Dear Editor:

I read with interest the paper by Reboa et al. reporting good results after STARR procedure in a group of constipated patients. Less satisfactory results were achieved using the stapled transanal mucosectomy, first described by Pesca-tori, Favetta, Dedola and Orsini in Techniques in Coloproctology in 1997 for the treatment of rectal internal mucosal prolapse (and not, as stated by the authors, by Longo, who instead reported it for the cure of hemorrhoids one year later).

STARR is a novel operation which gained some popularity despite being introduced in the clinical routine prior to a randomized controlled trial showing its efficacy compared with other manual and less costly techniques. Unfortunately, the authors do not quote at all several important references underlying the limits and the risks of this novel procedure. These include the papers by Dodi et al., Tech Coloproctol, 2003, reporting severe bleeding and pain; Jayne and Finan, Br J Surg 2006, criticizing the introduction in the clinical practice before an adequate scientific evaluation; Pescatori et al., Int J Colorectal Dis 2006, Bassi et al., Tech Coloproctol 2007, describing postoperative recto-vaginal fistulae; Gagliardi et al., Dis Colon Rectum 2006, reporting poor results in large rectoceles and a fatal pelvic sepsis; Arroyo et al., J Am Coll Surg and finally Pechilivanides et al., World J Surg, 2007, reporting high short-term reintervention and recurrence rate.

The same omissions are found on the website www.emorroidiastipsi.com in which transanal stapling supporters state that the STARR is an operation which carries no risk. This simply is not true.

The STARR is an appealing procedure, but its supporters should give the readers an honest and comprehensive review of the existing literature, including both pros and cons of the operation, aimed at minimizing the risk of failure, in the interest of the patients.

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Authors' reply

The original findings by A. Longo regarding stapler-assisted trans-anal surgery for the treatment of hemorrhoids and outlet obstruction syndrome are universally known. He is recognized as the leading author in this field and his references in this paper is mandatory.

STARR is frequently quoted as a novel operation which has gained popularity despite being introduced in the clinical routine prior to a randomized controlled trial showing its efficacy compared with other manual and cheaper techniques. Actually, apart from a randomized trial including 50 patients by Boccasanta et al.,1 this is a common limitation of many surgical procedures currently attempted for the resolution of outlet obstruction syndrome, and this should prompt the need to perform a randomized clinical trial in this setting.

However, literature data on STARR are currently available only on a few hundreds of patients, thus suggesting that the procedure still requires a careful prospective assessment as well as an adequate learning-curve that cannot be readily achievable with a few operations.

This was the true message of our report, avoiding any enthusiastic support to STARR with the primary aim of an objective assessment of the clinical outcome of these patients, supported by nonmetric and defecographic findings. Thanks to the comment of our reader, we now have another opportunity to stress that this is not “easy surgery”. It requires a specialized approach that only the modern coloproctologist used to stapling devices can provide, and not the traditional proctologist. Moreover, a learning phase with a simpler procedure such as the stapled anopexy for the treatment of hemorrhoids is advisable, with at least 30 to 50 operations regarded as the cut-off before starting with STARR Procedure. As a matter of fact, looking at the complication rate, those Authors2,3 who dealt with a rather low number of patients (less than 16 patients) experienced very poor results with a high rate of postoperative bleeding (14-21%), urinary retention (8-26%), pelvic sepsis (7%), urge to defecate (19-25%) and pain (7-28%) while the corresponding figures are remarkably lower with the increasing number of patients.4,5

REFERENCES
Dear Sir,

I was never able to meet Prof. Ahmed Shafik in person. In comparison to others expressing their feelings following his death I cannot say that I have worked with him, nor was I one of his students. My link with Professor Shafik is through his scientific papers.

My first contact took place as a resident in Surgery when I studied his paper on the pathogenesis of anal abscess and fistula. The original and more complex Shafik theory of anorectal sinus was in contrast to the cryptic glandular and the perineal infection theories of Eisenhammer and Goligher. The originality of his theory was the distinguishing mark of a sharp, unique and sometimes unconventional mind.

The contribution of Professor Shafik to pelvic floor medicine was immense. Over 500 peer reviewed articles are listed in Pub Med. He was unique in the extent of his imagination, exploration and discussion. His papers ranged from his descriptions of the patho-physiology of colorectal, lower urinary tract and genital diseases in both males and females to the development of new surgical techniques. He was a pioneer in surgery and developed techniques such as the cutaneous uretero-ureterostomy urinary diversion “Shafik I” and the ileo-ureteral neo-bladder “Shafik II” procedures. Shafik’s description of the pudendal canal syndrome where entrapment of the pudendal nerve in Alcock’s canal could be treated by surgical decompression led to a reduction in the symptoms of proctalgia, scrotalgia, prostatodynia, vulvodynia as well as amelioration in erectile dysfunction and faecal incontinence.

Shafik’s scientific work was distinguished by a methodological rigor in medical research. He first investigated his ideas in animal models and with cadaveric dissection. He obtained a theoretical and empirical rationale for his clinical diagnosis before he embarked on any new therapeutic intervention with controlled trials.

In the last years of his life functional anatomy and physiology were his most important areas of interest. Prof. Shafik investigated the macro and microscopic anatomy of the pelvic floor musculature and highlighted more than one hundred reflexes regulating and coordinating pelvic organ function. His work increased our understanding of urinary and faecal continence, voiding problems, defaecation, sexual dysfunction and pelvic pain. He expanded our knowledge of the function of the gastrointestinal and genital systems by discovering four reflexes involved in swallowing and eighteen reflexes which control genital function and sexual performance in both sexes. He described nineteen syndromes and explained the aetiology of a number of other diseases which previously had been considered idiopathic.

Shafik identified the central role of Cajal cells in the generation of the electric waves responsible for colonic motor activity. The absence of Cajal cells in the specimens of patients with total colonic inertia confirmed this brilliant hypothesis. In a series of nine patients with inertia coli, he found that treatment with colonic pacing induced spontaneous rectal evacuation in 66.6% of cases providing a new therapeutic option in the treatment of severe constipation.

Shafik suggested a relationship between the colonic motor disorders due to an aberrant focus in colonic pacemakers, called “tachyarrhythmia”, and the symptoms of Irritable Bowel Syndrome (IBS). Colonic pacing in IBS patients not responsive to the other classical therapeutic measures, induced the normalization of the tachyarrhythmic pattern with a reduction of IBS symptoms. On the basis of finding the same pathophysiological electrical and motility patterns Shafik proposed a new explanation for the pathogenesis of early diverticular disease suspecting this to be an advanced stage of IBS.

In his busy laboratory and clinic in Cairo, Egypt, Shafik pioneered new advances in medical, bio-engineering and diagnostic technology. He developed an electrified urine catheter for decreasing bacteriuria and a fecoclofowmetry system to provide a quantitative and qualitative assessment of defecatory function. New routes for drug administration in advanced pelvic malignancy (bladder, prostate and uterus cancer) using rectourethroginal communicating veins (haemorrhoidal, vesico-vaginal and the vesisco-static venous plexus) were evaluated. Submucosal anal injection with a high local concentration of chemotherapeutics agents could be given with reduced systemic effects. According to Shafik this anatomical pattern could explain the supposed relationship between constipation and lower urinary tract symptoms (LUTS), causing mainly urinary tract infections in female patients.

Thanks to his work in gastroenterology, colorectalology, urology, gynaecology, and andrology Shafik was one of the few surgeons, if not the first and only one, with an effective trans-disciplinary view of the pelvic floor that he considered as a functional unit. He discovered important relationships between the different compartments enhancing the understanding of pelvic physiology and anatomy and he emphasized the importance of connective tissue in pelvic physiology.

The fascinating originality of his papers and his scientific proposals, as well as his unique character, appearance and expression, made Ahmed Shafik a figure on the world stage. Like all great thinkers and prophets his teaching was sometimes surrounded with scepticism by the scientific community and accepted with difficulty because according to his critics his work was not supported by evidence based medicine. Shafik preferred to create and describe innovative surgical operations and explain new concepts in physiology and anatomy rather than carrying out meta-analyses or undertake prospective controlled trials. He worked off the beaten track to show us alternative and attractive new ways.

Creativity and unconventionality were the main distinguishing marks of Ahmed Shafik. He showed us that curiosity was central in our work and that clinical practice and academic science have to coexist in the same individual. The surgeon is both a physician and a scientist, and he has to balance the demands of his clinical practice with his academic commitment. Professor Shafik pursued the unitary view of the pelvic floor for his entire life as a scientist. We shall miss him greatly.

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