Comparing operations for POP: the importance of standardization of surgical technique

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In the past decade, scientific literature regarding surgical treatment for pelvic organ prolapse (POP) has been overwhelmingly about the use of meshes, which has gained credibility after recent publications that report good anatomical outcomes. Nevertheless, results must be considered taking into account the increasing number of reported postoperative complications that have led to some important, cautious reviews and warnings, such as the ones included in the updated US Food and Drug Administration (FDA) communication in 2011 [1]. In this scenario, it is appropriate to review previous studies in order to balance safety and efficacy of surgical therapeutic options.

Different types of operations should be carefully reappraised and given their appropriate place in POP management. Special attention should be given to potential conclusion biases inherent to the methodological inconsistencies regarding criteria for population inclusion, cure/failure, and outcomes when various studies addressing a surgical technique are analyzed together. In fact, those points have been raised by some authors [2, 3]. Another aspect, but no less important, is the one related to the lack of standardization of surgical techniques when evaluating the supposed “same operation.”

Several types of operations have been described to support apical prolapse [4]. Recently published, the extended Colpopexy and Urinary Reduction Efforts (CARE) trial

brought some important issues to the forefront in respect of surgical management of the apical compartment [5]. Despite the unexpected recurrence rate observed over time, abdominal sacrocolpopexy is considered the most durable technique for restoring the prolapsed vaginal apex to a normal anatomic position [4]. However, in the absence of well-controlled and designed studies, definitive conclusion about a gold standard procedure shall be considered merely a matter of speculation. Even if randomized controlled trials and/or meta-analyses are undertaken in the future, questions on appropriate interpretation of results would be subject of criticism and debate due to intra- and interobserver variations. In fact, surgeries and surgeons are basically impossible to ideally control for in such circumstances [6]. A good example is the number of technical variations of the McCall culdoplasty and uterosacral ligament suspensions (USLS). Those techniques have undergone diverse technical modifications over the years, including anatomic landmarks, surgical route, and type and exact position of sutures. Physicians should clarify and inform their readers what they mean by “modified McCall” or “high McCall”. Everyone speaks a unique language when attempting to reach a possible common conclusion.

The best approach is, of course, another subject of numerous debates. Many surgeons advocate that the procedure performed by laparoscopy seems to have important advantages over the abdominal and vaginal approaches, allowing proper dissection in critical areas, correct identification of uterosacral ligaments and both ureters, as well as placing sutures in a more cranial position, which might positively impact treatment results. As a natural consequence of the lack of standardization among procedures, each being potentially “different” from each other, crucial questions emerge from this discussion: Shall we separately analyze the results obtained from each technique modification, or shall we put them all in the same pocket?

In contrast to the time when vaginal mesh kits were perceived as making surgical skill redundant, surgeons must

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always pay special attention to operative techniques, a fundamental factor in both efficacy and safety. Manuscripts should clearly provide detailed descriptions of surgical techniques, which does not always occur. This concern is especially pronounced in light of the multicenter studies that allow the possibility of suiting surgical practices to local preferences, mainly because many surgeons may have personal views about issues of technique. Even small modifications and differences between procedures should be clearly described and discussed in multiple comparisons and meta-analyses. Moreover, emphasis on utilization of uniform materials, such as surgical suture, and perioperative care should be provided in a maximal attempt to produce reliable conclusions. In summary, better description and reporting of surgical procedures are paramount. This would provide all readers, surgeons, and researchers a critical analysis of the treatments studied and their application in clinical practice.

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