LETTER TO THE EDITOR

Response to the 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,

Our group is honored to receive the commentary made by Dr. Rita Pastore regarding the video "Old tools for old problems. Two-stage coloanal anastomosis. Pull-through" This surgical approach does not compete with the traditional stapled anastomosis; rather, it is intended for specific indications, as Dr. Pastore mentioned. These include intersphincteric resections and hand-sewn coloanal anastomoses, similar to the one performed in this case, either with primary intention and protective ileostomy or deferred according to the pull-through technique.

Another noteworthy point is that this technique was described before the introduction of Total Mesorectal Excision (TME) by Heald and the advent of laparoscopic surgery. As it is well exposed, it is based on the potential adhesions that would be generated between the first and second stages of the procedure. However, it should be noted that this concept is not entirely certain in the current context. This is primarily because we remove the entire mesorectum during surgery, and secondly, because laparoscopic surgery generates a limited amount of adhesions. We could observe this point in two reoperations. One was performed to treat a prolapse of a coloanal anastomosis, which was extremely easy to access perineally, and the redundant colon exteriorized without encountering any adhesions.

In this case, we performed a levatorplasty and redo of the coloanal anastomosis. The second procedure was the takedown of the coloanal anastomosis and creation of an end colostomy, when we also found no adhesion to the anorectal ring. This leads us to question the true mechanism by which this procedure works.

It is interesting to analyze the paper by Sage et al.,[1] referenced by Dr. Pastore, which reveals a notable morbidity rate that was not observed in our group. However, it should be noted that our patient population is comparatively smaller. They have an anastomotic dehiscence rate of 10.6%, comparable to the incidence of ischemia or necrosis of the descended colon. One of the fundamental principles of this procedure, as with any coloanal anastomosis, is the complete mobilization of the splenic flexure, a maneuver that we do not question, even in the context of a redundant sigmoid colon.

Another critical technical detail in the second stage of the procedure is the creation of a true coloanal anastomosis, with four cardinal stitches and between three and four stitches in each quadrant, ensuring adequate grip on the internal anal sphincter.

We fully agree with Dr. Pastore that a female patient who has undergone radiotherapy and partial intersphincteric resection is likely to experience a suboptimal functional outcome. Patients need to be informed of this possibility before surgery. However, this outcome is comparable to that of a primary or delayed coloanal anastomosis. Given the alternative of abdominoperineal resection, patients often accept this risk.

As mentioned in the paper by Denost et al,[2] it is as important to perform a good surgical technique as it is to have a pelvic floor rehabilitation team trained in the management of these patients, since functional impairment is the rule.

Another interesting comment is that about the oncological outcome. The risk of local recurrence is low if the procedure is indicated appropriately, and high-resolution magnetic resonance imaging is crucial for detecting a free intersphincteric space, even in undifferentiated tumors, where the probability of systemic disease may be higher than that of local recurrence.

Regarding the initial approach to the perineum promoted by the Bordeaux group, based on their extensive experience with more than 300 patients, is likely the appropriate approach. However, for us who have a smaller volume of cases, the laparoscopic approach to the intersphincteric space has proven to be a very helpful, provided that the anatomical conditions of the patient permit it. In obese male patients with a narrow pelvis and large prostate, accessing the elevator to perform this technical maneuver can be challenging.

We would like to thank Dr. Pastore for her comments and the SACP for granting us this space. Our only objective was to bring to the discussion a procedure described many years ago and that is performed by important groups in the world, especially thinking of the new generations of surgeons.

REFERNCES

1. Sage PY, Trilling B, Waroquet PA, Voirin D, Girard E, Faucheron JL. Laparoscopic delayed coloanal anastomosis without diverting ileostomy. *Tech Coloproctol.* 2018;22:511-18.
2. Denost Q, Moreau JB, Vendrely V, Celerier B, Rullier A, Assenat V, et al. Intersphincteric resection for low rectal cancer: the risk is functional rather than oncological. A 25-year experience from Bordeaux. *Colorectal Dis.* 2020;22(11):1603-13.

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