

Colostomy in Paediatric Practice: Observations at the University Benin Teaching Hospital, Benin City

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SUMMARY

A survey of 38 colostomies done in children in the University of Benin Teaching Hospital during a ten-year period, 1976 to 1985, has revealed significant emotional and economic problems relating to the care of the colostomies, such as the psychological effect of the colostomy and the difficulty of acquiring colostomy appliances. Because of these problems, there is a trend towards early primary definitive surgery.

Introduction

COLOSTOMY is a surgical procedure done for ano-rectal and distal colon pathology such as congenital ano-rectal anomalies and Hirschsprung's disease. It is mostly a temporizing measure while awaiting optimum time for a definitive surgery; it is then closed after some period following the definitive surgery.¹ It is important to observe the attitude of the patients and their parents towards colostomy.^{2 3} The aim of this study was to find out the complications and the attitudes and problems encountered by parents in this environment and make proposals which could improve results of treatment of those conditions for which colostomy is normally done.

Materials and Methods

The clinical data of all the children who were treated with colostomy in the University of Benin Teaching Hospital between January 1976 and December 1985 were studied. Follow-up records were then analysed for the clinical progress of the child, the time of definitive surgery, and the time of closure of the colostomy. By means of questionnaires, the care, problems and attitude towards colostomy among parents of the children who had colostomy were determined.

Results

Thirty-eight colostomies were carried out during the 10-year period. Nineteen of these were for imperforate anus, 15 for

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Hirschsprung's disease and 4 for other acquired ano-rectal pathology. Twenty-six of the colostomies were done in neonates, consisting of all the 19 colostomies for imperforate anus and 7 for Hirschsprung's disease; 7 other colostomies were done in those aged 5 weeks to 11 months, and 5 in the age group above 1 year (Table 1).

12 year old boy who had had sacral myelomeningocele closure as a neonate. The third was a 10-year girl with sacral agenesis; she has severe incontinence of both faeces and urine; she has refused colostomy and is still being followed up.

The complications associated with colostomy comprised 3 gross types. Excoriation of

TABLE I
Indications for Colostomy

Indications	Age			Total
	0-4w	5w-11m	1-15yr	
Imperforate anus	19	—	—	19
Hirschsprung's disease	7	5	3	15
Other colo-rectal pathology	—	2	2	4
Severe faecal incontinence	—	—	1	—*
	26	7	6	39

* the patient did not have a colostomy
w - weeks
m - months

Of the 19 cases of imperforate anus, 9 (47.4%) did not return for further treatment; 10 had definitive pull-through operation and colostomy closure was done during the same operation in 1 case; in the remaining 9 patients closure of the colostomy was not until 4 to 6 weeks after the definitive surgery. Six of the cases of Hirschsprung's disease have had definitive surgery and closure of colostomy, and 5 are still being followed up, awaiting definitive surgery. The other 4 (26.7%) were lost to follow-up.

There have been 3 cases in whom permanent colostomy had been indicated. One was for intolerable faecal incontinence in a 12-year old boy who had a mismanaged Hirschsprung's disease resulting in vesico-rectal and unretrorectal fistulae, chronic pelvic inflammation, and another was a

peristomal skin was most common (31 cases or 81.6%). Prolapse of colostomy was less frequent (20 cases, 52.6%) but caused anxiety to the parents; 8 had single episodes, it was frequent in 10 cases and 2 were irreducible requiring surgical intervention. Ulceration of the mucosa was noted in 5 cases (Table II).

Questionnaire response revealed that major problems experienced by parents were on acquisition and management of colostomy appliances (Table III). Standard colostomy appliances were not available and patients therefore had to improvise various cellophane sheets and bags, which was unpleasantly messy, and even with assistance from home-visiting nurses many parents had difficulty in coping. Emotional problems expressed included the tendency for parents to

TABLE II
Complications of Colostomy

Complication	No. of cases
Excoriation of peristomal skin	31
Prolapse	20
single, parents coped and reported	8
frequent, parents reported	10
irreducible, requiring surgical intervention	2
Ulceration of stomal mucosa, with or without bleeding	5

TABLE III
Problems encountered by 38 parents in managing Colostomies

Problem	No. of Parents
Difficulty in procuring colostomy appliances	33
Care unpleassantly messy	21
Difficulty with using improvised appliances	13
Severe complications of Colostomy	13
Other relatives reject colostomy	11
Difficulty with use of standard colostomy appliances	10
Cannot improvise any form of appliances	6
personal rejection because colostomy is strange	6
Unable to cope, requiring assistance frequently	5
Child emotionally unhappy with colostomy	3
Playmates reject child	2

seclude the patient from relatives and playmates. Complications reported were well attended to and did not seem to be major problem.

Discussion

The social stigma attached to diseases is adverse, and is worse still when an obviously abnormal situation of colostomy is created. The idea of colostomy sounds strange and odd when explaining the indication for colostomy to parents. Colostomy is nearly always temporary in neonates with

congenital diseases and even in older children when it is indicated.⁴ The length of time the parents have to cope with caring for the colostomy causes a lot of anxiety.

High ano-rectal anomalies comprise the most frequent indication for colostomy. Reports from Home-visiting nurses on patients who do not return for definitive surgery and follow-up indicate the non-acceptance of colostomy, and the children are neglected and die. The wide range of problems expressed by parents and the frequency of request for medical supervision indicates the anxiety surrounding colostomy. There were

relatively few incidences of complications requiring surgical revision of the colostomy.

Because of the obvious difficulty associated with care of colostomy, this author believes that many of the cases for which colostomy are being done can be treated by primary definitive surgery, without preliminary colostomy. The practice by So, Schwartz, Becker, Daum and Schneider of definitive surgery without preliminary colostomy in the treatment of Hirschsprung's disease is worth emulating.⁵ All low varieties of ano-rectal anomaly can be treated with primary definitive surgery. Many high varieties can also be treated with primary pull-through procedure.⁶ When preliminary colostomy is indicated, the definitive corrective surgery should be done early

to reduce the inconvenience and burden of inadequate facilities for the care of colostomy.

References

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