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CORRESPONDENCE

Sir,

We enjoyed the article by Rotholtz et al. [1] defining manometric variables in rectocele patients with symptomatic constipation, but have several comments. The manometric differences in these patients may be quite subtle and it was not stated whether differences in rectal compliance and sensation were detected between cohorts of patients with rectocele when incontinence was also a major symptom. We have found that the components of rectoanal inhibition are markedly different from age-matched normals in patients who present with passive incontinence and rectoceles, particularly when there is demonstrable external anal sphincter atrophy [2].

These patients have low squeeze pressures as expected, but a more rapid recovery of their pressure wave following inhibition (without differences in rectal capacity), suggesting that inherent internal anal sphincter behavior is a significant mechanism preventing fecal leakage when continence is already compromised.

The clinical importance of anorectal manometry in directing surgical management for rectocele patients is (as the authors stated) not defined. The manometric and clinical distinctions, as suggested by Pucciani et al. [3], between type I (so-called distension) rectoceles with relative rectal dyssynergia and high resting and squeeze pressures and the type II (so-called displacement) rectoceles where resting pressures are low and rectal capacity is high, appear at best to be artificial and were not reproduced by our group [4]. This being said, the ultimate goals of preoperative manometric rectocele classification include the ability to delineate those patients likely to benefit from surgery as well as to direct the use of a transperineal approach for the performance *en passant* of sphincteroplasty or levatorplasty [5]. These decisions appear at the moment to reflect the clinical presentation of rectocele patients more than their preoperative anorectal manometry results [6]. The finding by Rotholtz and colleagues that 9 of every 10 rectocele patients have additional demonstrable "pathology" of the pelvic floor which could conceivably contribute to their symptoms is important and shows, as Dr. Pescatori stated in his comment, what a minefield this surgery may become. Using enhanced transperineal ultrasonography as the primary imaging modality in patients presenting to a specialized pelvic floor clinic, our group has recently confirmed that at least three-quarters of referrals have multiple pathologies [7]. In the absence of clinical trials comparing defect-specific transvaginal, transperineal and endorectal rectocele repair, the coloproctologist is currently cornered when deciding just how much a rectocele contributes to the symptom complex of evacuatory difficulty, with no real surgical evidence base for when and how to operate. We cannot yet say in 2003 that manometry has anything to offer in getting us out of this corner.

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Sir,

I read with interest the article by Zimmerman et al. on the treatment of rectovaginal fistulas (RVFs) [1]. There are several treatment alternatives in common use, some of them quite sophisticated, but still the results are not really satisfactory. For several years, my colleagues and I have been practicing a simple technique for the management of RVFs [2]. The results we had obtained in treating anorectal fistulas [3] and pilonidal sinus [4] by cauterisation encouraged us to use cauterisation also with recurrent RVFs: 10 were

obstetric and 2 followed car accidents [2]. The fistulas were located in the lower (4 patients), middle (6 patients) or upper (2 patients) third of the vagina. Under general anesthesia, a cauterisation probe was introduced into the fistulous track, and an electric current was switched on at a frequency of 20 000 cycles s^{-1} and a power of 30 W. Two patients required 2 sessions to achieve fistula healing. All fistulas healed without recurrence during a mean follow-up period of 24 months. No complications were encountered.

We have since completed the treatment and follow-up of another 18 patients with RVFs: 11 of the low, 6 of the middle and 2 of the high vaginal type. The mean follow-up was 36 months. All fistulas of the low and 5 of the mid-type healed; recurrence occurred in 2 mid-type and in 2 high type fistulas. Recauterisation of these two fistulas did not achieve healing.

Fistula cauterisation is a simple and easy procedure without complications. I propose that this technique be performed before resorting to other more sophisticated techniques.

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Sir,

We were interested to read the letter by Dr. Shafik. He refers to a simple and easy technique for the treatment of rectovaginal fistulas [1]. Dr. Shafik reports a large series of patients with this condition, and an initial healing rate of 87%. A second repair was successful in 3 of 4 patients. It is surprising that Shafik's technique has not been utilized by other surgeons. In our opinion there are two reasons for this. At the time of the first report by Dr. Shafik, transanal advancement flap repair [2, 3] was advocated as the treatment of choice for women with rectovaginal fistulas. The excellent results after this procedure, reported in that period, resulted in little interest in alternative surgical procedures [4–6]. However, it has been demonstrated recently that the healing rate after transanal advancement flap repair is much lower than that reported earlier [3, 7]. It seems likely that nowadays surgeons would consider alternative techniques for rectovaginal fistula repair. A second reason for the hesitation among surgeons to utilize Shafik's technique is the fact that many women present with concomitant fecal incontinence [5] due to obstetric sphincter damage. Most techniques for rectovaginal fistula repair allow concomitant sphincter repair. At first glance, electrocauterization of the fistulous tract does not allow such a repair, making it a treatment modality only useful for a selected group of patients. Notwithstanding this criticism, we fully agree with Dr. Shafik that it is worthwhile to try a simple and easy technique before resorting to other, more sophisticated techniques.

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