Commentary on the article "Anatomical sphincteroplasty by combined reconstruction of the internal and external anal sphincter in the surgical treatment of anal incontinence"☆

Comentario al artículo «Esfinteroplastia anatómica mediante reconstrucción combinada del esfínter anal interno y externo en el tratamiento quirúrgico de la incontinencia anal»

I have read with great interest the article and video published by García Armengol et al.,[1] in which they describe in a precise and masterly manner how to perform a combined sphincteroplasty of both anal sphincters.

The great experience of the so-called ''Valencian School of Coloproctology'', and in particular of these authors, in the anatomical repair of the anal canal is well known.

On this occasion we find a technical modification in which the internal sphincter is repaired in addition to the external sphincter. As the authors point out, this technical modification has already been described by Wexner et al.[2] and published in subsequent series by other authors, with discrete results and benefits.[3,4]

These results, together with the fact that dissection of the internal sphincter requires greater technical skill, may have limited its widespread use.

However, we believe that this publication is very timely, as there is currently no effective tool available to treat patients with internal anal sphincter defects, as the so-called bulking agents (collagen, hyaluronic acid, etc.) are no longer available on the market, so we will undoubtedly have to consider surgical repair in order to restore the anatomy of the anal canal.

Having said this, we must not forget that, in contrast to the repairist approach to the sphincter complex as a treatment for structural anal incontinence, there is also the approach that opts for direct sacral root stimulation, which must also be taken into account.

As far as I am concerned, we are in complete agreement on the need to correct the deformity of the anal canal, in addition to trying to increase its length (whether or not sacral root stimulation is subsequently performed). I believe, like the authors, that this repair will at least achieve a more precise closure, regardless of whether or not it is with increased pressure.

We are pleased with the clinical and functional results they present, although the number of patients and follow-up does not yet allow us to clearly establish the true role of the technical modification they propose.

We invite the authors to carry out a comparative multicentre study (with and without internal plasty and even a group with direct sacral stimulation) in which we can evaluate the excellent preliminary results obtained in their pilot study with a larger number of patients and with long-term follow-up.

Conflict of interests

The author has no conflict of interests.

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