



Реабилитация детей детского возраста с проктологическими аномалиями

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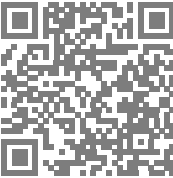
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Резюме

Материал и методы. Проведен анализ более 240 наблюдений. Больные условно подразделены на три группы 1) первичные с гладким послеоперационным течением, 2) повторные с различного рода осложнениями, требующими реоперации, 3) имеющие «регионарные» сочетанные аномалии мочеполовой системы, крестцово-копчиковой области и др. Особую группу составляют больные с сочетанными пороками развития.

Цель работы: Целью работы является оценка эффективности реабилитации больных детского возраста с проктологическими аномалиями.

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Заключение. В большинстве случаев это так называемые регионарные пороки мочевыводящих путей, крестцово-копчиковой области. Индивидуальное внимание следует уделить вопросу социальной адаптации и реабилитации детей, страдающих пороками развития толстой и прямой кишок. Реабилитация проктологических больных детского возраста — это комплексная медико-социальная проблема, которая требует интеграции знаний и действий специалистов многих служб, подчиненных различным ведомствам.

Ключевые слова: Аноректальные дефекты, анус, кишечник, восстановление



Rehabilitation of Pediatric Patients with Proctological Anomalies

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Summary

More than 240 observations were analyzed. Patients are conditionally divided into three groups: 1) primary with a smooth postoperative course,

A special group consists of patients with combined developmental defects. In most cases, these are so-called regional defects of the urinary tract, sacrococcygeal region.

Individual attention should be paid to the issue of social adaptation and rehabilitation of children suffering from malformations of the colon and rectum.

Rehabilitation of proctological patients of childhood is a complex medical and social problem that requires the integration of knowledge and actions of specialists from many services subordinate to various departments.

The aim of this work: The purpose of this work is to evaluate the effectiveness of the rehabilitation of pediatric patients with proctological anomalies.

Keywords: Anorectal defects, anus, intestines, recovery

Diseases of proctology vary completely in child than in adults. The main group of problems that require more complex treatment are developmental defects. Some of them appear and require correction in the first hours and days of the baby's life, while others may require intervention at later stages. There are situations when developmental defects in the area of the anorectal opening and the genitourinary system are combined (up to 35–40% according to our observations and literature data), and sometimes it is difficult to distinguish between the concepts of "proctological, urological" or "gynecological" patient [1, 9, 14]. A significant number of children born with malformations of the colon and rectum have noticeable deviations in their psychological development. Sometimes in the child's environment (family, preschool, school), an overly gentle attitude towards him is formed, which causes the development of feelings in the child own inferiority. Therefore, it is necessary to implement a system of rehabilitation measures, including medical and social rehabilitation. The main objectives of rehabilitation are surgical correction and conservative treatment (follow-up treatment), educational influence, vocational guidance, and ensuring adequate participation in social and work life.

The program of this study includes the study of immediate and long-term results of surgical treatment of sick children up to 20 years from the date of surgery, assessment of their health status, living conditions, organization of their medical care.

The result is based on an analysis of more than 240 observations. Patients are conventionally divided into three groups: 1) primary with a smooth postoperative course, 2) repeated with various kinds of complications requiring reoperation, 3) with "regional" combined anomalies of the genitourinary system, sacrococcygeal region, etc.

There were 108 children in the primary group with a smooth postoperative course, 60 of whom were operated on by us for the disease. Hirschsprung and 48 regarding atresia of the anus and rectum [6, 13]. Observations have shown that despite the absence of technical errors and complications after the surgical period, good long-term results are not observed in all cases; in approximately 26% of cases, various types of functional disorders remain, mainly episodic constipation and fecal incontinence; careful analysis of these cases made it possible to establish that residual functional impairments are not fatally inevitable and can be prevented (at least sharply reduced) with the help of rehabilitation measures [7, 8, 15].

Thus, in case of Hirschsprung's disease after a radical operation that eliminates the cause of the disturbance in the passage of intestinal contents, one cannot fully count on the spontaneous adaptation of the colon and its obturator apparatus to normal conditions [3, 13, 16]. At least three points must be taken into account: 1) in many patients a significant part of the colon remains unrecovered, sometimes functionally inferior, 2) a significant number of patients from birth do not have the ability to empty their bowels independently, that is, they do not develop the appropriate reflex mechanisms for defecation 3) with radical surgery, a section of the functioning colon is transferred to the site of the non-functioning rectum, which should subsequently perform the functions inherent in the rectum [4, 8, 12]. These factors determine the need and goals of rehabilitation treatment in the postoperative period [5]. The process of restoring the normal urge to defecate, training the newly formed rectum and its obturator apparatus is carried out simultaneously. The set of rehabilitation measures we have developed is as follows:

Within 10–15 days after discharge, warm microenemas are given every other day with a weak solution of potassium permanganate, and after the anastomosis is strengthened and the consequences of surgical trauma to the peri-rectal space disappear, they proceed to training cleansing enemas. The procedures are carried out simultaneously, preferably in the morning after breakfast, alternating warm and cool water procedures. Patients are recommended to take two or three courses of 15–20 days in a row with a break of one month between courses [7, 8, 15]. In this case, it is necessary to do retention exercises: the child is forced to empty the intestines not immediately, but in portions. The diet should be easily digestible, devoid of spicy foods and excess fiber. 2–3 months after discharge, physiotherapeutic procedures including electrical stimulation of the perineal muscles are prescribed. UHF, use of device type STIM-1. In total, postoperative treatment takes up to 6 months. In most cases, it achieves the main goal of normalizing bowel movements. If there is no complete effect, the treatment is repeated. Subsequently, the diameter of the colon normalizes, sometimes over a period of 3–5 years or more. It should be noted the great educational role in this matter of both parents and the attending physician [9, 11, 16].

In case of anorectal anomalies (atresia of the anus and rectum), the tasks of rehabilitation treatment are, in principle, reduced to those mentioned above, but

their implementation is complicated by the need to bring the function of the newly created anus closer to normal. In the system of rehabilitation measures, mechanical and physical therapy, exercise therapy are brought to the fore. With a tendency narrowing of the anus requires preventive bougienage, which is carried out from 1.5 to 3 months after the operation. In this case, there is no need to strive for excessive stretching of the anal ring; it is enough to maintain its diameter within the range of 14–16 Hegar bougie numbers. At the same time, UHF and iontophoresis are prescribed to the perineal area, as well as muscle stimulation selectively according to the type of bodybuilding [7, 15, 16]. In cases of functional disorders, they resort to an appropriate diet that helps to weaken or strengthen the action of the intestines, as well as cleansing and training enemas. Medical examination of patients at least 1–2 times a year after surgery is absolutely necessary. In our observations, thanks to continuity of treatment and rehabilitation measures, good long-term results were achieved in all cases.

The group of repeat patients consisted of 102 children the vast majority of whom (92) had previously been operated on in other medical institutions. All of them had persistent dysfunction of the colon, caused by complications of the primary intervention or its non-radi-cality. In this group, the basis of rehabilitation treatment was repeated reconstructive interventions aimed at eliminating external and internal fistulas of the colon, eliminating stenosis of the anus and rectum, creation of the anus, etc.

It should be noted that the rehabilitation treatment of children in this group is less effective than the previous one. Additional difficulties arise due to the fact that before admission to our clinic, the patients were operated on several times, but, as is known, the success of repeated operations is inversely proportional to their number. And although in all cases we were able to achieve satisfactory anatomical results through reoperation, the functional outcomes in almost 25% of cases leave much to be desired. It is this group of patients that needs individually adjusted rehabilitation treatment. It is carried out (with some variations) by the same methods as in primary patients (mechanical and physical therapy, exercise therapy, electrophoresis, etc.), but it requires a longer time, sometimes calculated in years. In our observations, positive results were achieved in most patients, but in some cases the question arises about the need for sphincteroplasty.

A special group consists of patients with combined developmental defects. In most cases, these are so-called regional defects of the urinary tract, sacrococcygeal region, etc [6, 8].

Of the 40 patients in this group, in 27 cases, anal atresia was combined with hidden anomalies (for example, vaginal duplication, urethral diverticulum and ectopic valves of the ureteric orifice, ureterohydronephrosis, etc.), which remained unrecognized before admission to our clinic and caused severe clinical complications. In this regard, we immediately note that all newborns with anal atresia, especially “high” forms, must be subjected to a primary urological examination, and if associated anomalies are identified, the issue of further tactics must be promptly resolved before complications arise. We performed repeated operations in 17 children with favorable long-term results.

In 9 cases, anal atresia was combined with anomalies of the external genitalia (hypospadias, cryptorchidism, etc.), which were corrected in a timely manner.

The most difficult to treat are children who have anal atresia combined with the absence of the distal spine. Despite the correct and timely intervention to create the anus, children suffer from fecal and urinary incontinence of neurogenic origin. The use of traditional methods of rehabilitation of these patients turns out to be ineffective and further efforts are required to improve them [7, 16, 17].

Particular attention should be paid to the issue of social adaptation and rehabilitation of children suffering from malformations of the colon and rectum.

Our analysis indicates that such patients experience great difficulties associated with their adaptation to society. These problems can manifest themselves at various stages, including communication with peers, mastering the school curriculum and choosing a profession. A significant proportion of children may experience specific deviations in their psychological and social development. Almost 60% of the children examined experience acute psychological trauma due to their illness and its consequences. The physical and emotional suffering that accompanies this pathology can lead to the formation of characteristics characterized by an inferiority complex. These traits include withdrawal, timidity, irritability, tearfulness, and lack of confidence in one's own abilities. There have also been cases of statements about suicide [9, 11, 14, 18].

Over time, these traits can become stronger, often causing depression, feelings of despair and loneliness. It is obvious that such conditions significantly complicate social adaptation. Disorder of adaptation mechanisms due to illness can lead to the development of psychological problems, such as neuroses, stuttering and others that require the intervention of specialists — neurologists, teachers, psychologists [2, 6].

Our research has shown that in a family environment, parents cultivate a gentle attitude towards a chronically ill child. The negative side of this approach is that the child is artificially isolated from real life and, therefore, his social adaptation is even more difficult.

Currently, the issue of schooling conditions for chronically ill children remains controversial. An increasing number of researchers are inclined to believe that children suffering from chronic diseases should be educated in conditions that are as close to normal as possible. This approach contributes to a faster and more natural adaptation of them to the surrounding life [9, 11, 14, 17].

The analysis showed that, along with regular or special training conditions, there can and should be compromise solutions. In some cases, children in the first years after surgery can study at school only if certain measures are organized to soften the sick child's adaptation to being in school (a conversation with the teacher and doctor about the child's illness, exemption from a number of lessons and extracurricular activities, the opportunity to repeatedly leave the classroom during lessons in the toilet room, etc.), and in the most severe cases, home training should be organized.

It is also necessary to solve the problem of professional guidance and training of people who have suffered from proctological diseases of the profile discussed since childhood. The issues of indications and contraindications

for them, for example, for admission to universities, have not yet been developed; there is no clear definition in choosing a specialty.

According to our data, approximately 20% of the studied individuals who underwent surgery in childhood for Hirschsprung's disease note that their opportunities in choosing a profession and obtaining a higher level of education were limited due to the disease. However, qualified medical and social consultation could help determine the profession most suitable for the health

and desires of a teenager, which plays an important role in social rehabilitation [18, 19].

Rehabilitation of proctological patients of childhood is a complex medical and social problem that requires the integration of knowledge and actions of specialists from many services subordinate to various departments. First of all, this applies to doctors, teachers, sociologists, psychologists, and social security workers. Only their joint actions can enrich the national economy with invaluable material through the human mind and hands.

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