

Dear colleagues, pediatric surgeons,

I return to Halleran et al's article "The cutback revisited - The posterior rectal advancement anoplasty for certain anorectal malformations with rectoperineal fistula" [1] because it accurately defines the state of colorectal surgery.

1. The declared purpose of the article is false. The authors state that they turned to the cutback because “surgical repair (read posterior sagittal anorectoplasty—PSARP) can present a major challenge to the surgeon given the proximity and inherent risk of damage to the urethra in men and the vagina in women” [1]. First, references to the articles are not correct. Over a 15-year period, the urological injury was only in one case with perineal fistula [2]. Secondly, for several decades, the authors of the article treated only children with anorectal problems and used only PSARP for ARM. In none of the articles, as in the works of other authors, perforation of the urethra or vagina is not mentioned as a serious problem. Thirdly, simple suturing always was sufficient to eliminate the damage and this damage did not affect the results of treatment [2, 3].

The authors deliberately do not mention the really serious problem that occurs after the correction of the perineal fistula by PSARP. "Children with ARM and good prognosis for bowel control (low-type) are at the greatest risk for severe constipation and its consequences" [4]. The cause of constipation and fecal incontinence after PSARP is due to the destruction of the anal canal, the existence of which these authors groundlessly deny.

2. The authors of the article deliberately distort the meaning of all cited articles. They state that "The key problem with the cutback anoplasty for rectovestibular fistulae is the inadequacy of the perineal body in females, and there is evidence that the PSARP results in superior outcomes in this population" [1]. First, the statement about the inadequacy of the perineal body in females is not supported by reference because it is false. Secondly, it has nothing to do with the possibility of applying the cutback procedure in females. Thirdly, the use of this operation in girls with both perineal and vestibular fistulas showed the normal function of the anorectum [5].

The statement "that the PSARP results in superior outcomes in this population" is false. First, Stephens and Smith, who are referenced by the authors of the peer-reviewed article, published their article in 1971, and PSARP was first published in 1982 [6]. Secondly, a comparison of treatment results shows that preservation of the anal canal during cutback anoplasty leads to good long-term results in 85% of patients, satisfactory in 15% of cases in the absence of poor results [7]. After PSARP, "constipation in "low" ARM has been reported in 42%-70% of cases"

[3, 8]. Thirdly, during PSARP the internal anal sphincter (IAS) is removed, the puborectalis muscle is transected, the levator plates are detached from the rectum, and a rectum with impaired blood supply and innervations is inserted in the place of the removed IAS. Instead of the irretrievably lost function of the anal canal, a perineal fistula remains, which cannot perform the function of the anal canal. Therefore, in theory, PSARP cannot be better than a cutback that preserves the anal canal.

3. Further, the authors write: - "In children with rectoperineal fistula, a simple cutback procedure may leave the neoanus in a position anterior to the center of the sphincter, which theoretically could impair future continence" [1]. What theory can we talk about if as long-term studies show, in patients after the cutback despite the anterior displacement of the neoanus, its function is normal [4,5,7,9]?

The authors refer to the alleged statements of Potts, that "Long-term follow up of patients with perineal and vestibular fistula undergoing cutback anoplasty found a high incidence of soiling along with a poor cosmetic outcome" and "with Potts' recognition of the need for circumferential sphincter muscle around the anal opening" [1]. That's a lie! In an article by Potts et al, published in the same 1954, they recommend cutback anoplasty without suturing the anal canal to the skin and report good results (**Figure 1**) [10].

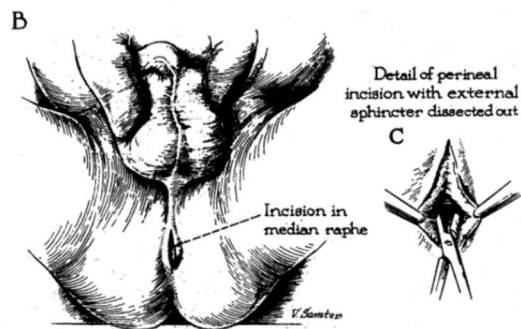


Figure 1 with explanations in it (Из статьи Potts et al [10]).

Thus, in every link related to cutback anoplasty, the authors of the peer-reviewed article resort to lies.

4. **Anatomical names do not correspond to scientific work** and are contrary to common sense. Firstly, with cutback anoplasty, we are talking about the intersection of the subcutaneous portion of the external anal sphincter. As shown by numerous studies, its intersection during the cutback procedure does not impair the function of fecal retention [4, 5, 6, 7, 9, 10]. The pediatric surgeon must be aware that he is transecting the subcutaneous part of the external

sphincter and not the muscular complex, as the authors of the peer-reviewed article write. Because the entire muscle complex includes the levator plates on both sides, the puborectalis muscle, and the three parts of the external sphincter.

The authors describe the terminal part of the intestine under various names. (1) "until posterior **rectum** has been adequately mobilized to be advanced to skin level" [1]. (2) "Even in experienced hands, a long **rectoperineal fistula** adherent to the urethra or vagina risks injury". The authors claim that after their operation (3) "There is virtually no rectum that is discarded, thus the inherent value of distal rectum (the **internal sphincter** present within the anorectal wall) is preserved" [1]. It is obvious that the authors confuse the rectum with the perineal fistula and the anal canal because the internal anal sphincter is an integral part of the anal canal.

5. The authors of the peer-reviewed article misdiagnosed and proposed surgery, without scientific justification and without evidence of its effectiveness, since the outcomes of treatment in comparison with other methods are not known.

The article presents 10 cases of ARM, where a narrow fistula opens in the ring of the subcutaneous part of the external anal sphincter, supposedly displaced anteriorly from the center. Scientifically, these cases refer to congenital anal stenosis, and not to perineal fistula. Secondly, the correction proposed by the authors has nothing to do with cutback anoplasty. Simply cutting the narrow, rigid ring would eliminate all problems, as it would preserve the anal canal and prevent recurrent anal stenosis from developing [10].

Authors from 6 institutions and 3 different countries (USA, Ireland, and Canada) operated on 10 patients under the age of 8 months (no minimal and mean age) "with a perineal fistula opening that was small (less than Hegar 12 in newborns)". On average, 1.7 patients per facility. With a diameter of anal stenosis of 1.2 mm or less, after 4-8 months, a megarectum develops and the puborectalis muscle is damaged. After "adequate mobilization" the internal anal sphincter and rectum with a violation of their vascularization and innervation, the application of skin-intestinal sutures without dilatation of the neoanus cannot proceed without stenosis. The claim of good functional outcomes is false. It is not indicated who is the author of the operation and how many patients were operated on in each of the institutions. Against the backdrop of solid lies, I tend to think that there were no operations. This article is written to assert that PSARP is the method of choice for most ARMs.

Conclusion

1. The article is a cascade of false citations, which is incompatible with science.
2. The authors of the article unknowingly or deliberately distort the anatomical names and physiology of anorectal malformations, which looks like ignorance.
3. Wrong diagnosis, unjustified operation, unknown results - all this begs the question, for what purpose was this manuscript invented?

It is clear that the intention of this article was to preserve the false claim of the advantage of PSARP in low types of ARM (with perineal, vestibular, urethral, vaginal, and without fistula), because this is actually the only operation that these surgeons are able to do.

4. The analysis of this article adds new accusations to this group of authors. They unreasonably deny that with low types of ARM from birth there is a functioning anal canal, which they completely destroy, which leads to disability of patients.
5. Dear colleagues, I have repeatedly sent you my analyzes of articles by Peña, Levitt and their admirers, a small part of which was published, in which I showed that these authors are not engaged in scientific research. Their works is a description of their experiments on children.

It is unacceptable!

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