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to attain and achieve training and educational goals and competencies are crucial.

Decades from now, obstetrics and gynaecology consultants of the future may well be quizzed by their curious trainees, 'What did you do during the COVID pandemic of 2020? And how did you learn?' Hopefully, they would be able to say that they continued to contribute to patient care as part of modified maternity and gynaecology services, that they were able to maintain training and achieve competencies through alternative means and, in the process, learnt many formative lessons on how to provide new levels of caring. ■

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## Authors' reply re: Maternity services in the UK during the coronavirus disease 2019 pandemic: a national survey of modifications to standard care

*Sir,*

We wish to thank Yoong et al. for their interest in our report on modifications to standard maternity care in the UK surveyed during the COVID-19 pandemic,[1] and for their subsequent letter.[2] We had reported the extent to which maternity services had been modified in the UK, in response to a need to protect staff and service users from the risk of infection with SARS-CoV-2, but also in response to staff shortages caused by redeployment and periods of staff self-isolation. An international survey of maternity and newborn health workers identified that similar service modifications were also implemented worldwide, and staff perceived that women feared attending for maternity care because of the presumed risk of being infected with SARS-CoV-2.[3] At the time of our manuscript submission, the impact of service reconfiguration in the UK had not yet been established. Although the widespread impact remains unknown, we welcome the recent Office for National Statistics report showing that rates of stillbirth and preterm birth in England and Wales during the first three-quarters of 2020 have not risen, and in fact have fallen in line with trends over recent years.[4]

Yoong et al. report on the impact of the COVID-19 pandemic on obstetrics and gynaecology training-grade doctors in London.[2] Although some training issues have been caused by the uncertainty of working within a health service during a rapidly evolving pandemic, other concerns have been caused by staff redeployment away from maternity care, without any decrease in demand for this urgent and emergency service. The international survey described above also identified that 90% of staff from low- and high-income countries experienced higher stress levels than usual, and maternity services were impacted by acute staff shortages.[3] In October 2020, the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) published a statement intended to reduce the impact of the COVID-19 pandemic on maternity services during the winter of 2020/21;[5] this statement included a recommendation that maternity service staff should not be redeployed elsewhere within the hospital, and a request that health service leaders recognise the current challenges and pressures on maternity staff and provide appropriate continuing support for wellbeing. We hope that this, along with the continually updated RCOG/RCM guidance and support resources available on the RCOG COVID web pages (www.rcog.org.uk) for trainees and all other maternity service staff, will continue to be accessed by our colleagues over the winter period, and that they find these useful in alleviating their concerns and fulfilling their needs. ■

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## Re: Hysteropexy in the treatment of uterine prolapse stage 2 or higher: laparoscopic sacrohysteropexy versus sacrospinous hysteropexy – a multicentre randomised controlled trial (LAVA trial)

*Sir*,

We appreciate van IJsselmuiden et al.[1] for their efforts in conducting the first ever multicentre randomised controlled trial to compare laparoscopic sacrohysteropexy (LSH) with sacrospinous hysteropexy (SSHP). However, we have some questions regarding the methodology and results of this trial. What were the reasons for including women with histories of previous pelvic floor or prolapse surgery in the exclusion criteria? Would randomly and equally allocating these women into two surgical groups affect the study result or design? Nevertheless, we are interested in the conduct of anterior or posterior colporrhaphy through the laparoscopic method.

Women presenting with anterior vaginal wall prolapse were higher in number: pelvic organ prolapse quantification system (POP-Q) stage Aa or Ba >0 (LSH group 81%; SSHP group 72.6%) than those presenting with apical prolapse (LSH group 46.6%; SSHP 45.6%) in table 1 in their study. The majority of the study population appeared to have combined anterior and apical compartment prolapse rather than apical prolapse alone. Furthermore, their table 2 shows that the overall anterior compartment failure rates were 50.9% and 56.9% in the LSH and SSHP groups, respectively, in a 1-year follow-up interval. The failure rate is extraordinarily high compared with that in a previous study.[2] Hysteropexy surgery is beneficial for women with apical prolapse. It is not beneficial for women with combined anterior and apical compartment prolapse with prominent cystocele. Most women were satisfied with the 1-year surgical results and would recommend surgery to someone else (LSH 87.7%; SSHP 89.7%) despite the high recurrence rate of anterior wall prolapse at a 1-year follow up.

In the statistical analysis section, additional anterior vaginal wall repairs were significantly higher in the SSHP group than in the LSH group (SSHP $n = 61$, 98.4%; LSH $n = 55$, 85.9%; $P = 0.010$). We would like to know how this small number difference ($61 - 55 = 6$) in these groups can cause a significant difference in $P$ value and how this $P$ value was calculated. This trial assumes a failure rate of 3% on the basis of the outcomes of SSHP in a previous prospective study. However, the data population is relatively small, and the non-inferiority margin was set at 10%.

The primary outcome is defined as a composite outcome of the surgical failure of the apical compartment after 12 months of follow up and as the recurrence of uterine prolapse (POP-Q stage 2 or greater). Surgical success is defined as the absence of prolapse beyond the hymen. In the POP-Q stage system, POP-Q stage 2 is defined as the most distal prolapse between 1 cm above and 1 cm below the hymen.[3] The most prominent prolapse, which descends beyond the hymen, is the stage 2 prolapse. It elicits clinical controversy and conflicts with regard to the definitions of surgical failure and success. We hope that this letter will deliver the message that precise preoperative patient selection and study design are crucial, as they may have substantial impacts on clinical outcomes and treatment success. ■

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