Dear pediatric surgeons!

Recently, in the open access appeared the article “Can Anorectal Stenosis be Managed With Dilations Alone? A PCPLC Review". It was signed by 17 authors who, as members of the Pediatric Colorectal and Pelvic Learning Consortium, based on supposedly collective experience (this cannot exist in principle), impose methods for diagnosing and treating anorectum diseases on pediatric surgeons. An analysis of the article shows that the author is Richard Wood, since he is a co-author in 5 of the 12 references Only these links describe the methods proposed in this article, and all other links do not have scientific evidence and do not confirm the ideas that are declared in the article, which is typical for the works of Richard Wood.

1. If the other 16 authors were involved in this article, they should note that there is no diagnosis of Anorectal Stenosis in any classification.

2. The article states that «Congenital anal stenosis is defined as an anus that lies within an intact sphincter muscle complex but is pathologically narrow. The narrowing of the anal canal is usually located at the dentate line ...» {2,3}.

A) The anus is surrounded by the subcutaneous portion of the external anal sphincter (EAS), which makes up 10% of the length of the muscle complex. Congenital anal stenosis is located below the internal anal sphincter (IAS). The length of stenosis in newborns is 2 mm and is equal to the thickness of the subcutaneous tissue and skin over the anal fossa. Above the rigid ring of anal stenosis is the normal anal canal. The statement that “the narrowing of the anal canal is usually located at the dentate line” is not true. Good results from the cutback procedure confirm that the stenosis is a short, rigid ring [1].

B) Link number 2 says, «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» {2}. Therefore, it was a false citation. Reference number 3 provides an overview of surgical treatment. It does not contain scientific research supporting claims made by Wood. Thus, this quotation was also false.

3. The article states that “Congenital rectal stenosis can be similarly defined as a well-developed, normally positioned anus within an intact sphincter complex but with a pathological narrowing located proximal to the dentate line [4].

A) Reference number 4 describes a case of rectal stenosis with a normal anal canal {4}. This was a false quote. The anal canal, unlike the rectum, is always in a closed state. A narrow anal canal is normal.

B) I found in open access14 articles on rectal atresia and rectal stenosis that included radiographic studies. X-ray analysis of these cases showed that the atresia or stenosis in the form of a thin membrane was not in the rectum, but in the anal canal approximately 1 cm from the anal verge. This discovery allows the membrane to be resected from an anal approach without damaging the anal canal. As was done in the two described observations [2]. Thus, what was considered rectal atresia/stenosis should be called anal canal atresia/stenosis.

4. The authors set out to determine whether dilatation of stenoses could be an effective treatment for patients. However, complications within 30 days after surgery were requested from different centers. Obviously, in the early postoperative period there can be no comparison of the results of treatment using different methods.

5. Currarino Syndrome. In addition to 14 cases with anal atresia/stenosis, I found a case described as Currarino Syndrome [3]. Analysis of X-ray studies showed that rectal obstruction was caused not by atresia, but by compression of the intestine by a retrorectal mass [2]. This case led to a search of publicly available cases of Currarino Syndrome. Only one of 15 cases described a case of ARM with a fistula into the bladder in combination with other elements of the syndrome. In other cases, there was the so-called incomplete Currarino Syndrome, where presacral mass was combined with spinal abnormalities and constipation. This is easy to check.

6. Spinal imaging.

In 197, Levitt and Pena concluded that “At present no solid evidence supports the concept that tethered cord by itself affects the functional prognosis of patients with anorectal malformations” [4]. Subsequently, to justify the poor results of posterior sagittal anorectoplasty (PSARP), they changed their approach. However, the anal canal functions normally in all patients where it has not been destroyed, regardless of combination with other anomalies (heart, kidneys, spine, etc.) [5]. Don't the authors ask the question: should multiple studies of the spine be performed if the results do not influence treatment tactics? Doesn't it seem absurd to require these studies to determine a supposedly poor prognosis? Moreover, a contrast enema, which accurately determines the location of the obstruction, makes it possible to diagnose presacral masses by the expansion of the retrorectal space [2].

7. The three procedures performed in patients with anal stenosis included the anterior anorectoplasty in 1 (7.7%), cutback anoplasty in 4 (30.8%), and the PSARP in 8 (61.5%). There is no comparison of the results and cannot be with such a period of observation.

8. In other cases, bougienage of stenoses was performed. The article does not and cannot compare surgical treatment with bougienage with such a short period of observation. Therefore, the statement “that patients with anal and rectal stenosis can often be managed successfully with dilations alone” is not only unfounded but contradicts scientific facts.

In congenital anal stenosis, the narrow ring is formed by fibrous tissue and is therefore rigid. Each bougienage leads to a rupture of some elements of the fibrous ring, which becomes slightly wider, but in the interval between bougienages the fibrous tissue is restored. Although the ring becomes wider, its diameter does not change with age. Therefore, when the rectum expands with age, the fecal masses formed in it become incompatible in width with the throughput of the rigid ring. This is how severe constipation and megarectum/megacolon occur. The only reasonable method of treatment that

does not damage the anal canal is a cutback procedure with dissection of the ring along with a subcutaneous portion of the EAS. In this case, there is no need for perineal plastic surgery, which only leads to inflammation and iatrogenic secondary stenosis. As numerous publications have shown, after timely execution of the cutback procedure, fecal incontinence does not occur, and constipation can only occur if megacolon has already occurred by the time of the operation. I suggest a modification of the cutback procedure to avoid stenosis and cosmetic defect [6].

In case of anal canal stenosis, the membrane, located 1 cm from the anal verge, is easily excised from the anal access. I do not recommend suturing the mucosal edges. It is enough to insert an endotracheal tube into the rectum for one week and the mucosal diastasis will close without inflammation or stenosis.

Conclusion.

All the authors of the article were brought up with Peña's experience. He became a guru in pediatric colorectal surgery. He did not conduct any research, but referring to his experience, he proposed various diagnoses and operations, which were picked up by young surgeons. They admired the beautiful PSARP operation he showed in his courses. The rectum was easily detected, the muscle complex was opened layer by layer, the rectum was relegated to the place of the anal canal and ended with the formation of a beautiful butt. The skill of a cutter was perceived as the skill of a surgeon. However, this operation destroyed the anal canal: the IAS was removed under the guise of a fistula; puborectalis muscle was crossed as a non-essential application; the levator plates were separated from the rectum; all portions of the EAS were intersected, except for the subcutaneous one, which became known as the muscle complex; there was a massive intersection of the nerve fibers of the pelvic floor. Instead of the anal canal created by nature, Peña created a perineal fistula, which led to severe constipation, fecal incontinence, urological and sexual problems. Removal of 2/3 of the anal canal with functional megacolon, the creation of an alleged cloacal malformation with the destruction of the anal canal and urethra was picked up by the surgical community, whose understanding of the scientific fact had atrophied.

There are no references to Peña's work in the peer-reviewed article. His disciple, fashioned in the image and likeness of the guru, is preparing to take his place. Wood, like Peña, modifies PSARP, with a false understanding of the anatomy and physiology of the anorectum in health and in ARM. He doesn't do any research. His task is to litter the scientific space with old ideas in order to stop research that will contradict his "textbooks".

The article under review contains a huge amount of false information. It has no scientific content. The conclusions do not correspond to the material and contradict scientific knowledge. Pediatric surgeons who do not know the anatomy and physiology of the anorectum normally and with ARM should not operate on children with ARM. Parents and children with ARM undergoing pull-through surgery should be aware to different opinions with the help of artificial intelligence to protect themselves from the wrong actions of surgeons.

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