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COMMENTARY

Commentary to "Fact or myth? The long shared common wall between the fistula and the urethra in male anorectal malformations with urethral bulbar fistula"

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The first impression after reading this paper is a negative one. Using the word "myth" and "dogma" when referring to an anatomic feature seen and documented repeatedly (hundreds of times) by direct observation, is ludicrous. It is like looking at the sky and say that it is blue and then somebody decided to verify the color of the sky using a new sophisticated colorimeter and found that the sky is black!!

We must ask ourselves: how do the authors could reach such conclusions so distant and opposed to the direct intraoperative observations? The only possible answer is that the methods that they used were inaccurate and misleading, which may have induced them to create a new real "dogma".

The measurement of the common wall using the images of the distal colostogram, I think, is not reliable. The radiologic images presented in this paper show a space between the rectum and the urinary tract. The rectum is full of contrast as well as the urinary tract; the space in between them has no contrast and there is no way to say what it is. Actually, according to the radiologic images, one could conclude that there is no common wall.!

Figure C, described as "long common wall", actually shows a deficient colostogram. The lowest part of the rectum is compressed by the sphincter mechanism; the study was done without enough hydrostatic pressure. Figure D shows a colostogram image consistent with a case without a fistula and again; there is no way to determine what kind of tissue is in between the bowel and the urinary tract.

I cannot comment on the measurement of the common wall done during LAARP, simply because I did not quite understand how was it done. The description of (quote) "measuring the length of the fistula with a cystoscope and a calibrated catheter", is not clear.

During the discussion, the authors made a series of very valuable comments. They mentioned that reaching the fistula via laparoscopy in cases of bulbar fistula "has its challenges" and a "significant risk for injuring the urethra". In addition, they go on to say that "as the surgeon proceeds with dissection of the distal rectum, separating the anterior rectal wall from the posterior urethral wall will become more difficult. In addition, the lowest part of the rectum will be particularly challenging to dissect". Yet, interestingly, they still recommend the procedure.

The fact remains that the laparoscopic repair of recto-urethral bulbar fistula results in a significant number of patients with a posterior urethral diverticulum. This may not be the case in the series of the authors, for which they must be congratulated, but it is a fact in the series of many others.

The laparoscopic repair of recto-urethral bulbar fistulae has other disadvantages not mentioned in this presentation:

- High incidence of prolapse.
- By definition, the laparoscopic approach includes an unnecessary dissection of a rectum that is located very close to the perineal skin. When the malformation is approached via PSARP, the rectum requires minimal dissection. This takes us into a paradox: the laparoscopic approach was created in an attempt to perform minimally invasive operations and indeed, it is minimally invasive in cases of recto-bladder neck fistulas, in those cases, the laparoscopic approach avoids a laparotomy. In cases of recto-urethral-bulbar fistula, the laparoscopic approach is an example of what can be called "LAPAROSCOPIC MAXIMALLY INVASIVE PROCEDURE". It invades unnecessarily the peritoneal cavity and detaches the rectum, again unnecessarily, from its natural attachments to the pelvic structures, which may explain the high incidence of prolapse.

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We should not argue with success, consequently, if the authors find the laparoscopic approach for recto-urethral-bulbar fistula, technically easy, they have good memory, follow their patients for long periods of time, have good results, no cases of prolapse, no cases of posterior urethral diverticulum and bowel control, obviously, they must continue doing what they are doing.

Finally, the authors must meditate about how reproducible are the technics that they are recommending and what are their recommendations for those surgeons who reported high number of prolapses and posterior urethral diverticulum.