

## Letters to the Editor

### *To the Editor:*

We thank the editor of the *Journal* for providing us with the opportunity to respond to a letter [1] that criticizes our opinion article. We suggest a careful reading of the quoted article [2] where, in the abstract, it states: "In conclusion, multidisciplinary CO<sub>2</sub> laser laparoscopic excision of deep endometriosis with colorectal extension improves pain, QOL [quality of life] and sexuality with high fertility and low complication and recurrence rates," which, according to the published article, is based on 50 bowel resections in 56 women, with results as "confirmed endometriosis in 42/49 resections," with detailed microscopy of depth of invasion and 6 endometriosis lesions outside the muscularis, and life table analysis on a very limited number of events. Such claims indeed confirm the importance of letters to the editor permitting discussions for the benefit of the readership.

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### References

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2. Meuleman C, D'Hoore A, Van Cleynenbreugel B, Beks N, D'Hooghe T. Outcome after multidisciplinary CO<sub>2</sub> laser laparoscopic excision of deep infiltrating colorectal endometriosis. *Reprod Biomed Online.* 2009;18:282–289.

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### *To the Editor:*

We congratulate Khong et al [1] on this large retrospective series with the objective of estimating the clinical

significance of bowel involvement in women with pouch of Douglas obliteration undergoing laparoscopy to treat endometriosis.

Our concern is that the article raises more questions than answers: most importantly, what can gynecologic endoscopic units do preoperatively to predict obliteration of the pouch of Douglas in women scheduled for laparoscopic intervention? There is a growing body of evidence to support the use of specialized imaging techniques in the preoperative evaluation of women with chronic pelvic pain. We believe that office sonovaginography (SVG) with incorporation of the "sliding sign" is an essential preoperative imaging technique in women with suspected endometriosis. Office SVG is performed preoperatively via introduction of 10 to 20 mL of ultrasound gel into the posterior fornix of the vagina before performance of transvaginal ultrasound. Of importance, the ultrasound gel forms an acoustic window between the tip of the transvaginal probe and the surrounding vaginal structures. Namely, the anterior and posterior vaginal fornices and the anterior and posterior vaginal walls. This enables systematic evaluation of the posterior compartment of the pelvis including the retrocervical area, uterosacral ligaments, pouch of Douglas, rectovaginal septum, and rectosigmoid colon. Sonovaginography helps in accurately mapping not only the location of endometriosis but also its extent.

The ultrasound sliding sign is considered positive (i.e., no pouch of Douglas obliteration) when the anterior rectal wall glides smoothly over the posterior cervix (retrocervical region) and the rectosigmoid colon glides smoothly over the posterior uterine fundus. If either of these anatomical regions demonstrates that the anterior rectal wall does not glide smoothly over the retrocervix or posterior uterine fundus, the sliding sign is negative, and the pouch of Douglas is deemed to be obliterated. According to our preliminary results, use of the sliding sign at SVG predicts obliteration of the pouch of Douglas with a sensitivity of 83% and negative predictive value of 94% [2].

We suggest that all women with suspected endometriosis or with a history of endometriosis undergo SVG preoperatively to establish whether the pouch of Douglas is obliterated and to ensure appropriate triaging to an advanced laparoscopic surgeon if appropriate. This new ultrasound technique not only has the potential to negate the need for 2 laparoscopic procedures but also enables proper