Author's response to reviews

Title: Fistulotomy and drainage of deep postanal space abscess in the definitive treatment of posterior horseshoe fistula

Authors:

Resit Inceoglu (inceoglu@asg.com.tr)
Dr Rasim Gencosmanoglu (rgencosmanoglu@marmara.edu.tr)

Version: 2 Date: 13 Oct 2003

We are grateful to the reviewers for their constructive criticisms on our paper. We revised the manuscript accordingly. The modifications are given in separate pages as point by point responses to the comments of the reviewers. I declare that both authors agreed on the revision.

We hope you will find the revised manuscript satisfactory. If any further changes are necessary, we would be happy to improve further.

Thanking you again and looking forward to hearing from you soon.

Revisions according to the reviewers' comments:

Reviewer 1 (Pravin Gupta):

We appreciate very much the prompt response.
1. As mentioned in the manuscript, this study was a retrospective one. We usually do not perform radiologic studies in patients with anorectal abscess fistula disease, since the preoperative diagnosis can be easily established by physical examination. Additionally, intraoperative findings and the courses of fistula tracts also direct surgeons to choose which type of operative procedure they should perform. However, if patients describe rectal discomfort, fullness or deep pelvic pain which may indicate the presence of an associated condition, we prefer MRI for detecting this as well as demonstrating the extent of the abscess fistula disease. In the present series, we needed to employ MRI in 6 patients. The other 7 patients who underwent preoperative contrast fistulography or US were referred to or attended our institution after diagnostic studies at other centers. In these patients, MRI was not employed since the previous radiologic documentation of their disease was satisfactory. This is the reason of the heterogeneity of preoperative radiologic studies.
2. We do not use antibiotic prophylaxis in the surgical treatment of perianal fistula even it is associated with an abscess formation. According to our observation which is parallel to the literature, once the perianal abscess is drained the infection regresses quickly. However, the present series included 3 patients with type II diabetes mellitus, in whom ciprofloxacin 500 mg and metronidazole 500 mg twice a day were prescribed for 5 days postoperatively. Fortunately, no wound infection developed in these patients in the post-operative period.
3. Except 2 patients, all were discharged on post-operative day 2. The remaining 2 patients were hospitalized for 4 days postoperatively due to excess pain during wound care and they received narcotic analgesic and sedation with midazolam in the first 2 days during wound dressing changes. As mentioned in the manuscript, all patients were followed up weekly until a complete wound healing was observed. Although this study has a retrospective nature, it has been our policy to follow-up the patients undergoing fistulotomy for complex perianal fistula strictly in the early postoperative period. As a general rule, we invite those patients on every Saturday morning to the institution to examine their wounds.
4. We agree with the reviewer that Crohn's disease or specific infectious diseases such as...
tuberculosis or actinomycosis should be ruled out in the presence multiple external openings. In the present series, there were 5 patients with more than 2 external openings. Preoperative colonoscopy was performed in three of them, while the remaining two patients underwent colonoscopy some time later in the late postoperative period. In all these patients, excised tract tissue was sent to both histopathologic and microbiologic examinations, fortunately no inflammatory or specific infectious disease was found. Furthermore, a complete healing without recurrence was achieved in these patients.

5. Gentle probing of both the internal and the external openings usually allows proper demonstration of the fistula tracts without resulting in any false route. Injection of hydrogen peroxide helps to estimate the fistula tract and may be performed when the probe could not be passed through the narrowed portion of the tract. However, we did not encounter this problem in any patients during the operation.

6. There was a blind upward extension of the tract into the supralevator space where the opening in the levator ani needed dilatation in one patient as reported in the manuscript. This patient was the one who needed extended hospitalization period due to excess pain during the wound dressing changes. One of the important points in the management of these patients is to prevent premature closure of the wound which can be achieved by deep wound dressing especially in the early postoperative period. This type of wound care sometimes requires narcotic analgesic administration prior to the wound dressing. The wound healed completely without any complication 18 weeks after surgery in this patient.

Reviewer 2 (Ngoi Sing Shang):

1. This study was a retrospective analysis of 25 consecutive patients with posterior horseshoe fistula and deep postanal space abscess. It is not our routine clinical practice to perform postoperative anal manometry, transanal US or transanal MRI in the assessment of status of the anal sphincters unless the patient describes any symptom relevant to anal incontinence. None of the patients in our series suffered permanent anal soiling or discharge in the close long-term follow-up (median 35 months). On the other hand, it is not surprising that those patients undergoing internal sphincterotomy and fistulotomy may experience temporary anal soiling and some degree of drainage from open wounds in the early postoperative period. If anal discharge continuous after a complete healing of fistulotomy wounds, investigations for anal incontinence should be performed. All patients were questioned for any symptom of anal incontinence at their routine visits and none of them complained permanent anal discharge. Their digital anal examination also revealed satisfactory anal tonus. Therefore, any further investigation was not needed in patients of this series.

2. We tried to eliminate redundancies and shorten the manuscript. However, the overall length did not change significantly because we had to respond to other reviewer comments.

3. Ultrasound was used as a diagnostic tool in 3 patients of the present series. Actually these patients were either referred or admitted to our institution following diagnostic studies at other centers. The ultrasound image submitted was the most illustrative one available in the archives. We re-scanned this image in order to achieve a more satisfactory figure; however, the result did not improve probably because the quality of the images on thermal paper deteriorated over time. Also, the initial low resolution may have been inadequate for successful reproduction. If the reviewer strongly feels that this figure should be removed, we will abide by this recommendation.

4. Grammatical and spelling errors in the manuscript were corrected.

Reviewer 3 (Feza Remzi):

We thank the reviewer for his appreciation of our work. Although the reviewer concluded in his report that this manuscript should be "rejected" because too small an advance, we would like to respond to the comments.

1. As mentioned by the reviewer, we performed the Hanley procedure in our patients. This is stressed in the revised version of the manuscript. We did not assert that we described a new
This study was a retrospective analysis of 25 consecutive patients. We just tried to present our results similar to many other retrospective clinical studies in the literature.

2. In this series, no complication was observed in any patient. Wounds were closely followed up until they were completely healed. It is the policy of our department to examine open wounds weekly until they are completely healed following anorectal surgery, particularly after operations performed for complex perianal fistula. At routine patient-visit, the general status of patients are also assessed beside wound care and dressing. It is not our routine clinical practice to perform postoperative anal manometry, transanal US or transanal MRI in the assessment of status of the anal sphincters unless the patient describes any symptom relevant to anal incontinence. None of the patients in our series suffered permanent anal soiling or discharge in the close long-term follow-up (median 35 months). It is not surprising that those patients undergoing internal sphincterotomy and fistulotomy may experience temporary anal soiling and some degree of drainage from open wounds in the early postoperative period. If anal discharge continues after a complete healing of fistulotomy wounds, investigations for anal incontinence should be performed. All patients were insistently questioned for any symptom of anal incontinence at their routine visits and none of them complained permanent anal discharge. Their digital anal examination also revealed satisfactory anal tonus. Therefore, any further investigation was not needed in patients of this series.

3. As mentioned in the manuscript, this study was a retrospective one. We usually do not perform radiologic studies in patients with anorectal abscess fistula disease, since the preoperative diagnosis can easily be established by thorough physical examination in this condition. Additionally, intraoperative findings and the courses of fistula tracts also direct surgeons to choose which type of operative procedure they perform. However, if patients describe rectal discomfort, fullness or deep pelvic pain which may indicate the presence of an associated condition, we prefer MRI for detecting this as well as demonstrating the extent of the abscess fistula disease. In the present series, we needed to employ MRI in 6 patients. The other 7 patients who underwent preoperative contrast fistulography or US were referred to or attended our institution after diagnostic studies at other centers. In these patients, MRI was not employed since the previous radiologic documentation of their disease was satisfactory. This is the reason of the heterogeneity of preoperative radiologic studies employed to the patients among our series.

4. We did not use setons. As described in the "surgical technique" in the revised manuscript, all fistula tracts were unroofed.

5. This study was performed in the Department of Gastrointestinal Surgery at the Marmara University Institute of Gastroenterology. This department was held on 1997. We initially constitute some guidelines in the routine follow-up of patients relevant to their diseases. Although this study was retrospective in nature, we could easily reach the follow-up details of the patients from their hospital records. The small patient population allowed us to follow our guidelines strictly.

6. Finally, submitting a manuscript to "classic" hard copy medical journals requires a great patience, since the period of "consideration for publication" in these journals usually takes a very long time, varying 3 to 9 months. The period of re-consideration of revisions may also take an additional 3 to 4 months. Once your paper is accepted for publication, you should wait for at least 6 months to have its published copy. For instance, at present, I have 6 papers which have been accepted for publication some times (varying 5 months to one year) ago in various hard copy journals and I am still waiting to have my articles be published. I should honestly say that BMC journals are very quick in consideration period, which takes 6 to 8 weeks in maximum. Once a manuscript is accepted for publication in BMC journals, its abstract immediately appears in the website. Furthermore, the abstract will be available in a couple of days in PubMed. Moreover, full text of the paper will also appear in both the website of the journal and in PubMed in two weeks. These are the features that should not be underestimated especially in the "rapid communication era" which we are living in. On the other hand, BMC journals are open access. Therefore, everyone can easily reach any paper, free of charge, via internet, whenever they need. This provides much more readers to authors. The higher the number of readers of an open access journal, the more frequent is the citation of a paper that published in it. I am sure that the impact factors of BMC journals will increase in time. I believe that the principle aim of every author is to share his experience and knowledge on particular topic with people as much as possible. I hope BMC journals will be gained their deservedly importance in
the near future. This is the reason why I submit this manuscript to BMC Surgery. Nevertheless, I thank the reviewer his recommendation for submitting this manuscript to another journal in order to have a "better chance" for publication. However, I preferred to re-submit this manuscript to BMC Surgery after appropriate revision.

Many thanks for the reviewer's constructive criticism on our paper and for allowing me to share my opinion.

Rasim Gencosmanoglu, M.D.