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Response

To the Editor:

Thank you for your comments on our article, "Outcomes after Rectum or Sigmoid Resection" (2007;14:33–38). We are fully aware of your extensive experience in the surgical treatment of deep endometriosis invading the bowel. We, like you, think that the years of experience and careful surgery, together with the discussions at meetings, are important to formulate suggestions or new hypotheses about management.

We did emphasize that extrapolation from bowel resections for cancer to bowel resections for endometriosis should be done carefully because in endometriosis radicality is less whereas nerve-sparing techniques can be applied. To substantiate this fully with data is, however, not yet possible.

We share your opinion that laparoscopy permits a more careful dissection than laparotomy and that this approach will lead to a more conservative surgery with less damage. Again the data to substantiate this are not available. Moreover, when series are compared, it is still unclear whether differences in outcome are due to the technique or to the surgeon. We did not include inflammatory diseases, such as Crohn's disease, because this is beyond the scope of our review.

We expect and hope, like you, that in the future data will become available to demonstrate that the complications for a bowel resection for endometriosis will be less than for other indications such as cancer. We do believe, however, the conclusion in comparison with sigmoid resection, complications increase when a lower rectum resection is performed and that the sexual complications are much higher than many of us thought. This will remain valid also for endometriosis surgery. Today, the real complication rates for low bowel resections in deep endometriosis are unknown because the numbers available are small and because the diameter of the nodule, probably the single most important factor to influence the importance of the dissection, is rarely reported. For endometriosis surgery today, even if the incidence might be several times lower, the complications associated with a low rectum resection should stimulate us to avoid any unnecessary low rectum resection. Because sufficiently large randomized controlled trials are difficult to organize, careful observation and reporting are the best we can do for the moment. We might even urge the AAGL to open a prospective registry to evaluate outcome according to the type of surgery, stratified by size of the nodule and localization.

The actual trend all over the world of increased bowel resections, including low bowel resections, is an evolution that contrasts sharply with the high complication rates. It also contrasts with our experience and yours, we believe. Finally, the purpose of this review was to provide a basis for discussion, to give a message of caution for the low bowel resection, and to encourage careful reporting.

Philippe R. Koninckx, MD, PhD
Leuven, Belgium

María L. Ret Dávalos, MD
Córdoba, Argentina

Carlo De Cicco, MD
Rome, Italy

Bert De Decker, MD
Andre D'Hoore, MD
Leuven, Belgium

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Shveiky et al. Complications of hysteroscopic surgery: "Beyond the learning curve"

To the Editor:

I read with great interest the recent article[1] entitled "Complications of hysteroscopic surgery: 'Beyond the learning curve.'" The authors correctly conclude the most common complication of operative hysteroscopy, in experienced hands, seems to be related to cervical dilation or uterine entry techniques.