Where to for pelvic organ prolapse treatment after the FDA pronouncements? Comment

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Dear Editor,

With great interest I read the recently published article in the *International Urogynecology Journal* from Van Geelen and Dwyer titled “Where to for pelvic organ prolapse treatment after the FDA pronouncements?” [1].

One of the issues the authors try to address is the ongoing debate on the optimal approach for apical prolapse repair. They state that there is level I evidence that abdominal sacrocolpopexy (ASC), either by laparotomy or laparoscopy or with the aid of a robotic device, is more effective and durable in correcting anterior and apical anatomy than the vaginal approach using sacrospinous colpopexy. As a reference, they use an article by Maher et al. published in 2004 [2]. In this article, ASC is compared with vaginal sacrospinous colpopexy in 95 women. The objective success rate was 76 % in the abdominal group and 69 % in the vaginal group ($P=0.48$). The abdominal approach was associated with a longer operating time, a slower return to activities of daily living, and a greater cost than the sacrospinous colpopexy ($P<0.01$). Both surgeries significantly improved the patient’s quality of life ($P<0.05$). The subjective success rate was 94 % in the abdominal and 91 % in the vaginal group ($P=0.19$).

This level I evidence does not support the above-mentioned statement of the authors that ASC is more effective than vaginal sacrospinous colpopexy. On the contrary, it shows that there is no significant difference in terms of objective and subjective cure rate between ASC and vaginal sacrospinous colpopexy.

Also, it does not justify the extrapolation of ASC data by laparotomy to other techniques, such as laparoscopy or robot-assisted laparoscopy.

In this light, the recently published article by Nygaard et al. is also very interesting [3]. These authors temper the general feeling that ASC is superior in terms of durability. By year 7, the estimated probability of composite (symptomatic or anatomic) pelvic organ prolapse failure after abdominal sacrocolpopexy was 0.48 when combined with a Burch urethropexy and 0.34 without a Burch urethropexy.

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