This new book by Professor Pescatori is a small gem. It reminds me of the first time I opened John Goligher’s Surgery of the Colon, Rectum and Anus or Bill Hughes’ Proctology, both of which became my personal colorectal bibles. Each of these books is designed to teach the trainee and colorectal surgeon alike the way forward for complex anorectal problems and how best in those circumstances to pragmatically use the available evidence base. The hand of Sir Alan Parks weaves through Pescatori’s work and it is clear that the great man had a seminal influence on his (i.e. Pescatori’s) approach to proctology, where more sophisticated texts are now turning towards complicated surgical problems and proctological reconstructions. The structure of the book incorporates a rather unique approach with each chapter ending with an ‘unforgettable complication.’ The medicolegal subtext is particularly evident in each one of these complex cases where the avoidance of medicolegal suits related to a tertiary colorectal referral base is one of the keys to any successful practice. The holistic nature of this book, paying attention to the psychological aspects of each case, bears witness to this concept and recognizes the marriage as it were between patient expectations in cases where there is already considerable morbidity prior to referral along with the background of often multiple failed procedures and the ability of the surgeon to deliver on at least some of those expectations. The sheer honesty of many of Professor Pescatori’s remarks reminds me of the open honesty both in print and in person of John Goligher.

The book covers the gamut of proctological practice as it would be referred to a proctologic specialist and the author cautions us in today’s climate of some surgical innovations where in some cases the tried and true validation of newer technologies has not been strictly applied and where to some extent market forces have driven specific use in the absence of randomized clinical data. Topics beautifully illustrated include the assessment of patients with recurrent anal fissure or who suffer specific complications after conventional surgery as well as incorporating a consideration of recent sphincter-saving alternatives. The newer stapled haemorrhoidopexy procedures (and their variants) are analysed with a deliberate emphasis on those patients who functionally fare badly after these so-called “painless” procedures. For me, the “British” stiff upper lip may be evident in the remarks made concerning the swap some patients have to make for complex fistula cure with a “little incontinence,” where clearly we who practise in other parts of the world feel perhaps a greater cultural pressure concerning outcomes which may be more regionally unacceptable. The issue of imaging and its specific role in the multiply operated fistula case is not really addressed although I appreciate that some have little interest in its use even in high procedures. I personally feel that anything which complements the surgeon’s 3-dimensional view prior to surgery and which aids in “getting it right” is of advantage but that is both a theoretical and a practical matter of interpretation. The implication in this chapter with which I would agree is that our beloved Parks’ classification system may not translate meaningfully to these more thorny fistulae-in-ano many of which have in part been iatrogenically induced and which do not follow expected anatomical patterns.

Professor Pescatori deftly deals with rectovaginal fistula touting John Northover’s “rule” that we tend to stick with what works best in our practice. For me, like an approach to functional rectal disorders, it is wisest to use something simple in the first instance with a modicum of success where
what is employed initially is unlikely to compromise subsequent surgical repair if recurrence rears its unwanted head. It has always been hard for me to understand why the perianal sinus is the proctologist’s domain but we appear just as bad at its successful management as our general surgical colleagues. It may be that we will move towards the more minimalist trephine approach (not mentioned) of Israel’s Moshe Gips. There is no doubt that the surgical management of some rectal cancers is becoming more minimalistic, particularly in elderly frail patients and those where there is a complete or near-complete response to neoadjuvant therapy and these issues are nicely addressed although we currently don’t have all the answers to know whether such approaches are safe. The issues pertaining to perineal and perianal resurfacing are nicely covered with fine representative images. Such is of relevance for our expertise which also is often sought in the management of patients presenting with Fournier’s gangrene.

The surgeon whose specialist interest is in the management of the difficult range of pelvic floor disorders is particularly at risk where there is a poor correlation between anatomical correction and symptom improvement, where a dominant pathology may have been operated upon in the face of multi-compartmental disease and where pre- and postoperative symptom scoring systems are at best fairly subjective. Professor Pescatori in my opinion quite rightly cautions us regarding some of the novel stapled technologies but this dual dialogue where some invoke widespread use almost devoid of complications and others seem saddled with sometimes intractable post-STARR “neo-symptoms,” reflects our poor understanding of the indications and contraindications for these procedures. What he tells us is that once we get severe functional disturbances after such surgery, these patients are often resistant to conservative therapies or re-operative interventions. On the other side of the functional coin, he has provided us with a healthy perspective concerning the innovative procedures for the management of anal incontinence. Such perspective seems realistic given the decline in some particularly expensive procedures such as the dynamic graciloplasty and the artificial bowel sphincter which require frequent troubleshooting (and explantation) and which have been reflected in the decline of their use in worldwide proctological audits. Pescatori in his final chapter tackles rectal prolapse without being in any way prescriptive, although this section provides insight into why the lofty ideals of the UK PROSPER trial have sadly failed to advance the cause.

Overall, this is a unique text based on the author’s personal experience over the last 4 decades in a life devoted to understanding both the science and the human aspects of his practice. The loving hand-painted artistic representations of many of his patients’ complaints is a testament to the great affection he has for them and for his craft. I would recommend this book to all those interested and involved in a tertiary referral proctological practice.

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Prevention and Treatment of Complications in Proctological Surgery
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2012, XV, 201 p., Hardcover
ISBN: 978-88-470-2076-4