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Dear Editor-in-chief

We would like to thank all the esteemed reviewers for taking out time to review the manuscript and providing invaluable suggestions which have helped to improve the manuscript markedly.

. The changes which have been carried out in the manuscript have been marked in *italic yellow* in this fie and have been highlighted in yellow color in the main manuscript as well.

All the recommended changes have been carried to the best of my ability. In case, there are further changes or suggestions, kindly let me know. I shall be extremely happy to comply.

Sincerely
Pankaj Garg
Corresponding author

COMMENTS TO AUTHORS

REVIEWER-1

Dear author, Thank you for your good work. I have some comments and questions need reply from you;Material methods:

Electrocauterization around the internal opening to create a fresh wound, could this cause stool pass through in the widened internal opening and make he fistula more complicated? Do you think closure with suture or staplar after electrocauterization may help early healing?

Ans: *In PEFACT procedure, the internal opening is not widened. If internal opening is widened, then there would be some chance of stool passing through the internal opening. In this procedure,*

only the mucosa (superficial layer) all around the internal opening is electrocauterized so as to create a fresh raw wound which heals with granulation tissue. The internal and external sphincters are not cut. Due to this, the internal opening is not widened as compared to pre-operative status.

The aim of this procedure is to close the internal opening by secondary intention (granulation). Therefore, closing the internal opening by suture or stapler is not done in this procedure.

What about the cases with internal opening could not be found or high openings?

Ans: *Perfact procedure can also be done effectively in fistula cases where internal opening cannot be localized accurately during the operation. The possible reasons of failure to identify the internal opening are twofold. First, it could be due to temporary closure of the internal opening due to debris. Second reason could be the closure of the collapsible fistula tract (which passes through the sphincter complex) due to external pressure of the sphincter muscle. As per published literature, this can happen in up to 15-20% of cases. In the earlier published series of PERFACT procedure, internal opening could not be found in 15.7% (8/44) cases[5]. Still this procedure was successful in 87.5% (7/8) [5]. The MRI was done preoperatively in every case. This helps to fairly localize the position of the tracts in the majority of cases and give a reasonable idea where the tract is coursing towards the rectum. This information along with the examination findings during the operation (induration of the sphincter in the region of internal opening) helped to determine the most likely location of the internal opening. At that place, the superficial cauterization was done. This was a safe step to do as it created only a superficial wound with no injury/damage to either of the sphincters.*

I would like to ask about curved, long and thin fistula tracts, how do you can curette

them ?Also what about secondary tracts ?

Ans: *At times, the tracts was curved and branching. Preoperative MRI, which was done in all cases, helped to accurately localize the tracts. Once this was done, it helped to curette the tracts (primary tract as well as the branching secondary tracts). For this purpose, the curettes of different sizes and lengths were kept handy. Cleaning the curved tracts usually don't pose much problem as the tracts were usually flexible and adapted to the shape of the curette.*

The transshpincteric (not transassphincterik) supralevator tract was drained and curetted through ischiorectal fossa, Why was not through external opening? How much this is safe since a new tract is created and may lead to complications?

Ans: We thank the esteemed reviewer to point this out. The transshpincteric supralevator tract was drained and curetted through ischiorectal fossa through the external opening only. The Figure -2 also shows this. We missed mentioning this part. We have rectified this mistake and have mentioned this in the revision.

Emptying regularly of fistula tracts: how many times and frequency you do emtying procedure?

Ans: The cleaning is usually done twice a day. We have included this in the manuscript

You have mentioned that "No povidine iodine, hydrogen peroxide or any liquid was injected in the tract during the cleaning process as this would have prevented the internal opening from closing."However one possible explanation for the persistence of anal fistula is the epithelialization of the fistula tract, which prevents the fistula from closing. We reasoned, therefore, that ablation of this epithelial tissue using silver nitrate solution (a corrosive chemical agent) would damage the tract and lead to healing with fibrosis and eventually closureof the tract without surgical intervention.

That we have showed in our study "Should We Consider Topical Silver Nitrate Irrigation as a Definitive Nonsurgical Treatment for Perianal Fistula? " which was published in Dis Colon Rectum. July 2014 - Volume 57 - Issue 7 - p 882–887. Our study demonstrates that application of silver nitrateoften produces a favorable outcome in the treatment of anal fistulas. This procedure is noninvasive, lacks the complications of the conventional treatment modalities, and offers the opportunity for treatment on an outpatientbasis. Silver nitrate solution may be considered as a firstlinetreatment modality of anal fistula. It also is noteworthy that secondary tracts and blind tracts are a main cause of recurrence after treatmentof anal fistulas. Therefore another strength of this modalityis that because we are using silver nitrate solution, aliquid, it can flow into these secondary tracts, perhaps reducingthe rate of recurrence.We have suggested that silver nitrate most likely eradicates anal fistulas via 2 mechanisms.First, it has cauterizing and corrosive propertiesthat may be useful for ablating the granulation and epithelizedtissue lining the fistula tract and for inducinghealing with scar tissue formation and eventual closureof the fistula tract. Second, silver nitrate has antimicrobialcharacteristics, which may facilitate the healing ofthe anal fistula by reducing the microbial load.I recommend you using silver nitrat for irrigation the tract beside the mechanical cleaning with curret which may increase the rates of healing.

Ans: We would like to thank the esteemed Reviewer for this wonderful suggestion. We have read the wonderful article "Should We Consider Topical Silver Nitrate Irrigation as a Definitive Nonsurgical Treatment for Perianal Fistula?. We would definitely like to try to use this procedure along with PERFACT procedure as well as independent of the studied procedure.

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REVIEWER-2

COMMENTS TO AUTHORS

It is a very interesting study, with an important number of cases but there are some considerations to do:?

You may write PERFACT instead of perfact.?

Ans: I have modified the manuscript as suggested by the esteemed Reviewer.

I don't understand core tip, you ought to remove it.?

Ans: It is the requirement of the journal. The decision regarding this can be taken by the Editor only.

You have to write Figure and the number without -.?

Ans: This has been changed in the manuscript as suggested.

References 11-13 in the text are not correctly written, change [11-13] for [11-13] ?

Ans: This has been as suggested.

I don't understand Figure 3, why you can see stitches in preoperation figure??

Ans: This was a loose draining seton put during the previous operation done by an other surgeon. This has been added in the figure legend.

Figure 3: Cauterization around the internal opening & widening of external opening. Loose draining seton (Blue colored) can be seen in the pre-operation (left) photograph which was

inserted during the previous operation by another surgeon 3 months before PERFACT procedure was done. *Left- Pre-operation, Right- Post operation*

Figures 1 and 6 are the same. You have to remove one of them.? Figures 5 and 7 are the same. You have to remove one of them.

Ans: Thanks a lot for the suggestion. I agree that they depict the same concept and lead to repetition. Therefore, as recommended, Figures 6 & 7 have been removed.

REVIEWER-3

COMMENTS TO AUTHORS

This is a very nice study on Perfact procedure. I have no specific comments for the authors

Ans: We would like to thank the esteemed reviewer for the nice and encouraging comments

REVIEWER-4

COMMENTS TO AUTHORS

A new procedure to treat supraelevator fistula-in-ano has been analyzed and discussed. Unfortunately the study cannot give any conclusion. The major limitation lies in its study design. A comparative study should be performed to evaluate safety and efficacy of this procedure. Furthermore the rationale of this technique should be better discussed. It appears to be similar to the concept of the VAAFT technique; why should it be more effective than a video-assisted technique?

Ans: We would like to thank the esteemed reviewer for the comments and the suggestions.

This was a prospective cohort study with no control group. Undoubtedly, a control group would have added value to the study. However the comparative study was not feasible as the prevalence of supralevator fistula is quite low. Secondly, no other procedure in the literature has been shown to be effective in supralevator fistula especially the transsphincteric supralevator fistulas. Therefore, a comparative study couldn't be planned.

PERFACT procedure is quite different from VAAFT. In VAAFT, the internal opening is closed by a stapler or by suturing whereas in PERFACT, the mucosa (superficial layer) all around the internal opening is electrocauterized so as to create a fresh raw wound which heals with granulation tissue. The aim is to close the internal opening by secondary intention whereas in VAAFT, the aim is to close the internal opening by primary intention. Closure of tissues by primary intention put tissues under tension which increases the risk of failure. That could perhaps be the reason that PERFACT procedure seems more effective than VAAFT especially in complex and supralevator fistulas.

REVIEWER-5

COMMENTS TO AUTHORS

This study describes a novel simple method to treat supralevator fistula with satisfactory cure rate of 80% and minimal risk to incontinence. The morbidity was also minimal as there was no cutting of sphincter muscle and the wound was quite small. Perfact procedure allows to treat supralevator fistula without dividing either internal or external anal sphincter. Therefore, the continence scores didn't show any deterioration in any of the patients postoperatively and this procedure aimed to cure supralevator abscess and fistula in a single step.The internal opening is treat by superficial cauterization in the anal canal and seems to be might be a good alternative to other methods of closure like plug, suture, flap, stapler or a clip. The

postoperative management was quite significant. It aimed to keep the tracts clean and empty. Any inadequacy in this care was detrimental to the final outcome

Ans: We would like to thank the esteemed reviewer for the nice and encouraging comments