Long-term reoperation risk after apical prolapse repair in female pelvic reconstructive surgery: A Letter

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To the editor,

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. This study has been lacking in the literature.

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

Our studies are based on Danish national registers which 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 the health care is tax based and operations are free of charge for all inhabitants.

In this present study possible operations performed prior to 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 why 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 sacrohystereopexy. Contrary, many women choose the Manchester procedure which is uterine preserving and without mesh. In a range of Scandinavian studies, the Manchester procedure was superior regarding complications, relapses, reoperations and financial expenses compared to 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?
References:


