after extensive division of adhesions she was found to have moderate diverticular disease of the sigmoid colon with a loop stuck to the left posterolateral aspect of the uterus forming the fistulous communication. Given the degree of adhesions and the anatomy, she underwent a subtotal hysterectomy and oversewing of the colonic defect. Apart from a minor wound infection the remainder of her recovery was uneventful. Presumably the fistula resulted from trauma arising from the conduction of diathermy current during the endometrial ablation.

While the introduction of minimally invasive but equiefficacious hysteroscopic techniques should be encouraged, serious complications may still arise.

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Do women overreport nocturia?

EDITOR,—S B Pinion and colleagues found similar results in their trial of hysterectomy versus two "conservative" surgical treatments for dysfunctional uterine bleeding, with 95% and 90% of women respectively reporting an acceptable improvement in symptoms after 12 months.¹ Both groups, however, reported a significant increase in urinary symptoms one year after the procedure. The authors state, in a footnote to the table that give these results, that "women tended to over-report nocturia in self report questionnaires." According to the methods section of the paper, both preoperative and postoperative symptoms were ascertained by self report questionnaire. Do the authors suggest that differential reporting occurred at these times? On what evidence do they base their assertion that women overreport nocturia? "Overreporting" implies reporting more symptoms than are present, presumably as measured by some external and objective criteria, yet the *Oxford Concise Medical Dictionary* defines a symptom as "an indication of disease or disorder noticed by the patient himself." Patients are the best judges of their own symptoms; this is as important in research as in clinical practice.

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Laparoscopic hysterectomy is an alternative

EDITOR,—We question S B Pinion and colleagues' recommendation for hysteroscopic endometrial ablation in dysfunctional uterine bleeding and believe that laparoscopic hysterectomy is an alternative with a high likelihood of success.¹ In the analysis of their results the authors disregard the fact that 17 of the 96 women studied underwent

hysterectomy within the 12 months of follow up. Another 11 required additional hysteroscopic treatment. These outcomes call into question the advantage of the "shorter recovery period" for the hysteroscopic procedure compared with hysterectomy.

In addition, 15% of the patients experienced the same or increased dysmenorrhoea at follow up, 22% had irregular periods, and 7% had bleeding lasting longer than seven days. The claim of 70-90% satisfaction among the women who underwent hysteroscopic treatment must be regarded as high. Although the outcome in patients who received both hysteroscopic ablation and subsequent hysterectomy is not analysed separately, these patients' satisfaction is more likely to be attributable to the hysterectomy since only one patient in the group who underwent hysterectomy only was reported as being dissatisfied.

Laparoscopic hysterectomy offers the unquestioned advantage of a short postoperative recovery period and final release from abnormal menstrual bleeding. The size of the uterus in cases of dysfunctional bleeding is usually not large, permitting straightforward laparoscopic removal. Hysteroscopic ablation should be reserved for women unwilling to undergo the irreversible effects of hysterectomy.

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Ignoring urinary incontinence may reduce long term satisfaction

EDITOR,—The prevalence of urinary incontinence among the women treated for dysfunctional uterine bleeding in S B Pinion and colleagues' study was high (50%).¹ This is considerably higher than estimates of urinary incontinence in the general population.² It is disturbing that despite this finding none of the women seem to have been considered for urodynamic investigations and surgery for incontinence at the time of hysterectomy.

For many reasons a large number of women with urinary incontinence never receive help for their condition, although considerable evidence indicates that it greatly impairs the quality of their life. Research has shown that many doctors feel uneasy about discussing urinary problems and feel poorly trained to manage them.³

Pinion and colleagues' data show that 80% of the incontinent women had symptoms of stress incontinence alone, and therefore genuine stress incontinence is a likely diagnosis for many in this group. A recent meta-analysis confirmed the efficacy of surgery for genuine stress incontinence,⁴ although morbidity is clearly associated with such surgery and the first procedure is most likely to be successful.

Hysteroscopic surgery for dysfunctional uterine bleeding has the obvious short term advantage of reduced cost, morbidity, and stay in hospital. In the long term, however, cutting unnecessary corners and ignoring symptoms such as urinary incontinence may result in poorer satisfaction among patients and possibly even greater cost and morbidity owing to the need for further surgery later.

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Amenorrhoea need not be an end point

EDITOR,—Results from an audit of this hospital's use of endometrial ablation over the past four years accord with S B Pinion and colleagues' findings¹ and the interim Royal College of Obstetricians and Gynaecologists' interim report of its national audit of the procedure. Review of more than 300 episodes of treatment supports statements that discharge on the same or the next day is safe and acceptable. Dysmenorrhoea improved in a quarter of women (52/210), and pain at other times of the menstrual cycle improved in 36 of 95. Since endometrial ablation reduces menstrual flow it is not surprising that patients with the variant of painful periods associated with passage of clots should derive benefit.

The accumulated experience supports Pinion and colleagues' proposal that endometrial ablation should be regarded as an option for the 30-40% of hysterectomies performed for dysfunctional uterine bleeding.² Women benefit from the quick postoperative recovery and reduced morbidity,³ and managers with a budget to consider welcome the contribution towards cost effectiveness. This will be particularly pertinent if, as we have found, electrocautery or resection, or both, prove as effective as laser surgery.

Consumer satisfaction can be improved when more attention is directed to the psychological component associated with women presenting with menstrual disorders at the perimenopause. Satisfaction after hysterectomy is higher because the women understand that surgery will abolish periods. Amenorrhoea need not be an end point. Women at the perimenopause with dysfunctional uterine bleeding often like to experience less menstrual flow and better cycle control but still appreciate a regular bleed to reaffirm that they are not at the end of their reproductive life. I suggest that if this issue is discussed more fully before surgery there should be an enhanced perception of satisfaction after endometrial ablation.

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Appropriate comparison would be to compare the best of the old treatments with the best of the new

EDITOR,—S B Pinion and colleagues compared hysterectomy with endometrial ablation in the management of menorrhagia and not just dysfunctional uterine bleeding as suggested in the title of their paper.¹ Of the group treated conservatively, 29% had positive findings, mainly fibroids; the percentage with positive findings rose to 34% in those treated by hysterectomy. While there is no evidence that endometrial ablation is appreciably less effective in women with small

submucous fibroids,² the title is nevertheless misleading.

We have two, more serious concerns. Only 12% of the patients randomised to hysterectomy underwent vaginal hysterectomy, which is a low figure, considering the indications for surgery. Vaginal hysterectomy has a lower morbidity than abdominal hysterectomy; patients have a reduced need for postoperative analgesia and are discharged home earlier.³ The most appropriate comparison for a treatment designed primarily for dysfunctional uterine bleeding must be vaginal hysterectomy. The use of abdominal hysterectomy increases the chance of a type I error being made in favour of the conservative procedure when it comes to factors such as duration of stay in hospital and recovery.

Our second concern relates to the high failure rate of endometrial ablation in the study, with 28 of 96 patients randomised to endometrial ablation requiring retreatment (n=11) or a hysterectomy (n=17) within one year. This figure is considerably higher than that in most published series from centres reporting on 100 or more patients^{2,4} and is higher than the failure rate for endometrial resection in our hospital after five years.⁵ We performed total endometrial resection on 527 patients over five years. Only 18% of these patients required repeat ablation or hysterectomy, or both, during the first five years. Lifetable analysis shows that the need for repeat surgery peaks during the first two years after endometrial ablation. Given that 29% of the women in Pinion and colleagues' study required repeat surgery at one year, we wonder how many more will develop symptoms in the subsequent years. The high failure rate after conservative surgery increases the chance of type II statistical error in favour of hysterectomy when long term success and patients' satisfaction are considered.

Prospective randomised studies continue to be the best way to assess new treatment strategies, and this study is a potentially valuable addition to our knowledge. We have to be careful, however, that the comparison is appropriate and that the best of the old is compared with the best of the new.

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Vaginal hysterectomy is a certain cure

EDITOR,—S B Pinion and colleagues' study comparing endometrial resection and hysterectomy largely ignores the benefits of vaginal hysterectomy.¹ The authors conclude that "hysteroscopic surgery can be recommended as an alternative to hysterectomy for dysfunctional uterine bleeding" despite the finding that 28 of 105 patients required a second operation and that the proportion of

patients who were "less than very satisfied" in the hysteroscopic group (22%) was double that in the hysterectomy group (11%).

In a retrospective audit in our hospital (1989-92) 231 consecutive women complaining of menorrhagia that had been refractory to medical treatment were offered hysterectomy. Women who required surgery for prolapse were excluded, and the surgery was performed by a single consultant firm. Of the 231 women, 157 (68%) had a vaginal hysterectomy (in Pinion and colleagues' study vaginal hysterectomy was performed in only 12 (12%) of 99 cases). In our series 74 patients underwent abdominal hysterectomy, and 62 had a well recognised contraindication to the vaginal route (uterine cavity > 10 cm (33); adnexal disease (18); prophylactic oophorectomy (five); previous caesarean section (five); coincident bladder neck procedure (one)). Vaginal hysterectomy was not performed in 12 of the women in whom no such contraindication was found in the case notes. Vaginal hysterectomy was converted to the abdominal route during surgery in only one case.

Of the 157 vaginal hysterectomies, 69 were done by a consultant, six by a senior registrar, 60 by a registrar, and 22 by a senior house officer. Thus this series does not reflect the personal experience of one surgeon. It does show that junior staff may be taught vaginal hysterectomy without undue difficulty; in contrast, there is a considerable learning curve for endometrial resection. The average length of stay was 4.1 nights for vaginal hysterectomy and 5.0 nights for abdominal hysterectomy, compared with 7.3 nights for all hysterectomies in Pinion and colleagues' study. Complication rates were similar regardless of the route of hysterectomy in our series. Since 1992 the usual stay after vaginal hysterectomy has been three nights, and previous caesarean section is no longer considered to be a contraindication to vaginal hysterectomy.

Vaginal hysterectomy offers the benefits of a certain cure for dysfunctional bleeding, and large studies have shown a quicker recovery and fewer complications after it than after abdominal hysterectomy.² Endometrial resection, with its known substantial failure rate, has not been shown to be an attractive alternative to vaginal hysterectomy, which we believe is the preferred treatment in most cases.

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Establish severity of blood loss and psychological status before surgery

EDITOR,—In the paper on their trial of hysterectomy, endometrial ablation, and endometrial resection for dysfunctional uterine bleeding S B Pinion and colleagues do not say how they assessed depression.¹ They do, however, report extremely high levels of depression before surgery, which, despite falling afterwards, remained significantly raised. These findings are in keeping with the likelihood that a complicated relation exists between emotional problems and dysfunctional uterine bleeding.^{2,3} For example, if a woman is

suffering from uncomfortable and unusually heavy menstrual blood loss it is easy to see why she might feel miserable and will feel much better after successful surgery. Psychological distress may also alter a woman's perception of her periods or her help seeking behaviour. The criteria used in this study to define clinical dysfunctional uterine bleeding are unclear. The diagnosis seems to have been based on detailed histories of menstrual blood loss; this approach has been shown to be unsatisfactory. When this loss is measured objectively it is poorly predicted by several of the criteria that the authors list: days of bleeding,⁴ amount of menstrual protection used,⁵ and women's subjective reports of loss.⁶ While we accept that the routine measurement of blood loss may not be practical, independent measures such as haemoglobin concentrations can be useful to identify iron deficiency anaemia.⁷

As removal of the endometrium is relatively simple, cheap, and safe it is likely to replace hysterectomy as the first line surgical treatment for dysfunctional uterine bleeding. For these reasons it is also likely that more women who complain of heavy periods will be offered surgical intervention (other than dilatation and curettage). Although this might well be a step forward for women who require surgery, an increasing number of women may be subjected to surgery on the basis of an unverified complaint, which could well be psychological in nature.

We therefore suggest that particular attention should be paid to establishing the severity of blood loss and the psychological status of a woman before she is offered surgery for dysfunctional uterine bleeding. This should include not only taking a detailed history of complaints but also paying attention to the way in which the woman describes her symptoms, since spontaneous descriptions of severe blood loss (such as "it was embarrassing; the blood poured down my legs at the supermarket") are particularly convincing.³ Moreover, simple psychiatric screening is easily available and can provide helpful information in this group of women. Whatever the relation between dysfunctional uterine bleeding and emotional disorder, awareness of a woman's psychological status is useful when deciding on surgery, preparing for operation, and providing high quality aftercare.

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Follow up survey in Taunton shows high level of satisfaction

EDITOR,—S B Pinion and colleagues show that hysteroscopic surgery is associated with high levels of satisfaction among patients.¹ We recently wrote to 217 women who had had endometrial resections