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COMMENTARY

Commentary on the paper titled: "Partially absorbable mesh or native tissue repair for pelvic organ prolapse: a randomized controlled trial"

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This randomized controlled trial of 163 women with primary pelvic organ prolapse (POP) stage ≥2 aimed to compare the efficacy and safety of a partially absorbable mesh kit to native tissue repair at 24 months postsurgery. The study was conducted in five teaching hospitals in The Netherlands from 2011 to 2013, and operations were exclusively performed by experienced surgeons in pelvic floor reconstruction and vaginal mesh insertion. Prolift +M™ was used in the mesh arm, a 50–50 blend of monofilament, nonabsorbable polypropylene mesh and absorbable polyglecaprone 25. Mesh insertion was performed via transvaginal trocar guidance, which does not permit resection of redundant vaginal tissues or simultaneous hysterectomies or T-incisions. It does, however, allow for additional native tissue surgery for restoration of level I support. Native tissue repairs were more heterogeneous, allowing vaginal hysterectomy with vault suspension, modified Manchester Fothergill procedure, uterosacral vaginal suspension, and sacrospinous ligament fixation for the apical compartment in addition to anterior colporrhaphy. Gynecologists performing the 2-year follow-up assessments were not blinded to treatment allocation. The main outcome of this study was the overall anatomic success [defined as Pelvic Organ Prolapse (POP) stage < II] at 24 months postsurgery.

Overall results showed no significant difference in anatomical or subjective benefit of partially absorbable mesh over native tissue repair at 24 months' follow-up. Anatomic success was 45% in mesh and 32% in native tissue repair [relative risk (RR) 1.4]; composite success rates were 88% for mesh and 73% for native tissue (RR 1.1); global impression of improvement was 86% for mesh and 77% for native tissue (RR 1.1). There was no significant difference in benefit/risk ratio between procedures, including adverse events such as mesh exposure, de novo pain, and dyspareunia.

One limitation of this study was the inability to reach the prespecified sample size (n = 176). In addition, of 81 women allocated to the mesh arm, 10% crossed over to native tissue repair. The authors speculate that a simultaneous television program on complications of vaginal mesh surgery may have complicated recruitment, highlighting the existing ambivalence toward mesh procedures in vaginal surgery. Results from this study showing equivalent outcomes of native tissue repair and partially absorbable mesh insertion may prospectively support a more accurate selection of patients to either treatment option. Long-term follow- up is definitely needed, as previous studies indicated higher mesh exposure rates after 24 months.

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