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IA: Males Decisions

The most important decision in the initial management of Imperforate Anus (IA) male patient during the neonatal period is whether the baby needs a colostomy and/or another kind of urinary diversion procedure to prevent sepsis or metabolic derangements. Male patients will benefit from perineal inspection to check for the presence of a fistula (wait 16-24 hours of life before deciding). During this time start antibiotherapy, decompress the GI tract, do a urinalysis to check for meconium cells, and an ultrasound of abdomen to identify urological associated anomalies. Perineal signs in low malformations that will NOT need a colostomy are: meconium in perineum, bucket-handle defect, anal membrane and anal stenosis. These infants can be managed with a perineal anoplasty during the neonatal period with an excellent prognosis. Meconium in urine shows the pt has a fistula between the rectum and the urinary tract. Flat "bottom" or perineum (lack of intergluteal fold), and absence of anal dimple indicates poor muscles and a rather high malformation needing a colostomy. Patients with no clinical signs at 24 hours of birth will need an invertogram or cross-table lateral film in prone position to decide rectal pouch position. Bowel > 1 cm from skin level will need a colostomy, and bowel < 1 cm from skin can be approach perineally. Those cases with high defect are initially managed with a totally diverting colostomy. Diverting the fecal stream reduces the chances of genito-urinary tract contamination and future damage.

Pyloric Stenosis Revisited

Reviewing 137 consecutive cases of Pyloric Stenosis during a 6.5 year period managed by the author at the region of Bayamon, and dividing the patients into the three most commonly encountered metabolic disturbances: hypochloremia, alkalosis and hypochloremic alkalosis, we found that the most important factor ($p < 0.001$) determining the probability of developing a metabolic disturbance was age at diagnosis; the older the child the higher the probability of developing hypochloremic alkalosis. Neither age, sex, race, birth weight, gestational age, firstborn, the presence of a palpable pyloric muscle (olive), or the hospital stay showed any association to the metabolic derangements characteristics of this condition. Post-op vomiting(22%) was a

self-limiting event which resolved during the first 48 hrs after surgery upon resuming the oral feeding schedule. Persistent vomiting (4%) after myotomy is caused by an associated allergic gastropathy.

Vascular Access: Neonates

Vascular access is indicated to administer fluid, drugs, and nutrients in sick neonates. Peripheral venous cannulation is the initial preferred method. Complications associated to peripheral teflon catheter use are: extravasation with skin loss, phlebitis, and bacterial colonization. Within the first two weeks of life, umbilical vessel cannulation should be considered. Central venous catheter placement should be considered for long term delivery of TPN, antibiotics or venous sampling. Routes of access are: the external jugular veins, facial veins, internal jugular veins, the saphenous veins and the subclavian veins. Catheters are of silastic material (Broviac) or polyurethane. Complications associated to central vein catheters are:(1)sepsis- most common and serious, no other source of infection and positive blood culture. They are associated to fibrin sheath formation and thrombosis within the catheter. Most are managed with antibiotics, for fungi- catheter must be removed. (2) Mechanical- dislocation, occlusion, and breakage. (3) thrombosis- the result of hypercoagulability.

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