

## The title is misleading: an opinion paper is not a consensus paper

Sir,

The article 'Consensus on current management of endometriosis' by Johnson and Hummelshoj (2013) for the World Endometriosis Society (WES) Montpellier Consortium leaves an uneasy feeling of bias. The conclusions might be partly true considering the highly respected and knowledgeable participants. The article gives the impression that it is based on scientific arguments, but methodologically it is an opinion paper voted by those present. The conclusions therefore only have the value of an educated opinion of the participants, and do not reflect the opinions of those not participating. The conclusions do not represent a consensus on endometriosis and the title therefore is misleading. Indeed, a large number of surgeons involved in treating patients with severe endometriosis were absent since they were attending a deep endometriosis surgery meeting at the same moment.

It is beyond the scope of this letter to question or discuss any specific opinion on which the WES Montpellier Consortium agreed. To highlight some of the underlying biases, however, might be illustrative. 'Women with endometriosis require individualized care over a long-term period ... (conclusion 4)' reflects the view that endometriosis is a recurrent disease. This concept is challenged by the low recurrence rates following adequate surgery of cystic ovarian and deep endometriosis. 'A multi-disciplinary network (conclusion 5)' is a statement that is poorly defined while no evidence of superiority in endometriosis care has ever been provided. 'The blind leading the blind' should be avoided: it is unclear whether it is more beneficial for patients undergoing surgery for endometriosis to be operated on by a pelvic surgeon familiar with the disease and skilled in ureter and bowel surgery or by a gynecologist calling upon the urologist or bowel surgeon when needed. Conclusion 10 surprisingly suggests that severe endometriosis in adolescents should be treated differently. Conclusion 23, that 'The best surgical approach to deep endometriosis is unclear', is at least superficial since no distinction is made between a low rectum resection and a sigmoid resection considering the severe long-term side effects of the former.

The absence of some conclusions equally suggests bias. In the absence of data, we cannot exclude that medical treatment of severe endometriosis for many years without surgery makes the disease worse and later surgery more difficult. With the knowledge that in 8% of bowel resections the margins are not free, without documented increased recurrence, a strong argument can be made against the ultra-radicality of bowel resections. Finally, it is surprising that the efficacy of medical treatment is not discussed knowing that there is no medical therapy (except painkillers) with proven pain relief of endometriosis that does not affect menstruation or the menstrual cycle. This indeed makes blinding impossible, which induces bias and questions the results of the many randomized control trials.

In conclusion, the paper by Johnson and Hummelshoj is not a consensus paper but an opinion paper by those participating in the discussion. The conclusions and references are thus at risk of being incomplete with bias, and different from a consensus by a club of deep endometriosis surgeons.

## Reference

Johnson NP, Hummelshoj L, for the World Endometriosis Society Montpellier Consortium. Consensus on current management of endometriosis. *Hum Reprod* 2013;**28**:1552–1568.

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