The solution to endometriosis isn't always in vitro fertilization

Subspecialty inherently focuses clinicians on outcomes related to their expertise. With reproductive endocrinology and infertility (REI) increasingly focusing on the "I" and that "I" often standing more for in vitro fertilization (IVF) than just infertility, it is tempting to look at gynecologic and other comorbidities primarily in how they affect IVF outcomes. In the quest for the highest live birth rate per cycle, broader patient wellness shouldn't be lost. One of the founders of Johns Hopkins Hospital, Sir William Osler, said, "The good physician treats the disease. The great physician treats the patient who has the disease."

There are times with endometriosis when medical management may not be sufficient or may simply delay the inevitable. It's not just that the number needed to treat (NNT) can be as favorable as four for an additional live birth with surgery for advanced endometriosis (1), but surgical intervention can have implications for pain and other considerations. A full 30% of patients may have decreased renal function at the time of diagnosis of ureteric endometriosis, with potentially as many as 25%–50% of nephrons lost (2). Despite a predilection for the left ureter, ureteral involvement can be bilateral in 12% of cases, and similarly have a 12% rate of recurrence (3). Recognition is central to avoiding progression, where particularly with bilateral disease, delays in diagnosis can increase risk for needing long-term dialysis and renal transplantation.

In this issue of *Fertility and Sterility,* Drs. Ananth, Nezhat, and Humphries use video to demonstrate operative technique for this situation in "Use of a shaving technique for surgical management of partial ureteral obstruction due to endometriosis." (4) In the case presented, the patient has extrinsic compression of the ureter, has the lesion shaved through use of the laser, and ultimately remains without recurrence 14 years after the surgery. Efficient and effective dissection coupled with clear labeling for core anatomic landmarks give the video value even for those who don't perform advanced retroperitoneal dissection.

The American Board of Obstetrics and Gynecology (ABOG) oral board examinations hold REI specialists accountable to surgical skills (including management more advanced than this, such as performing ureteral anastomosis when deep infiltrating endometriosis becomes intrinsic, having progressed in to the ureteral muscularis). Videos such as the one by Ananth et al (4) in this issue can help make tangible surgical techniques that some may not have encountered in residency or fellowship. Heterogeneity of training does not exempt REIs from accountability to one's boards or patients. Even those well into their careers who feel that they have escaped this far without seeing patients with meaningful ureteral endometriosis may find this video eye opening and encourage us to look at our patients more broadly. After all, it is hard to find what we are not looking for. Like many surgical scenarios, once it is seen it is difficult to unsee it, which shapes our future awareness. The authors, in coupling context, intravenous pyelograms, and surgical video, renew our respect for the toll that endometriosis takes on women, and remind us of how our patients have needs beyond simple conception. Sir Osler hoped for nothing less than this perspective from us.

J. Preston Parry, M.D., M.P.H[a,b]
[a] Parryscope and Positive Steps Fertility, Madison, Mississippi; [b] Department of Obstetrics and Gynecology, University of Mississippi Medical Center, Jackson, Mississippi

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