

LETTER TO THE EDITOR

Comment on:

Old Tools for the Same Old Problems. Coloanal Anastomosis in Two Stages: Pull-Through"

Duran F, et Al. Rev Argent Coloproct. Vol 35, Nro 3, 2024.

Dear Editor,

Duran et al. present a video of a partial intersphincteric resection (ISR) for ultra-low rectal cancer and a two-stage coloanal anastomosis using the Turnbull-Cutait pull-through technique. This procedure, first described in 1961 by Cutait from Brazil¹ and Turnbull² from the USA, involves the excision of the rectum and exteriorization through the residual rectal stump of the colon to be anastomosed. This serves as a perineal colostomy until its resection in the second stage of surgery when the late coloanal anastomosis is performed without protection.

The underlying principle of this approach is based on two key concepts. Firstly, it is derived from the understanding that pelvic adhesions formed between the initial and secondary stages of surgery can reduce the occurrence of an unblocked anastomotic leak. Secondly, it is founded on the principle that adverse events associated with the management and closure of an ostomy can be avoided. Notwithstanding, this technique has not been widely adopted, partly due to the development of surgical stapling that facilitates the creation of distal anastomoses, and because it is not without complications. One of the largest recently published series, including 85 patients treated at a single institution, reported a 25% rate of pelvic sepsis, 10.6% of anastomotic dehiscence, 25.9% of anastomotic stenosis, and 10.6% of ischemia/necrosis of the descending colon. Additionally, 29% of patients experienced poor functional outcomes.

A recent multicenter randomized study compared single-stage coloanal anastomosis with protective ileostomy (CAA) with delayed handsewn coloanal anastomosis with pull-through technique (P-TA).^{4,5} The study population included 92 patients who underwent surgery over six years, with 46 patients in each group. A three-year follow-up analysis found equivalent oncologic outcomes between the two groups. The overall morbidity rate was 19.6% in the P-TA group compared to 13% in the CAA group (P = NS). The anastomotic leak rate was 13% vs. 24% for the P-TA and CAA groups, respectively, suggesting a possible trend toward superiority of P-TA. The long-term fecal continence rate, as measured by the Wexner scale, was 10.9% in the P-TA group and 13% in the CAA group, with both groups exhibiting moderate incontinence. The low anterior resection syndrome score (LARS) was 32 vs. 34 in the P-TA and CAA groups, respectively, suggesting a trend toward higher scores in the CAA group. While these differences were not statistically significant, the possibility of a type II error should be considered due to the limited sample size. Furthermore, a higher recruitment rate for larger studies is unlikely due to the limited number of surgeons willing to use this technique.

In the case presented, there were no intra- or early postoperative complications, despite the high technical complexity of the procedure performed, for which the authors should be congratulated. Regarding functional results, a higher degree of incontinence could be expected in a woman with partial ISR and

radiation treatment. For functional assessment objective measurements using incontinence scales and LARS would be desirable.

In this regard, Denost et al.⁶ published the results of the largest series (303 patients) of ISR for rectal cancer performed over 25 years (1990-2014). Functional results were considered good or moderate in 58% of patients and poor in 42%, although only 12% required a definitive colostomy due to poor function. The colonic J-pouch was performed in 72% of cases, and no significant functional difference was observed when compared to those who underwent straight anastomosis. The authors concluded that the limitations of the ISR procedure were functional rather than oncological, and, therefore, they advised implementing a postoperative bowel rehabilitation program to enhance the quality of life. In the case presented, a 3-month follow-up does not permit the evaluation of the oncological results. A close follow-up is therefore recommended, especially in the first three years, to monitor for any potential local recurrence. This is particularly important in this patient, who exhibited a poor response to neoadjuvant CRT (no downstaging of Stage III) and has a poorly differentiated tumor, which several authors consider a contraindication for an ISR,^{7,8} including Schiessel et al.,⁹ who described this technique.

Concerning the oncological results, a technical detail that merits commentary is the approach to the intersphincteric space. The authors of the video consider it preferable to perform it by abdominal laparoscopic means because it facilitates the subsequent perineal time. However, Denost et al.⁶ prefer to start with the transanal approach because they believe that it facilitates the removal of part of the pelvic floor fascia and results in a lower rate of positive circumferential margin and consequently a better oncological outcome, compared to a laparoscopic pelvic dissection.

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