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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[1] and the Gießen complaint list.[2]

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Reply

To the Editors: We note the comments of Soellner et al. and their conclusion that sending women with chronic pelvic pain without obvious disease back to their general practitioners after a diagnostic laparoscopy is in-

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.

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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.

The article in question was originally submitted to the American Journal of Obstetrics and Gynecology as a full-length report with the appropriate references, including Querleu's work. As a courtesy we sent a copy of the manuscript to him and he acknowledged its receipt. Our work was accepted as a case report, and certain revisions were necessary, among them a reduction in the number of references. Only two references were allowed; therefore we selected our publications, which describe the techniques used in this procedure. Because we were unable to credit other workers we wished to acknowledge, at the conclusion of our article we clearly indicated our willingness to make additional references available on request. References 1 through 3 cited by Querleu are brief letters, not comprehensive descriptions of procedures. Further, these letters address vaginal and laparoscopically assisted vaginal radical hysterectomy without paraaortic node dissection (which they first performed in November 1989). Our case report describes a radical hysterectomy with both pelvic and paraaortic lymphadenectomy performed totally via laparoscopy. His peer-reviewed article, published in 1990 by the American Journal of Obstetrics and Gynecology (reference 4 in Querleu's letter) included the statement, "... it is at this time impossible to explore paraaortic nodes by laparoscopy." We performed our first radical hysterectomy with paraaortic node dissection in June of 1989. This procedure was presented at our own postgraduate courses and various other meetings that were attended by members of the French groups cited by Querleu.[1-5] We maintain that our report is the first of its kind. To date, we have done four radical hysterectomies (two for Stage IB disease) and 16 paraaortic node dissections. Incidently, the work of Dargent and Salvat[6] regarding pelvic node dissection deserves to be mentioned. They reported their experience with pelvic node dissection in 1989.

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.[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.

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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[1] and the Gießen complaint list.[2]

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, anorgasmy, or withdrawal from sexual intercourse because of pelvic pain.[3] 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[4, 5] 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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