SUMMARY

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ANATOMICAL SPOTLIGHTS:-

Rectum:- Continues with the Sigmoid colon upward; downward it is distended to form the rectal ampulla. In normal conditions, it is empty, while the Sigmoid colon acts as fecal reserviour. Passage of feces stimulates the desire to defecate.

Anal Canal:- Begins at the lower end of the rectal ampulla, ends with the anus.

Sphincteric System:- External and internal sphincters keep the anal canal and anus closed. External sphincter can be voluntarily contracted and more firmly acclude the anus.

Innervation:- Two systems.

1/Intrinsic:-

a: Myentric or Aurbach's plexus controls the gastrointestinal tract movement.

b: Meissener's plexus which controls the gastrointestinal secretions.

2/Autonomic:-

a: Parasympathetic: from 1,2,3 sacral, the postganglionic fibres are part of Aurbach's plexus.

b: Sympatheic: from T8 - L3 external sphincter is supplied by Pudental branch (S 2,3).

Bowel Training:- The ability to control bowel is influenced by both neurological and psychological maturation. There is wide variations to control bowel movement, but most of children gain bowel control between 2-3 years.

Bowel Habits:- 96% of children fall within the range of opening their bowel between 3 times per day and every other day. Disturbance of bowel habits in children compromise chronic constipation, fecal incontinence, encopresis and Toddler's diarrhea.

I/ CONSTIPATION:- The most common causes are:

1- Idiopathic 2- Hirschsprung's disease which is the most common organic cause. It is congenital anomaly in which there is partial to complete colonic obstruction with absence of intramural ganglion cells in the distal alimentary tract.

3- Any other lesions causing painful defecation may lead to holding up with consequent constipation and fecal impaction.

4- Psychogenic.

Whatever the cause of constipation, it will lead to fecal impaction.

Treatment of chronic fecal impaction:-

1- Evacuation

2- Effective stool softening

3- Patterning: Developing the habit of normal daily defecation.

III/ FECAL INCONTINENCE:- It means passage of stool in socially inappropriate setting after 5 years.

Causes:- 1- The most frequent form of acquired fecal incontinence is that caused by fecal impaction.

2- Myelomeningeocele is the commonest congenital abnormality resulting in fecal incontinence.

Diagnosis:- 1- History 2- Rectal examination.

3- Manometric studies to asses the sphincteric function.

Management:- 1- Regular emptying of the rectum by using rectal suppositories or enema in cases where the patient fail to feel stool in contact with the anal canal.

2/ Biofeedback Training:- The goals of this training is to increase strength of the external sphincter contraction and to teach the patient to detect and respond to small volumes of rectal distension.

3/ Treatment of constipation and habit training in cases of fecal incontinence due to fecal impaction.

III/ ENCOPRESIS:- It is the repeated involuntary passage of stool without presence of organic cause, it indicates severe psychological troubles.

Management:-

1. About one-fourth of cases have associated constipation and fecal impaction, so reduce impaction by using laxatives or enema.

2. Combined treatment of catharatics and possible management technique, in which there is reward on

successful bowel movement and mild punishment on failure of bowel movement.

IV/ DIARRHEAL DISORDERS:-

1- Toddler's diarrhea or may be called irritable bowel syndrome of infancy. It occurs with mild psychopathology, it is considered as mild psychosomatic disorder, self-limited disorder. Such patients depend upon the strength of anorectal angulation to maintain continence, failure of either mechanisms resulting in fecal incontinence.

2- Psychogenic diarrhea:- Accompaning periods of nervous tension. Excessive stimulation of parasympathetic result in increase motility and secretion of mucus with consequent diarrhea.