

Iatrogenic problems in children with anorectal pathology

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The analysis of the article by van der Zande et al., “Antegrade continence enema treatment can lead to proximal colonic dilation while preserving motility in children with constipation,” published in 6/2026 Journal of Pediatric Surgery [1], provides insight into the current state of pediatric colorectal surgery. Although the article did not reveal some questions, it opened opportunities for the search for truth.

1. The authors performed a single-center, retrospective review of all colonic manometry (CM) studies at the Division of Gastroenterology, Hepatology, and Nutrition of Pediatrics, Nationwide Children's Hospital, Columbus, OH, USA. However, only seven of the 10 co-authors worked at this hospital. The article does not indicate how Koppen and Benning, who work at the University of Amsterdam, the Netherlands, participated in the study.

2. Van der Zande, who also works in Amsterdam, is listed as simultaneously working at Nationwide Children's Hospital in Columbus. She likely participated in the data analysis at that hospital, but why did she receive financial support from the Cultuurfonds, the Jdefonds, and the Amsterdam University Fund to conduct this research?

3. Why was a retrospective review of all colonic manometry selected if the purpose of the study was to determine the cause of right colonic dilatation during treatment with antegrade continence enema (ACE)? Why were cases with a dilated right colon, which did not undergo colonic manometry, excluded?

4. **Contrast enema.** (a) The water-soluble contrast was administered by gravity to allow gradual retrograde filling of the colon. However, the value of hydrostatic pressure, which depends on the height of the balloon above the anterior abdominal wall, is not specified. Because the higher the hydrostatic pressure, the wider the colon becomes, without standardizing hydrostatic pressure, it is impossible to accurately measure intestinal width. (b) median age at CE of 11 years, IQR 4-17 years). Obviously, the width of different parts of the colon depends on the age of the patient. For example, the width of the ascending colon in children without constipation aged 4-7 years is 3.09 ± 0.27 cm, and at the age of 11-15 years - 5.28 ± 0.32 cm. This means that the width of the intestine at 7 years is approximately two times less than at 17 (**Table 1**) [2]. (c) The authors did not consider the projection magnification, which, firstly, depends on the height of the beam source above the tabletop, and secondly, on the volume of the pelvis (**Figure 1**).

Table 1. Normal sizes of the colon and anal canal (cm) in children of different ages

Age	Statistical indicators	Anal canal length	Widths of different parts of the intestine (cm)						Height of the cecum dome	volume of the colon (ml)
			Rectum	sigmoid colon	descending colon	transverse colon	ascending colon	cecum		
1-11 months	n	7	12	12	11	10	10	10	9	9
	fluctuations	1.7 - 2.5	1.3 - 3.0	1.4 - 2.0	1.7 - 2.4	2.3 - 2.7	2.4 - 3.4	2.4 - 3.0	1.4 - 2.7	350-800
	mean (M±m)	2.2±0.15	2.24±0.09	1.73±0.06	2.05±0.06	2.51±0.07	2.71±0.13	2.62±0.10	2.13±0.12	562±38
3-Jan years	n	7	9	9	8	7	6	6	6	6
	fluctuations	2.3 - 2.8	3.0 - 3.7	1.8 - 2.4	2.3 - 2.5	2.4 - 3.8	2.5 - 3.6	2.5 - 3.6	2.4 - 3.5	600 - 800
	mean (M±m)	2.55±0.10	3.21±0.11	2.11±0.08	2.54±0.08	3.02±0.23	3.09±0.27	3.26±0.21	2.95±0.13	675±12
4 -7 years	n	9	9	8	9	8	7	6	7	8
	fluctuations	2.5 - 3.6	3.0 - 3.9	2.4 - 2.6	2.6 - 2.9	2.9 - 4.2	3.2 - 5.4	3.2 - 4.6	3.5 - 4.2	650 - 1100
	mean (M±m)	3.17±0.14	3.43±0.14	2.52±0.03	2.76±0.07	3.75±0.15	4.24±0.35	3.95±0.26	3.72±0.10	910±16
8 -10 years	n	18	19	19	19	18	18	15	13	17
	fluctuations	2.6 - 3.7	3.2 - 4.1	2.1 - 2.6	2.5 - 3.2	3.0 - 4.3	3.6 - 5.7	3.6 - 5.4	3.5 - 4.9	750 - 1200
	mean (M±m)	3.11±0.10	3.72±0.05	2.41±0.03	2.81±0.06	3.56±0.09	4.62±0.17	4.35±0.16	4.02±0.24	1000±21
11 -15 years	n	13	15	13	15	14	11	13	11	15
	fluctuations	3.1 - 3.9	3.6 - 4.6	2.2 - 2.6	2.5 - 3.2	3.6 - 4.4	3.9 - 6.4	3.9 - 6.0	3.8 - 5.2	900 - 1200
	mean (M±m)	3.43±0.10	3.95±0.07	2.36±0.03	2.82±0.05	3.89±0.15	5.28±0.32	5.10±0.21	4.46±0.19	1050±32

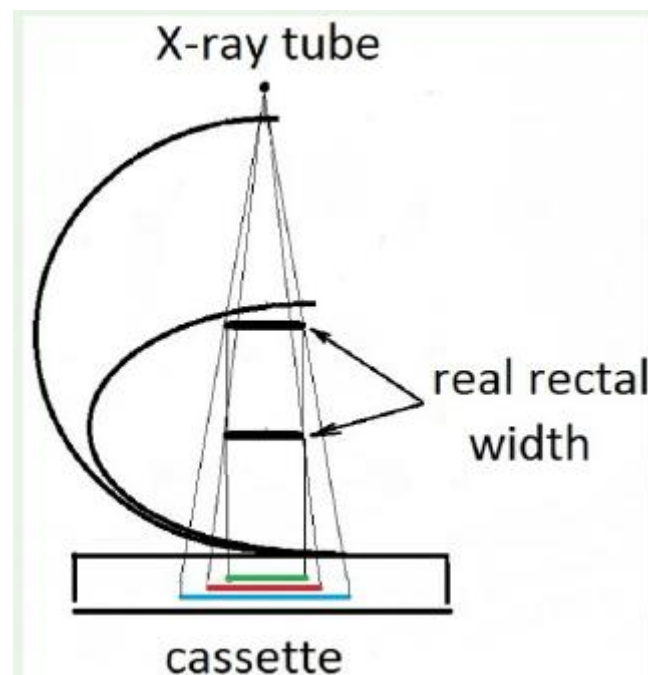


Figure 1. Magnification of the rectum on an X-ray depending on the width of the pelvis (diagram). The green line is the actual width of the rectum; the red line is its image with a small pelvis; the blue line is its image with a large pelvis.

In the caption to the radiograph from van der Zande's article (Figure 2) does not indicate age, previous surgeries, or conservative treatment methods. In Figure 2B, the contrast agent was likely administered through a colostomy, which is inconsistent with the stated goal of dilating the right colon in ACE. The entire left colon was resected. The radiograph was taken at high magnification and only captures part of the abdomen. It is impossible to judge anything from this x-ray.

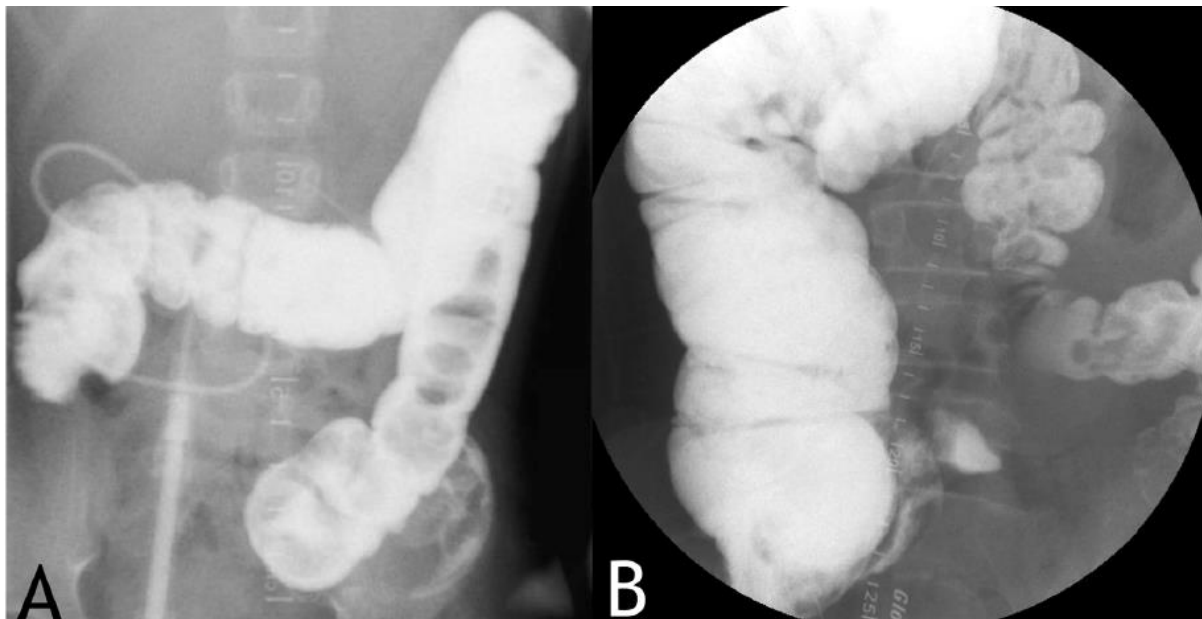


Fig. 2. Two contrast enema studies with no dilation (A) and with dilation of the proximal colon (B).

Thus, the radiographic examination was not standardized for hydrostatic pressure, patient age, projection magnification. The width of different sections of the colon was not measured and compared with age standards. The radiologist had only one way to assess the width of the right half of the colon - compare it with the width of the left half. This implies that right colonic dilation is accompanied by narrowing the left part. Of all the measurements, the only statistically significant finding was the lack of difference in lavage volume between patients with and without a dilated right colon (430 ml versus 462 ml, $p = 0.634$). This confirms the assumption that the expansion of the right half was accompanied by a narrowing of the left half of the colon because the excess fluid volume in the dilated colon was compensated for by the reduced volume in the left half of the colon.

In 2017, Koppen and Benning, et al., of the Division of Pediatric Gastroenterology and Nutrition, Nationwide Children's Hospital, Columbus, published a paper defining "normal" rectal width in children younger than 6 years of age using radiographs taken during attempts at pneumatic reduction of intussusception [3]. The obtained results cannot be considered normal

because patients with intussusception are seriously ill, in whom mesenteric compression results in a sharp relaxation of the colon. Secondly, the width of the rectum can only be measured on a lateral image, because on a frontal radiograph, its sections overlap, exaggerating its width. Thirdly, intussusception straightening is performed under pressure >100 mmHg, which leads to expansion of the lumen. Analysis of the presented radiograph showed that the width of the rectum in children under 6 years of age was the same as in adults [4]. This article demonstrates that the authors do not possess scientific methodology. Therefore, the results obtained are meaningless. They have never been used, including in the article being analyzed. 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» [3]).

Manini et al presented radiographs of the colon with contrast medium before and after ACE treatment (Figure 3) [5].

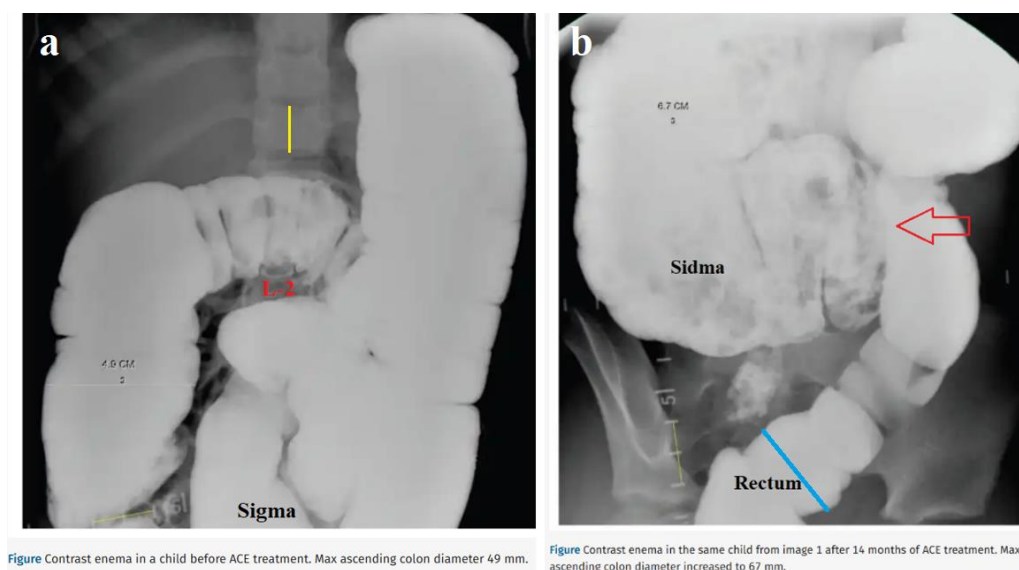


Figure 3. (a) Based on the D-11 height measurement, the child's age was approximately determined (6-7 years). Before ACE, megacolon with a dilated and elongated sigmoid colon and moderate dilation of the ascending colon was detected. (b) After ACE treatment, a sharp narrowing of the rectum (3 cm - blue line) and part of the sigmoid colon was detected. The red arrow indicates the transition zone where the wide sigmoid colon joins the sharply narrowed sigmoid colon, which the authors mistakenly considered to be the ascending colon, even though it is in the pelvis. This patient, like all patients with megacolon, had a dilated rectum (megarectum) upon admission. This means his rectum was significantly wider than 3.9 cm (see

Table 1). Thus, he had dilated the entire colon proximally to the transition zone due to narrowing of the distal colon.

Table 4 from the article by van der Zande et al. shows important characteristics of colonic function in patients admitted from a surgical ward where treatment of chronic constipation begins with high doses of Senna over a long period [1].

Bowel management issues:

Stool output with each flush-75%, fecal incontinence >1 per week 49%, regular abdominal pain 71%, hard stools - 33%, prolonged duration (>1 h) to flush response 48%.

Flush regimen: Use of stimulant - 90%.

Complications with flush: Pain -56%, nausea/vomiting -34%, bloating/distension - 20%, anxiety 4%.

All the listed symptoms can be explained by the absence of peristalsis in the narrowed distal segment of the colon. Any penetration into it of feces or other bolus causes a strong contraction. Due to the obstruction of outflow from the proximal intestine, pressure in it increases, and it gradually expands. Due to the contraction of the distal segment: stool output with each liquid flush is only 75%; regular abdominal pain, nausea/vomiting - 34%, bloating/distension - 20%, occur because peristalsis of the proximal segment increases to push the bolus; stool becomes hard because it is retained for a long time in the contracted, non-peristaltic segment. These symptoms intensify during the introduction of lavage fluid, because 90% of patients received with it a stimulant laxative, which increased peristalsis of the proximal segment and contraction of the distal segment. As shown previously, high doses of Senna not only damage the intestinal nervous system, but also the mucous layer. The passage of the bolus through the inflamed mucosa of the distal segment (colitis) causes severe pain [6].

Due to the special selection of patients with right colonic dilation combined with colonic manometry, patients with dilation but without manometry from the study were excluded, which significantly reduced the statistical evaluation and understanding of the causes of this phenomenon. As it turned out, "Proximal colonic dysmotility was not significantly more common in patients who developed dilation of the proximal colon" [1]. The colonic manometry did not help clarify the cause of proximal colonic dilation, did not affect the diagnosis and treatment of patients. However, the entire "Discussion" section was devoted to colonic manometry.

Discussion

In a similar article by Nassif et al, from the Division of Pediatric Gastroenterology, Hepatology and Nutrition, Cincinnati Children's Hospital Medical Center, Cincinnati the authors reported 22 children with ineffective ACE therapy who had contrast enema (CE) and colonic manometry (CM) findings. Data was compared among the cohort who had a normal versus abnormal CM study, and between those who had a duration of ACE use <36 months versus ≥36 months. Thirteen (59%) of 22 children had normal colonic manometry. Patients with ACE duration ≥36 months had a higher prevalence of right colonic dilation (83.3% vs 30%, $p = 0.027$) and larger maximal right colonic diameter ($p = 0.02$). Within this group, right colonic contractile amplitude was lower than left colonic contractile amplitude ($p = 0.02$). In the presented radiograph with the dilated right half of the colon, the entire left half is sharply narrowed, without haustration, resembling a long aganglionic zone in Hirschsprung's disease (**Figure 4b**).



Figure 4. From the article Nassif et al [7].

1. Thirteen (59%) of 22 children treated with ACE for severe functional megacolon had normal colonic manometry. This documents the low diagnostic accuracy of colonic manometry.
2. Patients with ACE duration ≥36 months had a higher prevalence of right colonic dilation (83.3% vs 30%, $p = 0.027$) and larger maximal right colonic diameter ($p = 0.02$). It is no coincidence that right colonic dilation has been reported only at Children's Hospital in Columbus and Children's Hospital in Cincinnati. Only the pediatric surgical departments of these hospitals use Senna in large doses without time limits [8]. Therefore, the longer Senna is prescribed, the more severe the consequences. This is demonstrated by comparing radiographs.

In Figure 3b, the distal segment is narrow, but there is haustration, while in Figure 4b, the distal segment is significantly longer and narrower with no haustration, resembling a long aganglionic zone in Hirschsprung's disease.

3. Within this group, right colonic contractile amplitude was lower than left colonic contractile amplitude ($p = 0.02$). The radiograph (Figure 4b) shows high tone in the left colon. First, the contrast enema image is more definitive than colonic manometry data. Second, it demonstrates that the dilation of the right colon is the result of obstruction of the left colon.

Figure 5 shows radiographs of patients after high doses of stimulant laxatives (glycerin, soap, Senna), in children, as well as in adults after long-term use of recommended doses.

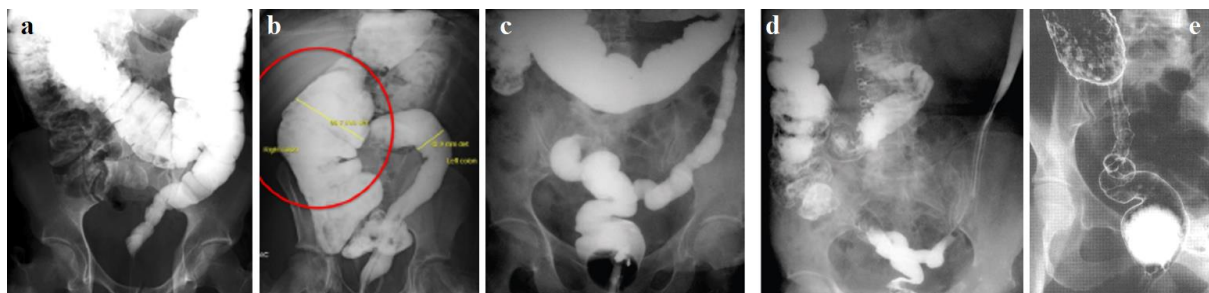


Figure 5. (a) From the article by Bischoff et al. [9]. The authors believe that in patients with rather spastic, narrow and hyperactive left colon, a colonoscopy showed signs of nonspecific colitis due to the chronic irritation produced by the phosphate solution. Some patients had signs or symptoms of severe colitis including the presence of blood and mucus in stool. However, hypertonic sodium phosphate enemas have long been widely used worldwide. Sometimes they cause hyperphosphatemia with severe consequences, but colon damage has not been described. Therefore, the authors' assertion that severe colon damage is caused by Fleet enema seems unrealistic. However, in severe cases of constipation, the authors increase the amount of laxative (usually a senna derivative) daily, 2, 3, 4, 5 or 10 times more than what the Textbooks recommend. They added glycerin and soap to the daily for ACE colonic irrigation solution. Meanwhile, these stimulant laxatives have limitations in volume and frequency of use due to potential complications [10, 11]. The same article states that "Sometimes, the "painful experience" derives from the fact that he/she suffers from severe chronic diaper rash equivalent to a second-degree burn of their buttocks. Therefore, they do not want anyone to get near that area, and if someone tries to give an enema, they frequently touch the irritated area, and that is why they feel that an enema is painful." [9]. Firstly, what the authors call "severe chronic diaper rash equivalent to a second-degree burn of their buttocks" is referred to in many articles as the formation of blisters on the perineum because of prescribing high doses of Senna [12].

Secondly, skin contact with stool containing Senna is significantly shorter in time than when it accumulates in the rectum before flushing once a day. Thirdly, inserting the tip into the inflamed rectum causes pain, which is felt by the child. The authors' statements are contradictory, illogical, and their assertion that the use of high doses of Senna is safe and effective contradicts their own data. The analysis suggests that the enema provokes pain but does not cause it.

(b). An X-ray from an article by Nassif et al. [7]. The X-ray presented in the article confirms that high doses of Senna, which are prescribed in the pediatric surgical department of Cincinnati Children's Hospital Medical Center, lead to dysfunction of the left half of the colon. This is manifested by a sharp narrowing, lack of haustration, and impaired emptying of the right half, resulting in the latter's expansion. Unfortunately, no scientific studies were provided (rectoanal inhibitory reflex, histology, histochemistry, colonoscopy, etc.). This article is very bad advertising for colonic manometry.

(c-d) An elderly woman had been taking the usual recommended doses of stimulant laxatives for many decades. In recent years, small volumes of stool impacted in the left colon caused her excruciating pain, because of which she often had to go to the hospital. When filled, narrowing of the left half of the colon with the absence of haustration is determined **(b)**. After emptying, the left side of the colon is spasmodic **(c)**. Her life was restored to normal after a colostomy on the ascending colon [13].

(e) Fu et al. described a 54-year-old woman who had lifelong refractory constipation. A barium enema study showed a persistent annular stenotic segment of the rectosigmoid colon 16 cm in length, 15 cm in luminal diameter, starting about 8 cm above the anal verge. The caliber of the distal rectum was normal. The proximal sigmoid colon was very dilated with fecaliths inside. The rectoanal inhibitory reflex was positive. Biopsy examination suggested that ganglion cells in the distal rectum were decreased in number whereas no ganglion cells could be found in the narrowed rectum. Acetyl cholinesterase staining was negative in a biopsy specimen of the narrowed part. The narrow segment of the rectum was resected. There was melanosis in the proximal colon. No incontinence was encountered and no laxatives were needed at least five years after the operation [14].

A analysis of the patient's medical history indicates that zonal aganglionosis is an acquired condition. The presence of a positive rectoanal reflex, negative acetylcholinesterase staining, and normal anorectal function after resection of the aganglionic segment indicate the absence of congenital aganglionosis (Hirschsprung's disease). The patient, who had suffered from

severe chronic constipation for over 50 years, had been taking numerous stimulant laxatives, including Senna, as evidenced by melanosis in the widened colon. Hypoaganglionosis distal to the stenosis also suggests intestinal damage from Senna preparations.

In the article by Bischoff et al., it is stated that “There is no demonstration that an enema administered from above (through the umbilicus and the appendix), works better than an enema given from below through the rectum” [9]. Thus, the authors create an ACE when children refuse enemas due to severe pain or when enemas fail to promote bowel movement due to severe spasm of the left colon. The authors claim, without evidence, that colitis and abdominal pain are caused by phosphate enemas. However, as shown above, these complications have not been described after the use of phosphate enemas. They arise because of iatrogenic intestinal damage caused by Senna preparations. Shifting the blame to a popular enema is absolving yourself of guilt. Admitting Senna's role in the complications is fraught with serious consequences for which one will have to answer. Despite the evidence of senna's harm, these authors continue to prescribe high doses of senna to children and publish false information about its safety. For example, an article by Peña et al. the same group of authors described 22 patients (average age, 19.6 years; range, 8-54) with various diseases who, over 13.7 years (range, 4-45), used antegrade enemas in 21 cases and rectally in one. All patients had a dilated right colon and a narrow, spastic, left, transverse, and descending colon. These patients complained of severe, colicky, abdominal pain during enema administration and complained that the duration for fluid to pass was progressively increasing. The authors could not explain the etiology of the problem and did not find a description of such symptoms in the literature [15].

Thus, they finally demonstrated that it is not the enema that causes the pain, because enemas have been used everywhere for a long time, but they found no such complications in the literature. Nevertheless, they settled on the hypothesis that the enema induced pathology, rather than provoked the symptoms. In a letter to the editor, I drew the attention of pediatric surgeons to the fact that this pathology arises from damage to the colon by high doses of senna [16]. Second, the authors "forgot" that in 2009 they discovered colitis in children with similar symptoms [9]. Thirdly, they “forgot” that for many years they used doses 2-10 times higher than those described in textbooks. The articles from two pediatric surgical centers (Columbus and Cincinnati) continue to disseminate false information about the safety of high doses of Senna, which causes damage to the colon and excruciating abdominal pain [17,18].

This is a continuation of the tactics of Peña, who claimed remarkable results with pull-through surgery through the posterior sagittal approach, which destroys the naturally created anal canal [19]. He disseminated an unsubstantiated diagnosis of cloaca and proposed operations that destroy in these patients the normally functioning bladder and urethra [20]. It was he who proposed removing the dilated rectosigmoid colon in functional megacolon to reduce the number of laxatives [21]. He used the Kriekenbeck classification to block access to publications by scientists who criticized him. For example, all eight articles on perineal blisters following high-dose Senna were published in non-pediatric surgical journals. If the pediatric surgical community is unable to protect children from unjustified experiments, then it is up to the affected patients, with the help of scientists and lawyers, to do so.

The results of a review of the colorectal surgery situation, represented primarily by two centers in Columbus and Cincinnati, draw attention to the following methodological shortcomings. **First**, all studies on the use of Senna and ACE include patients with anorectal malformations, functional megacolon, neurogenic bowel dysfunction, and Hirschsprung's disease, which have different etiologies, different colon sizes and functions before treatment. According to the authors of a systematic review, this makes it impossible to evaluate the effectiveness of the treatment [22]. **Second**, the authors do not describe the long-term results of ACE use. In the first review of ACE use in 163 cases treated over 18 years, the authors describe the technique and complications of this treatment method. But they do not compare this method with other treatment methods, so the authors' statement that: - "The ACE procedure using the umbilical V-V appendicoplasty provides an effective and cosmetically superior means for bowel management in children with ARMs." [23] is unfounded. **Thirdly**, in each of the numerous articles on ACE, the authors describe a period close to the time of publication, and those patients who were treated before this disappear from the authors' field of view. An article by Calisto describes a typical case in which a young adult who underwent surgery for an anorectal malformation receives a hospital discharge report. It states that the repair was a success. The neoanus lies within the sphincter complex; the anastomosis healed; the child was discharged, "doing well." Yet the person has built an adult life everywhere (at home, at work) in a room near the nearest bathroom just for him. The chart says success; the patient says otherwise [24]. **Fourth**, these authors' articles contain no information (age, diagnosis, previous surgery, or conservative treatment) under any of the radiographs. Therefore, they have no scientific value. **Fifth**, the literature contains overwhelming evidence that patients with anorectal anomalies have an anal canal, the preservation of which leads to results indistinguishable from normal.

However, the authors conduct no pre- or post-operative studies, continuing to destroy the anal canal. A PubMed search for "Levitt MA anorectal malformations" offers 144 references. Of the first 10 articles, 9 are review articles and 1 is a case report. Each review has approximately 10 authors. Literature reviews are not scientific research. They serve to propagate the authors' false ideas, as well as to breed "scientists" who provide positive reviews to other co-authors in other reviews and prevent the publication of articles that contradict these false ideas. This unscientific method is a continuation of the experience of Peña A., who published not even one (out of 104) of his studies. His articles were devoted either to scientifically unfounded experiments or to reports in which his department corrected the mistakes of other pediatric surgeons who had performed the procedure he had recommended. Sixth, these authors are unwilling to change the status quo due to a serious conflict of interest. Admitting that Peña's experience was unfounded experimentation that caused irreparable damage to continence, kidney damage, and other factors would be like opening the doors of hell for every leading pediatric surgeon. And for those who believed in it and earned a good living, it could mean losing their jobs. But this end is inevitable.

This literature review was necessary to understand the purpose of the article by van der Zande [1]. It was stated that the aim of this study was to evaluate colonic motility and anatomy in children treated with ACE, utilizing colonic manometry and contrast enema studies. Most patients were diagnosed with functional constipation (74%), spinal cord anomalies (14%), anorectal malformations (10%), childhood intestinal pseudo-obstruction (6%), and Hirschsprung disease (3%). The indication for colonic manometry was complications of ACE treatment. Most patients had an insufficient response to ACE, accompanied by persistent constipation and/or fecal incontinence. These children suffered from persistent abdominal pain, they often had hard stools, and a prolonged duration (>1 h) of flush response. Pain, nausea/vomiting, bloating/distension, and anxiety occurred during flushing. These symptoms occur with iatrogenic damage to the distal colon due to prolonged use of high doses of Senna. They are accompanied by narrowing the distal segment and dilation of the right half of the colon. However, the authors of the article determined colon width visually and did not compare it with age-appropriate norms. It turned out that in patients treated with ACE, dysmotility of the proximal colon was observed in only 6% of cases. Thus, in 94% of patients with severe ACE, colonic manometry had no diagnostic value. Therefore, the authors concluded that further research is needed. Analysis of the article indicates that van der Zande MJJ has received financial support for the promotion of colonic manometry. She was assisted in this by Koppen

IJN and Benninga MA, who are constantly supported by drug manufacturers and promote a high-resolution solid-state catheter (Unisensor AG, Attikon, Zürich, Switzerland) or a water-perfused catheter (Medical Measurement Systems, Enschede, The Netherlands). They always join pediatric surgeons who, without scientific justification, remove part or total the colon. Thus, the idea is imposed that without colonic manometry results, it is impossible to confirm the need for surgery. Scientifically unsubstantiated colon resections are promoted as advertising for high-resolution manometry [22]. Thus, the authors of the peer-reviewed article, in order to receive financial support from manufacturers of colonic manometry equipment, publish articles advertising this equipment, to the detriment of patients' health.

Conclusion

1. Peña's experience is nothing more than scientifically unfounded experiments on children. They lead to iatrogenic damage to the anorectal area and cause suffering for the patients.

2. All patients with an imperforate anus, from perineal to prostatic fistula in boys and from perineal to vaginal in girls, as well as with anal stenosis, have a normally functioning anal canal, which is in a contracted state, as is normal. Peña's assertion that this is a fistula or a rectal pouch contradicts science. Instead of preserving the anal canal, after which the child can be completely healthy, pediatric surgeons perform pull-through surgery, which destroys the anal canal, regardless of the approach. During posterior sagittal anorectoplasty the puborectalis muscle, which plays an important role in fecal continence, is crossed under the name of fistula. The internal anal sphincter, which is responsible for 50% of fecal continence, is removed and on its place, devascularized and denervated rectum is brought down, the role of which is the accumulation, not continence, of feces. The levator plates, which normally open the anal canal to reduce resistance to fecal passage, are separated from the rectum. The rectum is placed in the bed of the dissected deep and superficial portions of the external anal sphincter. Only the subcutaneous portion of the external sphincter, which accounts for 1/10th of the external sphincter and plays no role in fecal continence, remains intact. The more extensive the perineal dissection, the more invisible nerve pathways are severed, resulting in damage to reflexes not only to the anorectum but also to the urinary tract, leading to renal failure in a significant number of patients. As a result of pull-through surgery, each patient experiences a different ratio of chronic constipation to fecal incontinence.

3. Peña and his followers began using high doses of Senna—up to 10 times higher than those described in textbooks—to combat fecal incontinence and severe constipation. They attribute

severe complications, accompanied by patient suffering, to the effects of Fleet enema, ignoring the fact that this contradicts the facts. Those complicit in this iatrogenic colon damage spread false information among pediatric surgeons raised to believe in Peña's experience. Due to the damage to the left colon, doctors are forced to use antegrade colonic enema because patients, due to severe pain, refuse retrograde enemas, which are often ineffective in these cases.

4. In severe cases of functional megacolon, Peña and his followers, ignoring the pathophysiology of the disease, began to prescribe a short course of high doses of Senna instead of long-term conservative treatment. If there is no effect or children are unable to withstand the pain after an enema, they perform a resection of the colon, which allows for a temporary reduction in the number of laxatives.

5. The persistent disregard for reliable facts, the false claims of the positive effects of Peña's experiments with obvious iatrogenic damage to the anal canal, urinary system, and colon in children, with the tacit consent of scientists, defies logical explanation. This cannot continue.

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