

Dear colleagues, pediatric surgeons,

For more than 3 decades, you believed in the correctness of the allegations of Mr. Peña and his students regarding the pathological anatomy and physiology of ARM. You were convinced that patients with ARM have no anal canal. Therefore, in principle, there can be no normal function of the anal canal after surgery. You do not even have to think about how to improve the results of treatment since PSARP is an ideal method of surgery.

I cannot be politically correct regarding Mr. Peña, because the facts prove the falsehood of his articles and the harmfulness of his many years of non-scientific activity. Unfortunately, most pediatric surgeons grew up on faith in a scientific luminary. Secondly, coryphaeus did not allow the publication of ideas contrary to his provisions. Thus, a whole generation of pediatric surgeons not having the opportunity to engage in scientific activities grew.

I am sending an open letter to Mr. Peña, as well as a disappointing short-term analysis of my attempts to change the situation to save patients with ARM.

M. Levin

Mr. Peña,

In 1996, I turned to you, as a well-known scientist, with a request to help publish my article on the method of perforation of the perineum in newborns with ARM without a visible fistula. We have corresponded with you for 1.5 years. In my letters, I cited manometric, radiological, and histological evidence of the presence of a functioning anal canal in most newborns with ARM. I also shared with you my methods of operation, which retained all the elements of the anal canal. When comparing our long-term results published in Russian with the results of posterior sagittal anorectoplasty (PSARP), there was no doubt about the advantage of operations that preserve the anal canal.

You wrote: «You used the word "anal canal" in a rather indiscriminate way. First, start by defining what an anal canal is for you. We don't even know if a child with imperforate anus has something called "anal canal". "Anal canal" is a very well defined area with a specific type of histology innervation and special

characteristics. We don't know if that even existed in children with imperforate anus. How can you use that word so loosely?" (Letter attached).

You ignored my manometric evidence (presence of anorectal inhibitory reflex, normal anal pressure in the so-called fistula), as well as radiological symptoms (wide opening of the anal canal under the influence of high rectal pressure). 24 years have passed. You have not published any work to resolve the most important ARM problem. In all your articles, you have begun to argue that in most patients with ARM the anal canal is absent or so badly changed that saving it makes no sense.

Pediatric surgeons believed you for a long time because they could not imagine that all your achievements and remarkable results are a lie. Here is an example of the startling absurdity from the same letter: - "The structure called puborectalis muscle has been extensively described in the literature but actually nobody had directly seen this specific thing that everybody discussed". You lied about the role of the puborectalis muscle in stool retention to justify its intersection during PSARP. This idea, not confirmed by any research, contradicts all scientific articles that can be read on the Internet, as it is well known that this muscle plays an important role in stool retention. In one article, you state that "... the lowest part of the rectum is usually collapsed from the muscle tone of the funnel-like striated muscle mechanism that surrounds the rectum in 90% of cases ...". Together with the co-authors, you explained the closure of the "rectum" by the contraction of the "rectal sphincter" [1]. How can you operate children with ARM and promote PSARP without knowing the anatomy and physiology of anorectum? From the textbooks, it is known that around the rectum there are no muscles, and there is no rectal sphincter. This article deals with boys with rectourethral fistulas. The area that is surrounded by muscles and in a contracted state is called the anal canal, which is destroyed during PSARP.

Mr. Peña! Your leadership in the field of anorectal surgery has led to the elimination of science, as a method of cognition and the search for optimal solutions for treating patients. Scientific publications reflecting the experience of pediatric surgeons following in your footsteps have turned into scoring for career advancement.

For example, Finnish authors have shown that "the rectoperineal fistula can be readily dilated and because, like all the others, it passes through between the limbs of puborectalis the patient is continent and does not require any more active treatment than such dilatation as is necessary to maintain it adequate size" [2]. "All males treated for low ARMs (rectoperineal fistula) with cutback anoplasty, incision of anocutaneous membrane, or dilatations had voluntary bowel

movements; 98% of patients were socially continent ($p = \text{NS}$); 67% of patients and 64% of controls were totally continent ($p = \text{NS}$). Constipation amongst patients (33 vs 3% in controls; $p < 0.0001$) declined significantly with age. Outcomes by bowel function scores were good at 85% and satisfactory in 15% [3]. Their anorectal manometry findings support the appropriateness of the minimally invasive approaches to the management of mild ARMs, and IAS-saving anatomical repairs for patients with more severe malformations [4].

After PSARP during a mean follow-up period of 4.3 years, constipation was found to be the most common late complication in both groups of patients (64.5% in the Low-type ARM group and 78.6% in the High-type ARM group). Compared to constipation, stool incontinence was much less frequent, with 4.7% in Low - ARM and 3.9% in High-ARM [5].

The constipation that occurs after PSARP does not disappear with age but leads to the development of megacolons [6]. The difference between the experience of the Finnish group and PSARP is so great that the question arises: why do you use PSARP and promote it, instead of changing tactics to more useful for patients?

How could you, without knowing the anatomy and physiology of anorectum, remove the upper 2/3 of the anal canal in children with functional constipation [7], what led to fecal incontinence? [8].

How could you suggest surgeries in patients with cloaca without studying the pathological anatomy and physiology of ARM, having no idea about the location of the urethral and anal sphincters?

Who allowed you to do unreasonable experiments on children?

As can be seen from References, all the above questions apply equally to Mr. Mark Levitt.

Messrs. Alberto Peña and Marc Levitt! I believe that you have done tremendous harm to pediatric colorectal surgery. You cannot complain that I lied to you or exaggerated something. You were on the Forum list and have never refuted my accusations against you. I have no other words to evaluate your activity because you continue to operate on children with ARM, destroying the functioning anal canal created by nature.

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<https://www.anorectalmalformations.com>

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October 17, 1996

Michael Levine, M.D.
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Dear Dr. Levine:

Thank you very much for your letter and the new manuscripts that you sent to me.

I must be very honest with you and tell you that I don't think your material can be published at the present time. Of course, you are free to send your manuscripts to any Journal of Pediatric Surgery that you want.

However, I have several problems with reading your manuscripts:

Basically, you sent me manuscripts related to all the colorectal pathology in children which is extremely ambitious. We could spend hours discussing each one of your remarks. There are so many contradictory, controversial, confusing remarks in your manuscript that there is no way to discuss each one of those.

If you want to write a paper, you have to define, in the introduction, your specific goals. What is it that you want to demonstrate? What is the center of your hypothesis? Why do you think your paper should be published? How do you contribute to the better care of these patients? Once you define that in the introduction of your paper, then in the material and methods you are going to tell us the cases that you are using to demonstrate your hypothesis. Your results should show something very specific and then you will discuss those results and eventually you will come up with specific conclusions.

There is one specific valuable thinking in your work which is the fact that if you study radiologically a newborn with imperforate anus, and you see the end of the rectum located two or three centimeters above the

Re: Michael Levine, M.D.

perineal skin, doesn't mean that is the real end of the rectum because the lower part of the rectum may still be surrounded by striated muscle which has a specific tone and it takes much higher intrarectal pressure to really show the real distal end of the rectum. That is a very valuable fact that I always emphasize and I think that you are trying to say that. Then you become involved in many controversial issues and you use confusing terminology. For instance, imperforate anus without fistula is a specific type of defect that is found only in 5% of all cases. For some unknown reason, you have an extremely high incidence of that defect. How do you know that those patients did not have a fistula? Where were they operated and what kind of techniques the surgeons used? Many times surgeons operate on patients and don't see directly the fistula site. You used the word "anal canal" in a rather indiscriminate way. First, start by defining what an anal canal is for you. We don't even know if a child with imperforate anus has something called "anal canal". "Anal canal" is a very well defined area with a specific type of histology innervation and special characteristics. We don't know if that even exists in children with imperforate anus. How can you use that word so loosely? In your specific treatment of introducing a tube through the perineum in children with imperforate anus, are you trying to suggest that that is the way we should treat children with imperforate anus? If that is what you are trying to suggest, why don't you just say it? Do you think this is a better way to treat children? Why do you think it is better?

The structure called puborectalis muscle has been extensively described in literature but actually nobody had directly seen this specific thing that everybody discusses. Even in your diagrams, you created that structure by painting it.

Finally, the large manuscript on "Physiology and Pathology of the anorectal zone" is also too ambitious. There are plenty of textbooks describing the physiology and pathology of the anorectal zone. Do you think you are writing something essentially different from what people wrote in the past? Do you have a specific contribution? If you do, why don't you become more specific about what you are saying and what others already said. The discussion of your manuscript on physiology and pathology could take us weeks and certainly nobody would be able

Dear Colleagues,

For over 3 years, I'm sending materials about anorectal malformations to journals, to forum participants, and to my website. These were the results of many years of manometric, radiological, and clinical studies. Prior to this, my studies were published in numerous articles in Russian. Repeated attempts to publish my researches in the journals of Pediatric Surgery and Pediatric Radiology were unsuccessful. I was refused on the grounds that they contradicted accepted dogmas. I had no other way out to introduce pediatric surgeons to my works. I felt the obligation to do this, firstly, because the results of the operations I proposed were significantly superior to the results of posterior sagittal anorectoplasty. Secondly, I was struck by the lack of basic knowledge in anatomy and physiology of pediatric surgeons on anorectum.

For three years I promoted knowledge, most of which was known among adult surgeons. I expected that children's surgeons would be interested in understanding the normal anatomy and physiology of anorectum to understand the pathological physiology of anorectal malformations. Unfortunately, a broad discussion of the issues raised did not work. During this time, I received many words of support and gratitude. But I cannot publish them without the permission of their authors, so as not to endanger them from excommunication from the publication of their works, etc. The following example led me to this fear. I believe that over the past 30 years, the most significant study in the field of ARM was an article by Ruttenstock et al, in which they practically proved that all patients with visible fistulas have a functioning anal canal. Please note: the article is published in a reputable journal, but not in pediatric surgery. Since then, none of the co-authors have dealt with this topic, and not one of the pediatric surgeons referred to this article.

Below I give two letters with a negative assessment of my works because their authors have nothing to fear.

jalves1968 <jalves1968@gmail.com>

03.03.2017, Пт, 8:31

Jose Alves

Dear Michael

I have been receiving many review papers from you the past year or so and would like to thank you for your continued interest and contribution to this field.

I do however in every your review papers experience a very aggressive undertone towards people like de Vries and Pena which scientific work I value very much.

I accept that there are differences in opinion. I also accept that facts change with every new scientific evidence that emerges. But new research should not be presented in such a way that other authors are denied their scientific value of their work.

I respect your work and other scientist alike and as a scientist myself I believe we should all follow this principle.

Thank you

Jose alves

In 1995, I corresponded with great respect with Mr. Peña until I realized that he was not interested in evidence and not only did not know the anatomy and physiology of anorectum, but fundamentally did not want to know, because this knowledge rejected PSARP as a useful operation for ARM. Since I began to use the Internet to this day, I have not found a single scientific article by Mr. Peña. All his articles represent the experience of unsubstantiated operations on children and a lie about positive results. The PSARP operation, which Peña performs and promotes, destroys the anal canal and makes children disabled for the rest of their lives. Peña was on the Forum list, but he never made a refutation of my accusations. Every day, which does not stop him from his unscientific activities, turns into a disaster for some babies with ARM.

From: Ivo.deBlaauw@radboudumc.nl <Ivo.deBlaauw@radboudumc.nl>

Отправлено: 13 июля 2018 г. 11:24

Кому: nivel70@hotmail.com

Тема: Re: Anorectal malformations

Dear Michael,

Please remove me from the mailing list as well. At first it seemed reasonable what you wrote but at the moment your papers are just as non-scientific as all other papers you say that are untrue.

You seem to get stuck in theoretical thinking and not as much in clinical thinking. It appears to me that you have never seen or operated on a child with a perineal fistula.

I wish you all the best,

Ivo de Blaauw

I agree with two of the three conclusions in this letter. Firstly, all my radiological and manometric research methods, as well as surgery methods, are the result of theoretical research. Secondly, I never operated on patients with a perineal fistula. But I developed a method of operation that was performed by Professor Nikiforov.

Imagine how many theoretical developments work in a nuclear power plant (chemical, electrical, mechanical, nuclear, etc.). Or, for example, how many theoretical developments are invested in a rocket leaving gravity. Therefore, I do not agree with the definition that my theoretical studies have no scientific value.

As evidence, I propose to analyze the x-ray from an article by Thomeer et al, in which Dr. Ivo De Blaauw took part [2].

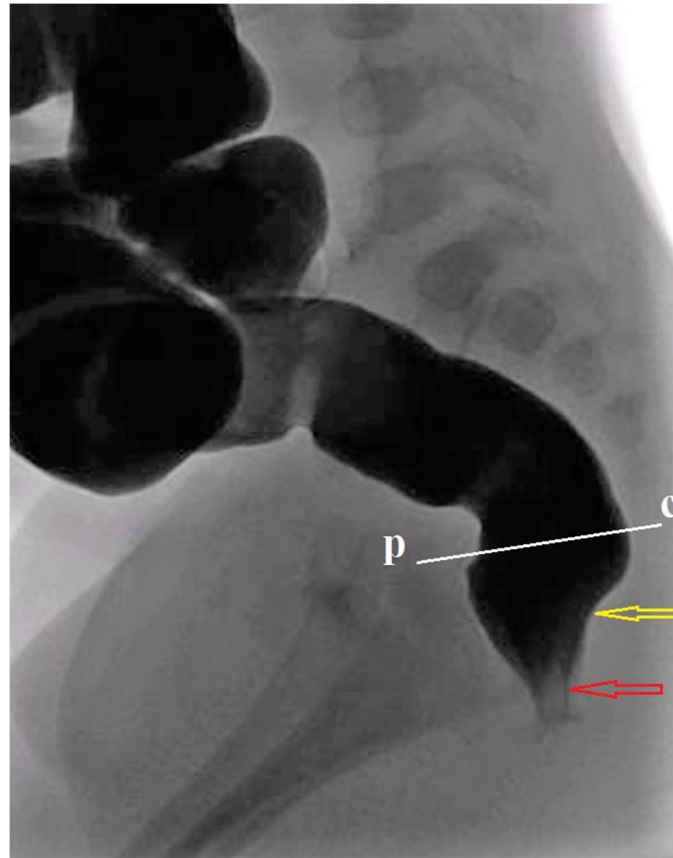


Figure 1 c. (Signature from the article). One-month-old female neonate with a vestibular fistula (a–d). MRI and correlated drawing shows axial slices (a, b) of the distal orifice with typical layered aspect of the intrasphincteric region (like a starfish), which was therefore interpreted as a normal colon (b). This starfish sign (*) refers to the layered aspect of the bowel on perpendicular view. c shows the anterior position of the rectal orifice on fistulography, with a normal composition of the intrasphincteric part, as in normal colon.

Analysis. The white line is a P-C line. It is held between the rectum above and the anal canal from below. In the anal canal, there is an enema tip in the form of enlightenment against the background of a contrast medium (red line). The enema tip blocked a narrow fistulous foramen located in the vestibule so there is no leakage of contrast medium, despite the opening of the anal canal. During the administration of the contrast medium, the high pressure arose in the rectum, which led to the reflex opening of the anal canal. The yellow arrow shows a slight depression on the back wall at the top of the anal canal. These are concavity due to the puborectalis muscle. Since the length of the anal canal at this age is from 1.7 to 2 cm, the width of the rectum is ≈ 1.4 cm, i.e., within normal limits [3].

Conclusion: Ectopy of the anal canal on the vestibule with stenosis of the outlet and the normal width of the rectum.

Discussion. From anatomy, it is known that the part of the intestine that is located caudally of the pubococcygeal line which is constantly closed as a result of contraction of the surrounding sphincters and which is wide opened under a certain pressure in the rectum, is called the anal canal, and not "the intrasphincteric part, as in normal colon". On the roentgenogram, there is a typical

picture of a normal anal canal. It is in constant contraction because there is an internal anal sphincter, which is connected by nerve connections to the rectum, external anal sphincter, and puborectalis muscle. During the PSARP operation, the puborectalis muscle is intersected, the internal anal sphincter is dissected, the elevators plates are separated from the rectum and all nerve connections are intersected. Instead of a functioning anal canal, a perineal fistula is formed. Since the rectum is not connected by neural connections with levator plates, the latter do not open the reduced rectum during the accumulation of feces, which causes chronic constipation, fecal retention, and the development of megacolons. The absence of an internal anal sphincter and neural connections of the intestine with striated sphincters (EAS and PRM) leads to fecal incontinence. If the fistulous course is narrow, constipation predominates, and if wide, fecal incontinence predominates. Urinary incontinence and sexual dysfunction result from denervation of the pelvic organs.

I turn to pediatric surgeons. Thank you for following my work. I'm in a hurry to tell you how the anal canal functions in normal and in ARM, because every day one of the newborns with an ARM can get lucky and the anal canal will be preserved, or it will be irretrievably destroyed for someone. I remain hopeful that among those surgeons for whom I explain my work, there are scientists who check the validity of my ideas and the advantage of my methods of operation.

I wish you and your patients' success.

respectfully

M. Levin.

P.S. I urge a discussion of anorectal problems. I really appreciate your support and would be grateful if you would allow me to publish them on the Forum.

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