of causality, which is unlikely to be accomplished at the level of an independent patient in clinical medicine.

Meanwhile, **clinical approach** deals with individuals, families. The service provider's mission (= clinician) is to do the best for the patient. Although criticized for an insufficient attention to prevention, clinical medicine is not only inherently related to the treatment (treatment, cure) of the patient, but also to the prevention. In fact, in recent decades, time and resources devoted to prevention of the 'disease' have been significantly increased, especially in the area of secondary prevention (screening). At times, clinicians have emphasise the importance of the primary prevention. On the other hand, it is true that the inner, intrinsic of clinical approach is the focus on the individual, or sometimes even the family, regarding the diagnosis and therapeutic intervention, with the aim of realizing tertiary prevention, ie healing (though essentially without restitutio ad integrum) but meanwhile, education and health promotion to the patient and also to his/her family environment remains the other side of the medal of modus operandi of every clinician.

In conclusion, let's hope that all of the above elaboration, with the emphasis in the last part of it, has answered the basic question of this paper "Focus on health or illness?".

Diagnoses and Surgical Management. (Personal Case)

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Congenital posterior urethral-perinal fistula is a rare anomaly of which there have been reported only one case to date. This report outline the simple clinical presentation, diagnosis and simple technique surgical management. Congenital posterior urethral-perineal fistula is a rare anomaly. This is a rare case in the world literature. There are reported only six cases since 1964. Dr. William C. Brown, Dillon, Heusele has reported one case (diagnosis and new surgical technique). Other authors have reported rare cases: Le Duc has reported one instance ofan urethral-rectal fistula in the absence of any anorectal abnormality. Out of the 7 cases previously reported one is actually an urethral scrotal fistula but it is included since it has a similar embrylogic origin to the rest of the series.

The embrylogic basis for these anomalies is unclear. However two main theories have been proposed. Olbourne believes that if delay occurs in the descent of the anorectal septum at four weeks of gestation, then a fistula could result between the inferioraspect of the rectum and the primitive urogenital sinus. This may occur along the distance between entrance of the mesonephricduct which is the area of the prostatic urethrea and the urogenital ostium which will be the future area of the bulbons urethrae. Later dissolution of the anal membrane leaves the fistula at the site of the anal rectal junction. If the urethral folds start their fusion too far forward then a fistula may result.

In contrast to this I believe that the lateral ridges of the urorectal septum grow. into the cloaca and divide it as they meet in the midline. A defect in this midline joining would certainly account for fistula.

The anal plate which forms separately forces the opening to develop outside the anal sphincter and anus. This is important for surgical management. Woodhead

attempted of the fistula by endoscopically fulgurating the opening in the urethra; Elder's technique for correction was a combination of open excision and technique of fulguration which has provided outcome at six months.

A six year old boy from Southern part of Albania visited at Clinic of Urology in Tirana. His father explained that his child has dribbling urine from perineum with voiding. Physical examination in the clinic revealed no anorectal malformations. His urinary stream was normal in force and calibre. (The child's long miction was points-points urinefrom perineal fistula). The biochemical analysis were normal. The patent's urinalysis and urine culture were within the normal limits.

U.I.V. The kidneys were normally functioning and so were the ureter and bladder. Avoiding cystourethrogram revealed a prominent posterior urethral between prostate and bladden neck was fistula. At this study it was not yet know whether the fistula opened into the rectum or opened into the perineum. For this reason the child was scheduled for uretroscopy and cystoscopy-chomocystoskopy. This examination is conducted under anaesthesia with ketamini. Before the operation we put in fistula meatus a cutaneopennealis catheter uretheral Nr. 4Ch.

During urethroscopy urethre at two o'clock we observed in the posterior urethral wall above veromontary, on the left side position and the catheter uretheral looked inside in urether. The diagnosis is clear. Fistula urethro-perineal-cutanea.

The position Trendelenburg with incision median suprapubic prepareted blodder looked one cordon fibrous 2 cm with catheter uretheral inside. This cordon was coming between left lob prostate in apex and bladden neck.

We made excision and put 2 suture with vicrol 3,0 in the uretrae outside. In the urethare and bladder put one Foley catheter Nr. 12 ch and removed it after seven days. The child' went home after nine days. After six months or one year the child was in a good health. The congenital urethrae perianal is closed. The congenital urethral-cutaneo-perianal is a rare case. The approach to repair of posterior urethral-cutaneo-peranal congenital fistula with incision suprapubik median in Tredelenburg position with sunture and excision ligation cordon fibrotic is very well for me. (this is good result).

In view of the success of this procedure we believe that endoscopy (1) for defining the diagnosis and operation is very efficient. The child stays 10 days in hospital and enjoys good health.

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