available to the surgeon wishing to perform a pubovaginal sling procedure without using a permanent mesh or graft: rectus fascia, autologous fascia lata, or cadaveric allograft of fascia lata. Rectus fascia use permits using a universally familiar Pfannenstiel technique but requires a longer abdominal incision than other methods to permit harvesting a long-enough graft to use for a sling. Autologous fascia lata uses a minimal suprapubic incision but requires a lateral thigh incision and intraoperative repositioning while under anesthesia from lateral decubitus to dorsal lithotomy. Furthermore, the technique required to harvest such a graft can be a challenge; either a wide subcutaneous dissection is done, or a long tubular fascia stripper device (which is fairly operator dependent and which few urogynecologists or urologists have had an opportunity to routinely use) is required. Cadaveric fascia lata bypasses that requirement for harvest from the patient herself and permits a small suprapubic incision, but does introduce an additional exposure of the material to degradation during the processing by solvent dehydration and irradiation. This concern appears to be central to the authors’ reference to inferior long-term surgical results with use of cadaveric grafts, but review of their reference for this takes the reader back to a 2014 report in the Turkish Journal of Urology regarding fascia lata slings using bone anchors (infrequently used now) and a 1999 report by Fitzgerald et al of 35 patients who underwent reoperation for recurrent SUI after cadaveric fascia lata sling, when the graft was noted to be absent or degraded in 7 patients (BJU Int 1999;84(7):785–788). Other reports of satisfactory long-term results with allograft fascia lata are available (Obstet Gynecol 1996;88(6):1045–1049).

My personal preference is to use cadaveric fascia lata, having found it provides more reliable graft length, shape, thickness, and fiber integrity than both rectus and autograft fascia lata. It further avoids a thigh dissection (tolerable, and relatively low risk, but not desired by patients) and permits use of 2 very small suprapubic incisions of perhaps 2 cm. This method logically minimizes the risk of wound complications associated more frequently with rectus fascia slings.—ACW

Surgical Technique Used in the UK for Native Tissue Anterior Pelvic Organ Prolapse Repair (VaST)

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Int Urogynecol J 2020;31:1519–1525

ABSTRACT

Despite previous studies suggesting that surgery using polypropylene mesh provides a better anatomical cure of pelvic organ prolapse, the well-known complications of mesh-augmented repair have led to renewed interest in native tissue surgery. PROSPECT (PROlapse Surgery: Pragmatic Evaluation and randomized Controlled Trials) was a large United Kingdom–based surgical randomized controlled trial that compared outcomes of native tissue and mesh-augmented repairs. The study findings showed that both categories of repair have similar outcomes, but with mesh-augmented repairs there was an additional 10% risk of exposure and other mesh complications. To document surgical techniques used for both native tissue and mesh/graft repairs, surgeons used surgical techniques they routinely used in their practice and completed a questionnaire at the start of PROSPECT. Surgeon responses to the questionnaire demonstrated significant variation in surgical techniques used to perform anterior repair. Previous questionnaire studies of surgical techniques used for native tissue anterior repair were limited by study design and the variable terminology used by surgeons.
The aim of VaST (Variation in Surgical Technique)—a multicenter United Kingdom–based prospective observational study—was to describe and categorize existing native tissue anterior repair surgical techniques to gain greater insight around variations in technique and understand why such practice variation continues.

The study was conducted in urogynecology theaters in 21 UK centers. A purposive sampling strategy was used to recruit surgeons for this prospective qualitative study. Data were obtained using video-recorded observations of surgery, audio-recorded interviews with each surgeon, and field notes. Thematic analysis was performed using computer software to develop themes of surgical technique for native tissue anterior repair. The themes developed represent variations observed in all steps of the procedure (including the method of infiltration, incision, dissection, fascial repair methods, skin trimming, skin closure, and surgical terminology) for native tissue anterior pelvic organ prolapse repair used by each of the recruited surgeons.

A total of 30 consultant surgeons were recruited. Surgical technique varied among surgeons in all steps of the anterior repair procedure: infiltration, dissection, method of fascial repair, type and method of suturing, and suture placement. Filming of surgery followed by interview allowed immediate validation of findings and gave greater insight into the variation of surgical techniques used to perform native tissue anterior repairs.

Terminology used to describe surgical techniques differed among surgeons. A difference was found in a number of cases between the surgical techniques observed in real time and on video and the techniques described by each surgeon during interview. There was no consistent terminology to describe these surgical techniques and anatomical landmarks and no uniformity among surgeons for the concept of fascia in histological terms.

Compared with previous questionnaire studies, the use of qualitative methods in VaST gives a greater insight into the variation of surgical techniques used to perform native tissue anterior repairs and inconsistency in terminology used to describe them. These findings demonstrate the need to standardize surgical terminology. Future meaningful research of prolapse surgery may be prevented by inconsistencies in terminology. Surgical outcomes could be affected by variation in technique, and this should be explored in future studies to evaluate which anterior repair techniques are the most effective. The themes generated from this study will be used to assess the influence of surgical technique on surgical outcomes. Finally, the origin of the tissue repaired (generically called fascia) could be more accurately confirmed by a histological study of the excised tissue.

**EDITORIAL COMMENT**

(This article reveals the remarkable variation in nearly every facet of surgical technique for a commonly performed prolapse repair, which has been consistently reported as having unsatisfying rates of failure. Despite the seeming simplicity of native tissue repair of cystocele, skilled surgeons in multicenter research group varied greatly in every discrete step of the surgery. It would be a mistake to assume that intersurgeon variation stops with this minor component of a multistep prolapse repair; surely some significant variation exists between most experienced surgeons with regard to most of what they do. Even those with common training histories will evolve and refine technique over time, particularly because medical practice rarely facilitates observation of colleagues or proctoring of practitioners. The authors opine reasonably that this variation in technique may result in surgical repairs that vary in effectiveness and that greater standardization is needed, particularly in the context of outcomes research. This may well be true. The most relevant test, however, is the effectiveness of a surgical treatment, or how generalizable the results of a surgical treatment might be in real-world practice, rather than the efficacy tested in a tightly controlled surgical study. We will likely never see a study that definitively reveals the optimal, incontrovertible method for native tissue anterior colporrhaphy—if one combination of techniques was truly superior, its practitioner would have reported having achieved those results.

This article does, however, bring to mind the work of Atul Gawande, a Boston-based surgeon who emphasizes the importance of continued professional growth not simply by continued independent practice after training, but by observation of their work by an experienced outsider or colleague. Such an observer would function literally as a coach, critiquing and observing all the elements of a surgeon’s performance to help them see weaknesses or habits to which they themselves may have become blind. Such a coach would easily identify variations in technique from other surgeons. Consider this link to Dr Gawande’s compelling talk about his experience working with a coach and its favorable impact on his surgical practice (https://www.ted.com/talks/atul_gawande_want_to_get_great_at_something_get_a_coach).—ACW)