Mulayim and Sendag lose the advantage of simultaneously treating a cystocele and reducing the recurrence or de novo risk of anterior wall prolapse by only taking a double bite using Mersilene tape (Ethicon Inc, Somerville, NJ) without supporting the bladder base with a flat mesh. In women with a large cystocele, it will probably remain un repaired after their technique, and an additional anterior colporraphy may be needed in the same session or later. According to our experience, a flat polypropylene mesh provides good bladder base support and concomitant cystocele treatment as can be seen in Fig. 1.

Mersilene tape is 1 of the most commonly used materials in cervical cerclages and can be easily removed at term pregnancy without let or hindrance. Mersilene mesh and type 3 meshes have fallen out of favor because of the increased risk of surfaceing and erosion; thus, polypropylene meshes with the lowest stiffness have taken their place, which allows the development of well-organized, fibrous connective tissue [5]. A study conducted by Dällenbach et al [6] with the aim of identifying the risk factors for mesh erosion after laparoscopic lateral mesh suspension found that the use of Mersilene mesh was associated with a significantly increased risk of erosion compared with macroporous polypropylene mesh (odds ratio = 5.3; 95% confidence interval, 1.2–24.0; p = .03).

The suspension strength of the original technique arises mainly from lateral retroperitoneal fibrosis provided by the mesh arms [3]. We believe that the use of Mersilene tape may impair the lateral attachment strength to the abdominal wall with an undesired mobility of the mesh arms. In addition, suspension of the vaginal apex with only 2 stitches rather than a surface seems to be less secure and, therefore, naíver for avulsion of the vault.

It is essential to restore the vaginal length without compromising the caliber in pelvic organ prolapse surgeries. The total vaginal length was reduced from 6 to 5 cm after the operation performed by Drs. Mulayim and Sendag [1]. Although 6 cm is already shorter than the average, it does not make any sense to observe vaginal shortening after a successful pelvic organ prolapse surgery. According to our unpublished data, the total vaginal length was increased 10.14 ± 4.19 mm after the surgery (p < .001). Moreover, the use of the aforementioned technique in non-hysterectomized patients would result in an anatomically unfavorable cervicovaginal angle. Postoperative pain scores and continence measures of the operated patients would also be beneficial for addressing the speculation.

Based on the previously mentioned issues, we think that stitching Mersilene tape to the vaginal vault does not provide additional benefits and remains experimental until new and more satisfactory results are achieved.

Murat Yassa, MD
Bartin State Hospital, Department of Obstetrics and Gynecology, Bartin, Turkey

Ozan Dogan, MD
Health Sciences University, Sisli Hamidiye Etfal Research and Training Hospital, Department of Obstetrics and Gynecology, Istanbul, Turkey
Niyazi Tug, MD
Associate Professor of Gynecology, Health Sciences University, Sehit Prof Dr Ilhan Varank Sancaktepe Training and Research Hospital, Department of Obstetrics and Gynecology, Istanbul, Turkey

References

https://doi.org/10.1016/j.jmig.2018.09.788

Author’s Reply
To the Editor:
First of all, I would like to thank my colleagues for their kind congratulations, but I think there is a misunderstanding regarding the “Mulayim technique” [1]. Our technique is indented to treat apical prolapse. Our patient had a stage 1 or 2 cystocele and rectocele and stage 4 vault prolapse according to the Baden-Walker grading system, so there was no need to treat the cystocele and rectocele, and she had no complaints concerning the anterior or posterior compartments. There is literature and an explanation about this issue; restoration of uterine/vault (apical) level I support and continence measures of the operated patients would also be beneficial for addressing the speculation.

We use 5-mm Mersilene tape (Ethicon Inc, Somerville, NJ) rather than Mersilene mesh. The study by Dällenbach et al [3] is about meshes almost 2 × 4 cm or with even larger diameters, so surface area is a matter for erosion. Moreover, we do not know the results regarding Mersilene tape; there are no data.
The other concern is about vaginal length. Our patient had a total abdominal hysterectomy before, so the 6-cm vaginal length was probably because of that operation; therefore, the Mulayim technique had no role. Because our report was a video article and we had a word count limitation, we did not report details regarding the results. After this report, we performed uterus-preserving lateral suspensions with the Mulayim technique as well and have 2 patients so far. Therefore, we will follow up with those patients. We plan to report the short-term outcomes of those patients’ results with details in this journal. Our results are so encouraging, so we have to be patient.

We do not agree with our colleagues because we have no data regarding Mersilene tape use and no robust data concerning anterior compartment results after apical support with a lateral suspension operation. Of course, studies should be conducted in a larger number of patients with longer postoperative follow-up periods.

Baris Mulayim, MD
Department of Obstetrics and Gynecology
Saglik Bilimleri University
Antalya Education and Research Hospital
Antalya, Turkey

References

https://doi.org/10.1016/j.jmig.2018.10.011

Regarding “When Less Is More: Minimally Invasive Surgery Compared to Laparotomy for Interval Debulking after Neoadjuvant Chemotherapy in Women with Advanced Ovarian Cancer”

To the Editor:

The article entitled “When Less Is More: Minimally Invasive Surgery Compared to Laparotomy for Interval Debulking after Neoadjuvant Chemotherapy in Women with Advanced Ovarian Cancer” reported data highlighting that the adoption of the minimally invasive approach provides similar oncologic results to open abdominal procedures [1]. The authors reported a higher debulking rate for patients having minimally invasive surgery in comparison with open surgery, suggesting similar survival outcomes between groups [1]. Surprisingly, they reported that patients having minimally invasive surgery are more likely to have complete and optimal cytoreduction in comparison with patients having open surgery. Although we strongly believe in the adoption of minimally invasive surgery, patients affected by advanced-stage ovarian cancer would not be the ideal candidate for minimally invasive surgery (if we aimed to remove all intra-abdominal disease) [2]. Because of the nonrandomized, retrospective study design, the inherent allocation bias might impact the interpretation of the results. Patients affected by stage IIIC and IV ovarian cancer are likely to have macroscopic disease located in areas not easily visible via minimally invasive surgery (e.g., the omental bursa and the hepatorenal recess of the subhepatic space) [3]. Moreover, imaging tools often are not useful in detecting small nodules [4]. Primary cytoreductive surgery via laparotomy (performed in a highly specialized center) would be the more effective method to achieve complete resection in patients with advanced ovarian cancer. With the widespread adoption of diagnostic laparoscopy in small centers in which oncologic experience is lacking, the number of patients undergoing neoadjuvant chemotherapy and interval debulking surgery is growing. Given the possible limitation of the current available level A evidence, the ongoing Trial on Radical Upfront Surgery in Advanced Ovarian Cancer (TRUST) would clarify if interval debulking would uphold the effectiveness of primary cytoreduction [5]. In 2004, Rose et al [6] published a famous randomized study questioning the usefulness of interval debulking surgery in advanced ovarian cancer patients having a residual tumor exceeding 1 cm in diameter after primary surgery. In this study, 95% and 99% of patients were managed by gynecologic oncologists at primary and interval debulking surgery, respectively [6]. This investigation showed that for patients with advanced ovarian carcinoma in whom primary cytoreductive surgery was considered to be maximal, the addition of a secondary cytoreductive attempt to postoperative chemotherapy with paclitaxel plus cisplatin did not improve survival outcomes [6]. Therefore, the question is as follows: Is interval debulking surgery useful in those patients (treated in a high-quality center) or not? If the answer is no, the type of surgical approach (i.e., minimally invasive vs open abdominal surgery) does not have any impact on their outcomes. We applaud the authors for their results but are concerned on the application of this treatment modality in centers lacking oncologic experience. In fact, with the introduction of the concept of interval debulking surgery, many patients with potentially operable stage III ovarian cancer undergo diagnostic laparoscopy followed by neoadjuvant chemotherapy and interval debulking surgery. We are concerned how the adoption of the minimally invasive approach (especially in centers lacking oncologic experience) limits the possibility to have effective cytoreductive surgery for patients with advanced-stage ovarian cancer. In light of the current evidence, primary debulking plays an important role for patient outcomes [2,3,5–7]; therefore, the use of minimally invasive surgery should be reserved only in centers that might guarantee the possibility of complete cytoreduction when judged to be feasible. The centralization