

## Answer to reviewers

Februari 23, 2015



Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 15952-review (AMEpc3256\_locked\_for\_submission)).

**Title:** Urethral complications after tension-free vaginal tape procedures: A surgical management case series

**Author:** Sergouniotis Fotios, Jarlshammar Björn, Larsson Per-Göran

**Name of Journal:** *World Journal of Nephrology*

**ESPS Manuscript NO:** 15952

The manuscript has been improved according to the suggestions of reviewers:  
We answer in detail below to the specific comments of each reviewer:

### **Comments to reviewer No 503339**

Thank you very much for reviewing our manuscript. We have found four questions in your review that we would like to comment below:

**Reviewer's question 1:** *"While the details for the 9 cases presented give moderate details of the surgery's impact on life quality, it would be helpful to learn the Authors' judgement of whether or not to classify the surgery as generally successful. As presented in Table 2, 4 of the 9 women required reoperation after mesh removal to correct the impact of erosion into the bladder of the corrective mesh."*

**Answer 1:** The tension-free vaginal tape (TVT) procedure is a good operation method with a success rate of 80% and results to a vast improvement for quality of life of the operated patients. However, even a minimal invasive procedure as the TVT operation would include a new set of complications.

If an urethral erosion occurs after the TVT procedure, then it is necessary to remove the intraurethral mesh, as explained below (answer 4). In our series more than half of the patients (4/9) do not require re-operation with a new mesh after the intraurethral mesh has been removed. This can still mean an important improvement in the quality of life of the re-operated patients. Furthermore, five out of seven (5/7) patients experienced improvement of their urgency symptoms after the intraurethral mesh was removed.

**Reviewer's question 2:** *"While tables 1 and 2 are helpful, it would be greatly improve comprehension of the techniques employed to have a staged diagram of the steps in placement of the corrective mesh as initially employed."*

**Answer 2:** We do not fully understand this question. We give a thorough description of the secondary procedure that was performed to manage the urethral complication by removing the intraurethral mesh (*Results section- The best method for removing the intraurethral mesh based on our experience*).

Concerning the primary operations, there are four different types of tension-free vaginal tape procedures that are represented (TVT-retropubic, TVT-O, MiniArc, TVT-Secure) and it would be superfluous to describe them in this case series.

**Reviewer's question 3:** *"Finally, do the tension-free vaginal tape procedures improve life quality sufficiently to advocate their use with greater frequency. The Authors might state their current view of whether their feeling that "urethral complications after sling procedures might be more common than described in the literature" is sufficient reason to restrict this surgery in potential candidate according to conditions that they might list. "*

**Answer 3:** The urethral complications after sling procedures might be more common than described in the literature, but that does not mean that the tension-free vaginal tape (TVT) procedures should be restricted. Urethral injury is still a rare complication, while the TVT procedures have a high success rate and a great improvement in the quality of life of the operated women.

We have included this comment in the discussion section of the manuscript (p.18)

**Reviewer's question 4:** *"Overall the intervention clearly has limited benefit in approximately one-half of women to whom it is applied."*

**Answer 4:** A urethral complication after a TVT procedure is an adverse event that has to be managed, otherwise it can result to more serious complications as, for example, urethral stones and urethrovaginal fistulas (*discussion section-page 19*). Therefore, the removal of the intraurethral mesh is in most cases necessary. However, it often leads to relapse of stress-incontinence (the suburethral support to the urethra decreases when the intraurethral part of it is removed). In our study we have showed, though, that more than half of the patients do not require re-operation with a new mesh and that the subjective symptoms (de-novo urgency, voiding dysfunction) are improved.

#### **Answer to reviewer 503176**

Thank you very much for reviewing our manuscript. We have found one comment in your review that we would like to answer:

**Reviewer's comment 1:** *I think that Figure 1 is superfluous..Could be simply put in words*

**Answer 1:** We have removed figure 1. Figure 1's data are included in table 2.

#### **Answer to reviewer No 503175**

We thank reviewer 503175 very much for their effort and time in reviewing our article.

#### **Answer to reviewer No 503228**

Thank you for reviewing our manuscript. We have found four comments in your review

that we would like to answer:

**Reviewer's comment 1:** *"In the result section of the abstract, you'd see almost no data related to the results of the study."*

Answer 1: We have added now more data in the result section of the abstract.

**Reviewer's comment 2:** *" Introduction is too much long."*

Answer 2: We have shortened the introduction section.

**Reviewer's comment 3:** *In the methods section, in the second paragraph, " Including urethrocystoscopies..." authors talk about relevance of cystoscopy. Methods section is not where they should talk about such a thing.*

**Answer 3:** The part concerning urethrocystoscopies is now moved to the discussion section (pages 19-20)

**Reviewer's comment 4:** *In the case report, also, it is conventional to give the manufacturer of the instruments used for the operations.*

**Answer 4:** We have now included the manufacturer's name for the instruments used for the primary operations in Table 1. The manufacturer's name for the instruments used in the secondary operation for removing the intraurethral mesh are mentioned in the subsection *"The best method for removing the intraurethral mesh based on our experience "* of the results section.

## Comments to the editor

- 1) We enclose a language certificate letter by a professional English language editing company (Ameditor Inc) , as mentioned in "The Revision policies of BPG for article". Our manuscript had been also previously edited by by Scribendi Inc editing company (Scribendi Inc, 304-405 Riverview Drive Chatham, Ontario N7M 0N3 Canada) before submission to your journal.
- 2) We have added comments concerning ethics approval, informed consent, conflict-of-interest and data sharing.
- 3) We enclose a signed PDF form of conflict-of-interest statement and a signed copyright assignment form.
- 4) We have adjusted the abstract section so that it meets the word count requirements and added data according to the reviewers' comments.
- 5) We enclose an audio file describing the core tip of our article.
- 6) We have shortened the introduction section according to the reviewers' comments.
- 7) The part concerning urethrocystoscopies is now moved from the materials and methods to the discussion section according to the reviewer's comments.

- 8) We have removed figure 1 and emerged figure 1's data along with comments.
- 9) We have added a Comments section according to your instructions.
- 10) We have added more data in table 1.

Thank you again for publishing our manuscript in the *World Journal of Nephrology*.

Sincerely yours,

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