ENDOMETRIOMAS, STRIPPING OR COAGULATION?
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According to several studies in the literature, laparoscopy can be effectively considered the best surgical approach for ovarian endometriotic cysts. Nevertheless, a recent paper by Jones et al, which gathered the answers to a questionnaire of 651 UK specialist gynecologists, still reported a rate of laparotomy of 42.3% in the treatment of ovarian endometrioma.

There are several papers in the literature comparing different surgical techniques in order to treat the endometriotic cysts with lower rate of recurrence and a higher pregnancy rate. Nevertheless, it can be summarized in two schools of thought:

• cystectomy with excision of the endometriotic cyst
• drainage/aspiration of cyst content and ablation of the cyst capsule with laser or electrocoagulation.

The study of Beretta et al was the first randomized trial in which these two different approaches have been compared, showing no statistically significant difference in the rate of disease recurrence between the two groups (6.2% vs 18.8%), but a higher pregnancy rate at 24-month follow-up in the group treated with complete cyst excision. It must be pointed out, however, that the pregnancy rate of the ablation group is one of the lowest in the literature compared to other series, with a pregnancy rate of 57% using the KTP/S32 laser to ablate the capsule. This very low pregnancy rate makes one question the technique used to ablate the endometriosis. These two different surgical techniques were retrospectively compared by another group who concluded that laparoscopic excision of ovarian endometriomas at 42-month follow-up is associated with a lower reoperation rate than that of fenestration and ablation (23.6% vs 57.8%).

The safety of the surgical removal of endometriomata in terms of damage to ovarian reserve has been recently questioned. Muzii et al performed a histologic analysis on 26 ovarian endometriomas, showing ovarian tissue removed with the cyst pseudocapsule in 54% of cases, while this is an accidental finding in nonendometriotic benign ovarian cysts. Nevertheless, in none of the specimens examined the ovarian tissue adjacent to the cyst wall show the follicular pattern that is observed in normal ovaries. The role of excisional surgery in damaging ovarian reserve, at least immediately after the procedure, has been reported in a recent paper which studied 31 patients who underwent excision of monolateral (n = 25) or bilateral (n = 6) benign ovarian cysts. The authors showed a percentage of reduction of the ovarian volume of 33.6%.

The risk of ovarian reserve reduction should be considered especially when approaching bilateral endometriomata, in fact Busacca et al recently reported a prevalence of post...
surgical ovarian failure of 2.4% (95% CI 0.5%-6.8%) in 126 patients operated for bilateral endometriotic ovarian cysts.

Considering the post-surgical improvements of painful symptoms and the relatively high rate of pregnancy, which might vary between 23% and 67%,17,18 in symptomatic patients with ovarian endometrioma the benefits of surgery should convince the surgeon to operate on the patient without taking into account the risk of ovarian failure.

References: