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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1 Pinion SB, Parkin DE, Abramovich DR, Naji A, Alexander DA, Russell IT, *et al.* Randomised trial of hysterectomy, endometrial laser ablation, and transcervical endometrial resection for dysfunctional uterine bleeding. *BMJ* 1994;309: 979-83. (15 October.)

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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- 4 Jarvis GJ. Surgery for genuine stress incontinence. *Br J Obstet Gynaecol* 1994;101:371-4.

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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- 2 Rees MCP. Menorrhagia—current management. *British Journal of Sexual Medicine* 1989;16:467-70.
- 3 Magos AL, Bowmann R, Lockwood GMN, Turnbull AC. Experience with the first 250 endometrial resections for menorrhagia. *Lancet* 1991;337:1074-8.

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