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objective and subjective outcome criteria for pelvic support, incontinence, and sexual function, is a plus. Not surprisingly, the anatomic outcomes at a mean of 2 years are excellent and symptomatic improvements have followed suit.

While randomized comparisons confirming solid anatomic and subjective outcomes are welcome with open arms, analyses such as this one inevitably raise several questions going forward. First, can the results of this study be applied to a typical, tertiary referral population with recurrent prolapse, especially since the current cohort is a highly selective one (ie, thin, healthy, and having little previous pelvic surgery)? Second, does uterine preservation in 30% of the current cohort represent an unaccounted confounding factor in this study where the authors have done a terrific job of recruiting a relatively “pure” population? Third, do surgical nuances, which admittedly vary from study to study, influence long-term outcomes? In particular, does anchoring mesh to the sacral periosteum rather than the anterior longitudinal ligament increase the possibility of osteomyelitis? Likewise, does performing an extended dissection between bladder and vagina to the level of the bladder neck increase the chance for unrecognized, or recognized, organ injuries in the hands of a less-experienced surgeon? Finally, and this is more an observation rather than a question, the handling of overt preoperative stress urinary incontinence (SUI) is somewhat puzzling to me. As it appears, none of the women in this study was offered a concomitant anti-incontinence procedure, which has the potential benefit of addressing preoperative SUI in the same setting without significant attendant increase in morbidity. Fortunately, in this population, the rate of SUI resolution after the prolapse procedure alone was high and the appearance of new-onset, overt SUI was quite low.

With emerging outcomes such as those in the current study, several conclusions can be drawn. In experienced hands, robotic- and laparoscopic-assisted sacral colpopexies are associated with similarly solid anatomic outcomes. Robotic procedures are associated with greater costs and may take longer to perform (at least initially), while laparoscopic procedures require specialized expertise. Robotic procedures are also useful because surgeons trained in the open approach can often transition to robotic surgery directly without undergoing specialized laparoscopic training. Finally, as the outcomes are relatively immature, durability should be monitored closely.

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EDITORIAL COMMENT



There is a lot to like about this well-designed, prospective RCT comparing robot-assisted and laparoscopic sacral colpopexy by a high-volume, experienced surgeon. Compared to 2 previous similar RCTs,^{1,2} the current paper offers a longer mean follow-up period and a higher number of recruited patients. The use of standardized questionnaires, as well as the utilization of both

AUTHOR REPLY

We would like to thank you for your positive critique and the opportunity to further discuss the implications of our results.

