Correspondence

Comment on: Endometrial abnormalities in breast cancer patients with tamoxifen therapy (Prevedourakis, *et al., Gynaecological Endoscopy* 2000; **9:** 23–6)

Dear Sir,

We have read the study by Prevedourakis *et al.* (Endometrial abnormalities in breast cancer patients with tamoxifen therapy).[1]

The authors state that 'monitoring of the uterine cavity in patients receiving tamoxifen is mandatory especially where there is postmenopausal bleeding'. This statement is made despite all 16 asymptomatic, premenopausal women and 9/13 asymptomatic postmenopausal women having negative findings. Of the remaining four asymptomatic women in the postmenopausal group, one had a benign polyp and three had simple hyperplasia.

Cohen *et al.*,[2] in a study of 224 asymptomatic postmenopausal women treated with tamoxifen for a diagnosis of breast cancer, found that 0.9% (two patients) had carcinoma and 5.6% had hyperplasia. Only one of the women in the latter group had complex atypical hyperplasia. All other patients had benign findings. In comparison, the likelihood of significant pathology was higher in symptomatic patients (carcinoma 21.5% *and* hyperplasia 35.7%) although there were only 14 patients in the symptomatic group. The findings of Cheng *et al.*[3] support the latter results. In their study, 67% (22/33) of postmenopausal women receiving tamoxifen, who reported bleeding, had significant pathology.

Where endometrial abnormalities do occur in the context of tamoxifen use, these often comprise focal hyperplasia on an atrophic background. This has led to concern regarding the false-negative rate of endometrial sampling alone. The poor correlation between ultrasound appearances of the endometrium, and histological findings is also well documented. Such reports have fuelled the argument in favour of hysteroscopic assessment in tamoxifen users.

In a randomized cross-over study of transvaginal ultrasonography vs. office hysteroscopy in 53 asymptomatic women taking tamoxifen, only 21% said they would opt for hysteroscopy if offered, compared with 68% who indicated they would accept transvaginal scan.[4] Hence the routine screening of asymptomatic women on tamoxifen using endometrial sampling with or without hysteroscopy may conceivably lead to non-compliance with tamoxifen therapy. In the light of the benefits to patients with breast cancer, this is a significant concern. As the authors point out, prompt investigation of symptomatic patients is important, but there is no evidence to suggest that the routine screening of the asymptomatic group is justified. A benefit in terms of improved mortality rates has not been demonstrated. Good patient education emphasizing the prompt reporting of abnormal bleeding would seem a more appropriate strategy.

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Comment on: Laparoscopic resection of a uterine horn following a pregnancy and rupture at 30 weeks' gestation. (Jones, *et al. Gynaecological Endoscopy* 2001; **10:** 65–68)

Dear Sir,

We read with interest the above case report. Transperitoneal migration of the gamete resulting in a rudimentary uterine horn pregnancy is a rare but well-known event. A recent case report in the *British Journal of Obstetrics*

and Gynaecology[2] discussed the occurrence of an ectopic pregnancy in a blind tubal remnant as a result of intrauterine transmigration of the zygote from the other normal tube. We would like to bring to the attention of the authors that the first reported case of a patient with a non-communicating rudimentary uterine horn, where a spontaneous conception occurred as a result of transperitoneal gamete migration from the opposite tube, was published in the *Journal of Obstetrics and Gynaecology* in 1998.[3] Furthermore, in 1999 Chou *et al.*,[4] from China, reported a case of a pregnancy in a non-communicating rudimentary uterine horn which proceeded to term.

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Comment on: Adenomyosis and endometrial ablation (Neis & Brandner, *Gynaecological Endoscopy* 2000; **9:** 141–45)

Dear Sir,

We read with interest the article by Neis & Brandner[1] describing the difficulty in making a prehysterectomy diagnosis of adenomyosis and its relation to the success of endometrial ablation. However failure of ablation cannot be attributed to adenomyosis diagnosed after hysterectomy. This is because we do not know how many satisfied ablation patients would also have this histological diagnosis of adenomyosis if they were to have hysterectomy. The histological diagnostic criteria for adenomyosis are not uniform.

We also feel that dysmenorrhoea or a large endometrial cavity should not necessarily be absolute contraindications to endometrial ablation.

Women at high risk from major surgery or with a strong wish to avoid hysterectomy may be satisfied with a relative reduction in menstrual flow despite a degree of persistent dysmenorrhoea. The nature of dysmenorrhoea may also be important; several studies have shown a reduction in dysmenorrhoea following endometrial ablation. It seems plausible that dysmenorrhoea associated with heavy flow may be improved by successful ablation whereas premenstrual dysmenorrhoea may not.

The development of second-generation ablation techniques could affect management of this group of patients. Attempting transcervical resection of the endometrium (TCRE) for a larger cavity puts the woman at increased risk of haemorrhage or excess irrigation fluid absorption. These risks do not apply to microwave endometrial ablation (MEA). It is technically possible to treat any size of cavity with MEA as long as access is not obstructed by fibroids.

Individual patient counselling and realistic expectations about the outcome of treatment seem more useful than a blanket refusal to consider ablation for women with an enlarged cavity or dysmenorrhoea.

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Comment on: Who is for endoscopic surgery and whom is endoscopic surgery for? (Garry R., *Gynaecological Endoscopy* 2000; **9:** 281–3)

Dear Sir,

I read with interest the above editorial[1] and broadly agree with many of the conclusions. In the UK at least, gynaecological endoscopic surgery appears to have reached a plateau; probably most possible operations have been attempted, many procedures have been shown to be possible but widespread acceptance remains low. The credibility gap for many procedures between being possible and practical on a day-to-day basis remains to

be bridged. At the same time other minimally invasive alternatives such as the tension-free vaginal tape, Thermachoice device, etc. have bypassed equivalent endoscopic procedures, making them at least partially redundant. That being said, there are most certainly procedures which have been shown to be safe, effective and worthy of wider acceptance.

Most of the reasons why endoscopic surgery may not thrive outside specialist centres are outlined in the editorial. Lack of interest in the surgical side of the speciality, reduced time for training, emphasis on intrapartum obstetrics, pressure on theatre time and waiting lists etc., may all play a role. In the current UK medical climate there may also be a reluctance to leave tried and tested techniques and introduce new ones. Could I draw attention to another possible problem?

Most surgery is better performed with experienced nursing and medical staff assisting the surgeon, and whilst this applies generally, it applies even more to laparoscopic surgery. High quality, safe surgery is the result of an experienced surgeon working in partnership with his or her assistants. Nothing can replace teamwork between scrub nurse, camera holder, surgeon and assistant working together on a regular basis.

Laparoscopic surgeons from the USA often appear to have a much more stable theatre environment with long-term teamwork being more evident. In the UK, shortage of theatre staff leaves the bare minimum to cope with the list. Changes in junior doctor training and working conditions also mean that traditional teams are changing with a significant chance of there being different SHOs and trainees in theatre on many occasions according to shift patterns, etc. The result of this, in my own experience, is that apart from myself and the scrub nurse, there is often a largely inexperienced and changing team each session, who have no knowledge of the procedure and little of their role. The learning curve for the team is continually restarting.

The solution in smaller units would appear to be the long overdue practice of nurses working closely with individual surgeons as surgeons' assistants. This would create a stable team and allow the medical trainees to be present as supernumeraries to learn the technique.

At the present time I can work in this way in the private sector on a regular basis, paying my nurse assistant myself, but not in the National Health Service. I believe that the creation of this type of environment would be conducive to the wider, safer and less stressful implementation of laparoscopic surgery.

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Comment on: Sequestration and extrusion of intramural fibroids following arterial embolization: a case series (Jones, *et al. Gynaecological Endoscopy* 2000; **9:** 309–13)

Dear Sir,

As a hysteroscopist with a great many patients with various types of fibroids, I read this article with great interest. Indeed, it seems that arterial embolization is an excellent alternative to surgery in a selected group of patients.

The phenomenon of sequestration and extrusion of intramural fibroids following arterial embolization and subsequent hysteroscopic resection is particularly interesting. I once attended a symposium on fibroid embolization during which the incidental extrusion of necrotic fibroid was also mentioned; on that occasion I wondered whether resection would have been an alternative. It is good to find that it is indeed feasible.

The authors do not consider the described events as complications, but feel that patients should be warned about the possibility of their occurrence. At our unit, we definitely agree with this statement. But perhaps the combination of embolization and hysteroscopic resection could be used as a therapeutic option by creating the extrusion intentionally? In this way it might be possible to provide an alternative to GnRH analogue pretreatment in cases of large type II fibroids, especially since reduction in fibroid size is claimed to be more distinct post-embolization than after GnRH analogue medication (64%[1] vs. 30–50%[2,3]).

The authors stated that the fibroids of patients 5 and 6 had a projection of 'only' 50% into the uterine cavity. This is not surprising since by definition this is the upper limit of projection of a type II submucous fibroid, according to the classification adopted by the European Society of Hysteroscopy in 1990.[3] A more pronounced protrusion into the cavity would have to be classified as a type I submucous fibroid. In this respect the title of the article is somewhat misleading in mentioning intramural fibroids only.

Finally, we do not agree with the statement in the discussion that the main risk from type II submucous fibroids is uterine perforation. In 13 years' experience of at least several hundred fibroid resections we have literally never seen this complication. This applies even to cases in which the distance between fibroid and serosa was not more than 2–3 mm according to the preoperative assessment by transvaginal ultrasound and saline infusion sonohysterography. We speculate that extrusion of the fibroid during the procedure because of the uterine contractions increases the distance as one continues. This is confirmed during transrectal ultrasound guidance of these high-risk procedures. In our experience, the main hazard, however, of the intramural extension of fibroids is the risk of fluid overload as a result of intravasation of non-conducting distension medium. According to the literature there is a clear relationship between both the size (via operating time) and the degree of intramural extension of submucous fibroids and this risk.[4]

In cases of large type II submucous and perhaps even intramural location, it certainly seems an interesting concept that one could operate on fibroids which are markedly reduced by embolization, and then lessen the abovementioned complications by resecting tissue which is non-vital and therefore, perhaps, less likely to cause rapid intravasation.

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