Review of: "Anorectal Malformations with Visible Fistulas. Theoretical Substantiation of a New Version of the Cutback Procedure"

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Potential competing interests: No potential competing interests to declare.

Dear authors, I have read with great attention your manuscript. This is a very interesting technique. However, I have some disagreements and some doubts that would appreciate if you could solve:

1. The authors mention that visible fistulas have a normal anal canal. What do you consider a normal anal canal? In ARM there are some absent structures such as the pectinate line. Dr. Peña talks about that most ARM do not have anal canal except rectal atresia, and that the perineal fistula has a primitive anal canal (*Surgical Treatment of Colorectal Problems in Children. 2015. ISBN : 978-3-319-14988-2.*)
2. The authors mention that according to Uemura et al. the epithelial and ganglionic distribution was the same in the distal rectal end of the ARM and in the normal anal canal. Neverthless, Dr. De La Torre, explains that the first neurons appear 1 or 2 cm from the pectinate line. This means that despite the existence of mucosa with rectal epithelium in the anal canal, the normal plexuses are located higher up.
3. The authors mention an article written by Ohama et al.involving 5 children with anorectal malformations where a preoperative manometric study was performed using a probe inserted from the distal colostomy. The study revealed rhythmic activity in all patients and a positive reflex pressure drop during rectal distension. Consequently, they conclude that ARM cases with visible fistulas unveiled the functional attributes of the normal anal canal (with rectoanal inhibitory reflex). You also mention that in the rectoanal inhibitory reflex, the pressure reduction in the anal canal results from the relaxation of the IAS. I understand that ARM have normal motility because they present ganglion cells, but how can be possible for the rectoanal inhibitory reflex to exist if the fistula is not surrounded by the anal sphincter? I could comprehend its existence just if the fistula is partially surrounded by the sphincter. Could you please clarify this fact?
4. We can read in your manuscript that despite the posterior incision resulting in the normal functioning of the anorectum, some surgeons treat vestibular fistulas, due to cosmetic concerns, repositioning the isolated fistula to the center of the subcutaneous EAS ring. I think that this decision is made not only for cosmetic reasons but also because the anus immediately behind the vagina without the perineal body will contraindicate a vaginal delivery in a potential future pregnancy.

5. Finally, I would like to know the number of patients the authors have treated with this new technique and the follow-up time. Also, do the authors have real surgical images and/or videos?