The Author Replies

To the Editor—We thank the authors for their very thoughtful and astute response to our study. First, the authors correctly identify the inadequacy of the clock-face technique. This inadequacy led to the development of a more accurate grid technique that evaluates the entire specimen in smaller, consecutive sections. Our follow-up study using this improved technique is ongoing, and we plan to report our results once completed.

After reviewing our data, the authors are again correct: the median scatter in any direction was 1.00 cm, less than the previously reported mean of 1.35 cm. However, what remains interesting is that we focused on a tumor scatter of 2 cm or more. When we reevaluated our results based on a 1-cm margin, 16 patients had cancer cells scatter 1 cm or more in any direction outside the residual ulcer. Six of these patients had cancer cells present at 1 cm or more distal to the ulcer. In addition, these numbers do not include those 7 patients who appeared to have complete clinical response, but had microscopic tumor underlying normal mucosa. Thus, 30.7% (23/75) of patients would have had positive margins or cancer left behind if a 1-cm margin from the residual ulcer was used to determine the distal margin during radical surgery, if the circumferential margin was used to determine the distal margin during local excision, or if surgery was avoided entirely.

Again, we thank the authors for their extremely insightful response. The reexamination that they provoked only reconfirms the importance of understanding the pathologic and microscopic response of rectal cancers to radiation. This unpredictable pattern of tumor scatter occurred in almost one-third of patients, revealing that we continue to operate based on an invisible margin.

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Dis Colon Rectum 2013; 56: e346
DOI: 10.1097/DCR.0b013e318293e3f0

Surgical Treatment of Acquired Rectourethral Fistulas: Our Experience With Posterior Transrectal Transsphincteric Approach

To the Editor—We would like to congratulate Hechenbleikner et al[1] on their systematic review of the treatment of acquired rectourethral fistulas (RUFs), a rare but severe complication of rectal/urinary tract surgery or radiation therapy. Several operative techniques and approaches have been proposed over the years.

To report our experience of RUF treatment, we would like to share information on the long-term outcomes of our extensive series (published in part in 2011,[2] but not mentioned by Hechenbleikner et al, perhaps because they were reporting RUFs as a complication of interventions). Our updated series now includes 15 RUF patients, secondary not only to prostatic open or endoscopic surgery (14 cases), but also to radical cystectomy with ileal orthotopic neobladder (1 case). Between 1988 and 2012, our patients underwent posterior transrectal transsphincteric surgical repair according to the York-Mason procedure/technique.[3]

All cases were successfully treated; only in 1 patient, who had Crohn's disease, did RUF recur 11 years after the repair. We found no evidence of postoperative urinary or fecal incontinence or anal/urethral strictures.

In terms of surgical approach, we do not agree with Hechenbleikner's conclusions, who consider transsphincteric repair less efficacious than the transperineal technique, because of limited exposure and the inability to excise and repair the fistula adequately.

The results of our series demonstrate that the transsphincteric approach allows maneuverability, excellent exposure of the fistulous tract, scarless dissection, meticulous repair with layered and transverse closure, and avoidance of overlapping suture lines. In addition, the minimal risk of urinary/fecal incontinence make this technique safe and uncomplicated.

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Dis Colon Rectum 2013; 56: e346
DOI: 10.1097/DCR.0b013e318293de43