When we compare these findings by sex of the pregnancy, we find a substantial decline in weeks of gestation for female pregnancies exposed to the earthquake in Month 3 and 2—the decline in weeks of gestation is, respectively, 0.234 and 0.265 weeks. These effects are significant at the 0.05 level to report statistical significance (these cut-points are, of course, just useful conventions). There is nothing essential about a P < 0.05 or a P < 0.10 threshold). As in Torche and Kleinhaus (2012), the effect is much weaker for males (the strongest effect is significant only at the P < 0.13 level).

In sum, the main findings for the effect of earthquake exposure on gestational age reported in Torche and Kleinhaus (2012) remain. Earthquake exposure early in the pregnancy has a negative effect on gestational age. This effect is sex specific: it is much stronger for female pregnancies. This effect is relevant because natural disasters, as well as other sources of acute stress are, unfortunately, prevalent around the world, and they may affect individual outcomes even if exposure occurs before birth.

We appreciate the opportunity to further test these findings and to contribute to an important methodological discussion.

**References**


**Poor results after surgery for rectovaginal endometriosis can be related to uterine adenomyosis**

Sir,

The interesting paper by Mabrouk et al. (2012) suggests that it may be useful to reconsider the surgical strategy for bowel endometriosis, which may carry a high risk of major complications and, even after extensive bowel resection, may have no beneficial effect. The authors used extensive preoperative imaging, including transvaginal ultrasound (TVS) and magnetic resonance imaging (MRI), to diagnose colorectal endometriosis. However, in no case was the presence of uterine adenomyosis mentioned. Today, uterine adenomyosis is diagnosed by MRI or TVS and several authors have described the association with endometriosis (Brosens et al., 2011). In a prospective study Kissler et al. (2008) found that severe dysmenorrhea of long duration in patients with endometriosis is significantly related to uterine adenomyosis. Larsen et al. (2011) found a correlation between the severity of endometriosis and the degree of uterine adenomyosis and in a recent prospective study, Gonzalez et al. (2012) found in a correlation between uterine adenomyosis and deep endometriosis with poor prognosis, particularly endometriosis of the rectosigmoid. Parker et al. (2006) concluded that persistence of dysmenorrhea and non-menstrual pain after optimal endometriosis surgery may indicate adenomyosis.

It is therefore surprising that the authors, while reporting extensive imaging for the detection of bowel endometriosis, make no mention of the simultaneous presence of uterine adenomyosis. In our view it is no longer acceptable to operate on severe endometriosis without exploring the uterus by MRI or TVS to exclude the presence of uterine adenomyosis.

**References**


Gonzalez M, de Mattos L, Gonçalves M, Blasbalg R, Dias J Jr, Podgaec S, Barcat E, Abrão MS. Patients with adenomyosis are more likely to have deep endometriosis. Gynecol Surg 2012 (in press).


and visual analogue score for pain symptoms (Mabrouk preoperative scores of the short form-36 health survey questionnaire). We also tried to examine if satellite lesions could influence (the incidence of recurrence, quality of life and symptom improve-
lesions, positive margins and vertical infiltration) and clinical data
the potential relationships between histological findings (satellite
histopathological patterns of colorectal endometriosis and investigate
patients desiring a pregnancy.
workup when endometriosis is clinically suspected, particularly in
concomitant adenomyosis should be included in the preoperative
with endometriosis. We also agree that preoperative evaluation of
the post-operative improvement pattern of pain symptoms associated
we (Blazar et al., 2012) remarked that dysmenorrhea and dyspareunia
ameliorated after a 20-months follow-up regardless of the presence of
endometriosis. No significant differences in pain relief score among the
two groups of patients with or without adenomyosis were observed.
In our study 18 of 47 patients (38%) at stage IV of endometriosis
had concomitant adenomyosis at the time of surgery (JZ thickness of
> 12 m). In agreement with Landi et al. (2008), we did not demon-
strate a statistically significant impact of the presence of endometriosis
on post-operative pain relief.

References
Brosens I, Kunz G, Benagiano G. Is adenomyosis the neglected phenotype
Ferrero S, Camerini G, Menada MV, Biscaldi E, Ragni N, Remorgida V. Uterine

Reply: Poor results after surgery for rectovaginal endometriosis can be related to uterine adenomyosis
Sir,
We appreciate our colleagues’ considerations regarding the need for
preoperative investigation of simultaneous presence of adenomyosis
in patients with severe endometriosis.
We agree that the presence of uterine adenomyosis can influence
the post-operative improvement pattern of pain symptoms associated
with endometriosis. We also agree that preoperative evaluation of
concomitant adenomyosis should be included in the preoperative
workup when endometriosis is clinically suspected, particularly in
patients desiring a pregnancy.
However, in this study, our primary end-point was to evaluate the
histopathological patterns of colorectal endometriosis and investigate
the potential relationships between histological findings (satellite
lesions, positive margins and vertical infiltration) and clinical data
(the incidence of recurrence, quality of life and symptom improve-
ment). We also tried to examine if satellite lesions could influence
preoperative scores of the short form-36 health survey questionnaire
and visual analogue score for pain symptoms (Mabrouk et al., 2012).
In the literature, there are different results concerning the influence
of adenomyosis on post-operative symptoms after radical surgery for
severe endometriosis.
In a recent review of literature, Brosens et al. (2012) remarked that
these two pathological conditions are frequently associated and that
they could be two phenotypes of a similar endomyometrial dysfunc-
tion syndrome.
Parker et al. (2006) showed that, following surgical excision of endo-
metriosis, non-menstrual pelvic pain and dysmenorrhea were signifi-
cantly more likely to persist with increasing junctional zone (JZ)
thickness, suggesting adenomyosis.
Ferrero et al. (2009), in a prospective study including 50 women with
bowel endometriosis with or without uterine adenomyosis, concluded
that the presence of uterine adenomyosis may determine the post-
operative persistence of dysmenorrhea at 6, 12 and 18 months’ follow-up.
Differently, Landi et al. (2008) in a retrospective study on 80 patients
treated for endometriosis stated that dysmenorrhea and dyspareunia

Predicting ovarian aging: anti-Mullerian hormone
Sir,
In an otherwise perceptive and well-written article (Loh and
Maheshwari, 2011), the authors state that ‘Despite being a good
marker of ovarian response AMH fails to predict who will get preg-
nant’. While it is true that some studies have found this to be true,
we (Blazar et al., 2011) and others (Eldar-Geva et al., 2005; Nelson