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PII: S0002-9378(22)00660-3
DOI: https://doi.org/10.1016/j.ajog.2022.08.025
Reference: YMOB 14690


Received Date: 10 August 2022
Accepted Date: 14 August 2022

Please cite this article as: Shah NM, Menefee SA, Letter to the Editor: Comparison of Two Geographic Prolapse Surgery Registries, American Journal of Obstetrics and Gynecology (2022), doi: https://doi.org/10.1016/j.ajog.2022.08.025.

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Letter to the Editor: Comparison of Two Geographic Prolapse Surgery Registries

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Conflicts of interest: The authors report no conflicts of interest.

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Word count:
Abstract: 400/400
To the Editor,

Thanks to Drs. Husby and Klarskov for their interest in our article, “Long-term reoperation risk after apical prolapse repair in female pelvic reconstructive surgery.” In this study, we described longitudinal outcomes after apical suspension using the Kaiser Permanente Southern California database. We found no statistically significant difference in frequencies of reoperation for recurrence after sacrospinous ligament fixation (SSLF; 9.1%) versus uterosacral ligament suspension (USLS; 6.1%, P=0.074) after correction for multiplicity. When time-to-event distributions were compared to account for variable follow-up, the difference remained non-significant (P=0.05). We concluded that SSLF and USLS offered comparable durability of repair.

In their letter, the authors speculate whether limitations of our study – including a relatively “small” sample size for the SSLF group, attrition bias, and inability to isolate hysteropexy – could explain the absence of a meaningful difference in reoperation after SSLF versus USLS. Our results are consistent with Level I evidence from multicenter, randomized controlled trials demonstrating that SSLF and sacrospinous hysteropexy are equivalent to USLS in terms of reoperations for recurrence.1-3 Therefore, we concluded that the statistical trend of higher reoperations after SSLF seen in our paper was most likely explained by selection bias and unmeasured confounding. It is doubtful that expansion of the sample size for SSLF would reveal a higher frequency of reoperations because a cohort of 464 women is larger than most prospective studies and our use of time-to-event analysis relied on person-years rather than persons. It would be interesting to see whether more comprehensive follow-up, such as is possible in the Danish national register, would impact results over the long-term.

The authors additionally question whether inclusion of sacrospinous hysteropexy may have affected results. Though we cannot separate vault suspension from hysteropexy based on procedural codes, we expect the number of hysteropexies in this cohort (spanning 2006 through 2018) to be very low. The option of hysteropexy for apical prolapse repair is a recent phenomenon in the United States. Popularity surged after publication of randomized surgical trials demonstrating comparable efficacy to vaginal hysterectomy with USLS.2,3

Lastly, Manchester procedures were not included because this procedure is not routinely offered to women in our country. We preferentially employ the proximal uterosacral ligaments for support rather than the distal segments that are often attenuated in advanced prolapse. Though the Danish papers on this procedure are thought-provoking, stark demographic differences between the American and Scandinavian populations limit generalizability to our practice.
References

