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EDITORIAL

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Treatment of endometriosis—a special skills module only?

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Endometriosis probably affects 6% of the UK female population [1]. It can be identified on over 240,000 websites and appears in over 10,000 articles on a Medline search. Despite this, its aetiology remains uncertain, its pathology disputed [2, 3] and its treatment poor. Most medical treatments are based on ovulation suppression and inducing amenorrhoea. The treatment regimens are usually of short duration and have a high drop-out rate because of intolerable side effects.

The recurrence rate of symptoms is high, particularly of chronic pain and dyspareunia [4]. This in itself leads to significant changes in quality of life scores, which do not seem to improve despite some relief of symptoms as measured by structured questionnaires [5]. There is some evidence to suggest that the greater the extent of the disease, the more symptomatic women are, although equally there are reports of patients who are severely symptomatic despite appearing to have laparoscopically trivial disease [4].

An appalling statistic collected by the National Endometriosis Society is the length of time from the first symptom to diagnosis—15 years. An invariable finding in patients with severe endometriosis is that symptoms start shortly after the menarche, probably when ovulation is established, and the symptoms are ignored or treated medically without a diagnosis for many years. Nodular infiltrating endometriosis can in fact be clinically diagnosed with some certainty by palpation of the utero-sacral ligaments and Pouch of Douglas and the posterior cul de sac, which is not something that is routinely undertaken by gynaecologists, who may be more concerned with adnexal tenderness or uterine enlargement [6]. Reluctance to be examined because of pain may be interpreted as evidence of psychosexual problems and a referral made for abdominal ultrasound scanning, which will almost inevitably be negative, further delaying the diagnosis. By and large, imaging techniques are unhelpful in the diagnosis in endometriosis except in the case of ovarian endometriomas. The finding of ovarian fixity and tenderness on vaginal scan may raise suspicion of endometriosis, but these findings may be apparent simply by conducting an accurate pelvic examination.

Even if a laparoscopy is eventually carried out, this may well be undertaken by an unsupervised gynaecologist in training, with inadequate instrumentation and a poorly positioned patient. Disease that is obvious at subsequent laparoscopy is thus missed, and the woman may be wrongly labelled as having unexplained pain, psychosexual problems or as a victim of child abuse. While accurate visual inspection of the peritoneal surfaces is important, the invasiveness of the disease will not always be initially apparent [7]. What appears to be a small superficial lesion can frequently be the head of a severe nodular or infiltrating area of endometriosis that can remain undetected beneath the surface. Laparoscopy should therefore include careful palpation of any suspect lesion with a blunt probe to check for possible infiltration or nodularity. It is unfortunately rare, but should be routine, for any lesion to be confirmed by excision and histological examination. The diagnosis of endometriosis is all too frequently made, if at all, by visual inspection only.

Histologic confirmation of endometriosis is rarely done at surgery because of concerns about potential morbidity, but a firm diagnosis is always helpful. This is vital in patients with recurrent symptoms following operative treatment, as it may be difficult to distinguish carbonisation following some ablative techniques from pigmented lesions of endometriosis. An error in diagnosis may lead to patients receiving further medical therapy in the absence of disease.

Surgical treatment remains predominantly laparoscopic with a myriad of energy sources being recommended on the basis of very little hard evidence or common sense. Excision of disease is uncommonly performed, although

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it is the only technique that provides histologic confirmation and that can treat all superficial or deep disease anywhere in the body. For the relatively small proportion of women with infiltrating nodular disease of the rectovaginal septum, the muscularis of the rectum and the utero-sacral ligaments, treatment options are more hazardous and the treatment results are worse because very few gynaecologists have the expertise to undertake the radical laparoscopic surgery required to dissect the endometriotic tissue away from the great vessels and ureter on the sidewall and to enter the rectovaginal septum.

The possibility of a rectal perforation or a minor resection of the anterior rectal wall is sufficient to make many surgeons unwilling to undertake this surgery, despite a simple primary repair being entirely adequate. A colorectal surgeon may be capable of performing an anterior resection although they have little understanding of the disease or of modern treatment options. There is thus an inevitability that they will advise surgery through a midline incision, often with a covering ileostomy and removal of much larger portions of the bowel than is necessary [8]. This is despite the existence of good case series demonstrating that laparoscopically assisted segmental resection or anterior wall resection produces good results with very low morbidity [9]. In some patients, it is possible to remove endometriotic disease from the bowel wall without rupturing the mucosa and with a simple seromuscular repair. A diverting ileostomy or colostomy is never necessary for treating colorectal endometriosis and would represent a significant departure from the standard of care for this disease. Although the patients are young and the initial operative morbidity low, the use of a midline scar and ileostomy is cosmetically objectionable to most women who become aware of simpler minimally invasive forms of treatment and condemns the patient to two unnecessary major surgical procedures: the initial diversion procedure and the follow-up procedure to reverse it. Adhesions resulting from unnecessary laparotomy can make subsequent surgery more hazardous and could compromise fertility and increase the hazard of egg collection in assisted reproduction techniques.

It can thus be seen that endometriosis is one of the most common human diseases, more prevalent even than conditions such as breast cancer, cervical cancer, sexually transmitted diseases and diabetes. It is poorly managed, and there is an overwhelming need to address this. Planned and radical excisional therapy with a view to excising all the identified lesions will cure 50% of patients and lead to good long-term symptom relief for up to 75% of patients with severe lesions and appropriate surgical management [6, 7]. However, this treatment should be carried out by appropriately trained surgeons and subject to scrupulous audit, neither of which exists outside of a very few specialist units.

These surgical training needs should be addressed with some urgency, with attention directed toward all the specialties—gynaecology, general surgery and urology—involved in the multi-specialty approach that is commonly necessary in the surgical treatment of this disease.

Endometriosis as a disease has an abysmally low profile in health care circles despite the obvious morbidity, and it is time that it was much better placed on the agenda of women's health care needs. Women should be able to received skilled advice and help with appropriate support to help them deal with this debilitating condition. The need for specialist centres dealing with endometriosis is every bit as real and perhaps more pressing than cancer services, since the morbidity of endometriosis lasts much longer than that of cancer, and endometriosis is much more common than cancer.

The surgery is specialist, as specialist as that of oncology or gynaecological urology, and deserves to be recognised as such with similar proper training—it is inappropriate to regard it as a special skills module only, as is currently planned by the RCOG.

The BSGE and the ESGE are realising that laparoscopic surgery requires special training, and there is finally the possibility of developing proper training on a Europe-wide basis. This, together with an appropriate audit of results, may be the beginning of the recognition of this type of surgery as a speciality in its own right, as it richly deserves to be.

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