

Dear colleagues,

Recently, the "Pediatric Colorectal and Pelvic Learning Consortium" published an article titled "Antegrade Continence Enema Alone for the Management of Functional Constipation and Segmental Colonic Dysmotility (ACE-FC)" [1], the results of which are seemingly considered valid and recommended for use in pediatric surgery. The key points of this article are as follows:

1. «The purpose of the study was to determine if antegrade continence enema (ACE) alone is an effective treatment for patients with severe functional constipation and segmental colonic dysmotility».
2. They underwent ACE as their initial means of management.
3. A total of 104 patients from 6 institutions were included in the study with a median age of 9.6 years (interquartile range 7.4, 12.8). At 1-year follow-up, 96 patients (92%) were successfully managed with ACE alone and 8 patients (7%) underwent subsequent colonic resection for persistent symptoms.
4. In patients with severe functional constipation and documented segmental colonic dysmotility, ACE alone is an effective treatment modality at 1-year follow-up.

The authors concluded that the fact that only 7% of patients, at an average age of 7.4 years, required colonic resection after 1 year of ACE treatment is evidence of success.

Firstly, severe chronic constipation is a persistent condition characterized by significant enlargement of the rectum and left colon (functional megacolon - FM), which results from anal canal achalasia (anismus, anorectal outlet obstruction). Duhamel demonstrated internal sphincter hypertrophy through anorectal manometry and emphasized the need for aggressive anal dilation (to accommodate four fingers) under general anesthesia for FM [2]. No treatment methods for FM can reduce the rectal width or resolve anal canal achalasia within a year. Thus, the lack of therapeutic effect after one year of ACE use should not be considered an indication for surgery.

Secondly, the effectiveness of any treatment method must be evaluated in comparison to others. For instance, from a physiological perspective, an antegrade enema is no different from a retrograde enema [3,4,5], yet it is associated with significant complications. According to Dolejs et al., the overall morbidity rate associated with ACE is 55%, mostly due to minor complications, but 13% of patients required additional surgery [6].

Thirdly, before recommending any method for practical use, it must be demonstrated to be superior to the results of other researchers. Furthermore, the treatment of FM should be comprehensive, involving not only cleansing enemas but also anal dilation, behavioral therapies (biofeedback, diaries, or toilet training), oral fluids, bulk-forming laxatives, stool softeners, fiber, osmotic laxatives, and stimulant laxatives [7].

Fourthly, the use of high doses of stimulant laxatives (Senna), significantly exceeding pharmacopoeial recommendations, is not only unethical but also dangerous. (a) High doses of Senna increase peristalsis and the tone of the anal canal, impeding bowel movements; (b) they cause intestinal spasms, manifesting as severe abdominal pain [8,9], which is often wrongly interpreted as an indication for surgery [10].

Fifthly, in a systematic review by Tabbers et al. on FM in children, colon resection was not included in the treatment protocol [7]. In the pediatric surgery center in Minsk (Belarus), bowel resection for FM has not been performed for many years, as the comprehensive conservative treatment outlined above has demonstrated good efficacy [11,12].

Conclusion: An article that lacks evidence, comparison with other studies, and an understanding of the pathological physiology of FM in children cannot be considered scientific. A review of the literature suggests that the authors did not apply pathogenetic conservative treatments and made decisions about the need for surgery based on incorrect assumptions. The fact that 7% of cases resulted in colon resection is indisputable evidence of poor outcomes from conservative treatment, especially since colon resection does not address anal canal achalasia. Over time, dilation of the bowel above the anastomosis is inevitable. The authors of the article had no grounds to recommend a technique that is not scientifically supported and has inferior outcomes compared to the comprehensive treatment described in the literature.

Note: The authors of the article follow Peña and Levitt, who unjustifiably proposed a transanal approach like that used in Hirschsprung disease [13]. Based on a study of 14 patients with over 3 months of follow-up, the authors concluded that this approach is a viable alternative to other surgical options. Long-term results of this method have not yet been published. In another article, it was reported that 50% of these patients experienced fecal incontinence for more than six months postoperatively, allegedly due to excessive stretching of the anal canal and the loss of the rectal reservoir [14]. One might be astonished and indignant that these authors did not

recognize that the removal of two-thirds of the anal canal would inevitably lead to lifelong fecal incontinence. The authors of the reviewed article appear to be continuing the unscientific experiments of their predecessors.

References

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Recently, Skaba et al in their article “Perioperative Histologically Controlled Fistula Resection in Patients with Imperforate Anus and Perineal Fistula” convincingly demonstrated that the perineal fistula they removed has the histological picture of a normal anal canal. Unfortunately for their patients, the authors did not know that the anal canal, unlike all other parts of the digestive tract, does not have an intermuscular nerve plexus. Therefore, they came to the false belief that by removing the fistula (read anal canal) during posterior sagittal anorectoplasty, they were honestly doing their duty.

1. Why don't they know that the anal canal does not have an intermuscular plexus?
2. Why don't they know that the distal part of the intestine is radiographically and manometrically indistinguishable from a normal anal canal?

3. Why don't they know that after a cutback procedure that preserves the anal canal, the functional results are normal if the procedure is performed before the development of megarectum?

Because Peña, Levitt, and Wood have dedicated their entire careers to promoting PSARP. They have access to publications, and the ability to block publications that contradict their false claims.

Michael Levin, MD, PhD.

If you have any questions, I suggest you visit my website:

<http://www.anorectalmalformations.com>

Look at "ARM embryology"

I am ready to answer any question

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