Management of recurrent pelvic organ prolapse. (Mini-commentary on BJOG-19-1139.R1)

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Mini-commentary on BJOG-19-1139.R1: Mesh inlay, mesh kit or native tissue repair for women having repeat anterior or posterior prolapse surgery: randomised controlled trial (PROSPECT)

Management of recurrent pelvic organ prolapse

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Recurrent pelvic organ prolapse (POP) is not clearly defined and its management is not as well understood as primary POP (Ismail et al, Int Urogynecol J, 2016, 27:1619-1632). Management of recurrent POP entails consideration of patient-specific risk factors, duration of time since the primary repair was performed, degree of patient bother, patient-specific goals, and review of complications of the initial POP surgery. In addition to patient considerations, the planned surgical procedure must be determined. Evidence for procedure selection in recurrent POP is limited. Vaginal mesh repairs were introduced to reduce the recurrence of POP; however, it is unclear if the use of mesh in vaginal repair of recurrent POP would lead to better outcomes.

In this issue, Glazener and colleagues provide evidence on the management of women with recurrent POP who desire surgical intervention (BJOG 2020 xxxx). As part of the PROSPECT study (Glazener et al, Lancet, 2016, 389:318-392), two parallel randomized controlled trials were performed: the Mesh Inlay Trial comparing native tissue repair to mesh inlay and the Mesh Kit Trial comparing native tissue repair to mesh kit. The study included 59 surgeons from 33 centers in the UK. Surgeons were allowed to perform procedures based on their usual technique and to use graft materials that they would normally use.

Limitations of available data and concerning complication rates have led to widespread unavailability of mesh kits making questions related to their use in the treatment of recurrent POP even more difficult to answer. As an alternative to mesh kits, pelvic reconstructive surgeons have the option to use a mesh inlay which can be fashioned from polypropylene mesh making the mesh inlay arm an important component of the study. The patient-centered primary outcome, change in Pelvic Organ Prolapse Symptom Score (POP-SS) at one year, did not differ between native tissue and mesh kit repairs or between native tissue and mesh inlay repairs. POP-SS did not differ at two years either.

The study was powered based on a 30% recurrence rate of surgical repair of anterior and/or posterior compartment POP. This plan led to an estimated 1240 study candidates. Assumption of 50% study acceptance was made and enrollment of 620 women was planned. While the design of this study reflects surgeons' usual practice allowing generalizability, recruitment targets were not reached limiting the ability to make conclusions.

Despite the limitations of results, this work informs future trial planning. Simpler study design with more realistic recruitment expectations is prudent. It is clear that not all POP recurrences are due to the same factors. Recurrences may occur due to the surgical approach, lifestyle factors, and changes in tissue quality due to aging. In future studies, it would be useful to better understand the surgical history of the study sample and the timing of POP recurrence.

The Mesh Inlay and Mesh Kit Trials illustrate the need for evidence regarding the management of women with recurrent POP and provide valuable information in the planning of future trials.

Conflicts of interest: None to report. A completed disclosure of interest form is available to view online as supporting information.