The WES Montpellier Consortium represented 34 national and international medical and non-medical organizations (from 51 invited organizations—all of those accepting the invitation then nominating their representatives from within their organization to the consortium) from a range of disciplines. We acknowledged that ‘a different group of international experts from those participating in this process would likely have yielded subtly different consensus statements’. There was a rigorous and systematic pre-meeting process designed to make the areas covered as comprehensive as possible, a 1-day consensus meeting and a post-meeting process (which included an online survey of consortium participants to refine the level of the consensus over our statements) that is clearly described in the methods section and the supplementary data link of the paper. We adopted a priori the GRADE system (Guyatt et al., 2008) to appraise evidence and theACCEPT Group consensus grading system to ascertain the degree of consensus around each statement (Kroon et al., 2011). The different disciplines represented spanned five continents and included medical societies, fertility societies, endometriosis organizations representing women who suffer from endometriosis, as well as surgical societies (including the International Society for Gynaecologic Endoscopy, the American Association of Gynecologic Laparoscopists, the European Society for Gynaecological Endoscopy and the Australasian Gynaecological Endoscopy and Surgical Society). We consider that our methodology led to a robust and comprehensive consensus process as possible and that our methodology sought to minimize bias (that can never be completely eliminated in any process); we leave this to the reader to judge.

It is healthy to debate the merits or otherwise of our more controversial statements and Konincx et al. have mooted excellent opinions to challenge some of our statements. However, much evidence does point to endometriosis as being a disease with a high recurrence rate after surgical removal (10–55% at 12 months following surgery, with an additional 10% per year after that) (Vercellini et al., 2009; Kroon, 2009), although there will inevitably be differences in outcomes based on the expertise of surgeons undertaking laparoscopic removal of the disease, one of the recurrent themes in our paper. We have already highlighted that ‘not all women with endometriosis require a large number of experts and some women are treated effectively for the rest of their lives by a single surgical procedure’. We agree that we cannot exclude the possibility that medical treatment for many years without surgery may make the disease worse and later surgery more difficult (although there are fewer published data to support this concept than the concept that disease progression is halted or slowed by long-term medical treatment that might make later surgery less difficult). The poor correlation between the completeness of excision of bowel endometriosis and future persistent or recurrent symptoms might tend to deter surgeons from ‘ultra-radicality’ in surgery, but, along with a growing literature in relation to deep endometriosis, it supports our statement that ‘the best surgical approach to endometriosis is unclear’. We have dedicated three sections of our paper to the efficacy of medical treatments of symptomatic endometriosis; statements 15 and 16 relating to empirical medical treatments, 25–28 to medical treatments and 29–37 to emerging medical treatments for women with symptomatic endometriosis. Konincx et al. surely cannot be suggesting that randomized control trial (RCT) results should be generally disregarded owing to the difficulty of participant blinding in trials of hormonal treatments.

We agree that such blinding is important when subjective outcomes such as pain and quality of life are assessed, but blinding is only one of the many quality features that serve to make the results of RCTs the least biased evidence when assessing the effectiveness of interventions. Without evidence from RCTs, we will struggle to even start to assess the merits of the multiplicity of studies of heterogeneous quality, we are prone to many more biases than are RCTs, and any form of consensus will prove yet more elusive.

In highlighting the controversy that remains regarding management of adolescents with endometriosis, management of women with deep endometriosis and the roles of networks of expertise (sometimes referred to as ‘centres of excellence’), Konincx et al. have pinpointed the very areas where we feel that we need to ‘drill down’ in relation both to improving our evidence base through clinical research as well as debate of such evidence as exists to reach consensus in these areas of clinical care to optimize outcomes for all women with endometriosis. Particularly in relation to deep endometriosis, we welcome collaboration with a group who modestly describe themselves as a ‘club of deep endometriosis surgeons’, but who represent a strong opinion from the surgical perspective in our field.

References


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Consensus on current management of endometriosis

Sir,

We welcome the recent consensus statement from the World Endometriosis Society (WES) on the current management of endometriosis...
(Johnson and Hummelshoj, 2013). It was a timely article unique in its methodology, especially its process of global networking and the inclusion of the views of women who suffer from endometriosis. The recommendations on the management of endometriosis in low resource settings and the development of centres (or networks) of expertise are commendable. However, we feel that the non-inclusion of transvaginal ultrasound scan as a non-invasive diagnostic tool of choice in the primary evaluation of women suspected of endometriosis is a significant omission.

Firstly, evidence has evolved on the role of the transvaginal ultrasound scan in the preoperative management of women with extra-ovarian endometriosis (Dessole et al., 2003; Abrao et al., 2007; Hudeлист et al., 2011; Benacerraf and Groszmann, 2012). In particular, pattern recognition of the sono- graphic characteristics of deep infiltrating endometriosis (DIE) of the posterior pelvic compartment has been well described (Bazot et al., 2007). Furthermore, ultrasound techniques that assess the status of the pouch of Douglas (POD) have also been described (Reid et al., 2013). This is especially important as >60% of women with an obliterated POD will have evidence of bowel endometriosis (Khong et al., 2011). Indeed, a systematic preoperative ultrasonographic assessment of the pelvis has demonstrated a high detection rate and low false-positive rate in predicting POD obliteration and presence of midline DIE in women with high stage disease (Reid et al., 2011).

Preoperative ultrasound evaluation therefore provides a stepwise approach to the diagnosis of higher stage disease giving valuable preoperative information. It has the potential to facilitate the triaging of women to the appropriate network of expertise. And with the failure of laparoscopy to sometimes correctly estimate the extent of bowel endometriotic disease in the posterior compartment and incompletely excise ‘skip’ lesions, preoperative imaging enables the laparoscopic surgeon to plan the surgical procedure within the context of a multidisciplinary team approach.

Furthermore, we also believe that maximum cyto reduction at the first surgical procedure is best achieved with preoperative mapping of location and extent of disease using transvaginal ultrasound scan. This has the potential to avoid the need for a diagnostic laparoscopy (Menakaya et al., 2013), reduce patient exposure to anaesthesia and result in significant cost savings for the health system.

Secondly, transvaginal ultrasound scan is a low cost readily available non-invasive diagnostic tool that has been subjected to robust evaluation of its accuracy in predicting posterior compartment endometriotic disease (Abrao et al., 2007). In contrast to the serum biomarkers described in the consensus paper, transvaginal pelvic ultrasound is ready for immediate introduction into clinical practice even in low resource settings.

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Reply: Consensus on current management of endometriosis

Sir,

We are grateful for the appreciation of our consensus statement on the current management of endometriosis (Johnson et al., 2013) from Menakaya and Condous and we believe they have raised valid points concerning imaging.

Our consensus process, and the resulting paper, was not designed to examine diagnostic techniques in detail. We are proposing a detailed consensus process to examine the diagnosis and classification of endometriosis to coincide with the 12th World Congress on Endometriosis in Sao Paulo, Brazil, in May 2014.

However, we acknowledge that there may be value in imaging techniques such as transvaginal ultrasound. Any diagnostic technique that accurately predicts the presence of a finding that would alter the type of surgery undertaken is valuable—the principle of ‘facilitation of triaging...