IUGA/ICS terminology and classification of complications of prosthesis and graft insertion–rereading will revalidate

TO THE EDITORS: As representative authors of the title document,[1] we believe the authors of a recent multicategory critique[2] might have most of their criticisms answered by a careful rereading of the document.[1] Despite significant methodologic difficulties involving the interrater reliability validation study contained within the article,[2] a positive data reinterpretation is also possible.

The study observers[2] have not been clearly identified. The retrospective observations are on variably notated medical records, whereas the IUGA/ICS Classification is designed for prospective "live" use with full clinical information. For example, the presence/size/timing or diagnosis and/or site of a mesh exposure, the category of most disagreement, may not have been clearly recorded, ideally with pictorial evidence.

Reinterpretation of the data from Table 3[2] would suggest that 77% (40/52) of the instances of noncorrelation in the vaginal complication categories were due to record issues rather than the "clarity" of the assessment tool. If corrected and added to the 43% (39/91) where correlation occurred, a very acceptable 87% (79/91) interrater reliability is possible.

As indicated, most of the answers to the multicategory criticisms, almost all unrelated to validation study, can be found within the title document.[1]

Category 1 criticism–Terminology and definitions: a terminology document will define terminology, eg, the reason for a 1 cm cutoff for (smaller/larger) mesh exposures is clearly explained.[1]

Category 2 criticism–Inability to categorize complications: category 1B[1] clearly covers the scenario of pain without mesh exposure with the pain subclassification (a-e) available to distinguish the type of pain. The authors[2] cite the IUGA/ICS Classification as "too complex in attempting to optimize the coverage of all possible (physical) complications" yet criticizes it for not additionally including functional (eg, bowel) disorders or recurrent urinary tract infection, the latter not necessarily related to the prosthesis or graft insertion.

Category 3 criticism–Lack of consistency with scale: the authors[2] state "the IUGA/ICS classification system does not allow gradation of the severity and this may be a barrier to its utility." Even the most cursory appraisal of the IUGA/ICS CTS Classification Table (Table 2 in Reference 1 and included in the critique) would note a clear increase in severity of complications across, and in general, down the table. The authors[2] pose the self-evident question, allegedly not answered by the IUGA/ICS Classification, "should the presence of multiple complications increase the degree of severity." The IUGA/ICS Classification[1] clearly deals with multiple and changing complications.

Authors of the IUGA/ICS Classification system for prostheses and grafts[1] and the recently published native tissue female pelvic floor surgical equivalent[3] encourage studies using the system including constructive criticisms related specifically to the results of well-performed prospective validation studies. Retrospectively, unclear data and a misreading of the title document[1] represent, we believe, multiple weaknesses in the current study[2] and the accompanying critique. ■

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REPLY

We greatly appreciate the interest Dr Haylen and colleagues have shown in our recent article evaluating the interrater reliability of the International Continence Society/International Urogynecological Association (ICS/IUGA) classification system for mesh-related complications. We are surprised by Haylen et al's assertion that the classification system is not appropriate for retrospective use and was "designed for prospective 'live' use with full clinical information" because it's clearly stated in the Preface of their most recent article they list "medical records and surgical audits" as among the possible applications of the system.[1] If indeed the intent of the ICS/IUGA Standardization Committee is that the system only be used in a prospective fashion with optimal data collection, then: (1) the classification system should be amended to make this explicit and (2) the applicability of the system will be severely limited as