Anorectal malformations

DIAGNOSIS

- If the patient does not have a normal anus in the normal position an anorectal malformation is present.
- A decision must be made about the level of the abnormality to decide if a colostomy or anoplasty is necessary.
- Remember: If a patient has one abnormality, look for others and exclude life-threatening anomalies.
- Massive abdominal distension which is interfering with breathing, can be present in boys and may necessitate urgent surgery.

DIFFERENTIAL DIAGNOSIS OF NEONATE NOT PASSING STOOLS

- Anorectal malformation
- Small bowel atresia
- Meconium plug syndrome
- Hirschsprung's disease
- Other causes of neonatal bowel obstruction
  eg malrotation and volvulus, anular pancreas

CLINICAL EVALUATION

MALES

- Examine the perineum for anal opening, covered anus or anocutaneous fistula along the median raphe. If present, the lesion is 'low': plan for anoplasty
- If there is meconium in the urine or on the urethral meatus: Lesion is 'high' with a fistula. Clinically a flat underdeveloped bottom. Usually needs a colostomy.
- 95% of boys present with 'high' lesion

FEMALES

95% of females present with low lesion: anal stenosis, anterior displaced anus or recto-vestibular fistula(opening in posterior rim of the introitus)

How many orifices can be seen?

Three: 'Low' lesion, can often be dilated to provide temporary relief of obstruction.
Two: Recto-vaginal fistula with opening above hymen
One: Cloaca. Always require a colostomy, lesions can be very complicated

RADIOLOGICAL EVALUATION

- "Invertograms" are rarely necessary, to obtain best information a proper investigation should be done at the tertiary institution after first day of life.
- Ultrasound gives an accurate indication of level of the malformation.

OPERATION

- Operation is urgent if the child has intestinal obstruction, contact us ASAP.
- There is mostly time to assess associated abnormalities and optimise the patient.
- Females with low lesions can usually be managed initially non-operatively. Contact us during the day to make appointment at the clinic.
- 'High' lesions require a colostomy and at age 4-6 weeks an anorecto plasty with a posterior saggital approach(PSARP).
- 'Low' lesions mostly need perineal operation without colostomy