Two Options, Same Relief in Mild Endometriosis

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LONDON — Patients with chronic pelvic pain and mild endometriosis can get temporary relief from excision or ablation of their lesions almost 70% of the time, according to a randomized controlled trial of both treatments.

“If you look at patients who have purely superficial lesions, not patients with infiltrating disease or ovarian cysts, regardless of which treatment, 67% will report pain relief 6 months after the procedure,” said principal investigator Jeremy T. Wright, M.B., president of the British Society for Gynaecological Endoscopy, and a consultant gynecologist at Woking (England) Nuffield Hospital and Ashford and St. Peter’s Hospitals NHS Trust, Chertsey, England.

The study, which Dr. Wright reported at the annual congress of the International Society for Gynecologic Endoscopy, included 22 chronic pelvic pain patients with mild endometriosis, meaning they had revised American Fertility Society scores of 1-2. The patients were randomized at the time of laparoscopy to either excision or ablation using monopolar diathermy. Before the procedure, participants in the study were asked to complete a symptom questionnaire that included a pain rating. Specific areas of pelvic tenderness also were identified and rated.

Two weeks after the procedure, the patients were asked to complete another symptom questionnaire. The questionnaire included nine areas of pelvic tenderness rated on a scale from 0 (no tenderness) to 10 (intolerable tenderness). The participants also again rated their pain on a scale of 1 to 10.

Before the procedure, the mean pain rating was 7.7. Two weeks after surgery, the mean pain rating was 3.3, indicating approximately 60% pain relief.

In addition, two patients involved in the study—one from each treatment group—became pregnant during the follow-up period. "These findings show that at diagnostic laparoscopy, there’s nothing to stop generalists from treating superficial lesions with the expectation that this will provide pain relief," Dr. Wright said in an interview.

He added that although the results for both treatments were equal, he believes ablation could possibly result in less thorough treatment. "If you are coagulating over great vessels or the ureter or part of the bowel, the coagulative process may extend to damage those structures, and so people are a bit jumpy about burning onto those structures."

On the other hand, if you are excising tissue, you are pulling it away from those structures and then cutting it, so you are much less likely to damage them. That means that with excision, you are more likely to be able to complete the treatment without leaving areas untreated," Dr. Wright said.

The researchers have continued following patients, and although a formal analysis of the data was not presented, Dr. Wright says it appears that pain relief does not persist. At 18 months, patients say their quality of life has improved. But if you repeat pain measurements, they are not much better in terms of global pain scores.

The American College of Obstetricians and Gynecologists recently released Committee Opinion #310, which states that “after a comprehensive preoperative evaluation and trial of combination hormone therapy and NSAIDs to treat dysmenorrhea,” laparoscopy should be recommended for diagnosing and for treating presumed endometriosis in adolescent patients. (Obstet. Gynecol. 2005;105:921-7).

According to the opinion, the objective of the therapy should be “suppression of pain, suppression of disease progression, and preservation of fertility.” With this in mind, the document recommends post-surgical medical therapy until the patients have completed child bearing.