Introduction
Fetal incontinence due to agenesis or damage of the sphincter apparatus is a major cause of social dilemma in the pediatric, adolescent and adult population. The anal sphincter consists of an internal sphincter which is a smooth muscle complex and is responsible among other factors for the maintenance of resting pressures. The internal sphincter is surrounded by an external sphincter which is a skeletal muscle complex and is responsible for the voluntary control of defecation. In the neonatal patient, anorectal malformations especially the high forms of anal atresia are associated with varying severities of incontinence. This monogram addresses the various “make-shift” options applied for the maintenance of incontinence.

Materials and Methods
Based on a literature search the various options offered for the management of fecal incontinence were selected and their advantages and disadvantages were investigated based on the patient series.

Results
Six most common methods were commonly employed (A-F) and are described: (A) Retrograde enemas- is a simple method offered to clear the colon at regular intervals and has been an effective method to control soiling. (B) Anal tampons- have been used with relative success in patients and involves the plugging of the anal canal with removal and defecation at desired times and places. (C) Anterograde enemas have be applied after exteriorizing the appendix (appendicostomy) and using the appendix for wash outs. (D) Anterograde enemas using Monti-ACE procedures: In patients with the absence of the appendix, surgically a part of the distal ileum is reconstructed to form a tube which is inserted into the cecum for anterograde enema applications. (E) Anterograde enemas using Chait Trapdoor™ Cecostomy Catheter: these pig tail catheters are placed directly into the cecum to facilitate application of enemas. (F) Sphincter training devices: Devices to locally stimulate the muscle have been used but no universally accepted or conform results have been achieved.

Discussion and Conclusions
The difficulties in the present surgical and medical management of fecal incontinence are exposed with the present methods used and expose the demand for tissue engineering of the sphincters to manage this condition which is a cause of social distress.

Disclosures
The authors have nothing to disclose.