Letters to the Editor

Regarding "Modified Laparoscopic Lateral Suspension: The Mulayim Technique"

To the Editor:

We read with interest the recent article by Mulayim and Sendag [1] describing the so-called “Mulayim technique” and proposing modifications to the original operation. We want to congratulate the authors for their efforts to improve the technique; however, we would like to point out some major technical flaws and safety concerns that are worthy of discussion.

Laparoscopic lateral suspension was introduced by Dubuisson et al [2] not only as an impressive alternative to sacropexy for apical prolapse by avoiding promontorium dissection but also allows the reduction of anterior compartment prolapse simultaneously. This technique was shown to be safe and effective with low complication rates and high long-term patient satisfaction [3]; 2 x 18 cm bilateral T-shaped mesh arms with an additional 2- to 4-cm central part are used to suspend the vaginal wall to the lateral abdominal walls through the subperitoneal tunnels. Dubuisson et al state that dissection of the vesicovaginal space to the lowest point of an existing cystocele and laying the mesh over the anterior defect to enable concomitant treatment is crucial. The association between apical and anterior compartment prolapses is well-known [4]. We believe that

![Fig. 1](image)

Transperineal ultrasonography of a uterus-preserving laparoscopic lateral abdominocervicopexy patient at her 12th postoperative month visit: (left) at rest and (right) on maximal Valsalva. The arrowheads indicate plane mesh laid over the anterior vaginal wall for concomitant treatment of a grade III cystocele. Please note the corrected retrovesical angle on Valsalva.
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 unrepaired after their technique, and an additional anterior colporrhaphy 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 surface erosion; thus, polypropylene meshes with the lowest stiffness have taken their place, which allows the development of well-organized, fibrous meshes with the lowest stiffness. 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, naïve 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.

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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 intended 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 avoids the need for anterior repair, even if the patient has a cystocele to treat [2]. Despite our technique intended to treat apical prolapse, we have to wait and see the anterior compartment results.

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.