To the editors

We read with great interest the study, “Long-term reoperation risk after apical prolapse repair in female pelvic reconstructive surgery.”¹ We share the authors’ dedication to study long-term outcomes after apical prolapse operation techniques. Studies of this kind have been lacking in literature.

Like the authors, we have been studying the reoperation rates for recurrent prolapse after apical suspension procedures for primary uterine prolapse² and after vaginal vault prolapse.³ As the authors did, we found higher reoperation rates after sacrospinous ligament fixation and sacrospinous hysteropexy than after uterosacral ligament suspension when we compared primary apical prolapse operations and vaginal vault prolapse operations.²,³ However, contrary to the present study, our findings were significant.

Our studies are based on Danish national registers that include data for all operations performed since 1977 in the country. We also have complete data on migration status and can therefore censor individuals if they emigrate. In Denmark, healthcare is tax-based, and operations are free of charge for all inhabitants.

In this present study, the possible operations performed before the implementation of the electronic medical record in 2006 are unknown, and the information on women exiting the Kaiser system is limited. This might lead to an underestimation of reoperations. The prognosis of surgery after a primary uterine prolapse is different from the prognosis of vault prolapse surgery. Therefore, the results of the present study might be blurred, as the hysteropexy and vault suspension groups are pooled.

We wonder whether these limitations can explain the reasons for the higher recurrence rate after sacrospinous ligament fixation and sacrospinous hysteropexy did not reach statistical significance in the present study.

In Denmark, only few women choose colpocleisis, sacrocolpopexy, and sacrohysteropexy; many women choose the Manchester procedure, which is uterine preserving and without mesh. In a range of Scandinavian studies, the Manchester procedure was superior with regard to complications, relapses, reoperations, and financial expenses compared with vaginal hysterectomy with suspension and sacrospinous hysteropexy.²,⁴ Do women in California have the option to choose the Manchester procedure? Or do the authors have an idea why this operation technique is so popular in Scandinavia but not in California?

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References


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