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Everything Changes Always in Favor of Our Patients

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To the Editor:

Our study aimed to investigate the long-term follow-up in terms of quality of life of 2 different surgical techniques commonly used to treat abnormal uterine bleeding: hysteroscopic endometrial resection (HEA) and laparoscopic supracervical hysterectomy (LSH) [1]. This article does not represent a negative attack on hysteroscopic endometrial resection but rather a description of 15 years of follow-up in 2 different groups of women who underwent a different surgical treatment, focusing our attention on quality of life. In the comment to our article, the indication to HEA has been questioned. In our previous randomized clinical trial [2], patient characteristics and inclusion and exclusion criteria were correctly described, and in our opinion this point is not actually questionable if we refer to the article recently published. This could be done maybe in 2003 when the first randomized clinical trial was published but not nowadays, after 12 years.

Our data showed that after a mean follow-up of 14.4 years, 29% of patients treated with HEA underwent further surgery, whereas no patients after LSH had symptom recurrence. The reintervention rate was significantly higher in the HEA group, which is in line with existing literature [3].

The lower reintervention rate and the better physical and mental profile make LSH a more suitable procedure to treat recurrent abnormal uterine bleeding when compared with HEA.

The complete resumption of symptoms achieved by LSH results in a better perception of quality of life. However, we want to reassure that in our daily practice we never suggest a hysterectomy as first and unique treatment for abnormal

uterine bleeding unresponsive to medical treatment. Fortunately, more and more new technologies or different surgical instruments are now available to perform surgical treatment with lower invasiveness, and we wish to underline that as another demonstration of the need of new devices able to reduce the failures of the ancient endometrial resection. We strongly believe that endometrial resection represents in some cases an efficacious alternative to hysterectomy, but we also have to remember that, despite the initial lower costs of this procedure, if repeated surgeries are needed to obtain the complete resolution of symptoms, the gap among LSH and HEA in term of costs is almost zero.

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Hysteroscopic Endometrial Resection Versus Laparoscopic Supracervical Hysterectomy-A Flawed Conclusion

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To the Editor:

In their recent article, Zupi et al [1] conclude that "because of an improved quality of life and lower reoperation rate, LSH [laparoscopic supracervical hysterectomy] should become the treatment of choice in women with abnormal uterine bleeding resistant to medical treatment and should be proposed to all women instead of HEA [hysteroscopic endometrial resection]." In this unfortunate statement, the reader is asked to accept the premise that LSH, a far more invasive procedure with a comparatively protracted recovery period, should be the initial form of surgical therapy for women who have failed to respond to medical management. This conclusion is both unwarranted and strikingly exceeds the study design.

Zupi et al [1,2] analyzed a series of 71 women who underwent HEA using a first-generation technique—a combination of HEA and endometrial ablation. The complications described for the 89 patients in the HEA arm of the study included 4 women with postoperative hemorrhage, 5 patients with fluid overload, and 2 conversions to LSH—an exceptionally high complication rate of 12.4%. The rate of significant complications is certainly not comparable with currently available second-generation endometrial ablation techniques collectively known as "global endometrial ablation."

The study establishes that the author, performing a first-generation technique in a select population, is able to show a better quality of life compared with a group who underwent LSH as determined by the Quality Metric's Health Survey Short Form 12. However, neither of these groups of women underwent similar quality of life measurements before their intervention. It would be helpful for the women to have acted as their own controls and to measure the change in their quality of life.

Common sense would support that women undergoing LSH would have a lower rate of reoperation than women managed with HEA. However, the conclusion that the lower reoperation rate that LSH offers should elevate it to the surgical treatment of choice for women with AUB is deeply flawed. Such a conclusion would have us offer LSH, a more invasive and morbid procedure, as a first-line approach despite the fact that endometrial ablation is still successful 70% to 75% of the time in avoiding hysterectomy.

Unfortunately, Zupi et al [1] neglect the important variables that determine the appropriateness of any management strategy. These include but are not limited to the following: (1) the patient's age, (2) the patient's emotional predisposition to one procedure or another, (3) the presence of submucous leiomyomas, (4) a history of multiple previous abdominal procedures, (5) coexisting morbidities that render the patient a poor surgical risk, (6) whether or not the patient has a high deductible insurance plan, and (7) whether or not the patient can take off a comparatively long period of time from work.

Although well-intentioned, the study reflects the results of a single surgeon who does not employ the commonly used techniques for endometrial ablation, which have far lower complication rates and are associated with far less morbidity and recovery.

Ultimately, both endometrial ablation and LSH work best for patients who are properly educated, screened, and motivated toward a particular intervention. The physician is obliged to share the best information available and counsel the patient accordingly. A properly informed patient will generally make appropriate decisions along with her physician.

Morris Wortman, MD, FACOG
Rochester, New York

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Patient's Satisfaction, First!

(1) CrossRef

To the Editor:

The purpose of our recently published article was to evaluate the long-term follow-up in terms of quality of life of 2 different surgical techniques commonly used to treat abnormal uterine bleeding: hysteroscopic endometrial resection and laparoscopic supracervical hysterectomy (LSH) [1].

The results of this long follow-up carried out in the group of patients included in the first study [2] have shown that the lower reintervention rate and the better physical and mental health scores make LSH a more suitable procedure to surgically treat recurrent abnormal uterine bleeding when compared with hysteroscopic endometrial resection.

The clarification made by Dr. Wortman about the important variables in his opinion not evaluated in the study causes us, as defined by him, a *flawed conclusion*. In our previous randomized clinical trial published in 2003 [2], patient characteristics and inclusion and exclusion criteria were correctly defined in terms of age, presence of submucosal myoma, concomitant gynecologic diseases, and adequate counseling about the 2 different surgical procedures. In this recent article, we found a very high percentage of patients at the 15-year follow-up, and our results can be compared with a snapshot of the lives of women included in the study; the definitive improvement of symptoms related to the LSH group results in a better patient satisfaction profile.

Not for this reason, in our clinical practice we exclude the possibility to suggest or perform hysteroscopic endometrial resection in women with abnormal uterine bleeding unresponsive to medical treatment. On the contrary, a complete explanation about the different surgical techniques is always guaranteed to the patients because new, simpler effective technologies are available, in particular for hysteroscopic procedures.

Indeed, in his comment, Dr. Wortman affirmed that "endometrial ablation and laparoscopic supracervical hysterectomy work best for patients who are properly educated, screened, and motivated toward a particular intervention."

The physician is obliged to share the best information available and counsel the patient accordingly. A properly informed patient will generally make appropriate decisions along with her physician."

We completely agree with Dr. Wortman about this statement, and we believe that in every area of medicine an accurate individualization of treatment is mandatory. On the basis of patient characteristics, we must honestly suggest the most appropriate and resolute treatment, not following our preferred approaches but always trying to reach the best results for our patients.

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