



Letters to the Editor

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The article by Damario, Holcomb, and Bodack [4(1):69–72, 1966] describing bilateral femoral neuropathy after combined laparoscopic-vaginal surgery suggests that placement of large accessory cannula may have a role in the etiology of this complication.

I would suggest that extreme lateral placement of any cannula runs a significant risk to injury to the femoral nerve. Such lateral placement usually occurs as an effort to avoid the inferior epigastric artery, and to obtain an advantageous angle of approach to the pelvic organs. This was brought home to me in a recent case involving investigation of primary infertility and a rigid ovarian cyst. During the procedure, which entailed an uneventful right ovarian cystectomy and chromoperturbation, a 12-mm port was placed approximately 2 cm medial to the left anterior superior iliac spine, lateral to the inferior epigastric artery as demonstrated by transillumination.

Almost immediately postoperatively the patient experienced numbness of the anteromedial aspect of her left leg and minor loss of flexor ability in the same leg. Over a period of 4 to 6 weeks the sensory and motor deficits resolved, leaving both the patient and myself greatly relieved. There is no question that the lateral cannula was the proximate cause of injury to this patient's femoral nerve.

I now believe it is far better to sacrifice some of the advantage of lateral cannula placement to preserve the femoral nerve. I would bet this complication has been and continues to be underreported.

Lawrence J. Lippert, M.D.
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Response

We appreciate Dr. Lippert's interest in our article. He describes an interesting case that is worthy of further discussion and mention. He proposes an alternative explanation of femoral neuropathy after advanced laparoscopic procedures; that is, extreme lateral placement of accessory cannulas.

It is well documented that femoral neuropathy may follow abdominal surgical cases such as total abdominal hysterectomy and urologic procedures. The etiology in such cases has been attributable to lateral traction of deep-bladed self-retaining retractors. After vaginal surgery or spontaneous vaginal delivery, the cause of femoral neuropathy generally is ascribed to prolonged exposure to the dorsolithotomy position. As we suggested, increased flexion, and abduction and external rotation of the thighs may potentiate such a neurologic injury. We believed that was the most likely explanation in our patient, although the woman's positioning did not particularly vary from our usual positioning. Perhaps the long procedure time and lack of full leg support in standard stirrups may have been contributory.

In considering Dr. Lippert's patient, the potential for injury due to the extreme lateral placement of a cannula appears plausible, particularly since the patient wound up with a unilateral injury rather than a bilateral injury as in our patient. I did not find a description of this cause for femoral neuropathy in the literature. Perhaps it is underreported. I think that surgeons performing advanced laparoscopic procedures should also consider this possibility.

Mark A. Damario, M.D.
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Letter to the Editor

I read with interest the article by Van Rompaey et al (4:73–75, 1996). The authors performed aggressive laparoscopic excision of endometriosis of the cul-de-sac and uterosacral ligaments. They presumably followed the patient in the office thereafter, yet did not mention an enterocele during that follow-up. The patient then conceived, delivered vaginally, and later developed an enterocele that was repaired laparoscopically with

good results. The authors thus seem to have provided evidence that pregnancy causes enteroceles that can be repaired successfully laparoscopically.

Their premise that aggressive excision of endometriosis may result in enterocele is not strongly supported by their evidence because of the intervening pregnancy, which itself is a risk factor for enterocele. In my opinion, more cases without intervening pregnancy and vaginal delivery would be required to establish a cause-and-effect relationship between laparoscopic excision of endometriosis and subsequent enterocele formation.

A parallel question is whether transection or resection of one or both uterosacral ligaments might cause uterine descent. In a large series of women undergoing aggressive laparoscopic excision of endometriosis, resection or transection of one or both uterosacral ligaments did not result in an increased frequency of uterine descent as judged by the patients or diagnosed subsequently by physicians.¹

Reference

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Response

These pertinent comments give us the opportunity to discuss the observation in a broader perspective than can be done in an article.

We hesitated to write up this case report since, as Dr. Redwine pointed out, and as discussed in the article, there is indeed at this moment no final proof of a cause-and-effect relationship between aggressive excision of rectovaginal endometriosis and a subsequent enterocele. The history of medicine, however, has taught us that evidence-based medicine is generally preceded by careful clinical observation. Numerous examples illustrate this, ranging from the discovery of penicillin, to ICSI in IVF, to clinical examination during menstruation for diagnosis of deep endometriosis,

to laparoscopic hysterectomy, salpingostomy, to almost our entire discipline of endoscopic surgery. We subsequently have to prove or disprove these observations and hypotheses by careful clinical trials. As clinicians we should remain aware, however, that absence of statistical evidence does not invalidate an observation (type II error in statistics), and that randomized, clinical trials have their biases of selection and inclusion criteria and of observation period. The dilemma of the randomized clinical trial is that when too much evidence of benefit exists, the trial becomes unethical to perform; when on the other hand the expected benefit is so little, it becomes unwise to perform. Clinical medicine and evidence-based medicine is a shotgun marriage, as evidenced by numerous discussion by clinicians in the literature (over 300 in the last 3 years).¹⁻⁷ Moreover quality is often difficult to quantify.⁸

With this case report we wanted to express our clinical concern while simultaneously increasing awareness of this association, since we realize that final proof or disproof will be difficult.

- At laparoscopy for pelvic pain, "subclinical" enteroceles are seen that are not apparent on clinical examination. In most of these women pain can be cured by a high McCall procedure. I am fully aware that this observation does not prove a cause-and-effect relationship. I still hesitate, however, to perform a randomized trial, since this would imply a second procedure for half of the women if the hypothesis is correct.
- Resection of a large nodule of endometriosis from the rectovaginal septum creates a defect that looks like a beginning enterocele. It seems logical to postulate that the progression to a clinical enterocele will depend on parity and levator muscle anatomy, on transection and removal of the uterosacrals, and on the postoperative repair sutures. Indeed, in recent years, after excision of deep endometriosis, prophylactic bowel suturing and pelvic floor repair are done more rigorously than was done 5 years ago. To evaluate the relative importance of these covariables large studies will be necessary to generate sufficient statistical power. A prerequisite, however, will be that we can reliably make the clinical diagnosis of a beginning enterocele. Moreover, I doubt whether a clinical trial including nonrepair would be ethical.

In conclusion, we invite the readers of the Journal of the AAGL to contribute to the methodology of diagnosing clinically and reliably a beginning enterocele to establish whether and how rigorous postoperative repair suturing including the uterosacral ligaments should be performed.

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Erratum

Through an oversight, we did not list that Dr. Corson receives royalties of the Dolphin hysteroscopic fluid-management system. [Corson SL: Hysteroscopic fluid management system *J Am Assoc Gynecol Laparosc* 4(3):375–379, 1997].

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