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LETTER

Interpreting Mid-Term LAWS versus Sacrocolpopexy Outcomes in Advanced Pelvic Organ Prolapse [Letter]

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Dear editor

Chu et al compared two clinically relevant reconstructive strategies for advanced multicompartment pelvic organ prolapse (POP): laparoscopic lateral abdominal wall suspension (LAWS) plus standardized posterior repair, and laparoscopic sacrocolpopexy (LSC) plus the same posterior repair.[1] That clinical setting is well chosen. In practice, these are often the patients in whom the choice of apical procedure is most difficult, and the inclusion of perioperative findings, pelvic organ prolapse quantification data, patient-reported measures, and 3-year complications gives the study real practical value.

What seems to need more caution is the causal weight placed on the between-group differences. This was a retrospective, non-randomized comparison, yet the manuscript reports only unadjusted between-group tests; the criteria used to select LAWS or LSC were not reported, and no matching, multivariable adjustment, or sensitivity analyses were described.[1] Under those conditions, differences in operative time, conversion or "surgical failure," and postoperative bowel symptoms may be influenced, at least in part, by case selection, anatomic complexity, or surgeon preference. That distinction matters because randomized comparisons of lateral suspension and sacrocolpopexy have generally shown similar short-term anatomic and subjective outcomes, rather than a consistent advantage for one procedure over the other.[2,3]

A related issue is that this study did not compare apical suspension routes in isolation. In the LSC arm, mesh was attached to both the anterior and posterior vaginal walls, whereas the LAWS arm used anterior mesh plus transvaginal posterior native-tissue repair.[1] Recent evidence suggests that lateral suspension can perform well in selected patients, but also that its posterior-compartment performance is less certain and that sacrocolpopexy with posterior reinforcement may still have a more established role in some complex multicompartment settings.[4] At the same time, lateral-suspension strategies that incorporate additional posterior support have also reported favorable outcomes.[5] The lower rate of defecatory dysfunction observed here may therefore relate to the posterior reconstructive strategy as much as to avoidance of presacral dissection. Making that distinction explicit would help readers interpret the bowel-function finding more precisely.

We would also soften the phrase "mid-term functional outcomes." In the present study, patient-reported outcome measures were collected at 6 months, whereas complications were tracked for 3 years.[1] By contrast, recent randomized and cohort comparisons in this field have aligned subjective outcome assessment with 12- to 24-month follow-up.[2,3,5] If longer-term PFDI-20, PFIQ-7, or PISQ-12 data were unavailable, it would be helpful to say so directly; if such data exist, reporting them would further strengthen the interpretability of the manuscript.

These comments are intended to sharpen the paper's message, not to diminish its value. The current data support a LAWS-based reconstruction with standardized posterior repair as a feasible option in selected patients and are compatible with the view that the procedure may be technically less demanding.[4,6] They are not, by themselves, sufficient to establish broad superiority over LSC across advanced POP phenotypes. Clearer reporting of treatment selection, adjusted analyses, and time-aligned functional follow-up would make the findings even more useful to readers deciding how best to apply them in practice.

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Author Contributions

B.P. conceived the idea and drafted the manuscript. C.W. contributed to the reviewed the manuscript. All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agreed to be accountable for all aspects of the work.

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