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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 improvement). 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 dysfunction syndrome.

Parker et al. (2006) showed that, following surgical excision of endometriosis, non-menstrual pelvic pain and dysmenorrhea were significantly 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 ameliorated after a 20-months follow-up regardless of the presence of adenomyosis. 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 demonstrate a statistically significant impact of the presence of adenomyosis on post-operative pain relief.

References


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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 pregnant’. 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 et al., 2011) have found that AMH can be a useful predictor of ovarian reserve. However, we agree that the current data do not support the use of AMH as the sole predictor of ovarian response to IVF stimulation. It is important to note that AMH levels are not uniformly reduced in women with PCOS and that women with PCOS may respond well to IVF treatment. Furthermore, AMH levels are not influenced by age and other factors such as smoking, obesity and polycystic ovary syndrome (PCOS) and therefore may not be a good marker of ovarian reserve in these populations. It is important to recognize that AMH levels are influenced by a variety of factors, including age, smoking status and body mass index (BMI). These findings emphasize the importance of considering multiple factors when evaluating ovarian reserve in women undergoing fertility treatment.