Q&A webinar Redo surgery for pull-through in Hirschsprung's Disease: When and how

Answered by Dr. Marc Levitt

Do you think in a surgical redo procedure the da Vinci robot is preferable above a laparoscopic procedure?
I think both robotic and laparoscopic are both good for the deep dissection of the pelvis.

How to avoid stricture?
Good blood supply, preserving a nice arcade and no tension on the pull-through are key.

In your experience which is the best way to prevent soiling in patients during the follow up?
Keeping the dentate line intact and not overstretching the sphincters. If those are both preserved, then soiling may need to be treated with laxatives if the colon moves slowly or loperamide and fiber if the colon moves too quickly. Always keep in mind the possibility of non-relaxing sphincters that may need to be treated with botox.

Our patient had stricture after Swenson surgery, I would say we delayed the dilatation because we didn't a month after surgery. Is dilatation routinely necessary?
Dilations are not usually needed. I do check at one month to be sure things are healing well, and if I am concerned I check again 1-2 months later. Sometimes if narrow I do have the family pass a Hagar dilator or a 24F foley.

What would you do when you find giant ganglions in the mapping only
I don't make any distinction as to the size of the ganglion cells. If there are ganglion cells present that is a good section of bowel provided the nerves at that location are 40 microns or less.
Addition from Professor Ivo de Blaauw:
Good question; first of all wait for final pathology. We generally look at the specimens with the pathologist. Giant ganglions have different definitions and sometimes controversial, particularly in relation to the clinical relevance. Furthermore, I would also relate it to other pathology of the intestine (size and aspect of fibers, even cells of cajal). You get into a field with different possibilities which controversial as well. For example, when they are when solely present, this is generally not a reason for resections. When found in the transition zone, I'd like to have it removed with the transition zone. Another option is to discuss it with another center of expertise (e.g. Washington, Nijmegen, other centers)

When you have a stenosis in the anastomosis after a Swenson…. How will you do the reintervention?
Dilations may work, sometimes with mitomycin or kenolog. But if a severe stricture exists a redo might be required.

Which kind of Lester W Martin Op did you perform? Nearly 30 years befor we contacted
When I met him in Cincinnati he had already retired. He did a lot of work on ulcerative colitis, and developed an operation (no longer done) which was essentially a very long Duhamel called a Martin procedure.

Do you accept the pull through colon to be passing above the DJ flexure or proximal jejunum, in case of splenic flexure or transverse colon pull-through?
If the transition zone is in the midtransverse colon or proximal, you need to derotate the colon otherwise the vessels cross and kink the 3rd portion of the duodenum. The splenic flexure can be brought down the patient's left side without causing this problem.

Dr. Levitt, Can you explain again in detail your technique to inspect and palpate for a retained soave cuff?
Digital exam, palpate the sacrum and pull down, and you should feel a rubbery structure – that is a retained cuff.

If anal canal is badly damage what your suggestion for that case, a stoma for rest of time?
If the sphincters are ok the patient does not need a stoma, and may develop bowel control. If the sphincters are damaged I would do a sphincter reconstruction. I would always try a Malone that often works. Almost never would a stoma be required.

Do you use US for Botox injections to achieve inter-sphincteric plane?
I inject both internal and external sphincter. With ultrasound one can distinguish between the two muscles but I do not think that is necessary to do.

Do you have experience with undine syndrome and Hirschsprung's disease? What are the pitfalls?
Yes I have had a few cases, mostly pulmonary considerations perioperatively are what the surgeon must worry about.