Dear colleagues, pediatric surgeons,
I am publishing a letter from the esteemed Dr. Eberhard Schmiedeke, in order with his help to assess the current situation with anorectal malformations (ARM) in children.

Dear colleague Michael Levin
Thank you for your discussion of a case of suspected long perineal fistula.
I agree with your criticism:

- The so-called fistula in ARM in fact is a mislocated and often hypoplastic anal canal, and should be preserved, to improve anorectal function.
- Alberto Peña and Marc Levitt deny this fact, which causes many paediatric surgeons to resect part of the "fistula", thus worsening the functional outcome.

These facts are well known to the paediatric surgical community, Risto Rintala published his technique of "sphincter saving" anorectoplastic, Stefanie Märzheuser (Berlin) also friendlies reports that she is able to preserve all of the "fistula"even in the most complex female cases, etc.
So I would like to ask you for a more moderate tone in the discussion.
Alberto Peña did achieve a lot for the children with anorectal malformation, both concerning surgical treatment, and by caring for the follow-up especially of those who do not become continent by themselves.
He deserves a little bit more of respect from your side.
And we will be more successful in convincing colleagues to save the "fistula" if we remain polite.
Yours sincerely

Eberhard Schmiedeke

First, unfortunately, what pediatric surgeons say on the sidelines does not affect the salvation of the anal canal in children with ARM and thus does not improve their lives. I have not found a single article, including Stefanie Märzheuser and Eberhard Schmiedeke, which claims that there is an anal canal with ARM. One of the articles with the participation of Schmiedeke concluded "ARM patients in Germany, assessed by independent researchers, show a high rate of fecal incontinence and insufficiently treated constipation" [1]. But there is no recommendation to preserve the anal canal.

Question 1. If "These facts (about the anal canal with ARM) are well known to the pediatric surgical community", who is preventing the publication of this scientific information?

Secondly, how can you deny the presence of the anal canal in patients with a low type of ARM, if proven to have an internal anal sphincter, functioning puborectalis muscle and levator plates, and anorectal reflexes? I cannot agree that with ARM "there is a mislocated and often hypoplastic anal canal". In order to judge the quality of the anal canal function in ARM, you need to know the normal physiology of the anorectum and the pathological physiology of ARM. But these problems are not studied or published. Even with chronic constipation, Peña et al removed the anal canal, calling it the rectum, resulting in fecal incontinence. And in ARM, he explains fecal incontinence not by the destruction of the anal canal, but by its congenital absence.

Question 2. Is the anorectal problem an area of scientific knowledge or the domain of Peña and Levitt?

Thirdly, Peña and Levitt denied the presence of an anal canal in ARM, destroyed and continue to destroy it, despite the fact that I have provided numerous scientific evidence of the presence of an anal canal in most patients with ARM. I debated with each of them personally by correspondence. They received scientific information in my forum and never once provided any evidence to support their hypotheses. Because they are not correct.

Question 3. Do they deserve "a little bit more respect from our side"?

I will try to answer these questions.

Stephens (1953) proposed the concept of a pubococcygeal line from the pubis to the coccyx. He showed that this line corresponds to the location of the puborectalis (PRM) separating the rectum and anal canal. ARMs were defined as high if the distal gut is located cranially from this line, intermediate - at the level of the P-C line, and low if caudal to this line. He showed the need to preserve PRM, which plays an important role in the retention of feces [2]. These views formed the basis for the Wingspread classification (1984). It was of great practical importance since the treatment was planned according to the level of ARM. For low-type defects, perineoplasty was performed, and for medium or high defects, colostomy was followed by a pull-through operation. The problem was that diagnostic methods to differentiate high and low APM levels in infants were not accurate.

The diagnosis of ARM is still based on two misconceptions. (1) Both the invertogram and the cross-table lateral film are produced from the idea that the gas in the rectum moves upward, while everything in the digestive tract is a move by a peristaltic wave. (2) It is not taken into account that the anal canal, both in normal conditions and in low types of an ARM at rest, is in a closed state, and opens only at a certain (threshold) pressure in the rectum [3].

In the article in which Peña first announces the remarkable results of posterior sagittal anorectoplasty (PSARP), he simultaneously made two unsubstantiated statements: (a) most patients with ARM do not have an anal canal; (b) PRM is not essential for fecal retention [4]. In one fell swoop, he unfoundedly "refuted" what had been proven by numerous studies of previous generations of scientists. Pediatric surgeons believed in the remarkable results of PSARP and liked this method, which quickly located the rectum. No one thought about the loss of the anal canal and the intersection of the PRM.

When he felt the support of most of the leading pediatric surgeons, he pushed for the Krickenbeck classification (2005), which is a simple listing of most ARM variants. As a result, he destroyed the mention of the anal canal. At the same time, he "tamed" the chief editors of children's medical journals. The scientific fate of the authors is very characteristic, who for the first time proved that the distal

intestine with low ARM has the functional features of the anal canal. They dared to publish their work in the magazine "Dis Colon Rectum" [5]. Since then, they have not had any research on this topic and I have never seen links to this article.

Peña's dictatorship limits publication articles by PSARP experience, less commonly with laparoscopic techniques and even less with the anterior sagittal approach. He makes it clear to everyone that PSARP is the ideal method for correcting ARM. Postoperative results: fecal incontinence, constipation, urinary incontinence, sex problems, etc., he explains by the congenital absence of the anal canal, malformations of the spine and genitourinary system. Physiological research is discouraged, since all problems are solved in the works of Peña et al. It is not surprising that pediatric surgeons exclusively involved in colorectal surgery are unaware of the normal physiology of the anorectum and the pathological physiology of ARM. They refer to the work of Peña and believe that PRM does not play an important role in fecal retention, even though the works s of pathophysiologists considers PRM to be the sphincter of retention. Thus, the deliberate lies of Peña and his associates in the conditions of dictatorship threw pediatric colorectal surgery in the period before 1953.

As a confirmation of this thesis, I will give an illustrative example from the article by Wood and Levitt [6] **(Figure 1).**

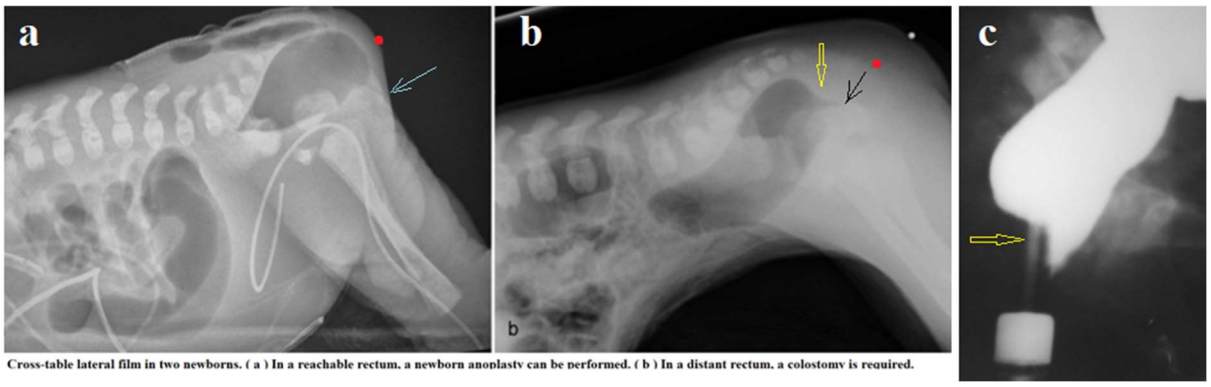

Figure 1. (a, b) From Wood and Levitt [6] with their caption. My designations.
(a). A premature boy (small vertebrae, no buttocks) with phlegmon in the sacrococcygeal region (gas under the skin). The zone of peristaltic contraction of the rectum with the expulsion of gas into the wide anal canal is visible. The blue arrow shows a narrow perineal fistula. The red dot is located at the putative location of the anal dimple. Judging by the fact that phlegmon had time to appear, this child is at least several days old, which confirms the presence of a fistula. **(b)** The radiographic equivalent of the rectoanal inhibitory reflex is seen in this full-term girl. The black arrow shows the penetration of gas into the upper anal canal because of the relaxation of the internal anal sphincter. The posterior wall at this level is pressed by the contracted PRM (yellow arrow). The contrast marker should be near the anus between the buttocks (red dot), not at the top of the buttock. It is drawn on the roentgenogram. **(c)** Rectoanal inhibitory reflex in a healthy infant.

In both cases, we found strong evidence of a functioning anal canal. In Figure 1a, the rectum has accumulated enough contents to create a threshold pressure for opening the anal canal. In Figure 1b, the rectal pressure is less than the threshold level. To make sure of this, it was necessary to put pressure on the abdomen, which would lead to the opening of the anal canal and the approach of the gas to the skin of the perineum.

Alberto Peña and Marc Levitt deny the presence of an anal canal in patients with ARA, which gave them a theoretical rationale to remove the internal anal sphincter, which they resected as a fistula or rectal pouch. They intersect the PRM, which supposedly does not play a significant role in retaining feces. They release the rectum from the surrounding tissues and place it in place of the internal anal sphincter. At the same time, it was necessary to separate it from the levator plates, which normally open the anal canal during bowel movements. What remains of the anal canal if reflexes disappear because of denervation? Denervated and overstretched external sphincter.

Now I want to draw a line and answer the questions posed earlier.

1. Alberto Peña and Marc Levitt without scientific research or references to any evidence, i.e., deliberately lied in articles about the absence of an anal canal to justify the advantage of a posterior sagittal approach.

2. As a result of this deception of public trust, they themselves and other pediatric surgeons for many years destroyed the functioning anal canal, which led to the disability of patients.

3. These authors never did any research. In their articles, they shared their делились of experiments that they conducted on children.

A) So, for example, having no idea and physiology of the anal canal, they removed 2/3 of the anal canal in children with functional constipation. As always, they reported wonderful functional results [7]. After 9 years, in passing, they reported that fecal incontinence occurs after this operation [8]. But the result was expected given that most of the anal canal was removed from these patients.

B) In the treatment of chronic constipation, in violation of the scientific recommendation of pharmacologists, they use Senna's preparations dozens of times higher than the recommended doses. This is a completely pointless practice, because Senna, by stimulating intestinal peristalsis, simultaneously increases the tone of the internal anal sphincter. This technique damages the colon, causes unbearable pain, because of which children and their parents are forced to agree to a pointless operation [9,10,11].

C) The same authors, without any reason, without researching the physiology and anatomy of an ARM with fistulas in the vagina, began to call most cases by cloaca [12], which is not true, since they have a urethra. They operate on these patients as if they had in fact, there was a cloaca, damaging to the urethra created by nature [13]. As always, bad results are attributed to a serious defect.

4. Now, when I cite scientific evidence of the presence of an anal canal in patients with low type ARM, they, as always, do everything possible to ensure that truthful information does not get on the pages of magazines and newspapers. This is facilitated by their "friendly" relations with the chief editors of medical journals. It is known to "the paediatric surgical community"?

5. Now, in front of me on one side of the scales are the fears of these people, who by their own lies have created a trap for themselves, and on the other side, the fate of tens of thousands of people of different ages, suffering from fecal incontinence and chronic constipation, urinary incontinence, and sexual disorders, as well as thousands of unborn children who will be treated pediatric surgeons trained by Alberto Peña, Marc Levitt and their followers. I believe that Alberto Peña and Marc Levitt should be held accountable for lying in science, for experimenting with children, for deceiving public trust, and most importantly for damaging the health of children. And the sooner the better.

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