1. The authors 5th reference by Handa, et al., similarly looks at sexual function after sacrocolpopexy. In that study, a significant number of patients who were not sexually active before surgery became sexually active after surgery (presumably because of resolution of vaginal bulging). Why do the authors believe that none of their patients who were not sexually active before surgery became sexually active postoperatively?

   The main factor is the availability of a sexual partner; the study by Handa et al included 224 women who had a sexual partner and some were classified as non-sexually active if they did not have intercourse in the 3 months preceding the study. Out of these patients who had a sexual partner 30 patients “became sexually active” and 11 patients stopped sexual activity [1].

   In the current study, patients were classified as sexually active if they reported sexual activity within a year before surgery. That more inclusive definition might have made all the difference. Another interesting factor is that in both studies non-sexually active women were significantly older.

2. What were believed to be the causes of dyspareunia in the 5 patients that developed new onset dyspareunia postoperatively?

   Menopausal vaginal atrophy and dryness was the leading cause as evidenced by a resolution in 3/5 patients with topical estrogen. A fourth patient required pelvic floor physical therapy in addition to topical estrogen. The fifth
patient required trigger point injection with steroids to a sore area corresponding to the distal edge of a non-exposed mesh.

3. The authors state that the use of perineorrhaphy was reserved for patients with a gaping introitus. Is there a benefit to reducing a gaping introitus with regard to prolapse success or sexual function that outweighs a possible increased risk of dyspareunia?

   The addition of perineorrhaphy in the study did not increase the risk of dyspareunia. The term “gaping introitus” is used to describe patients who continued to have a large genital hiatus at the conclusion of the sacrocolpopexy and a perineorrhaphy was deemed necessary by the operating surgeon. The authors do not advocate the systematic use of perineorrhaphy at the time of sacrocolpopexy. It is important though to distinguish the perineorrhaphy from a posterior repair, which might be associated with increased risk of dyspareunia, especially if a levator-plication is performed [2].

4. Do the authors have a sense of whether the postoperative patients have “normal” sexual function, or perhaps better or worse sexual function than a population that never had symptomatic prolapse? What questionnaire could be used to study this?

   As it is stated in the introduction, female sexual function is complex and has multiple determining variables and a natural “normal” decline in desire with aging and menopause that confuses the picture. While the study concluded that sacrocolpopexy did eliminate the “physical” bother from prolapse during intercourse it did not significantly affect other aspects of sexuality and ultimately did not change the number of sexually active women.

5. This study was a secondary analysis of a study powered to look at the success of reducing prolapse, not sexual function. Therefore, many comparisons did not reach statistical significance. How many patients would be necessary to appropriately power this study to look specifically at sexual function?

   A sample size calculation based on a paired t test for a one standard deviation change in the total PISQ-12 scores would require a total of 21 patients for an 80% power and alpha of 0.05. That number would go up to 100 total participants (20 patients with positive response to the individual question) if the study needs to be powered to answer the individual PISQ-12 question: “fear of incontinence restricts sexual activity” (80% power, alpha 0.01, McNemar test for a change from 20% to 7% positive response).

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6. In Table 2, 16 patients responded to PISQ 12-question #6 that they had urinary incontinence during intercourse. Did all of these patients get a sling? Did the 2 patients that had postoperative urinary incontinence have a failed sling, or did urinary incontinence develop postoperatively?

11 out of the 16 patients received a suburethral sling at the time of sacrocolpopexy; the remainder did not for varying reasons ranging from having had a prior sling or patient refusal or preoperative retention. The urinary incontinence developed postoperatively in one patient who did not receive a sling at the time of her sacrocolpopexy because she had a previous sling placed and did not leak on preoperative urodynamic testing. The second patient received a retropubic suburethral sling that corrected most of her stress incontinence but not her incontinence of urine at the time of intercourse.

7. Based on the results of this study and the original study looking at prolapse success, can the authors give a rationale for why they would choose to use porcine dermis or polypropylene in a sacrocolpopexy outside of a study protocol?

The randomized trial and the sexual function analysis both showed that the polypropylene mesh was not associated with higher complications than the porcine graft. While the porcine dermis performed well at one year, it is associated with a higher cost and the long-term results are not reported. The authors continue to use polypropylene mesh for sacrocolpopexy and reserve the porcine dermis graft to special situations where a polypropylene mesh is not appropriate such as patients with history of pelvic radiation and prior serious polypropylene mesh complications (chronic pain, recurrent vaginal exposure, bowel erosion.

References:
