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## Serious complications and recurrences after pelvic organ prolapse surgery for 2309 women in the VIGI-MESH registry

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# Serious complications and recurrences after pelvic organ prolapse surgery for 2309 women in the VIGI-MESH registry

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1 Title  
2 Serious complications and recurrences after pelvic organ prolapse surgery for 2309 women  
3 in the VIGI-MESH registry

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58

59 Abstract

60 *Objective:* To assess the incidence of serious complications and reoperations for recurrence  
61 after pelvic organ prolapse (POP) surgery and compare the three most common types of  
62 repair.

63 *Design:* Prospective cohort study using a registry.

64 *Setting:* 19 French surgical centres.

65 *Population:* 2309 women participated between 2017 and 2019.

66 *Methods:* A multivariate analysis including an inverse probability of treatment weighting  
67 approach was used to obtain three comparable groups.

68 *Main outcome measures:* Serious complications and subsequent reoperations for POP  
69 recurrence

70 *Results:* Median follow-up was 17.6 months. Surgeries were native tissue vaginal repairs  
71 (N=504), transvaginal mesh placements (692), and laparoscopic sacropexies with mesh  
72 (1113). Serious complications occurred among 52 women (2.3%), and reoperation for POP  
73 recurrence was required for 32 (1.4%). At one year, the cumulative weighted incidence of  
74 serious complications was 1.8% for native tissue vaginal repair, 3.9% for transvaginal mesh,  
75 and 2.2% for sacropexy; while those rates for reoperation for recurrence were respectively  
76 1.5%, 0.7%, and 1.1%. Compared with native tissue vaginal repair, the risk of serious  
77 complications was higher in the transvaginal mesh group (weighted hazard ratio 3.84, 95% CI  
78 2.43-6.08), and the sacropexy group (2.48, 1.45-4.23), while the risk of reoperation for  
79 prolapse recurrence was lower in both the transvaginal mesh (0.22, 0.13-0.39) and  
80 sacropexy (0.29, 0.18-0.47) groups.

81 *Conclusions:* Our results suggest that native tissue vaginal repairs have the lowest risk of  
82 serious complications but the highest risk of reoperation for recurrence. These results are  
83 useful for informing women and for shared decision making.

84

85 Keywords: registry, longitudinal study, mesh, pelvic organ prolapse, surgical complication.

86 Tweetable abstract: Laparoscopic sacropexy showed fewer serious complications than  
87 transvaginal mesh and fewer reoperations for recurrence than vaginal repair.

88

89 Introduction

90 Pelvic organ prolapse is a frequent disability that leads to surgical repair for around one fifth  
91 of all women.<sup>1</sup> About 1.1 woman per 1000 undergoes surgery for this condition in France,  
92 and around 3.6-3.8 per 1000 aged 60-79 years in the USA.<sup>2,3</sup> Information about the risks of  
93 adverse effects is essential for choosing the procedure most appropriate to the woman's  
94 clinical situation and expectations. To promote shared decision-making, this information  
95 must include the frequent or serious complications.<sup>4</sup>

96 The information that surgeons provide before the intervention comes from their own  
97 experience and their knowledge of the clinical studies. Surgical trials often include selected  
98 and small samples. Subjects included in trials are often younger and at lower risk than their  
99 target population.<sup>5,6</sup> This situation should encourage efforts to complete the results of trials  
100 with prospective registries implemented to reflect current clinical practice.<sup>7,8</sup>

101 The VIGI-MESH registry prospectively collects data about operations performed to treat  
102 pelvic organ prolapse and follows them up to track both their serious complications and  
103 reoperations for recurrence.<sup>9</sup> The registry has now been in operation for three years. We  
104 anticipate that the incidence of serious complications and of reoperations for recurrence  
105 might differ by the type of surgical repair planned (native tissue vaginal repair, transvaginal  
106 mesh placement, or laparoscopic sacropexy with mesh). The objective of our analysis was to  
107 assess the risks of the different surgical options used in real-world practice for prolapse  
108 repair.

109

110 Methods

111 Participation in the VIGI-MESH registry began after the Comité de Protection des Personnes  
112 Ouest III (Institutional Review Board) in February 2017 (IDRBC 2017-A000308-45) approved it  
113 and it was posted on Clinicaltrial.gov (NCT03052985). The Agence Nationale de Sécurité du  
114 Médicament et des produits de santé (national medicines agency) provided funding for the  
115 VIGI-MESH registry, but played no role in data collection or analysis, assessment of the  
116 complications, or interpretation of the results. The study had no support or involvement by  
117 any manufacturer of mesh.

118 Participation was offered to all women undergoing surgery for anterior, apical (uterine or  
119 vaginal vault) or posterior vaginal prolapse. Each participating woman received information  
120 about the VIGI-MESH registry and consented. Surgeons described each operation on a  
121 specific case report form. We checked the data collection by comparing surgeons' reports  
122 with mesh deliveries from the hospital pharmacies and the surgical codes of eligible  
123 procedures recorded by each hospital's medical data department.<sup>9</sup>

124 This analysis considered three surgical groups: obliterative or vaginal repairs involving native  
125 tissue and no mesh (hereafter, vaginal repair), transvaginal placements of mesh (hereafter,  
126 transvaginal mesh), and laparoscopic sacropexies, which included colposacropexies (in cases  
127 of previous or associated hysterectomy) or colpohysterosacropexies (when the uterus was  
128 left in place) that placed mesh by laparoscopy. These procedures are those most frequently  
129 used in high-resource countries.<sup>10</sup> The other, rarer surgical procedures (sacropexy by  
130 laparotomy, laparoscopy without mesh, and lateral suspensions) were not included in this  
131 analysis as they were rare in our registry.<sup>9</sup> The planned surgical group was used for the  
132 analysis; for example, a laparoscopic sacropexy converted to a transvaginal mesh procedure  
133 was analysed as a laparoscopic sacropexy.

134 *Outcomes:*

135 In accordance with the design of the registry, the surgeons reported complications and  
136 reoperations on a specific form during follow-up. To ensure the completeness of the  
137 surgeons' reports (for complications and reoperations), we checked the data collected by  
138 each hospital's data department to link and monitor medical events after the index surgery  
139 and surveyed the participating women (annual postal questionnaire).<sup>9</sup> Medical data are

140 analysed as they are received. Queries to surgeons asked them to confirm and detail any  
141 serious complications or reoperations when data for these appeared to be missing.

142 We used the Clavien-Dindo classification to define serious complications: cancellation of  
143 planned mesh repair due to intraoperative injury or subsequent surgical intervention related  
144 to complication (Grade III), life-threatening complication (Grade IV), or woman's death  
145 (Grade V).<sup>11</sup> Minor adaptations of the classification designated to describe specific POP-  
146 surgery complications were those previously used in the PROSPERE trial.<sup>12</sup> Conversion (for  
147 example, from laparoscopy to the vaginal route) due to operative difficulties, such as  
148 adhesions, was not considered a complication.<sup>13</sup> The complications analysed here, selected  
149 together with the steering committee, were those possibly attributable to the surgical  
150 procedure. Reoperation for prolapse recurrence was considered a failure but not a  
151 complication. For each complication, the operative files of the index surgery and subsequent  
152 procedures were reviewed by two of the authors (XF and AC). At the request of the  
153 reviewers we also analysed the risk of reoperation by creating a composite variable including  
154 the reoperations for complication of the prolapse surgery and those for recurrence of the  
155 prolapse or for de novo urinary incontinence.

#### 156 *Statistical analysis:*

157 Baseline comparisons of the three surgical groups for women's characteristics used ANOVA  
158 tests for continuous and Chi-square tests for categorical variables.

159 We used a propensity score approach with inverse probability of treatment weighting to  
160 balance the baseline differences between the surgical groups and limit indication bias.<sup>14,15</sup> A  
161 multinomial logistic regression was constructed to estimate each woman's probability of  
162 receiving one of the three types of surgeries given her baseline covariates (i.e., the  
163 propensity score). Variables of the propensity score model were prespecified before  
164 outcome analyses and included age, body mass index, smoking, diabetes, surgical history  
165 (hysterectomy, or surgery for stress urinary incontinence or pelvic organ prolapse), physical  
166 status score (ASA), menopausal status, and anatomical defect. Stabilized weights were used  
167 to estimate the average treatment effect in the entire population, and the extreme weights  
168 were truncated.<sup>16</sup> Balance between treatment populations was evaluated by standardised  
169 differences of all baseline covariates, with a threshold of 0.1 used to indicate imbalance.<sup>16</sup>



170 Survival curves were obtained with the Kaplan-Meier estimator. In the absence of earlier  
171 events, we censored events as of 10 December, 2019. Three weighted frailty models — one  
172 for serious complications, one for reoperations for POP recurrence, and one for any  
173 reoperation (for complications of POP recurrence or stress urinary incontinence) — were  
174 used to compare the three surgical groups. The models included a non-parametric  
175 estimation of the baseline hazard, a gamma frailty term for the centre effect, and weights  
176 that were based on the propensity score.<sup>17,18</sup>

177 All statistical tests were two-sided, a *P*-value <0.05 was considered significant. A multiple  
178 imputation (R mice package) strategy was used to deal with the missing data. We have  
179 verified the random character of the missing data; they are indeed missing at random,<sup>19</sup> and  
180 found no difference between patients with completely observed data and those with  
181 incomplete data; all imputed values fell in the range expected. All statistical analyses were  
182 performed with the R statistical package, version 3.6.1 or later (The R Foundation for  
183 Statistical Computing, <https://www.R-project.org/>).

184 Patients were not involved in the development of the VIGI-MESH registry. No core outcome  
185 sets were used.

186

187 Results

188 Between February 2017 and November 2019, 2309 women underwent a surgical repair for  
189 pelvic organ prolapse by 110 surgeons in 19 centres, agreed to participate in the registry and  
190 were included in the analysis. We estimate that the surgical procedures included in the  
191 analysis represent about 76.6% of eligible procedures for POP repair performed during the  
192 study period in the 19 centres (Table S1).

193 The vaginal repair group included 504 women (including 36 with obliterative repairs), the  
194 transvaginal mesh group 692, and the laparoscopic sacropexy group 1113 (including 128  
195 with robotic assistance; Table S2). Eight women in the laparoscopic sacropexy group needed  
196 a conversion (0.7%): three times to a laparotomic sacropexy, twice to laparoscopic lateral  
197 attachment, twice to transvaginal mesh, and once to vaginal repair. One or more other  
198 surgical procedures were associated with prolapse surgery, including midurethral sling  
199 placement and hysterectomy (Table S2).

200 The surgical groups differed in terms of age, body mass index, diabetes, menopausal status,  
201 smoking, previous hysterectomy, previous surgery for stress urinary incontinence or for  
202 pelvic organ prolapse, and anatomical defect (Table 1). Seven of the 12 covariates in the  
203 planned propensity score had weighted maximum standardised differences below 10%,  
204 while 5 (age, menopausal status, history of POP surgery, history of hysterectomy, and  
205 anatomical anterior defect) exceeded the threshold by a maximum of 4% (Figure S1).  
206 Despite the differences observed for the mean age of the surgical groups, the age  
207 distribution showed a large overlap between them (Figure S2).

208 Median follow-up was 17.6 months (0.4 to 33.8). Complications of Clavien-Dindo grade III or  
209 higher occurred to 52 women (Table 2). During surgery or in the first 48 hours, 7 women had  
210 an intraoperative injury, 4 a haemorrhage or haematoma, and 1 a cardiac infarct. From 2  
211 days to 2 months, 18 women required surgical treatment of complications (some women  
212 had more than one type): 1 had peritonitis, 1 appendicitis, 1 wound dehiscence, 1 bladder  
213 retention, 7 a haemorrhage or haematoma, 4 ureteral obstruction, 4 pelvic abscess, 1 severe  
214 postoperative pain, and 2 vaginal mesh exposure. Between 2 and 12 postoperative months,  
215 20 women required surgical treatment for a complication (5 women had 2 complications  
216 each): 11 had vaginal mesh exposure, 1 bladder mesh exposure, 3 severe chronic pain, 2

217 ureteral obstruction, 2 an incisional hernia and 3 a vaginal granuloma. Two women returned  
218 to the operating room more than a year after the prolapse surgery: 1 for an incisional hernia,  
219 and 1 for toxin injection. Complications necessitated 16 interventions to remove the mesh  
220 totally or partially (0.9%).

221 At 12 months the cumulative weighted incidence of serious complications was 1.8% for  
222 vaginal repair (95% CI 0-3.9), 3.9% for transvaginal mesh (95% CI 2.0-5.9), and 2.2% for  
223 sacropexy (95% CI 1.1-2.6). Compared with the sacropexy group, the risk of serious  
224 complications was higher among women in the transvaginal mesh group (Figure 1, Table 3).  
225 A concomitant total hysterectomy was associated with a higher risk of complications (Table  
226 3). A sensitivity analysis was performed by excluding both complications with debatable  
227 imputability (one case of appendicitis and one case of an overactive bladder requiring  
228 botulinum toxin); both results remained the same. The analysis limited to the women with  
229 an anterior defect found similar and significant hazard ratios (Table S3). Due to a recurrence  
230 of the prolapse, a second intervention was required for 32 women (1.4%): 14 after vaginal  
231 repair (2.8%), 6 after transvaginal mesh (0.9%), and 12 after sacropexy (1.1%). At 12 months  
232 the cumulative weighted incidence of reoperation for prolapse recurrence was 1.5% for  
233 vaginal repair (95% CI 0.4-2.5), 0.7% for transvaginal mesh (95% CI 0-1.4), and 1.1% for  
234 sacropexy (95% CI 0.3-1.9). Compared with the vaginal repair group, the risk of reoperation  
235 for prolapse recurrence was reduced in the transvaginal mesh and sacropexy groups (Figure  
236 2, Table 4), with no significant differences between the latter two groups.

237 Postoperative stress incontinence resulted in reoperation for 61 women (2.6%): 6 after  
238 vaginal repair (1.2%), 28 after transvaginal mesh (4.0%), and 27 after sacropexy (2.4%).  
239 When we considered the composite criterion of all reoperations (for complications,  
240 recurrence of prolapse, or postoperative stress incontinence), 124 women underwent  
241 reoperations (5.4%): 23 after vaginal repair (4.6%), 48 after transvaginal mesh (6.9%), and 53  
242 after sacropexy (4.8%). At 12 months the cumulative weighted incidence of reoperation for  
243 complicated prolapse recurrence or stress urinary incontinence was 3.2% for vaginal repair  
244 (95% CI 1.0-5.4), 6.9% for transvaginal mesh (95% CI 4.4-9.3), and 5.3% for sacropexy (95% CI  
245 3.7-6.9). The comparison between the groups shows a significant difference in favour of the  
246 vaginal repair group only if we consider the propensity score (weighted HR, Table S4).

247 The women included in 2017 and 2018 received a postal questionnaire (about complication  
248 and recurrence) and 61% of 1575 responded. The responses showed that 96.3% of the  
249 serious complications were already listed in the registry as were 94.1% of the reoperations  
250 for prolapse recurrence.

251

## 252 Discussion

### 253 Main findings

254 We report an analysis of data collected from routine care to compare the short-term efficacy  
255 and safety of the three most common surgical procedures for pelvic organ prolapse repair in  
256 a population of 2309 women. The events were uncommon: at 1 year the women in the  
257 vaginal repair group were exposed to the lowest risk of serious complications and the  
258 highest risk of reoperation for recurrence (1.5%), the women in the transvaginal mesh group  
259 to the highest risk of serious complications (3.9%) and the lowest risk of reoperation for  
260 recurrence (0.7%), and the women in the laparoscopic sacropexy group to an intermediate  
261 risk of serious complications (2.2%) and a low risk of reoperation for recurrence (1.1%), as  
262 were those in the transvaginal mesh group.

### 263 Strengths and limitations

264 The strengths of our study are its large prospective registry including 19 centres and  
265 numerous surgeons; these features enable the detection of rare events. The analysis covers  
266 operations performed in real-life situations: complex clinical situations were not excluded.  
267 Indeed, a high proportion of our population would not have been included in a randomised  
268 trial, because they were too old or had prolapse recurrence after previous surgery or various  
269 comorbidities. The regular and routine verification of the information from the hospitals  
270 databases and from the participants is evidence of validity.

271 Our primary outcome was based on a robust criterion, as the modified Clavien–Dindo  
272 classification has been found to be a valid and reproducible classification of complications in  
273 various surgical domains.<sup>11,12</sup>

274 Our results must be interpreted considering the absence of randomisation. The surgical  
275 groups had different characteristics. It is possible that the type of prolapse influenced the  
276 choice of the most appropriate surgical technique. However, we took the women's  
277 preoperative characteristics into account with the propensity score to emulate a  
278 comparative trial.<sup>14</sup> The data about the construction of the propensity score appear  
279 reassuring regarding potential unmeasured confounders that may bias our results. When we  
280 consider the variable with the greatest difference between the groups (anterior defect), the  
281 results of the analysis limited to the women with an anterior defect were similar to those for

282 all women. Within each surgical group, there were multiple and different surgical  
283 procedures. It is probable that some hysterectomies (especially in the vaginal repair group)  
284 were expediency hysterectomies performed to facilitate the intervention, whereas the  
285 surgeons appeared to avoid hysterectomies for women in the transvaginal mesh group. We  
286 were not able to consider some factors that might have promoted prolapse recurrence, such  
287 as family history, prolapse stage 3-4, a large genital hiatus or levator ani avulsion.<sup>20</sup> These  
288 limitations are the price of a "real world" study design, which can introduce variance but  
289 limits statistical power.

290 Another limitation is the shortness of the follow-up (median 17 months). However, a Finnish  
291 cohort found that most complications of POP surgery occurred within the first two  
292 postoperative months.<sup>21</sup> Five year after transvaginal mesh placement, another study found  
293 that 79% of the mesh exposures occurred during the first postoperative year.<sup>22</sup>

294 The number of events observed limited the number of explanatory variables we were able to  
295 add to the multivariate models. We were unable to specify some technical surgical details  
296 (such as the type of mesh or the sutures used), or the experience of both surgeons and  
297 centres, which may reduce the risk of complication. Assessing these factors may be useful  
298 for improving the procedures or determining if some procedures should be reserved to  
299 expert centres.

300 Interpretation

301 Our results about the relative risk of serious complications are similar to earlier comparative  
302 studies, reporting fewer complications with vaginal surgery without mesh.<sup>23,24</sup> The incidence  
303 of complications in our registry is lower than that reported in several trials. This difference  
304 may be explained by the definition used for complications, which considered only serious  
305 Clavien-Dindo complications. The risk of reporting failure seems marginal, as we  
306 systematically and regularly verified the information with the hospitals' data departments  
307 and with the women. Most participating hospitals are teaching hospital centres specialised  
308 in management of recurrent prolapse. This point may explain the low complication rate.

309 Conclusion

310 Of the three types of prolapse repair analysed, native tissue vaginal repair had a higher risk  
311 of reoperation for recurrence than the techniques with mesh (transvaginal mesh and

312 sacropexy); and transvaginal mesh has a higher risk of serious complications than the other  
313 two (vaginal repair and sacropexy). As concerns about mesh safety abound, our results offer  
314 real-world information for women that can enable them to participate in the choice of  
315 technique most appropriate for them.

316

317 Disclosure of interests

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326 Contribution to authorship

327 Study concept and design: Fritel, Fauconnier, Ragot.  
328 Acquisition of data: Fritel, de Tayrac, Campagne-Loiseau, Cosson, Ferry, Hummel, Deffieux,  
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336 integrity of the data and the accuracy of the data analysis. He attests that all listed authors  
337 meet authorship criteria and that no others meeting the criteria have been omitted.  
338 We affirm that our manuscript is an honest, accurate and transparent report of the VIGI-  
339 MESH registry; that no important aspects of the registry have been omitted; and that any  
340 discrepancies from the registry as originally planned and registered have been explained.

341 Details of ethics approval

342 Our study complies with French law. The Institutional Review Board (Comité de Protection  
343 des Personnes Ouest III) approved the protocol on 9 February 2017 (IDRBC 2017-A000308-  
344 45), and the study was registered by the national data protection authority (Commission  
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360 Bressler, Clément Bruhat, Sandrine Campagne-Loiseau, Michel Canis, Caroline Carlier-Guérin,  
361 Victor Cavillon, Olivier Celhay, Thomas Charles, Amélie Charvériat, Armand Chevrot, Pierre  
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### Figure and table legends

Figure 1. Kaplan-Meier curve free of serious complication (Clavien-Dindo grade III or more) as a function of time (months) and of surgical group (2309 women).

Figure 2. Kaplan-Meier curve free of reoperation for prolapse recurrence as a function of time (months) and of surgical group (2309 women).

Table 1. Women's baseline characteristics at the time of the index surgery for pelvic organ prolapse (N= 2309). Comparison between surgical groups with ANOVA tests for continuous and Chi-square tests for categorical variables.

Table 2. Description of serious complications (Clavien-Dindo Grade III or more) among 52 women by type, time to revision after POP surgery, and type of care for complication (some women may have more than one type of complication).

Table 3. Risk factors for serious complication (Clavien-Dindo grade III or more). Frailty model with centre as a random effect (N= 2309).

Table 4. Risk factors for reoperation for prolapse recurrence. Frailty model with centre as a random effect (N= 2309).

### Online supporting information

Figure S1. Standardized differences between surgical groups before and after adjustment.

Figure S2. Age distribution in each surgical group.

Table S1. Detail of inclusions in each centre.

Table S2. Surgical procedures for pelvic organ prolapse (N= 2309).

Table S3. Risk factors for serious complication after POP surgery in women with preoperative anterior defect (N= 1836).

Table S4. Risk factors for reoperation for serious complication, prolapse recurrence, or stress urinary incontinence. Frailty model with centre as a random effect (N= 2309).

Table 1. Women's baseline characteristics at the time of the index surgery for pelvic organ prolapse (N= 2309). Comparison between surgical groups with ANOVA tests for continuous and Chi-square tests for categorical variables.

Baseline characteristics		Vaginal repair N= 504	Transvaginal mesh N= 692	Laparoscopic sacropexy N= 1113
	Age, mean (sd), md= 2	67.0 (13.2)	69.5 (7.6)	61.8 (10.4)
	BMI, mean (sd), md= 12	26.2 (4.9)	26.4 (4.5)	25.2 (4.0)
	Smoking, (n %), md= 39	33 (6.5)	34 (4.9)	90 (8.0)
	Diabetes, n (%), md= 28	48 (9.5)	82 (11.8)	74 (6.6)
	Menopausal status, n (%), md= 7	433 (85.9)	679 (98.1)	896 (80.5)
	Physical status score (ASA), mean (sd), md= 82	1.8 (0.6)	1.9 (0.6)	1.7 (0.6)
	Hysterectomy, n (%), md= 18	132 (26.2)	145 (21.0)	140 (12.6)
Surgical history	SUI surgery, n (%), md= 27	64 (12.7)	77 (11.1)	71 (6.4)
	POP surgery, n (%), md= 34	111 (22.0)	151 (21.8)	136 (12.2)
	Anterior, n (%), md= 2	254 (50.4)	616 (89.0)	965 (86.7)
Anatomical defect	Apical, n (%), md= 2	255 (50.6)	429 (62.0)	754 (67.8)
	Posterior, n (%), md= 2	309 (61.3)	271 (39.2)	425 (38.2)

Significant differences between groups for each characteristic with  $P < 0.0001$  except smoking ( $P = 0.03$ ) and diabetes ( $P = 0.0008$ ).

sd: standard deviation; md: number of missing data; BMI = body mass index; ASA = American Society of Anaesthesiologists patient classification status; SUI = stress urinary incontinence; POP = pelvic organ prolapse

Table 2. Description of serious complications (Clavien-Dindo Grade III or more) among 52 women by type, time to revision after POP surgery, and type of care for complication (some women may have more than one type of complication).

Grade III or IV complication, n (%)	Vaginal repair N= 504	Transvaginal mesh N= 692	Laparoscopic sacropexy N= 1113	Overall N= 2309
Intraoperative injury	-	5 (0.7)	2 (0.2)	7 (0.3)
Cardiac infarct	1 (0.2)	-	-	1 (0.0)
Haemorrhage/haematoma	4 (0.8)	6 (0.9)	1 (0.1)	11 (0.5)
Visceral complication	-	-	3 (0.3)	3 (0.1)
Pelvic abscess	-	2 (0.3)	2 (0.2)	4 (0.2)
Retention or obstructed micturition	-	2 (0.3)	1 (0.1)	3 (0.1)
Overactive bladder	-	1 (0.1)	1 (0.1)	2 (0.1)
Ureteral obstruction	1 (0.2)	4 (0.6)	1 (0.1)	6 (0.3)
Mesh exposure	-	9 (1.3)	5 (0.4)	14 (0.8)*
Vaginal granuloma	1 (0.2)	2 (0.3)	-	3 (0.1)
Incisional hernia or dehiscence	-	-	4 (0.4)	4 (0.4)*
Other severe postoperative or chronic pain	1 (0.2)	-	3 (0.3)	4 (0.2)
<b>Time to revision</b>				
T1: 0 to 48 hours	3 (0.6)	7 (1.0)	2 (0.2)	12 (0.5)
T2: day 2 to month 2	3 (0.6)	7 (1.0)	8 (0.7)	18 (0.8)
T3: month 2 to month 12	1 (0.2)*	12 (1.7)*	7 (0.6)*	20 (0.9)*
T4: > 12 months	-	-	2 (0.3)*	2 (0.1)*
<b>Care for complication</b>				
Mesh placement cancelled	-	4 (0.6)	2 (0.2)	6 (0.3)*
Intensive care unit	1 (0.2)	2 (0.3)	-	3 (0.1)
Surgery for haemostasis/drainage	4 (0.8)	6 (0.9)	1 (0.1)	11 (0.5)
Appendicitis/peritonitis surgical cure	-	-	2 (0.2)	2 (0.1)
Mesh surgical ablation	-	9 (1.3)	7 (0.6)	16 (0.9)*
Upper urinary tract surgical procedure	-	2 (0.3)	1 (0.1)	3 (0.1)
Stitch surgical removal	1 (0.2)	1 (0.1)	-	2 (0.1)
Vaginal surgical revision	1 (0.2)	5 (0.7)	1 (0.1)	7 (0.3)
Hernia or dehiscence surgical repair	-	-	4 (0.4)	4 (0.4)*
Pudendal surgical infiltration	-	-	1 (0.1)	1 (0.0)
Bladder botulinum toxin injection	-	-	1 (0.1)	1 (0.0)
Reoperation for serious complication	6 (1.2)	21 (3.0)	17 (1.5)	44 (1.9)
Overall (Grade III and IV complications)	7 (1.4)	26 (3.8)	19 (1.7)	52 (2.3)

\* related to the number of women at risk.

Table 3. Risk factors for serious complication (Clavien-Dindo grade III or more). Frailty model with centre as a random effect (N= 2309)

Risk factor		Non-weighted HR (95% CI)	Weighted* HR (95% CI)
	Vaginal repair	1	1
Surgical group	Transvaginal mesh	3.21 (1.35 to 7.62)	3.84 (2.43 to 6.08)
	Laparoscopic sacropexy	1.61 (0.64 to 4.07)	2.48 (1.45 to 4.23)
Concomitant procedure	Total hysterectomy	2.48 (1.15 to 5.34)	4.13 (2.75 to 6.21)
	Midurethral sling	1.26 (0.59 to 2.67)	0.88 (0.54 to 1.43)

HR = hazard ratio; CI = confidence interval.

\*Weights based on the propensity score which included age, body mass index, smoking, diabetes, surgical history (hysterectomy, or surgery for stress urinary incontinence or pelvic organ prolapse), physical status score (ASA), menopausal status, and anatomical defect.

Exclusion of the two complications with arguable imputability (one case of appendicitis and one case of overactive bladder needing botulinum toxin) did not change the results (weighted HR for transvaginal mesh 3.76, 95% CI 2.38 to 5.95 and for laparoscopic sacropexy 2.23, 95% CI 1.29 to 3.84).

Table 4. Risk factors for reoperation for prolapse recurrence. Frailty model with centre as a random effect (N= 2309)

Risk factor		Non-weighted HR (95% CI)	Weighted* HR (95% CI)
	Vaginal repair	1	1
Surgical group	Transvaginal mesh	0.18 (0.07 to 0.47)	0.22 (0.13 to 0.39)
	Laparoscopic sacropexy	0.23 (0.10 to 0.50)	0.29 (0.18 to 0.47)
Concomitant procedure	Total hysterectomy	0.14 (0.02 to 1.06)	0.06 (0.01 to 0.27)
	Midurethral sling	0.45 (0.14 to 1.50)	0.59 (0.32 to 1.09)

HR = hazard ratio; CI = confidence interval.

\*Weights based on the propensity score which included age, body mass index, smoking, diabetes, surgical history (hysterectomy, or surgery for stress urinary incontinence or pelvic organ prolapse), physical status score (ASA), menopausal status, and anatomical defect.

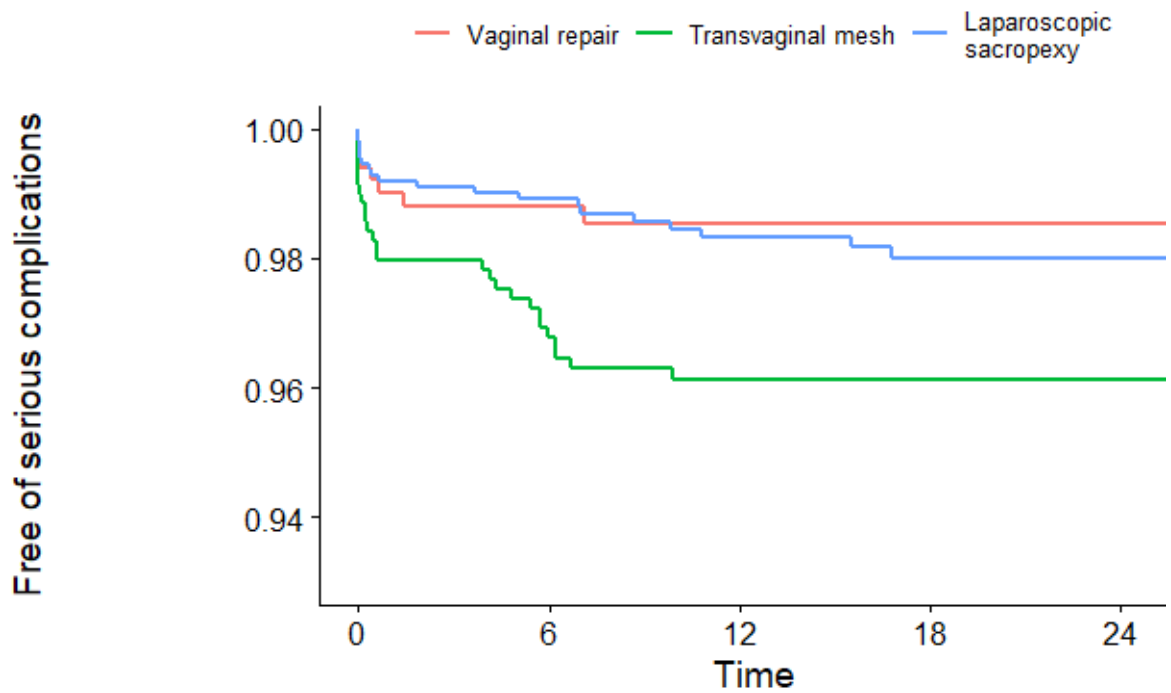


Figure 1. Kaplan-Meier curve free of serious complication (Clavien-Dindo grade III or more) as a function of time (months) and of surgical group (2309 women).

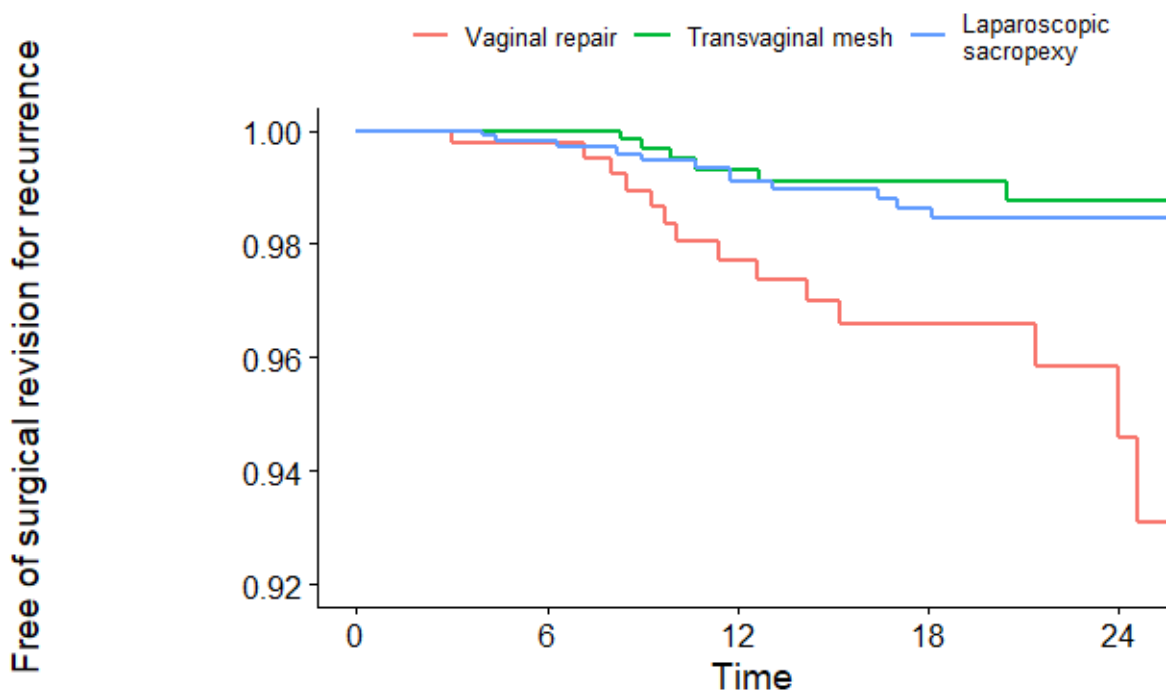


Figure 2. Kaplan-Meier curve free of reoperation for prolapse recurrence as a function of time (months) and of surgical group (2309 women).