Response to Letter to the Editor on “Utility of Endoanal Ultrasonography in Assessment of Primary and Recurrent Anal Fistulas and for Detection of Associated Anal Sphincter Defects”

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Dear Editor,

We were pleased to receive the constructive comments of Pal and colleagues on our article¹ published in *Journal of Gastrointestinal Surgery* concerning the utility of endoanal ultrasonography (EAUS) in the assessment of anal fistulas and associated anal sphincter defects.

The authors raised some important questions concerning our article which we are pleased to respond to. They suggested doing anal manometry to every patient with anal fistula, whether primary or recurrent, with symptomatic fecal incontinence (FI) which we concur with. However, none of the patients with primary anal fistula in our study presented with FI or had anal sphincter defect in EAUS, while 19 patients with recurrent anal fistula had a defect in the external anal sphincter, among whom 12 presented with symptomatic FI and the remaining seven had occult sphincter defect. Patients with primary anal fistula were not expected to have a sphincter injury since we already excluded patients with history of previous anorectal surgery, and indeed EAUS confirmed the absence of anal sphincter defects in these patients. Thus, performing anal manometry in patients with anal fistula who did not report symptoms of FI and did not have visible anal sphincter defects in EAUS would not have added significant information during pre-operative evaluation.

Regarding the correlation between anal manometry and EAUS findings, we have previously evaluated the correlation

between anal manometry, EAUS, and symptom severity in patients with post-traumatic FI and found FI secondary to anal sphincter injury during anal fistula surgery to have stronger correlation between anal pressures and the size of external anal sphincter defect in EAUS.²

As aforementioned, none of the patients with primary anal fistula presented with FI preoperatively neither any had visible anal sphincter defect in EAUS; therefore, the comparison between primary and recurrent anal fistula in this regard would have been deficient. Perhaps, if we have included patients with previous anorectal surgery, other than fistula surgery, this comparison could have been more relevant to underscore the utility of EAUS in the comprehensive assessment of patients with anal fistula.

Author's Contributions Sameh Hany Emile wrote and revised the manuscript.

Compliance with Ethical Standards

Conflict of Interests The author declares that there is no conflict of interest.

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