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- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

*The corresponding author has opted to make this information publicly available.

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Questions about these materials may be directed to the Obstetrics & Gynecology editorial office: obgyn@greenjournal.org.
RE: Manuscript Number ONG-20-882

Management of Fecal Incontinence

Dear Dr. Brown:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

***Due to the COVID-19 pandemic, your paper will be maintained in active status for 30 days from the date of this letter. If we have not heard from you by Jun 09, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

REVIEWER COMMENTS:

Reviewer #1: In this manuscript, the authors present a Clinical Expert Series on the management of Fecal Incontinence. The manuscript is well-written and informative. I have the following specific questions/comments:

1) Introduction - it would be nice to know why the prevalence of FI is anticipated to increase by 2050. I would expect this is related to an aging population but that could be stated.

2) The issues w/ the term FI vs. accidental bowel leakage is mentioned 3-4x in the manuscript. Its appearance in the introduction has an implication that clinicians are being spiteful in not using this term. I would recommend removing the sentence starting on line 79 for this reason and more importantly it isn't that relevant to the paragraph main idea. When the ideas around the term accidental bowel leakage is discussed on line 139, it is a better fit and sufficiently covers the concept.

3) The paragraph starting on line 100 would benefit from a figure. On this theme, Figure 2 could be more informative and related to this paragraph. In Figure 2, the ventral IAS is seen above the PR but the dorsal IAS has disappeared. This is misleading or at least confusing.

4) The paragraph starting on line 134 could be better organized. Ideas are repeated and condensing these instances could improve the paragraph flow.

5) Sentence starting on line 152 introduces terms that are likely incompletely understood by the general OB/GYN reader. What is anorectal assessment? How is levator ani dysfunction assessed? These assessments are indistinct even among FPMRS sub-specialists.

6) Paragraph starting on line 155 - there is a lot of discussion spent on anorectal manometry despite the data from this test, "not always correlat(ing) with symptom severity..." There are data to show manometry and digital rectal examination are equivalent. For a general OB/GYN readership this detail is likely lost but at the same time spending this much time discussing a test that has dubious benefit seems unnecessary.

7) In discussing endoanal ultrasound it is interesting to contrast this with anorectal manometry. Where US clearly has a role in young women having sustained a complicated laceration in childbirth, there is no such role in any specific demographic for manometry. While in a 80 yo woman presenting with new onset FI the benefit of an US is limited, there are other settings where it is very useful. This distinction is not discussed.

8) The role of anal sphincteroplasty is limited but again age and context do matter. If a young woman has sustained an perineal laceration with childbirth, has no FI symptoms, but has an endoanal ultrasound that demonstrates a >30 degree defect, should these women have a repair given restoring the muscle bulk COULD (no evidence to my knowledge can be cited) reduce FI occurrences in later life as the age-related decline in muscle inevitably occurs?

9) Line 204 - Can a specific moisturizer example be cited?

10) Figure 3 is cited in the paragraph starting on Line 198. Figure 3 references content that starts earlier in the manuscript. Should this figure be cited earlier?

11) In discussing fiber it would be helpful to cite how much fiber is in the average tablespoon of Metamucil (about 3
grams). This information would help readers operationalize the fiber recommendation. If a woman has to take 16g of fiber today, using Metamucil would mean taking 5-6 Tablespoons per day.

12) The RELIEF mnemonic seems kind of odd - what's "live" and "effort" reference?

13) Line 277 - for a published manuscript there is no role for hyperlink (i.e. ...them can be found here.).

14) It is curious that the evidence for PTNS in the management of FI is highlighted w/ 2 RCTs; yet, SNS evidence is highlighted with a case series. It seems likely that the efficacy of the first line surgical therapy would be different if it were assessed with an RCT.

15) Line 369 - adding that it is recommended neurovascular supply disruption should be avoided isn't that helpful. That could be said of nearly any surgery. What precisely is meant? If going into what this means is beyond the scope of the manuscript, then I would remove it.

16) I'm not sure mentioning the Gracilis surgery is relevant - it is not available in the US (as indicated). It has not been available for some time and I'm not aware of any change coming on this matter in the near future. The artificial anal sphincter is so infrequently done and so problematic a therapy, it is an option more in useful in academic discourse than a realistic therapy option.

17) Figure 3 should be re-done. Thing about 2 kinds of boxes or arrows. A box can be an "outcome" or an "action." Most - but not all - of the green boxes are actions. Non-green boxes are mostly, but not all, outcomes. Arrows are often "steps" in the decision tree but sometimes they imply a choice, "yes" vs. "no." Re-organizing the flow diagram such that actions, choices and outcomes are uniform would make the flow diagram more consistent.

Overall, interesting, basic discussion of FI. With some reorganization it could be useful to the general OBGYN.

Reviewer #2: Abstract:
Line 35, the first sentence does not make sense when stands alone. Once you read the article the reader understands. Please reword this. I believe the authors means that "fecal incontinence in common with 9% having monthly leakage episodes ...."

Introduction. Appropriate and well written.

Pathophysiology.
Line 82 should be "fecal continence is the result ...
Line 113. The authors mention that when "puborectalis is weakened the anorectal angle becomes more obtuse and FI may occur because of decreased resistance between the rectum and anal canal". Is this the only mechanism? Or is there some element of the effect on the mobility or the speed with which the stool enters the anal canal and the fact that the internal sphincter is unable to sample and to accommodate because of the speed at which the contents are entering? Please discuss.

Line 113-118. Please give consideration to some discussion as to any nerve damage that occurs with delivery. Neuropathy is not mentioned.

Lines 119 onwards. There should be a discussion of the increased risk of FI with inflammatory bowel disease (OR 7) and IBS. While the former is not common the latter is common in people with pelvic floor disorders. Studies have suggested that 60% of IBS pt report at least 1 episode of FI and 12% have > 10 lifetime episodes. Article by Markland for Pelvic Floor Network 2017 reported on this and that these pt have a significantly worse QOL. The issue of increased motility should be discussed as management of this is one of the treatments mentioned and recommended.

Diagnosis and Evaluation:
Line 162. Please consider broadening the discussion on what would be normal results for anal monometry as the physicians will see reports and they need to understand how it is done, what is normal range and what it means if the numbers fall outside the range.

Also discuss the indications for doing this testing - when and who.

Same for ultrasonography. The authors state it is less relevant to clinical care (line 184) so under what settings or clinical presentation would you recommend it?

Non-surgical treatments:
Lines 205-209. As this article is for the generalist obstetrician/gynecologist some specifics as to what could be used for perineal care would be helpful. Should they use A&D or natural vegetable oils or baby products for example?

Dietary Manipulation:
Line 227. Once again this is designed for the generalist. Include something practical like an appendix that outlines common sources of fiber, the best sources and the amount would be helpful.

Devices:
Line 279 - typo - should say device not decide.

The discussion on devices mentions one trial for each device. It would be hard for the practitioner to recommend based on this alone. Recommend that the authors state a range of improvement and cure from the studies as this would be helpful for counseling. If there is a paucity of well performed studies then just mention that.

References:
First one is all capitals.
Reviewer #3: I had the pleasure of reviewing your manuscript entitled, "Clinical Expert Series: Management of Fecal Incontinence." Your manuscript describes the epidemiology, impact, diagnosis, and management of fecal incontinence in a clear, easy to follow manner. The description of the anatomy and physiology of the fecal continence mechanism is well portrayed. The work adds to the existing knowledge in the field and would be of great interest to the readers of this journal.

I had only one specific question for you.

Line 184-185
- With regards to defecography and dynamic magnetic resonance imaging (MRI), you mention the potential diagnosis of rectoceles and internal rectal prolapse. These studies may also help identify paradoxical contraction of the levator ani complex or anatomic defects levator ani, both of which may be associated with FI. I believe that it would be important to include these.

Thank you for the opportunity to review your manuscript.

PRODUCTION EDITOR

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ASSOCIATE EDITOR - GYN

Thank you for this wonderfully written CES article. We have been experiencing record numbers of submissions and as a result have strict page limit considerations - please keep this in mind as you work through the revisions above. Also, consider which Figures might be okay to change to an online-only Appendix. It is likely that some text will be cut from your revised submission and/or figures moved to the online appendix anyway due to our need to not go over our page limit restrictions for the year.

EDITOR COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
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2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

3. Regarding your figures, both print and electronic (online) rights must be obtained from the holder of the copyright (often the publisher, not the author), and credit to the original source must be included in your manuscript. Many publishers now have online systems for submitting permissions request; please consult the publisher directly for more information. Permission is also required for material that has been adapted or modified from another source. Increasingly, publishers will not grant permission for modification of their material. Creative Commons licenses and open access have also made obtaining permissions more challenging. In order to avoid publication delays, we strongly encourage authors to link or reference to the material they want to highlight instead of trying to get permission to reprint it. For example, "see Table 1 in Smith et al" (and insert reference number). For articles that the journal invites, such as the Clinical Expert
Series, the journal staff does not seek permission for modifications of material — the material will be reprinted in its original form.

When you submit your revised manuscript, please upload 1) the permissions license and 2) a copy of the original source from which the material was reprinted, adapted, or modified (e.g., scan of book page(s), PDF of journal article, etc.).

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4. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

5. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

6. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.

7. The précis should be only one sentence.

8. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

9. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

10. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

11. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendices should be added to a separate References list in the appendices file.

12. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

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***

If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf),
and
* A point-by-point response to each of the received comments in this letter.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors and that each author has given approval to the final form of the revision.

***Again, your paper will be maintained in active status for 30 days from the date of this letter. If we have not heard from you by Jun 09, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

Sincerely,

The Editors of Obstetrics & Gynecology

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/ong/login.asp?a=r). Please contact the publication office if you have any questions.
Response to Reviewers RE: Manuscript Number ONG-20-882
June 12, 2020

Dear Editorial team and Reviewers,

Thank you very much for the opportunity to revise our manuscript, “Management of Fecal Incontinence.” Your careful review and insightful comments resulted in many revisions that we believe have greatly improved the manuscript. Our point-by-point response is below with our comments bolded, and two versions of the manuscript have been uploaded, one with changes tracked and another with changes accepted.

Sincerely,
Heidi Brown, Becky Rogers, and Keisha Dyer Hawkins

REVIEWER COMMENTS:

Reviewer #1: In this manuscript, the authors present a Clinical Expert Series on the management of Fecal Incontinence. The manuscript is well-written and informative. I have the following specific questions/comments:

1) Introduction - it would be nice to know why the prevalence of FI is anticipated to increase by 2050. I would expect this is related to an aging population but that could be stated.

   Thank you for the comment. Revised to clarify.

2) The issues w/ the term FI vs. accidental bowel leakage is mentioned 3-4x in the manuscript. Its appearance in the introduction has an implication that clinicians are being spiteful in not using this term. I would recommend removing the sentence starting on line 79 for this reason and more importantly it isn't that relevant to the paragraph main idea. When the ideas around the term accidental bowel leakage is discussed on line 139, it is a better fit and sufficiently covers the concept.

   Thank you for the excellent suggestion. We certainly did not mean to imply that clinicians were being spiteful in not using the term and deleted the reference at line 79.

3) The paragraph starting on line 100 would benefit from a figure. On this theme, Figure 2 could be more informative and related to this paragraph. In Figure 2, the ventral IAS is seen above the PR but the dorsal IAS has disappeared. This is misleading or at least confusing.

   Thank you for the comment. We have included a figure with relevant imaging and have revised Figure 2 based on your astute observation.

4) The paragraph starting on line 134 could be better organized. Ideas are repeated and condensing these instances could improve the paragraph flow.

   Thank you for the suggestion. We broke into a paragraph about screening, another about history, and another about further evaluation.

5) Sentence starting on line 152 introduces terms that are likely incompletely understood by the general OB/GYN reader. What is anorectal assessment? How is levator ani dysfunction assessed? These assessments are indistinct even among FPMRS sub-specialists.
Excellent points. Removed these unclear terms and provided simple language regarding digital exam for the general ob/gyn reader.

6) Paragraph starting on line 155 - there is a lot of discussion spent on anorectal manometry despite the data from this test, "not always correlating with symptom severity..." There are data to show manometry and digital rectal examination are equivalent. For a general OB/GYN readership this detail is likely lost but at the same time spending this much time discussing a test that has dubious benefit seems unnecessary.

Thank you for the feedback. We have decreased the level of detail presented about ARM.

7) In discussing endoanal ultrasound it is interesting to contrast this with anorectal manometry. Where US clearly has a role in young women having sustained a complicated laceration in childbirth, there is no such role in any specific demographic for manometry. While in a 80 yo woman presenting with new onset FI the benefit of an US is limited, there are other settings where it is very useful. This distinction is not discussed.

Thanks very much for this comment. We added the following language to the first sentence of the paragraph about EUS: Endoanal ultrasonography identifies defects in the internal and external anal sphincter muscles, and is most useful in situations where a patient has undergone pelvic trauma and surgical repair of the anal sphincter may be appropriate.

8) The role of anal sphincteroplasty is limited but again age and context do matter. If a young woman has sustained an perineal laceration with childbirth, has no FI symptoms, but has an endoanal ultrasound that demonstrates a >30 degree defect, should these women have a repair given restoring the muscle bulk COULD (no evidence to my knowledge can be cited) reduce FI occurrences in later life as the age-related decline in muscle inevitably occurs?

Thank you for the question – it’s an interesting one. Some providers use anorectal manometry to triage subsequent delivery planning in patients with a prior obstetric anal sphincter injury but we do not recommend anal sphincteroplasty for asymptomatic patients, since surgery, as you pointed out below, inevitably disrupts neurovascular tissue. Added the following statement to the discussion of sphincteroplasty: “There are not data to suggest that an anal sphincter defect identified in an asymptomatic woman should be surgically corrected.”

9) Line 204 - Can a specific moisturizer example be cited?

Added suggestions dimethicone, lanolin, and petrolatum.

10) Figure 3 is cited in the paragraph starting on Line 198. Figure 3 references content that starts earlier in the manuscript. Should this figure be cited earlier?

Excellent point. Moved to the top of discussion of treatments.

11) In discussing fiber it would be helpful to cite how much fiber is in the average tablespoon of Metamucil (about 3 grams). This information would help readers operationalize the fiber recommendation. If a woman has to take 16g of fiber today, using Metamucil would mean taking 5-6 Tablespoons per day.

Great point. Added a sentence clarifying that 1 teaspoonful of Metamucil contains 2.5 g fiber.

12) The RELIEF mnemonic seems kind of odd - what's "live" and "effort" reference?
Thank you for pointing those out. They're strange when taken out of context! They came from interviews with women with FI who wanted to emphasize the importance of living your life in spite of the condition and making personal effort to adopt behaviors and habits to improve your symptoms. Edited to provide more context.

13) Line 277 - for a published manuscript there is no role for hyperlink (i.e. ..them can be found here.).

Edited to add the website and delete the hyperlink.

14) It is curious that the evidence for PTNS in the management of FI is highlighted w/ 2 RCTs; yet, SNS evidence is highlighted with a case series. It seems likely that the efficacy of the first line surgical therapy would be different if it were assessed with an RCT.

Great point – I have added the summary from a 2015 Cochrane review that includes several parallel and cross-over designs, which, while they are not randomized, are at least controlled.

15) Line 369 - adding that it is recommended neurovascular supply disruption should be avoided isn't that helpful. That could be said of nearly any surgery. What precisely is meant? If going into what this means is beyond the scope of the manuscript, then I would remove it.

Thanks! Removed.

16) I'm not sure mentioning the Gracilis surgery is relevant - it is not available in the US (as indicated). It has not been available for some time and I'm not aware of any change coming on this matter in the near future. The artificial anal sphincter is so infrequently done and so problematic a therapy, it is an option more in useful in academic discourse than a realistic therapy option.

Thank you. We removed the mention of gracilis surgery. I think readers will wonder if we remove all discussion of artificial anal sphincter, so I have left in a sentence but removed additional discussion.

17) Figure 3 should be re-done. Thing about 2 kinds of boxes or arrows. A box can be an "outcome" or an "action." Most - but not all - of the green boxes are actions. Non-green boxes are mostly, but not all, outcomes. Arrows are often "steps" in the decision tree but sometimes they imply a choice, "yes" vs. "no." Re-organizing the flow diagram such that actions, choices and outcomes are uniform would make the flow diagram more consistent.

Thank you for the comment. The figure has been revised.

Overall, interesting, basic discussion of FI. With some reorganization it could be useful to the general OBGYN.

Thank you for your thorough review – it really improved the paper.

Reviewer #2: Abstract:
Line 35, the first sentence does not make sense when stands alone. Once you read the article the reader understands. Please reword this. I believe the authors means that "fecal incontinence in common with 9% having montly leakage episodes ...."

Thanks for pointing that out © Reworded.

Introduction. Appropriate and well written.

Pathophysiology.
Line 82 should be “fecal continence is the result ...
Thank you for catching that. Corrected.

Line 113. The authors mention that when "puborectalis is weakened the anorectal angle becomes more obtuse and FI may occur because of decreased resistance between the rectum and anal canal". Is this the only mechanism? Or is there some element of the effect on the mobility or the speed with which the stool enters the anal canal and the fact that the internal sphincter is unable to sample and to accommodate because of the speed at which the contents are entering? Please discuss.

I am not aware of mechanistic studies, but without the obtuse angle, some stool (especially loose or liquid stools) can slip into the anal canal without having triggered the recto-anal inhibitory reflex (which is activated by distension of rectal tissue), so I have added a sentence discussing that, without a citation.

Line 113-118. Please give consideration to some discussion as to any nerve damage that occurs with delivery. Neuropathy is not mentioned.

Thank you for the comment. We added this sentence: “Even in the absence of an obstetric anal sphincter injury, labor and delivery cause ischemia, stretching, and compression of neuromuscular tissues that contribute to continence.”

Lines 119 onwards. There should be a discussion of the increased risk of FI with inflammatory bowel disease (OR 7) and IBS. While the former is not common the latter is common in people with pelvic floor disorders. Studies have suggested that 60% of IBS pt report at least 1 episode of FI and 12% have > 10 lifetime episodes. Article by Markland for Pelvic Floor Network 2017 reported on this and that these pt have a significantly worse QOL. The issue of increased motility should be discussed as management of this is one of the treatments mentioned and recommended.

Yes! So sorry that we neglected to include a comment on stool consistency and motility in the pathophysiology section. The manuscript is already too long so I have added a brief discussion of these very important issues. Thanks for reminding us to add that to the pathophysiology section.

Diagnosis and Evaluation:
Line 162. Please consider broadening the discussion on what would be normal results for anal monometry as the physicians will see reports and they need to understand how it is done, what is normal range and what it means if the numbers fall outside the range.
Also discuss the indications for doing this testing - when and who.

Thank you for the comment. Another reviewer suggested that we discussed anorectal manometry in too much detail. We added that we do not suggest doing this testing. Our hope is that if physicians see reports they will also see interpretations from the physicians who ordered the testing.

Same for ultrasonography. The authors state it is less relevant to clinical care (line 184) so under what settings or clinical presentation would you recommend it?

Thank you for the comment. We added clarification that it is relevant when planning sphincteroplasty.

Non-surgical treatments:
Lines 205-209. As this article is for the generalist obstetrician/gynecologist some specifics as to what could be used for perineal care would be helpful. Should they use A&D or natural vegetable oils or baby products for example?

Great point – we added suggested ingredients based on comments from another reviewer – I have also listed some sample brands (though generic is just fine).

Dietary Manipulation:
Line 227. Once again this is designed for the generalist. Include something practical like an appendix that outlines common sources of fiber, the best sources and the amount would be helpful.

**Thanks for the comment. Added a bit of information and references to some handouts available for free through the AUGS and IUGA websites.**

**Devices:**

Line 279 - typo - should say device not decide. **Thank you! Noted after we submitted and have corrected.**

The discussion on devices mentions one trial for each device. It would be hard for the practitioner to recommend based on this alone. Recommend that the authors state a range of improvement and cure from the studies as this would be helpful for counseling. If there is a paucity of well performed studies then just mention that. **Thanks for the comment. These are relatively new devices – I have added a summary statement and qualified that we don’t have long-term data yet.**

References:

First one is all capitals.

**Thank you! Corrected.**

Reviewer #3: I had the pleasure of reviewing your manuscript entitled, "Clinical Expert Series: Management of Fecal Incontinence." Your manuscript describes the epidemiology, impact, diagnosis, and management of fecal incontinence in a clear, easy to follow manner. The description of the anatomy and physiology of the fecal continence mechanism is well portrayed. The work adds to the existing knowledge in the field and would be of great interest to the readers of this journal.

I had only one specific question for you.

Line 184-185

- With regards to defecography and dynamic magnetic resonance imaging (MRI), you mention the potential diagnosis of rectoceles and internal rectal prolapse. These studies may also help identify paradoxical contraction of the levator ani complex or anatomic defects levator ani, both of which may be associated with FI. I believe that it would be important to include these. **Excellent point – thank you for taking the time to review our paper and thank you for pointing that out. We have added this information.**

Thank you for the opportunity to review your manuscript.

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4. Figure 4: Please upload your permission letter to Editorial Manager. Done

ASSOCIATE EDITOR - GYN

Thank you for this wonderfully written CES article. We have been experiencing record numbers of submissions and as a result have strict page limit considerations - please keep this in mind as you work through the revisions above. Also, consider which Figures might be okay to change to an online-only Appendix. It is likely that some text will be cut from your revised submission and/or figures moved to the online appendix anyway due to our need to not go over our page limit restrictions for the year. Absolutely! No problem. Tried to cut sentences here and there as I did revisions. The figures that would best be converted to online only are probably the endoanal ultrasound images suggested by the first reviewer, which are now figure 3 a-c, and figure 5, the photo of the vaginal bowel control insert. Text sections that could be converted to online supplement have been highlighted with comments throughout.

EDITOR COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
   A. OPT-IN: Yes, please publish my point-by-point response letter.
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   Will do.

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