Complications Following Posterior Sagittal Approach—PSARP

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The complications following PSARP are early complications like wound infection, bleeding, mis-located anus, wound dehiscence, bowel retraction, recurrent fistula, transient femoral nerve palsy, injury to urethra, bladder, vas deferens or ureter, peritonitis, perineal skin excoriation and bladder dysfunction.

Besides, there are many delayed or late complications like ano-cutaneous stenosis, anorectal stricture, rectal mucosal prolaps, urethral stricture, neurogenic bladder, and more frequent functional problems like chronic constipation with overflow incontinence and primary fecal incontinence. The early complications can be avoided by meticulous haemostasis proper closure of the wounds without leaving any dead space, adequate dilatation of the pulled down rectal pouch without tension and good vascularisation of the pulled down rectal pouch.

Concerning the late complications, one has to distinguish between
1. Neurogenic problems due to sacral malformations or injury to the neuro erigentes
2. Secondary psychological problems
3. Sphincter insufficiency
4. Altered rectosigmoid motility.

For general evaluation of postoperative continence we propose a clinical score, modified according to our publication from 1983. However, this score should be used only for true or primary incontinence based on hypoplasia of sphincter muscles. For children with chronic constipation we propose a special score which involves chronic constipation and overflow incontinence. The classification concerning the degree of continence or incontinence depends on the postoperative treatment necessary. There might be no treatment necessary or special treatment to motility problems and chronic constipation or even special treatment for sphincter insufficiency. According this kind of treatment anorectal malformations are classified in type I in complete continence, in type II partial continence IIA continence with dietary management and/or laxative, type IIB constipation with overflow soiling but clean with enemas and type IIC partially insufficient muscle complex soiling occasional, no constipation).
Finally there is a group III of incontinent children (Type IIID: complete insufficient muscle complex encopresis, type IIIE: severe motility problems, constipation not manageable).

In conclusion we propose that 3 main and 5 subgroups of continence problems should be distinguished and that one should not speak anymore from degrees of continence. The details concerning the treatment of chronic constipation (conservative or operatively) and sphincter insufficiency are discussed.

Keywords: PSARP, complication scoma, motility disturbance, chronic constipation, overflow incontinence sphincter insufficiency, early/late complications.