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Ruptured ovarian endometrioma

To the Editors:

We read the report by Huang et al entitled "Long-term follow-up of patients surgically treated for ruptured ovarian endometriotic cysts" [1] with interest. The authors retrospectively reviewed 11 patients with ruptured endometrioma and a history of dysmenorrhea who underwent surgical intervention and followed-up examination for more than 3 years, and the authors concluded that emergency surgical intervention may lead to a better prognosis, particularly in patients without a history of previous endometrioma surgery [1].

Although the authors' conclusion suggesting that emergent surgical intervention may lead to a better prognosis might be correct, authors did not provide enough data to support their conclusion. For example, the authors failed to define the term "emergency surgical intervention". In addition, the term of "prognosis" is also unclear. Based on our understanding of this article [1], prognosis might include pain score, sonographic findings, serum CA-125 levels, further surgery (e.g., cyst aspiration), and pregnancy, but the above mentioned prognosis is not consistent in the article [1]. Of course, we should emphasize that this should not be construed as an argument against the authors' excellent work.

Only one patient underwent surgery 48 hours later after the sudden onset of acute abdomen, and the majority of the patients (64%; $n = 7$) were surgically treated within 6 hours [1]. Did the authors suggest to each patient that they should be treated within 6 hours?

If the abovementioned definition is acceptable, based on our understanding, three patients in this report had a future successful pregnancy [1] and all underwent surgical intervention within the first 6 hours (1 laparotomy and the other 2 laparoscopies). In addition, all of these patients did not have a history of endometrioma surgery, which may be the reason why the authors reached their conclusion: emergency surgical intervention may lead to a better prognosis if the outcome is evaluated in terms of the pregnancy. In contrast, if the need for further procedures was also included in the evaluation of the clinical outcomes, this would include two of seven patients (29%) in the emergency surgical intervention group who underwent cystic aspiration in comparison with one of four patients (25%) who was diagnosed by cystic aspiration on a follow-up examination. The need for further procedures seems to be similar between both groups, suggesting that no advantage was gained by patients who were surgically treated within 6 hours after the sudden onset of acute abdomen. We hope to see a further discussion regarding this issue.

In addition, the use of the laparoscopic approach might be a better choice compared with the use of laparotomy, although the authors did not reach this conclusion. In fact, the authors reported that the length of the hospital stay is related to the operative method used, showing a shorter stay in the laparoscopy group compared with the laparotomy group (3−5 days vs. 4−8 days) [1]. Furthermore, the operative time of the laparoscopy group was shorter in comparison with that of the laparotomy group (107 minutes vs. 127 minutes). All of these findings confirm the advantages of the use of laparoscopy for the management of women in various clinical situations, including ectopic pregnancy, tubo-ovarian abscess, and uncertain conditions [2−5].

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