I think that full articles should be based on more than one or two cases. I concur with Nezhat et al. that laparoscopic surgery is a potential tool in gynecologic oncology. However, such a sensitive field deserves more investigation before being submitted to the community of gynecologic oncologists. The French teams have published their early experience only as letters or oral communications in meetings, and not in full articles, and I feel that this is a wise policy. However, even these letters are referenced in the major data bases and should have been quoted. Progress in surgery is not a race between investigators but a field of long-term investigation.

In particular, laparoscopic surgery should not be used if there is a risk of undertreatment or overtreatment for the patient. The indication for paraaortic lymphadenectomy in the cases described in the article from Nezhat et al. (stage IA2 cervical carcinoma) may have resulted in overtreatment, because the probability of nodal metastasis in the paraaortic area is extremely low, as it is in early cervical carcinomas without diseased pelvic nodes.

Denis Querleu, MD
Pavillon Paul Gellé, 91 Ave. Julien Lagache, 39100 Roudnice, France

REFERENCES

Reply
To the Editors: Querleu has raised two issues in his letter. The first relates to our failure to reference his and other French groups' previously published work. The second point concerns the appropriateness, from an oncologic standpoint, of pelvic and paraaortic lymphadenectomy in addition to a radical hysterectomy for a stage IA2 lesion that includes vascular and/or lymphatic space invasion by tumor.

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The other issue is an oncologic one, which points out differences in treatment of early stage cervical cancers in Europe compared with the United States. In the United States vascular and/or lymphatic space involvement by tumor changes the therapeutic approach from simple to radical, on the basis of the increased possibility of extrauterine and/or nodal spread of tumor. Staging as advocated by the International Federation of Gynecology and Obstetrics does not include vascular and/or lymphatic space invasion by tumor as a parameter in staging, and therefore that feature often does not influence treatment. We do not believe this is the place to debate the issue. It was our preference to select for our first radical hysterectomy a patient with pelvic and paraaortic node dissection in whom carcinoma was not advanced. However, we selected one for whom the surgery was indicated.

Camran Nezhat, MD
5353 Peachtree Dunwoody Road, NE, Suite 276, Atlanta, GA 30342

REFERENCES
Longitudinal follow-up of chronic pelvic pain and occurrence of new symptoms 5 to 7 years after laparoscopy

To the Editors: This letter pertains to an article in the March 1992 issue of the Journal (Baker PN, Symonds EN. The resolution of chronic pelvic pain after normal laparoscopic findings. Am J Obstet Gynecol 1992;166: 855-6). Contrary to the research findings published by Baker and Symonds, we discovered a far lower percentage of women who had chronic pelvic pain without organic disease and whose pain resolved after diagnostic laparoscopy. This finding is the result of a 5- to 7-year follow-up study of premenopausal women.

Of the 75 women who underwent diagnostic laparoscopy because of chronic pelvic pain that lasted for more than 6 months, 40 (53.3%) had no relevant pelvic disease. After reassurance that there was no organic reason for their complaints, the women were discharged to their general practitioners. Six years later we wrote and invited those same 40 women to participate in a follow-up examination. Twenty-one women (52.5%) accepted our invitation. The women whom we could not contact or who did not appear for the reexamination were matched in age, social status, and duration of chronic pelvic pain before laparoscopy with the women who participated.

The women evaluated the development of pelvic pain themselves from the time laparoscopy was performed on the basis of a linear seven-point self-rating scale, ranging from very improved to very aggravated. In addition, we asked them to inform us of any newly occurring symptoms or disturbances that were not present at the time of laparoscopy or that had worsened in the follow-up period. In this case we used a semi-structured interview and the Gießen complaint list.

Eight women (38%) reported that they were free of pain or that their pain had decreased significantly, seven women (33%) could detect a diminution of pain, and six women (29%) reported no change in pain. Twelve women had not changed their habit of regularly taking analgesics. Seventeen women showed other functional symptoms, such as epigastric problems, headache, or lower back pain. With regard to sex, 14 women reported dyspareunia, anorgasmia, or withdrawal from sexual intercourse because of the pelvic pain. Ten women repeatedly became depressed and had sleeping disorders.

Although we could reexamine just 52.5% of the women who underwent diagnostic laparoscopy but in whom no pelvic disease could be found, we still interpret our results the same way. This group probably represented an invited number of women with a "bad outcome," but we maintain that sending the women back to their general practitioners is not an appropriate response to the complexity of the women's complaints. Unlike Baker and Symonds, we think that some form of psychologic counseling or multidisciplinary pain-management program should be offered to the women and that simply assuring them that there is no organic reason for their pain is not satisfying in most cases.

Further prospective long-term follow-up studies are necessary to prove the rather descriptive results of our retrospective study of a small cohort of women with chronic pelvic pain.

Wolfgang Soellner, MD,* Otto Huter, MD,*
Brunhilde Wurm, MD,* Johanna Kanter, MD,* and
Wilhelm Rumplmaier, MD*  
Department of Medical Psychology and Psychotherapy and  
Department of Obstetrics and Gynecology, University Hospital,  
Sonnenburgstr. 16, A-6020 Innsbruck, Austria

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In particular, laparoscopic surgery should not be used if there is a risk of undertreatment or overtreatment for the patient. The indication for paraaortic lymphadenectomy in the cases described in the article from Nezhat et al. (stage I A2 cervical carcinoma) may have resulted in overtreatment, because the probability of nodal metastasis in the paraaortic area is extremely low, as it is in early cervical carcinomas without diseased pelvic nodes.

Denis Querleu, MD
Pavillon Paul Gallé, 91 Ave. Julien Lagache, 59100 Roubaix, France

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The other issue is an oncologic one, which points out differences in treatment of early stage cervical cancers in Europe compared with the United States. In the United States vascular and/or lymphatic space involvement by tumor changes the therapeutic approach from simple to radical, on the basis of the increased possibility of extratubular and/or nodal spread of tumor.7-10 Staging as advocated by the International Federation of Gynecology and Obstetrics does not include vascular and/or lymphatic space invasion by tumor as a parameter in staging, and therefore that feature often does not influence treatment. We do not believe this is the place to debate the issue. It was our preference to select for our first radical hysterectomy a patient with pelvic and paraaortic node dissection in whom carcinoma was not advanced. However, we selected one for whom the surgery was indicated.

Camran Nezhat, MD
5355 Peachtree Dunwoody Road, NE, Suite 276, Atlanta, GA 30342

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Longitudinal follow-up of chronic pelvic pain and occurrence of new symptoms 5 to 7 years after laparoscopy

To the Editors: This letter pertains to an article in the March 1992 issue of the Journal (Baker PN, Symonds EN. The resolution of chronic pelvic pain after normal laparoscopic findings. Am J Obstet Gynecol 1992;166; 855-6). Contrary to the research findings published by Baker and Symonds, we discovered a far lower percentage of women who had chronic pelvic pain without organic disease and whose pain resolved after diagnostic laparoscopy. This finding is the result of a 5- to 7-year follow-up study of premenopausal women.

Of the 75 women who underwent diagnostic laparoscopy because of chronic pelvic pain that lasted for more than 6 months, 40 (53.3%) had no relevant pelvic disease. After reassurance that there was no organic reason for their complaints, the women were discharged to their general practitioners. Six years later we wrote and invited those same 40 women to participate in a follow-up examination. Twenty-one women (52.5%) accepted our invitation. The women whom we could not contact or who did not appear for the reexamination were matched in age, social status, and duration of chronic pelvic pain before laparoscopy with the women who participated.

The women evaluated the development of pelvic pain themselves from the time laparoscopy was performed on the basis of a linear seven-point self-rating scale, ranging from very improved to very aggravated. In addition, we asked them to inform us of any newly occurring symptoms or disturbances that were not present at the time of laparoscopy or that had worsened in the follow-up period. In this case we used a semi-structured interview and the Gießen complaint list.

Eight women (58%) reported that they were free of pain or that their pain had decreased significantly, seven women (33%) could detect a diminution of pain, and six women (29%) reported no change in pain. Twelve women had not changed their habit of regularly taking analgesics. Seventeen women showed other functional symptoms, such as epigastric problems, headache, or lower back pain. With regard to sex, 14 women reported dyspareunia, anorgasmia, or withdrawal from sexual intercourse because of pelvic pain. Ten women repeatedly became depressed and had sleeping disorders.

Although we could reexamine just 52.5% of the women who underwent diagnostic laparoscopy but in whom no pelvic disease could be found, we still interpret our results the same way. This group probably represented an inflated number of women with a "bad outcome," but we maintain that sending the women back to their general practitioners is not an appropriate response to the complexity of the women's complaints. Unlike Baker and Symonds, we think that some form of psychologic counseling or multidisciplinary pain-management program should be offered to the women and that simply assuring them that there is no organic reason for their pain is not satisfying in most cases.

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In particular, laparoscopic surgery should not be used if there is a risk of undertreatment or overtreatment for the patient. The indication for paraaortic lymphadenectomy in the cases described in the article from Nezhat et al. (stage IIA cervical carcinoma) may have resulted in overtreatment, because the probability of nodal metastasis in the paraaortic area is extremely low, as it is in early cervical carcinomas without diseased pelvic nodes.

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Camran Nezhat, MD
5555 Peachtree Dunwoody Road, NE, Suite 276, Atlanta, GA 30342

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Longitudinal follow-up of chronic pelvic pain and occurrence of new symptoms 5 to 7 years after laparoscopy

To the Editors: This letter pertains to an article in the March 1992 issue of the JOURNAL (Baker PN, Symonds EN. The resolution of chronic pelvic pain after normal laparoscopic findings. Am J Obstet Gynecol 1992;166: 835-6). Contrary to the research findings published by Baker and Symonds, we discovered a far lower percentage of women who had chronic pelvic pain without organic disease and whose pain resolved after diagnostic laparoscopy. This finding is the result of a 5- to 7-year follow-up study of premenopausal women.

Of the 75 women who underwent diagnostic laparoscopy because of chronic pelvic pain that lasted for more than 6 months, 40 (53.3%) had no relevant pelvic disease. After reassurance that there was no organic reason for their complaints, the women were discharged to their general practitioners. Six years later we wrote and invited those same 40 women to participate in a follow-up examination. Twenty-one women (52.5%) accepted our invitation. The women whom we could not contact or who did not appear for the reexamination were matched in age, social status, and duration of chronic pelvic pain before laparoscopy with the women who participated.

The women evaluated the development of pelvic pain themselves from the time laparoscopy was performed on the basis of a linear seven-point self-rating scale, ranging from very improved to very aggravated. In addition, we asked them to inform us of any newly occurring symptoms or disturbances that were not present at the time of laparoscopy or that had worsened in the follow-up period. In this case we used a semistructured interview and the Gießen complaint list.

Eight women (23%) reported that they were free of pain or that their pain had decreased significantly, while seven women (33%) could detect a diminution of pain, and six women (21%) reported no change in pain.

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