



Letter to the Editor

A letter to the editor on “Anterior Perineal PlanE for ultra-low Anterior Resection of the rectum (APPEAR) technique: A systematic review”. The APPEAR procedure is a sphincter-saving transsphincteric rectal resection technique, and the ischioanal fossa should not be considered as “The rectal no man's land”



Dear Editor,

It is a great pleasure to read the review article on the APPEAR procedure published in your journal written by Lynes et al [1]. The APPEAR procedure, developed in recent years by Williams, is a sphincter-saving surgical technique in which the anterior perineal approach is used by combining it with abdominal access [2]. First of all, the shortcomings on the anatomical description of the technique in the article are striking. Anatomical definitions are very important in the current evaluation of surgical methods and in determining its indications or drawbacks. When compared with the intersphincteric resection technique, different anatomical and surgical results have been obtained by using the perineal access, especially in lower rectal cancer surgery. The perineal access provides possible extrasphincteric rectal dissection on the surgical anal canal in the ischioanal fossa, unlike the intersphincteric dissection technique in rectal cancer surgery. The surgical anal canal may be considered as a nested-manner two cylindrical muscular tube localised between the puborectal muscle and the anal verge in the ischioanal fossa. When distal rectal resection is performed by using the anterior perineal access, the surgical dissection is performed in the extrasphincteric plane, and surgical resection is at the transsphincteric plane. Moreover, the proximal external anal sphincter segment is resected with the corresponding lower rectal segment. The internal anal sphincter muscle is usually protected [3]. In fact, all combined abdominal and perineal approaches are based on similar anatomical and surgical features because similar anatomic and surgical definitions were used for the combined abdominal and posterior perineal approaches by Pena [4].

Howbeit referred to “the rectal no man's land” in an article [5]. The term “the rectal no man's land” which is 4–13 cm in length as defined by NS Williams, has been used for the portion of the distal rectum situated within the funnel of the pelvic floor muscles [5]. The main aim of the perineal access in rectal cancer surgery is to provide surgical access to the surgical anal canal in the ischioanal fossa. The ischioanal fossa is an anatomical cavity filled with lipomatous tissues in the form of an inverted triangular prism in which the surgical anal canal is situated. It is worthwhile to emphasize that the place reached by the perineal access in the combined abdominal and perineal approaches is the ischioanal fossa. It is clear that the region defined as “the rectal no man lands” in the Review Article [1] consists of the ischioanal fossa. For this reason, the ischioanal fossa should not be considered as “the rectal no man's land”.

Conflicts of interest

None.

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