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Implementation of salvage irrigation-suction following gracilis muscle transposition
in cases of complex rectovaginal and rectourethral fistulas

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Responses to Reviewers' comments

Based on the reviewers' insightful and helpful comments, we have revised the manuscript accordingly. Our specific responses to the comments are listed below. Original comments raised by the reviewers are in *italics*, and our responses are in regular font.

Thank you again for your encouragement and consideration. We hope that this revised manuscript will be acceptable for publication in **WJG**.

Reviewer 1

However, The Authors should quote the Literature about the commonly reported improvement in QOL scores in fecally incontinence irrespective of treatment outcome. In this disease intervening "per se" seems to help psychologically the patient. Therefore, I would reinforce in the discussion that the improvement in both Wexner score and QOL score is the strength of the paper.

Thanks for your suggestion. We made a thorough literature review, and found that there was correlations between the Wexner score and the domains of SF36 in some disorders irrespective of treatment outcome (de Mello Portel la P et al *Eur J Obstet Gynecol Reprod Biol* 2012). However, no study on whether QOL is improved even fecal incontinence remain unchanged after RVFs/RUFs repair is reported. (Page 9, Lines 1-13).

Reviewer 2

1. Was fecal diversion used prior to gracilis interposition in any of the cases?

Fecal diversion were used 3 mo prior to gracilis interposition in 15/19 patients with

RUFs and RVFs (Page 6, Lines 12-15)

2. was a urinary catheter left in place for any length of time after the RU procedures?

Urinary catheter left in place for 1 mo after the RUF procedures (Page 6, Lines 15-18).

3. In one of the cases drainage was noted after one day, was this too soon to consider a failure and begin irrigation?

We apologized that we have made some mistakes. When I reviewed all the medical records, and found the colleagues put the suction drain as irrigation-suction drainage from postoperative d1 to postoperative d7 in one patient(MR#:301760, date of operation: 11/17/2009). Leakage was found in Day7 and irrigation-suction drain was start at once and quit at Day 19 in this case. The related data were analyzed again. (Page 7, Line 20-23)

4. Why were only RV fistulas of the upper third of the RV septum included and not lower fistulas?

I ever learned the classification of rectovaginal fistulas from Dr. Wexner's team when I was a research fellow there. RVFs were classified into simple and complex ones as the following criteria because the techniques and outcomes are pretty much different, referred to Frileux P et al Ann Chir 1994. Current study investigated the gracilis muscle transposition for complex RVFs so only RVFs of the upper third of the RV septum were included. (Page5 Line 21)

Rectovaginal Fistulas: Classification

Simple

- Mid or lower vagina
- <2.5cm diameter
- Trauma
- Infection

Complex

- High
- >2.5cm diameter
- IBD
- XRT
- CA
- Multiple failed repairs



5. *Only 5 pts underwent irrigation, this seems too few to provide meaningful comparison to the remaining group. This could use further discussion in the discussion section.*

Thanks for your comments. Indeed, the small number in secondary success group (only 4 patients) seems too few to provide meaningful comparison to the remaining group. However, the irrigation-suction procedure was not reported in gracilis transposition repair before and it's the rare events in our series. We redid the statistics, and should accept the results with caution, these were further discussed in discussion section. (Page 10, Lines 1-5).

6. *The authors could also better discuss the ideal indications for this procedure and when it should be considered.*

Thanks for your advice. We discussed the indications in details in discussion section. (Page 10, Lines 6-9)