Surgical repair of bilateral levator ani muscles with ultrasound guidance: comment

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We read the paper titled “Surgical Repair of Bilateral Levator Ani Muscles with Ultrasound Guidance” by Rostaminia et al. [1] with great interest. I would like to draw the attention of the authors to two previous publications in the literature on levator repair, as we believe they would be of interest to the readers and are relevant to this case report [2, 3]. In the former study published in 2007, the authors reported a case of repair failure in a woman with a large vaginal tear and levator avulsion diagnosed at the delivery suite [2]. An abstract was published last year on the outcomes of concomitant levator repair in 15 patients with levator avulsion having prolapse repair [3]. The approach and techniques were different from the index case report in that the repair was done with no ultrasound guidance, a piece of mesh was used to reinforce the muscle, and the repair was done via a low lateral colpotomy at the level of the hymenal remnant.

We consider levator avulsion easy to identify macroscopically, with no need for imaging guidance. However, we found the effect of levator repair on prolapse recurrence and hiatal area on Valsalva, a parameter significantly asso-

ciated with both signs and symptoms of pelvic organ prolapse (POP), rather disappointing. It is plausible that in women with levator avulsion there often is microscopic trauma and functional muscle impairment, and therefore, levator repair may not be an effective measure to reduce prolapse recurrence.

We are not sure of the indication for performing levator repair in the index case report, and the authors have rightly pointed out that it remains to be proven whether preemptive repair will reduce future occurrence of POP. For the time being, it may be prudent to limit such experimental surgery to patients who present with a condition that is strongly associated with avulsion, i.e., prolapse of the anterior and central compartments.

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