Evaluation and re-evaluation

Recommended treatments for a variety of problems are introduced with good intentions after evaluation, and sometimes, after unimagined complications or complications of unimagined extent, later withdrawn. For example, in the middle and late 1800s, in reputable teaching institutions in America and Europe, ergotamine was recommended not only to prevent postpartum haemorrhage but also to augment labour. The result – placental abruption, intra-uterine fetal death and uterine rupture, maternal death, and, for those babies who survived, possible cerebral palsy.

In the 1950s, cervical intraepithelial neoplasia (CIN) 3, little understood, was treated with radiation therapy. Just as treatments may be withdrawn, experts in a subject are also prone to error. Ralph Richart, the American pathologist who introduced the CIN classification, at first incorrectly estimated the progression rate of CIN to cancer.

A more recent well-publicised debate is currently being held regarding the use of synthetic mesh in repairing uterine and vaginal prolapse. The rationale for using mesh is clear: the patient with prolapse has tissue that is failing to support; repair using that tissue is prone to failure. Hence, synthetic mesh. But evidence has shown that reoperation, pain and discharge due to mesh erosion may be more common than was hoped.

A position statement[1] regarding the use of mesh in prolapse surgery has been released by the South African Urogynaecology Association (SAUGA) and is published in this issue of *SAJOG*. This details thoroughly SAUGA's concerns regarding the subject. Some recommendations may currently lack level 1 evidence; they await the support of randomised trials. This is acknowledged.

An article[2] in this edition, however, describes a randomised trial performed in India of mesh and autologous tissue repair for vaginal prolapse, and recommends the reconsideration of autologous repair. The study also has limitations but addresses the issue.

The profession is currently faced by uncertainty regarding power morcellation for the laparoscopic removal of fibroids and uterine tissue. An article in the next issue will report on the recognised complication of the dissemination of benign myomatous tissue within the abdomen after morcellation.

A further controversy is raging regarding the possible dissemination of leiomyosarcoma by morcellation: Amy Reed, an anaesthetist in Boston, USA, who has recently completed chemotherapy for stage 4 disease, underwent laparoscopic myomectomy with power morcellation in 2012. The leiomyosarcoma was not predicted preoperatively. Following the publicising of this case,[3] on 17 April 2014 the US Food and Drug Administration[4] issued a statement that it did not support power morcellation because leiomyosarcoma could not be predicted, with an estimated incidence of possibly 1 in 1 000 to 1 in 400 cases. On the same day the American College of Obstetrics and Gynecology[5] issued a statement that the matter was under review. The issue was also discussed at the 2014 South African Society of Obstetricians and Gynaecologists conference in Cape Town (selected abstracts are printed in this issue).

All treatments must be re-evaluated to assess whether their efficacy and safety can be sustained, or whether complications or failure will reach the levels at which modifications or alternative therapies will be explored. At times we may forget that all the treatments that we use are undergoing evaluation and re-evaluation, whatever the interval may be before shortcomings are revealed.

William Edridge
Editor
william.edridge@gmail.com

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