Analysis of the article by Jonker et al., “Patient-reported outcomes after subtotal colectomy in pediatric therapy-resistant constipation: A combined retrospective and cross-sectional study,” published in the June 2026 in "Journal of Pediatric Surgery".

The article by Jonker et al. discusses a very important and common problem in children [1]. However, it does not even mention the pathological anatomy and physiology of the anal canal, rectum, colon, and ileocecal valve in children with "functional constipation," synonyms for which include idiopathic constipation, idiopathic megacolon, and functional megacolon.

It is known that the so-called functional constipation in children begins in early childhood during potty training and early social interactions. Fecal retention causes rectal dilation and megacolon. This leads to a mismatch between the width of the stool and the throughput capacity of the anal canal. If the problem is not diagnosed promptly, the condition worsens and a vicious cycle occurs.. In addition to the gradual increase in the width and volume of the colon, changes in anal canal function occur, impairing stool flow from the rectum. The earlier treatment is initiated, the faster conservative treatments lead to recovery. Severe constipation results from delayed treatment and require long-term conservative treatment.

Since the beginning of the 20th century, attempts have been made to treat children with functional megacolon by resection of extended segments of the colon. However, as early as 1969, Duhamel stated that “recto-sigmoidectomy does not improve these children” [2]. Nevertheless, attempts to find a better surgical option continued, but all of them lacked scientific justification, and the authors never published long-term results. For example, Levitt et al. described transanal rectosigmoid resection, in which 2/3 of the internal anal sphincter (IAS) was removed. The authors recommended this operation because in 14 patients with more than 3 months of follow-up, the preoperative laxative dose was 68 mg of senna/d (range, 52–95 mg), which decreased to 8.6 mg postoperatively ($P < .001$) [3]. They did not publish long-term results. However, in the rationale for another resection option, it was stated that after transanal rectosigmoid resection, no reduction in laxative doses was observed, but fecal incontinence appeared [4], which would be expected after resection of 2/3 of the IAS, which is responsible for 50% of fecal continence function. Hutson et al. tried several surgical treatment methods. Some patients underwent hemi- or subtotal colectomy, which resulted in initial improvement followed by a relapse of symptoms. [5]. In a systematic review of published studies by Siminas and Losty concluded that surgical management and outcome(s) for

idiopathic constipation are based on low-quality evidence [6]. Tamura and Jaffray's experience show that around two-fifths of patients require a permanent stoma after surgery [7].

An article by Jonker et al, was resected the entire colon along with the ileocecal sphincter, which regulates the flow of contents from the small intestine into the colon; prevents the reflux of colonic contents into the small intestine; and is involved in the regulation of intestinal transit. An anastomosis was then performed in the abdominal cavity between the rectum and ileum. Consequently, part of the dilated rectum remained above the anal canal [1].

This operation has no scientific basis.

(1) The necessity and safety of total removal of the entire colon have not been proven;
(2) There is no evidence of the necessity and safety of resection of the ileocecal sphincter.
(3) The operation did not change one of the components of the pathogenesis of functional megacolon - the discrepancy between the width of the remaining rectum and the patency of the anal canal, the dysfunction of which is proven by:
(a) fibrous changes in the IAS and EAS [2, 8, 9];
(b) manometric studies that reveal dysfunction of the anal canal [10]. Some authors call this dysfunction "obstructive defecation" [11], others "spastic pelvis floor syndrome" [12] and anismus [13]. These and other names are characterized by the contraction of the anal canal, instead of relaxation of the IAS, in response to increased pressure in the rectum.
(c) Manipulations that weaken the function of the IAS and EAS (sphincterotomy [2,8,9, 14], injection of Botox into the EAS [9,10,15,16,17], stretching of the anal canal under anesthesia [18,19] have a pronounced clinical effect.

Only by analyzing the surgery can we conclude that it is associated with significant, unaddressed problems. The surgery does not address the anal canal obstruction and leaves a portion of the rectum dilated. Initial relief will be due to the easier passage of liquid small intestinal contents through the anal canal. However, given that these patients have long-stretched pelvic floor muscles, including the puborectalis muscle (descending perineum syndrome), which leads to fecal soiling, this symptom will intensify. Conversely, the stretched levator ani muscles, which normally open the anal canal to reduce resistance to stool passage, will not be able to do so fully, leading to constipation during the period when stool becomes hard. High rectal pressure will inevitably lead to reflux of feces into the ileum, causing its dilation and the proliferation of microbial flora.

1. <u>Conclusion.</u> This operation has no scientific basis. It does not comply with the Declaration of Helsinki since it is subject to Medical Research Involving Human Subject.

The peer-reviewed article does not provide any scientific evaluation method.

Subtotal colectomy was considered because of the following indications: (1) persistent symptoms of constipation affecting HRQoL despite optimal oral and rectal laxative treatment for three months, (2) treatment failure of ACE with/without segmental colectomy, (3) persistent diffuse severely dilated and prolonged colon identified by contrast enema studies and/or (4) prolonged colon transit time despite optimal previous (oral and rectal) treatment.

First, as previously shown, treatment with laxatives is not an optimal method for the treatment of grade 3 functional megacolon [20]. Without addressing anorectal obstruction, it is impossible to break the vicious cycle of pathogenesis. Second, the lack of effect with laxatives is an indication for the use of Botox, sphincterotomy, anal stretching, and daily enemas over several years, but not an indication for surgery. Third, the use of ACE differs from a standard retrograde enema in its frequent and sometimes serious complications, as well as the washout of colonic flora. Fourth, to determine the degree of colonic dilation, it is necessary to know the age-related norms. A study by Koppen et al. [21] is indicative; due to methodological errors, the normal rectal width in children under 6 years was determined to be the same as in adults [22]. Fifth, normal movement through the colon occurs because of peristalsis in accordance with the Bayliss-Starling intestinal law [23]. In an expanded segment of the colon, not every contraction occludes the lumen, resulting in no movement of the bolus and leads to a slower passage. In megacolon, this always occurs and in all sections. Manometric determination of prolonged colon transit time is a symptom of stage 3 megacolon, but not an indication for surgery.

2. <u>Conclusion.</u> An analysis of indications for surgical treatment shows that conservative treatment of patients with chronic constipation was not optimal in either quality or duration. This calls into question the appropriateness of surgical treatment in the cases described.

The authors violated statistical laws, resulting in significantly underreported complications and a preponderance of positive patient reviews. If total colectomy was performed in 46 patients, all indicators (%) should be calculated based on this figure. A total of 12 (26%) surgical patients were excluded from the analysis. The authors unjustifiably excluded patients over 18 years of age (N=4), even though they were operated on in a pediatric surgical unit and (N=2) who

refused to participate in the study (if medical records were unavailable or if patients/parents did not consent to review their medical records. Firstly, database records may be inaccessible if they are deliberately deleted. Secondly, if patients refuse to cooperate with doctors, this is evidence of disappointment in their expectations. Six patients were lost after surgery, which in modern Europe demonstrates a reluctance to deal with surgeons. At latest follow-up by telephone, the authors were able to contact 34 (74%) of the 46 operated patients.

3. Conclusion. Based on the analysis of the data shown in the article, 12 (26%) of patients believed their expectations were not met. Therefore, the percentage of positive results in the article is unreasonably overstated.

Median follow-up after subtotal colectomy was 68 months [IQR 27—129]. During this time, no objective examinations were performed to determine the condition of the anal canal, the width of the remaining part of the rectum, or the condition of the ileum. Rectoanal reflexes were not studied, and mucosal histology of the rectum and ileum was not examined. It is difficult to believe that the assessment of a major operation, which was not scientifically substantiated and accompanied by both minor complications (5% < 30 days / 12% > 30 days) and major complications (33% < 30 days / 34% > 30 days), was provided by specially selected sick children. Their assessment of their condition cannot replace scientific research, since it is based on the hope of improvement over time, on the belief that everything possible has been done, on gratitude, and on the awareness that they may need the help of these surgeons in the future. Therefore, although they clearly downplayed their complaints of fecal incontinence and the degree of constipation, they complained of abdominal pain, the nature of which was unclear.

HRQoL at latest follow-up PROMIS questionnaires were filled out by 29/34 patients (85%). In the pediatric self-reported cohort (5—17 years), mean Tscores for well-being (64.2 ± 6.3) and self-rated health (62.0 ± 8.4) were higher than the Dutch-Flemish population norms. In parent-proxy assessments for the same age, well-being (63.0 ± 5.4) was again scored highly.

4. <u>Conclusion.</u> HRQoL assessment based on questionnaire results is not reliable, i.e., not scientific, especially since it contradicts common sense.

Discussion

Practitioners have created a parallel reality that has no connection to science, but which has replaced scientific research. Their articles do not contain information about the normal and pathological anatomy and physiology of the digestive system. They disregard the scientific

facts that form the foundation of science, undermining the value of science as truth, without which it is impossible to understand and treat disease. This broad trend has become fashionable in gastrointestinal research.

Regarding chronic constipation in children, unscientific reality has emerged as recommendations for primary care physicians (Rome criteria I to IV). These recommendations are adopted by a Delphi vote of practicing physicians, based on personal opinions. They are accepted if more than 80% of the participants agree. They are periodically amended, which distinguishes them from scientific knowledge. Functional constipation is recognized as the cause of initial delayed stool passage during toilet training and social adaptation. This leads to delayed stool passage and the formation of large-diameter stools. Subsequent attempts at defecation cause pain and delayed stool passage. This leads to a vicious cycle, resulting in dilation of the rectum and colon [24, 25]. This type of constipation differs from other functional causes of constipation by the presence of megacolon. Therefore, before the advent of the Rome criteria, researchers referred to this type of constipation as functional megacolon or idiopathic megacolon. It follows that dilation of the rectum and colon is a reliable marker of this disease, provided secondary megacolon following surgery or trauma, congenital aganglionosis, and anorectal malformations are excluded. To determine dilation, age-related normal values must be known [26]. As shown above, Koppen et al. attempted to determine the normal rectal width in children under 6 years of age [21]. As a result of a violation of scientific methodology, they arrived at the absurd statement that the rectal width in children under 6 years of age is the same as in adults [22]. This article confirmed the previously described recommendation not to use radiographic examination to diagnose functional constipation [24]. For this "research," "Ilan Koppen received financial support from the Royal Netherlands Academy of Arts and Sciences (Academy Ter Meulen Grant) and the European Society for Pediatric Gastroenterology, Hepatology and Nutrition (Charlotte Anderson Travel Award) to conduct this research" [21].

The North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition and the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition reached a consensus on the definition, diagnosis, and treatment of chronic functional constipation in children, also using a Delphi method [27]. They cite the Rome III criteria and describe the symptoms of infantile colic as difficulty passing stool in infancy.

What the Rome IV criteria call functional gastrointestinal disorders (FGIDs) in children are symptoms of diseases that are not defined because of which patients do not receive pathogenetic treatment.

A). A subgroup of young children exhibits difficulties with stools that, according to the Rome III criteria, are classified as "infantile dyskesia." Parents describe infants with dyskesia as straining for many minutes, screaming, crying, and turning red or purple during physical activity. Symptoms persist for 10 to 20 minutes until soft or loose stools are passed. Stools are usually passed daily. Symptoms begin in the first months of life and resolve spontaneously within a few weeks. In the Rome IV criteria, this condition is described twice, first as "infant regurgitation." This phenomenon is part of normal infant development, and therefore uncomplicated regurgitation is not a sign of pathology. This is because babies are born with small stomachs. They eat greedily, which leads to gastric distension, and they regurgitate excess milk. This period lasts until 4-6 weeks and ceases when the volume of food consumed at one time becomes equal to or less than the stomach's capacity.

B). Infantile colic occurs also 1-2 weeks after birth and is characterized by regurgitation and cries, during which the infant's face turning purple. By 4-6 weeks of age, infants calm down. This variant is observed in children with lactose intolerance. As soon as the child begins to consume foods that require hydrochloric acid for utilization, lactase secretion decreases 10-fold. Undegraded lactose affects mast cells in the small intestine, triggering the release of histamine, which leads to the secretion of hydrochloric acid. The infant's cry signals unbearable pain, as the hydrochloric acid damages the mucosa and irreversibly disrupts the function of the lower esophageal sphincter. This is the beginning of gastroesophageal reflux disease (GERD) [28].

C). In young children, rumination syndrome (cyclic vomiting syndrome) is a symptom that indicates lower esophageal sphincter dysfunction. The clinical symptoms of reflux disease vary. Nighttime restlessness that resolves with fluids, anemia, and diarrhea may occur separately or in combination. Eliminating milk (lactose) results in symptom resolution [29].

D). In older children, functional nausea and vomiting, postprandial discomfort syndrome and epigastric pain syndrome, irritable bowel syndrome, and functional abdominal pain [30] are typical symptoms of reflux disease, which is often associated with other acid-related conditions (gastritis, duodenitis, biliary dyskinesia, etc.). Aerophagia is normal, as air is swallowed with each sip of food, entering the intestines and being utilized there. Healthy children do not belch. Belching is evidence of reflux disease [31].

Thus, the Rome IV criteria include a primitively presented selection of literature data that erroneously states the pathophysiology as unknown and proposes two causes of functional gastrointestinal disorders: disruption of the brain-gut axis and intestinal microbiota, which are neither provable nor refutable because they are so meaningless.

The NASPGHAN and ESPGHAN guidelines largely align with the Rome III criteria, but some recommendations and definitions require clarification. For example, the definition of intractable constipation as constipation not responding to optimal conventional treatment for at least 3 months is presented without any evidence. This definition contradicts the assertion that the later constipation is diagnosed, the longer conservative treatment is required. Secondly, it lacks any specific indicators. What can be considered optimal conventional treatment? Why is «Addition of enemas to the chronic use of PEG not recommended"? Finally, enemas, Botox, or anal canal stretching along with laxatives are more optimal treatments. The term intractable constipation suggests the possibility of surgical treatment.

Antegrade enemas are no different in therapeutic effect from retrograde enemas, but they are associated with surgery and multiple complications. They flush out the colonic microflora, which contradicts the role of intestinal microbiota. This procedure was proposed for patients with fecal incontinence after rectal cancer surgery to enable them to care for themselves. Children are under the care of their parents, who can administer retrograde enemas. Antegrade enemas are meaningless operations that worsen the condition and burden the lives of children. We see how a truncated literature review is being offered instead of an analysis. The only recommendation that does not contain the prefix concerns a colonic transit study, based on which one can obtain an indulgence for colon resection [27].

Whose interests are these doctors protecting which they don't engage in scientific research, but publish primitive literature reviews, thereby creating barriers to changing of the status quo? They promote the very devices and medications whose manufacturers fund them. Below are some examples, far from exhaustive.

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M.A. Benninga was part of the pediatric working committee of the Rome Foundation which developed the Rome IV criteria for infants and toddlers discussed in this review. M.A. Benninga is a scientific consultant for Shire, Sucampo, Astrazeneca, Norgine, Zeria, Coloplast, Danone, Friesland Campina, Sensus, Novalac [25].

Purpose of the peer-reviewed article is likely to promote colonic manometry, the results of which are supposedly an indication for a scientifically unsubstantiated and traumatic procedure whose results cannot be good. The practice of the Belarusian Center for Pediatric Surgery demonstrates that functional megacolon can be treated without surgery, without postoperative complications, without colostomies, and with a normal life in children of all ages. the Scientific research is needed to substantiate the optimal treatment for children with functional megacolon.

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