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LETTER TO THE EDITOR

Reply to Reck-Burneo et al.: imaging anorectal and cloacal malformations

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Dear Editors,

We thank Dr. Reck-Burneo and coauthors [1] for their interest in our recent article. We appreciate their valuable comments and suggestions concerning our imaging recommendations for patients with cloacal and anorectal malformations [2].

Our aim was to present imaging and procedural recommendations based on consensus within the European Society of Paediatric Radiology (ESPR) Abdominal Imaging Task Force and following public discussion at an ESPR meeting. We took into account differences in viewpoints among various European centers/national societies. A comprehensive review of imaging of cloacal and anorectal malformations was beyond our scope.

We completely agree that a multidisciplinary team approach is fundamental when treating patients with cloacal and anorectal malformations. Particularly for patients with cloacal malformation who require highly specialised reconstructive surgery, an individualised imaging approach resulting from close collaboration between the paediatric imaging and paediatric surgery teams (including all subspecialties involved) is crucial, and these infants should be treated in a dedicated paediatric centre.

Classifications are helpful for the majority of conventional cases, and we agree that the Krickenbeck classification is insufficient for the rarer and more complex cloacal anomalies.

All anatomical structures, including the urethra, must be identified and analysed. Furthermore, any potential fistulous tracts must be delineated. Because of their erratic nature and unpredictable course, these tracts are better depicted, and easier for the surgeon to understand, on fluoroscopic studies. Volumetric images can be achieved if rotational three-dimensional fluoroscopy equipment is available, as mentioned in Fig. 7 of our recommendations [2].

For the colostogram, after filling the colon, it is essential to maintain pressure to allow filling of any potential fistula, as also stated in Fig. 7 of our recommendations [2]. Dynamic filling techniques also apply for magnetic resonance studies, although they may not be equally easily achieved for technical reasons and particularly in young children.

We also agree that presacral masses must be ruled out, and this is part of the initial investigation of associated anomalies starting with a detailed and complete ultrasound examination of the entire abdominopelvic cavity and the spine. More advanced imaging such as computed tomography and magnetic resonance imaging may follow depending on the sonographic findings.

The above highlights how important it is for radiologists and surgeons to work together for a better understanding of the imaging needs, technical restrictions and treatment options for these complicated congenital anomalies.

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