Dr. Richard Wood

In recent years, you have published 20 articles in which, under the auspices of the Pediatric Colorectal and Pelvic Learning Consortium, you recommend methods for the diagnosis and treatment of anorectal malformations. Who gave you such powers? The fact that your texts were signed by practical doctors who, like you, do not know the physiology of the anorectal zone and the pathophysiology of ARM, does not make your recommendations scientifically sound. Following Peña and Levitt you continue to promote PSARP without publishing a single scientific paper.

Peña took over deVries's published method of the pull-through and established it as the most ideal method. He stated, without any basis and in contradiction to scientific facts, that in ARM the anal canal is absent, that the puborectalis muscle has no significant role in fecal continence, and that PSARP produces remarkable results. He, like you, never compared the long-term results after PSARP with the results after other operations, for example the cutback procedure. You claim to have performed more than 400 primary PSARPS. Why didn't you publish the long-term results of your work: how many patients died, how many patients required a repeat operation, how many patients you continued treatment with antegrade enemas, how they turned out to be better than retrograde enemas. What length and width were the perineal fistula you created, which by misunderstanding is called neoanus (new anal canal). How wide was the rectum after the operations, and did it correspond to the throughput of the fistula you created? Until you publish this data, you may not advertise PSARPS. And that's why:

In your article with Levitt [1], which is a lecture, the following radiographs are given.

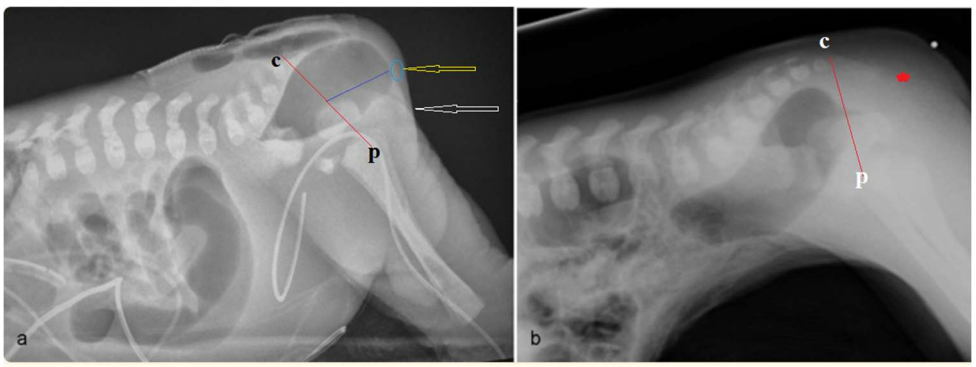

Fig. 1

Cross-table lateral film in two newborns. (**a**) In a reachable rectum, a newborn anoplasty can be performed. (**b**) In a distant rectum, a colostomy is required.

Figure 1 (a) shows a newborn boy with a perineal fistula, the opening of which is shown by me with a white arrow. As a result of the rectum contracts, gas moves into the wide-open anal canal between the pubococcygeal line (red) and the anal fossa (yellow arrow). The patient's condition was complicated by phlegmon of the sacrococcygeal region. Instead of using scissors to make a 1 cm incision from the ectopic opening (white arrow) to the anal fossa and inserting a tracheostomy tube into the anal canal for 2 weeks to avoid secondary stenosis, you recommend destroying the anal canal. PSARP involves isolating the internal anal sphincter from surrounding tissues (risk of damage to the vagina in girls and urethra in boys), replacing the internal anal sphincter by a denervated rectum, which is necessary to separate from feeding vessels, to mobilize it; intersection of the puborectalis muscle, as well as the deep and subcutaneous parts of the external anal sphincter. You call the subcutaneous part of the external sphincter a muscle complex, while this muscle is the thinnest (2 mm - blue oval), which is located below the anal canal. As the results after cutback surgery show, dissection of the subcutaneous portion of the external sphincter does not affect fecal continence [2].

In Figure 1 b, the radiopaque marker is located at the top of the buttock, and not between the buttocks, where the anal dimple is located. The normal location of the anal dimple is marked by me with a red asterisk. The gas is in the rectum at the level of the pubococcygeal line. The cone-shaped ending below this line shows reflex relaxation of the internal sphincter (radiological analogue of the rectoanal inhibitory reflex) [3, 4]. The rest of the anal canal is in a contracted state since the pressure in the rectum is below the threshold level. This is how the anorectal zone looks in healthy people. I would like to remind you that since Peña and Levitt lost control over the publication of articles, it has become clear to everyone that: - “According to present knowledge, the “fistula” in ARM represents an ectopic anal canal and should be preserved as far as possible to improve the chance for fecal continence" [5]. To open the anal canal, it is necessary to increase the pressure in the rectum by compressing the abdomen [6], and not to destroy the anal canal using PSARP. Perforation of the perineum during the anal canal opening allows to preserve all elements of the anal canal and completely cure the patient [7].

Since you neglect reliable scientific knowledge, you may have the opinion that every surgeon has the right to his own vision of the problem. The use of operations that harm the patient is not permissible from a legal point of view. If you are made aware of the presence of the anal canal in ARM and the need to preserve it and you continue to harm patients by destroying the anal canal, you are responsible to the patient and his family.

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References

1. Wood RJ, Levitt MA. Anorectal Malformations. Clin Colon Rectal Surg. 2018 Mar;31(2):61-70. doi: 10.1055/s-0037-1609020.
2. Pakarinen MP, Rintala RJ. Management and outcome of low anorectal malformations. Pediatr Surg Int. 2010 Nov;26(11):1057-63. doi: 10.1007/s00383-010-2697-z.
3. Levin MD. Pathological physiology of the anorectal malformations without visible fistula. A short review. Pelviperineology 2023;42(2):74-79. DOI: 10.34057/PPj.2022.41.02.2021-9-1.
4. Levin MD. Anorectal Malformations with Visible Fistulas. Theoretical Substantiation of a New Version of the Cutback Procedure. (Preprint) Qeios, CC-BY 4.0 · Article, August 30, 2023.
5. Amerstorfer EE, Schmiedeke E, Samuk I, Sloots CEJ, van Rooij IALM, Jenetzky E, Midrio P, Arm-Net Consortium. Clinical Differentiation between a Normal Anus, Anterior Anus, Congenital Anal Stenosis, and Perineal Fistula: Definitions and Consequences-The ARM-Net Consortium Consensus. Children (Basel). 2022 Jun 3;9(6):831. doi: 10.3390/children9060831.
6. Levin MD. Pathological physiology of the anorectal malformations without visible fistula. A short review. Pelviperineology 2023;42(2):74-79. DOI: 10.34057/PPj.2022.41.02.2021-9-1.
7. Levin MD. Theoretical Basis of New Surgical Tactics for Anorectal Defects without Visible Fistulas. Novosti Khirurgii. 2023. 31 (5); 397-404. (DOI: https://dx.doi.org/10.18484/2305-0047.2023.5.397.
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