapped. The end of the bag needs to be opened to allow the wind out. If it is a problem you may need to change the bag that you are using. Contact your Stoma CNS to arrange a review.

Stenosis:

This is when the opening of the stoma narrows and leads to difficulty in passing stool. This can lead to abdominal pain and the stoma not working at all. You will need to seek medical advice. It is rare that this can happen.

DILATATIONS



You have been asked by your surgeon to perform anal dilatations for your child in order to stretch the anus.

The purpose of stretching the anus is so that your child will be able to pass stool (poo) when the stoma is closed.

A member of the surgical team will do the first anal dilatation and decide what size dilator to use and how far to insert it.

You will be shown by the CNS/doctor how to perform the anal dilatations when your child is in hospital.

This can initially be distressing for both parents and baby/toddler, but soon becomes less stressful as you become more confident and your baby/toddler gets used to it.

Dilatations need to be done twice a day, morning and evening. Length of time that you will have to do them will be advised by your surgeon. The **Anal Dilators** are supplied by the hospital. When you come to clinic they can be exchanged for the next sizes you will need.

EQUIPMENT

- Anal (**Hagar**) Dilator (appropriate size as directed by your surgeon)
- K-Y jelly
- Wipes
- Clean nappy
- Barrier cream

WHAT TO DO

- Collect equipment
- Wash hands with soap and warm water, and dry thoroughly
- Run hot water over the dilator for 2-3 seconds just to warm it up
- Ensure child is relaxed, comfortable and on a flat safe surface
- Remove nappy and clean buttocks
- Position child as you were shown in hospital
- You may need someone to help you hold your child to perform anal dilatations
- Apply K-Y jelly to the anal dilator, check size again.
- Hold dilator like a pencil between the fingers and thumb and insert anal dilator gently into anus to approx. _____ cms
- Gently press anal dilator down for about 5 seconds and when still pressing down slowly and gently remove dilator
- Dilators should fit snugly into the anus, but should not be forced
- Following anal dilatation, clean the infants buttocks thoroughly and apply barrier cream of choice
- Wash hands

CARE OF THE ANAL DILATATOR

- Wash anal dilator after each use
- Wash in warm soapy water
- Drying with a paper towel
- Store in a dry, safe place.

Anal dilators do not need to be sterilized.

POTENTIAL PROBLEMS

Bleeding

Your child may have a very small amount of bleeding following anal dilatation and/or some streaks of blood in their next poo after dilatation. This is quite common, especially if your child has had anal/rectal surgery.

If you notice a larger amount of blood than you have been advised is normal by your surgeon/nurse, **STOP** anal dilatation and contact the number provided or your GP where further advice will be given.

Pain

Your child may experience discomfort with anal dilatations usually when increasing the dilator size to larger sizes. This should subside over a few days as the anus stretches.

If you notice that your child is experiencing pain or great discomfort **STOP** anal dilatations and contact as above.

Insertion difficulties

If at any time during the anal dilatation you are having difficulty with inserting the dilator, **STOP**. Forcing the anal dilatation will cause pain.

The anus may have narrowed and you will need to go back to a smaller size. Contact the above number for further advice.

Dilatation Routine:

- **Size __ : From__/__/__ until __/__/__**
- **Size __ : From__/__/__ until __/__/__**
- **Size __ : From__/__/__ until __/__/__**
- **Size __ : From__/__/__ until __/__/__**
- **Size __ : From__/__/__ until __/__/__**

NAPPY CARE

Following Stoma closure and PSARP surgery your child may suffer from nappy rash due to frequent exposure to stool.

Nappy rash can vary from mild redness to severe skin damage. This can often cause the child to experience pain and discomfort.

"PREVENTION IS BETTER THAN CURE"

PREVENTION OF NAPPY RASH:

- Immediately after surgery ensure that a barrier cream is applied to your child's bottom
- Change your child's nappy as soon as possible following a bowel movement
- Clean your child's bottom thoroughly with warm soapy (non-perfumed) water and a soft cloth or water wipes. Try to avoid using standard **BABY WIPES**
- Apply barrier creams/paste/powder as directed by your Stoma/Colorectal CNS

HEALING NAPPY RASH:

- Clean your child's bottom gently with warm water
- and a soft cloth, and pat dry gently
- If cleaning with a cloth becomes too painful, using the shower to rinse off the poo can help
- Bath daily to remove all creams/ointments
- Following removal of creams or after bathing, exposing the child's bottom to the air can help "dry" the skin
- If skin is not healing or there is evidence of infection (bright red spots on bottom) it is advisable to have your GP/CNS check it as it may need treatment with an antifungal cream

RECOMMENDED TREATMENTS

- Ilex paste
- Metanium
- Orobase Paste
- 3 in 1 (mixture of vaseline, orobase + metanium- mix equal amounts of each together in a clean tub)
- Sudocreme / Bepanthen (used for mild irritation)
- It is advisable to apply a layer of waterproof barrier over creams/pastes **e.g. Vaseline**
- If skin is to "wet" and prevents creams/pastes from sticking a light dusting of **Caldesene / Orohesive** Powder may be advised by your CNS.
- **For treatment of a bacterial infection an antibacterial cream will be prescribed**
- **For treatment of a fungal infection an antifungal cream will be prescribed**

REMEMBER:

In the case of the following, it is advisable to apply a barrier cream/paste prophylactically to your child's bottom:-

- Teething
- Change of diet
- Diarrhoea
- Antibiotics/Laxatives

DIRECTONS FOR USING ILEX

- Clean your child's bottom as advised
- Firstly apply a non-sting barrier film product and allow to dry
- Apply a layer of **ILEX** over the area of bottom needing protection. Allow 30seconds to dry
- Apply a layer of **VASELINE** over the **ILEX** and surrounding skin to prevent the nappy from sticking to the **ILEX.**
- When cleaning, only the stool should be wiped off using a soft cloth and water leaving the **ILEX** intact.
- Reapply additional **ILEX** if required, then reapply **VASELINE**.(This is to minimize further trauma to the skin)
- The **ILEX** should be entirely removed once a day using a soft cloth with a good amount of mineral/baby oil or in the bath

REMEMBER

Removing **ILEX** more often or without the use of mineral/baby oil may inhibit the healing process.

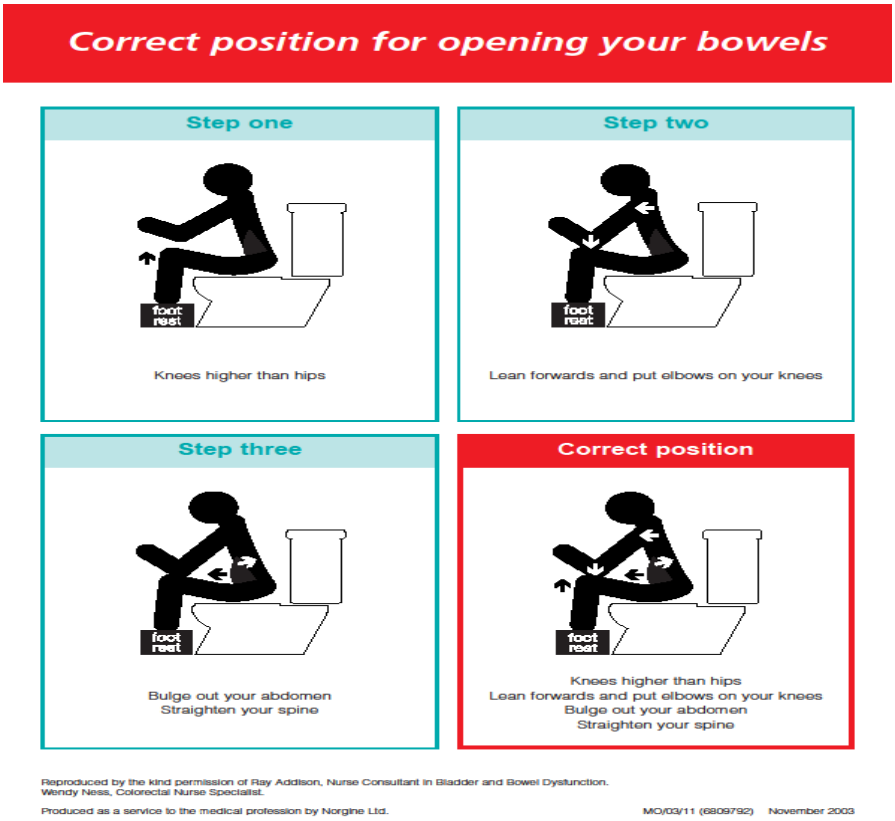
TOILET TRAINING

Choosing the right time to start toilet training is not always easy,especially if your child has had bowel surgery. Between the ages of 2 and 3 is usually a good time to start but each child is different.Things to consider when deciding if your child is ready for toilet training can include:

- Your child is emotionally ready (if the toddler is going through an aggressive or resistant phase..terrible 2's!!it is probably best to wait until this has passed.)
- Your child can understand simple instructions.
- Your child is able to sit and get off the potty with only a little help
- Your child can pull their pants up and down with a little help
- Have no major upheavals planned for at least a week to give a 'clear run' at toilet training.

TIPS FOR TOILETING

- Make sure the bathroom is warm and inviting! Close the windows and maybe put up some posters for your child to look at.
- Take advantage of the body's natural 'gastro colic reflex'. This is strongest in the morning and about 20-30 minutes after main meals.
- Try to keep to a routine, using the toilet around the same times every day and also when your child says they feel the need to go – always respond to the body's urge to poop!
- Stay with your child. Do not leave the child sitting on the toilet by themselves for long periods of time.
- Ensure the toilet is comfortable to sit on. Some children fear that they will fall into the toilet and so it is important to get an add-on seat for smaller children.
- A footstool is very important to ensure your child has good support for their feet.
- Put some toilet paper into the bowl first so that there is no splash back when a pooh is passed. Some children get a fright if there is a splash!
- When sitting on the toilet your child should be able to lean forward and rest their elbows on their knees with their knees higher than the hips
- Your child should be relaxed when sitting on the toilet and not straining.
- Talk to your child when following these steps so that they know what you are trying to achieve.



CONSTIPATION

Once all your Childs surgery has been completed, many families assume that their child will have no further problems. However we know from experience that the majority of children experience some degree of constipation or diarrhoea and have trouble establishing good bowel control following reconstructive surgery.

It is very important that you observe your Childs bowel habits and seek advice from your colorectal nurse or doctor if they are not having a regular poo or if the poo is becoming difficult to pass. If required a structured bowel management programme should begin early in order to prevent major problems developing at a later age. This includes the following:

- Fluid and diet diary
- Medication
- Toileting regime

DIFFERENT TYPES OF POO

The bristol stool chart is used to describe the type of stool your child is passing. It is important that you know what type of poo that is being produced as it can tell your doctor a lot. For instance, type 1 can indicate constipation as they are generally hard little lumps that look like rabbit droppings. Also some children will pass type 7 poo along with type 1 and this can be overflow diarrhoea with constipated stool. Involve your child with deciding what their poo looks like and keep it recorded in the diary section.

Type 3 & 4 are the ideal poo as they are soft and easy to pass.

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

FLUIDS & FIBRE

What goes in, must come out!

It is imperative that your child has a healthy well balanced diet. Take note over a few days of what your child is eating and drinking – are they honestly reaching the recommend fluid and fibre intake for their age? It can be difficult to achieve this but make small changes every day and gradually habits will change.

TIPS FOR INCREASING FLUIDS

- Encourage plenty of non-fizzy drinks for example, water, fruit juice and squash.
- Avoid excessive milk consumption as children can easily fill up with milk resulting in a poor dietary intake.
- For children who find it difficult to increase the amount they drink, try to include foods that contain high fluids e.g. gravy, sauces, soups, custard, jelly, ice lollies and fruit

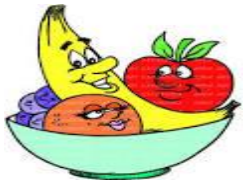
  For babies, try giving cooled boiled water between feeds**.**

Fluids

	Total water intake per day, including water contained in food	Water obtained from drinks per day
Infants 0 - 6 months	700 ml assumed to be from breast milk	
7 - 12 months	800 ml from milk and complementary foods and beverages	600 ml
1 - 3 years	1300 ml	900 ml
4 - 8 years	1700 ml	1200 ml
Boys 9 - 13 years	2400 ml	1800 ml
Girls 9 - 13 years	2100 ml	1600 ml
Boys 14 - 18 years	3300 ml	2600 ml
Girls 14 - 18 years	2300 ml	1800 ml

Fibre

HOW TO CALCULATE HOW MUCH FIBRE YOUR CHILD NEEDS:
Childs age in years + 5 grams for children over 2 years of age.
E.g: if your child is 7 years old, then you calculate it as 7 + 5 = 12.
Therefore a 7 year old should be eating 12 grams of fibre a day



TIPS FOR INCREASING FIBRE

Try to include some of the following fibre containing foods at each meal/snack:-

- Add linseed to breakfast cereals and yogurts (drink plenty of water if adding linseed to cereal)
- Wholemeal bread or Best of Both breads
- Wholemeal pasta and brown rice
- High fibre biscuits such as digestive, fig rolls, cereal and muesli bars
- Homemade muffins with wheat bran added
- Fruit and vegetables
- Pulses e.g. baked beans, kidney beans, chickpeas and lentils. These can often be added to Bolognese, soups, sauces, stews, casseroles for example.
- Potatoes and jacket potatoes with skin left on

A HIGH FIBRE AND FLUID DIET IS A HEALTHY DIET AND IS SUITABLE FOR ALL THE FAMILY.YOU SHOULD ENCOURAGE A REGULAR MEAL PATTERN AND INCREASE THE WHOLE FAMILY'S FIBRE AND FLUID INTAKE AT EVERY MEAL.

BY DOING THIS YOU WILL INCREASE THE WATER CONTENT OF STOOLS MAKING THEM SOFTER AND EASIER TO PASS.

The next few pages detail the amount of fibre in common popular foods. Try at least one new food a week and give it a few tries, don't give up after the first refusal, it can take a few attempts to develop a taste.

FIBRE CONTENT

BREAKFAST CERALS

Type	Portion	Fibre g's
All- Bran	Small bowl	7.2
Bran buds	Small bowl	6.6
Mini shredded wheat	Small bowl	3.4
Bran flakes	Small bowl	2.6
Raisin splitz	Small bowl	2.3
Muesli	Small bowl	2.0
Sultana bran	Small bowl	2.0
Weetabix	1 biscuit	1.9
Fruit 'n' fibre	Small bowl	1.4
Country store	Small bowl	1.2
Corn flakes	Small bowl	0.2

NUTS

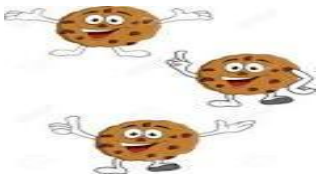
OVER 5'S ONLY DUE TO RISK OF CHOKING!

Type	Portion	Fibre g's
Peanut butter	Thickly spread	1.4
Almonds	6	1.0
Peanuts	10	0.8
Brazils	3	0.6

RICE & PASTA

Type	Portion	Fibre g's
Wholemeal spaghetti	3 tablespoons	3.1
Brown boiled rice	2 heaped tablespoons	0.6

BISCUITS & PASTRIES



Type	Portion	Fibre g's
Wholemeal scone	1	2.6
Cereal bar	1	1.0
Oat cakes	1	0.7
Jacobs fig roll	1	0.7
Cracker	1	0.4
Rich Tea	1	0.4
Digestive biscuits	1	0.3

BREAD

Type	Portion	Fibre g's
Wholemeal pitta	1 mini	1.8
Wholemeal	1 small slice	1.5
Brown	1 small slice	0.9
High fibre white	1 small slice	0.8
Hovis	1 small slice	0.8

VEGETABLE

Type	Portion	Fibre g's
Broad beans	2 tablespoons	7.8
Red kidney beans	2 tablespoons	4.3
Butter beans	2 tablespoons	3.7
Peas	2 tablespoons	3.0
Baked beans	2 tablespoons	3.0
Chick-peas	2 tablespoons	2.9
Potatoes (baked with skin)	1 small	2.7
Corn-on-the-cob	1	2.7
Broccoli Tops (raw)	2 spears	2.4
Carrots	2 tablespoons	2.0
Spinach	2 tablespoons	1.7
Lentils split (boiled0	2 tablespoons	1.5
Potatoes (new)	2	1.2
Oven chips	Small portion	1.2
Cabbage	2 tablespoons	1.1
Leeks	Stem	1.1
Sweetcorn (canned)	2 tablespoons	0.9
Turnip	1 tablespoon	0.8
Beetroot	4 slices	0.8
Tomatoes (Raw)	1 small	0.7

FRUIT

Type	Portion	Fibre g's
Pear	1 medium	3.3
Dates (dried)	5	3.0
Avocado	½	2.6
Prunes (dried)	5	2.3
Orange	1 small	2.0
Blackberries	10	1.5
Melon-cantalope	1 slice	1.5
Apple	1 small	1.3
Fruit cocktail	Small bowl	1.2
Kiwi fruit	1 medium	1.1
Banana	1 medium	1.1
Peach	1 medium	1.1
Raspberries	10	1.0
Pineapple	1 large slice	1.0
Grapefruit	½	1.0
Mango	1 slice	1.0
Strawberries	5	0.7
Grapes	10	0.6
Raisins	1 tablespoon	0.6
Tangerine	1 small	0.6
Plum	1 small	0.5

BOWEL MANAGEMENT

Despite good fluid and diet intake sometimes some children with Imperforate Anus may still suffer with soiling and/or constipation. This is uncommon but it can be a major source of stress for the child and parents. With early assessment and intervention the child can be socially clean and free from constipation and soiling.an individualized bowel management program will be put in place once you have met the Colorectal Surgeon and your Colorectal/Stoma CNSp.

Every bowel management program requires patience, dedication and time. Your child will be followed closely by your CNSp and effort will be required you and your child.

Initially as part of the assessment you and your child will be required to fill out a detailed fluid, diary and bowel chart for a period of time.

Once the assessment is completed your child's bowel management plan will be devised with you and your child's input.

In addition to toilet training routines there are three main bowel management options:

- **Medication**
- **Transanal irrigation**

A combination of these options may be appropriate for your child

MEDICATIONS FOR CONSTIPATION

There are a variety of medications/laxatives that the doctor may prescribe for your child to help treat their constipation. These medications may need to be taken regularly for some time before your child's bowels return to normal. They will not make your child's bowel "LAZY".

The types of laxatives available for children are divided into different groups depending on how they work:

BULK-FORMING LAXATIVES

- Used if fibre intake is low
- Increase size of stool so stimulating peristalsis
- Must have an adequate fluid intake
- Do not take before bedtime
- Once mixed with water , drink immediately
- Used in management of haemorrhoids & anal fissures
- E.G: Fybogel (over 6years of age only)

STIMULANT LAXATIVES

- Stimulant laxatives which stimulate contractions of the muscles in the bowel, shortening the time it takes stool to pass through the bowel.
- Some can take 8-12 hours to work
- E.G: Senna (Senokot), Bisacodyl (Dulcolax), Docusate Sodium, Glycerol, Sodium Picosulphate

STOOL SOFTENERS

- As the name suggests, these products ease the process of passing stool by softening the stool and lubricating its passage through the anus.
- E.G. Liquid Paraffin, Olive Oil Enema

OSMOTIC LAXATIVES

- This group of medications work by drawing fluid from the body into the bowel or by retaining the fluid it is taken with, so softening and increasing the bulk of the stool.
- Some of these medications can take 24-48 hours to act.
- E.G: Lactulose, Macrogols (Movicol), Magnesium Salts, Phosphates (Fleet), Sodium Citrate (Micolette Micro-Enema)

PLEASE KEEP MEDICATIONS LOCKED AWAY FROM CHILDREN IN A SAFE PLACE

IFYOU ARE CONCERNED ABOUT THE EFFECT OF LAXATIVES ON YOUR CHILD AT ANY TIME YOU SHOULD CHECK WITH YOUR DOCTOR.

DO NOT STOP MEDICATIONS WITHOUT CONSULTING YOUR HEALTHCARE PROVIDER

TRANSANAL IRRIGATION

Transanal Irrigation is simply a way to empty the rectum so to keep your child socially clean i.e. to remain free of soiling accidents. The aim of the irrigation is to do the washout daily with a solution of water, salt and sometimes a stimulant medication to stimulate the bowel and empty it of stool. This washout is performed on the toilet.

There are three different types of equipment that may be used to perform this irrigation:

- The Willis System
- Peristeen
- Braun Iry Pump

With the help of your CNSp you and your child will decide which equipment suits your child best.

You will be given specific instructions on the type of washout equipment your child will be using.

POTENTIAL PROBLEMS

- **BLEEDING:** slight bleeding after the washout can occur and this can be due to local trauma. Ensure you are lubricating the cone or catheter adequately and never use force to insert. If bleeding is perfuse STOP WASHOUT and SEEK MEDICAL ADVICE IMMEDIATELY.

- **POOR RESULTS:** this can be due to a build-up of stool in the rectum so contact your CNSp to discuss same. You may need to adjust volume and type of fluid for washout or commence on a laxative.

- **SOILING BETWEEN WASHOUTS:** frequency or volume of washouts may need to be adjusted, contact your CNSp.

- **FEELING FAINT DURING WASHOUT:** this may be due to the stimulant added to your washout or the fluid going in too quickly. Discuss with your CNSp.

- **BOREDOM:** sitting on the toilet for a long period of time can become boring for kids. Organise something for them to do at this time, homework, play a board game etc. make sure they don't feel shut away and might like to leave the bathroom door open.

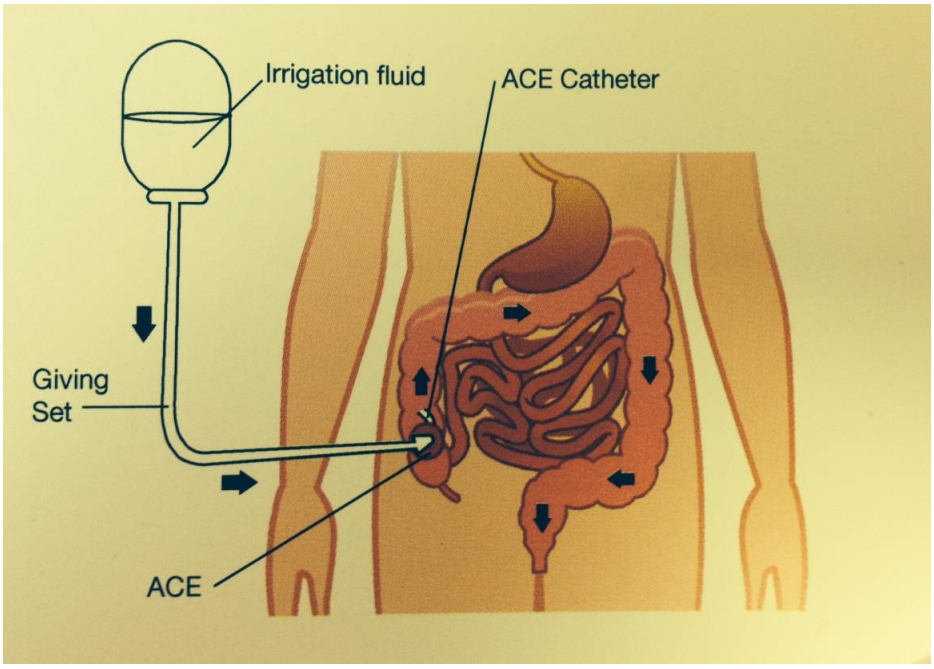
ANTEGRADE CONTINENCE ENEMA

The A.C.E (Antegrade Continence Enema) is another method of washing out the bowel via a catherisable channel between the abdomen and the bowel. This method may be chosen for independence, so your child can do their own washout with more ease.

This technique was first devised in 1990 by Mr P Malone and so sometimes maybe referred to as the Malone or MACE procedure.

The catherisable channel is made from a piece of either tissue from the appendix or the small bowel. It is usually on the right hand side of the abdomen or can sometimes be in your child's belly button.

After the operation, a catheter is left in the new channel for 4-6 weeks so to allow the tract to heal and prevent it from closing over. This catheter will be used for your child's washouts until it is due to be removed. Washouts will be recommenced 2-3 days after your child's operation, as per the surgeon's instructions.



You and your child will be shown how to do this washout in the hospital before discharge home by your CNSp. You will be given written instruction on how to do it and will be followed up weekly by your CNSp via telephone. You will return with your child to see the surgeon in the OPD 6-8 weeks after your surgery.

POTENTIAL PROBLEMS

- **SORE OR WEEPING AROUND THE SITE:** please seek medical advice.

- **POOR RESULTS:** this can be due to a build-up of stool in the rectum so contact your CNSp to discuss same. You may need to adjust volume and type of fluid for washout or commence on a laxative.

- **SOILING BETWEEN WASHOUTS:** frequency or volume of washouts may need to be adjusted, contact your CNSp.

- **FEELING FAINT DURING WASHOUT:** this may be due to the stimulant added to your washout or the fluid going in too quickly. Discuss with your CNSp.

BOREDOM: sitting on the toilet for a long period of time can become boring for kids. Organise something for them to do at this time, homework, play a board game etc. make sure they don't feel shut away and might like to leave the bathroom door open.

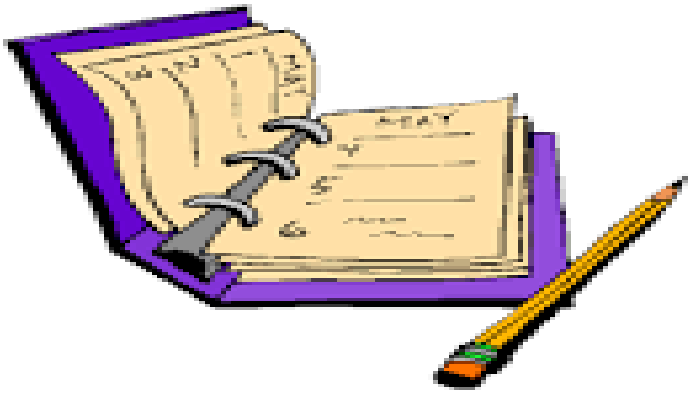
KEEP A RECORD OF IMPORTANT DATES

Procedures	
Biopsy	
Stoma	
Pull thru	
Stoma Closure	

OUT PATIENTS	
Name	**Date**

YOUR QUESTIONS

DIARY



☺ Update diary daily with your child, encouraging them to participate

☺ It is easier to see a change in pattern when it is written down

☺ Be truthful about how much they are drinking and eating

☺ Use the Bristol Stool Chart to document types of poo.

DAY &TIME	FIBRE AMOUNT	FLUID AMOUNT	TYPE OF POOH	MEDICATION TYPE & AMOUNT

DAY &TIME	FIBRE AMOUNT	FLUID AMOUNT	TYPE OF POOH	MEDICATION TYPE & AMOUNT

DAY &TIME	FIBRE AMOUNT	FLUID AMOUNT	TYPE OF POOH	MEDICATION TYPE & AMOUNT

…….where children's health matters

DAY &TIME	FIBRE AMOUNT	FLUID AMOUNT	TYPE OF POOH	MEDICATION TYPE & AMOUNT

Developed by Ann Costigan & Stephanie Orr,
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