

Talking to your doctor PART 1



Here are questions you need to ask about any surgeon you're considering for operative laparoscopy for endometriosis. There are many sources for this information: talks given by the surgeon or others from his or her practice to local association groups, flyers and brochures from the surgeon's practice, research studies in which the surgeon has participated, the surgeon's surgical nurse or office staff, and other members of the association who know the practices of surgeons in the area. If you are unable to obtain this information, by all means question the prospective surgeon. After all, it's *your* body going "under the knife."

1. **What surgical technologies does the surgeon use for endo?** Be aware that no one technology addresses all the needs in endometriosis, so if the surgeon describes only one approach, you need to be prepared to ask further questions. If the surgeon suggests use of medication to "clean up" what's left, are you comfortable with the fact that this almost certainly cannot eradicate all the endometriosis?
2. **What surgical techniques does the surgeon think are best for endo?** If your prospective surgeon uses a laser, be aware that excision is more difficult to learn than vaporizing/coagulating, and the technique described can give you a clue to the expertise of the surgeon. Besides becoming something of the preferred method for the removal of endo (not, of course, in all the implants), extensive use of excision can also tell you the surgeon is probably more skilled with the laser.
3. **Does the surgeon routinely send the removed implants to the pathology lab?** This indicates excisional techniques are being used where possible, and studies have shown that surgeons who routinely do this improve their recognition of the many appearances of endometriosis over time.
4. **Does the surgeon remove all the endo if at all possible?**
5. **How does the surgeon plan to treat lots of tiny implants on the peritoneum?** If he or she says that those small implants won't cause you any problems or says it takes too long to get them all, get another surgeon. Research shows that it's these implants that produce the most prostaglandin, which is strongly linked to the pain of endo. If the surgeon is not willing to spend the time to treat the disease, why bother having surgery?
6. **Does the surgeon think it is too dangerous to treat endo on bladder, bowels, etc.?** If the answer is yes, either the surgeon does not have the appropriate technology available or the surgeon is just beginning to learn the technology. The reason for great excitement about laser and other new technologies is precisely the ability to treat endo in these sensitive areas that for the most part cannot be treated with the older techniques.
7. **Is the surgeon aware of the work in recent years on the many appearances of endometriosis?** You might be able to ask what appearances he or she sees most often as an indirect way to get at this. Does the surgeon belittle these concepts? Find yourself a different surgeon! No surgeon willing to read the literature is likely to believe that the different appearances of endo do not matter.
8. **How many cases of endo with the surgical techniques the surgeon has described has he or she performed? Over what period of time has he or she performed these procedures?** Note whether the surgeon speaks enthusiastically about his or her work in this area – usually people who are good at what they do are enthusiastic about it. Dr. Camran Nezhat in the association's first book, *Overcoming Endometriosis*, states: "It takes at least one year of continuous practice of an average two to three cases a week (a total of 150 cases) before one is comfortable in videolaseroscopic or laser laparoscopic treatment of the disease."
9. **How long does the surgical approach typically take?** Depending on the procedures involved, there will be a range.
10. **May I have a copy of the surgeon's resume or curriculum vitae?** This will outline the surgeon's training, credentialing, if any, special course work done with the new technologies, and research publication. Typically a surgeon who does primarily medical work will not have the extensive research publications that an academic physician or surgeon will have, so do not judge a potential surgeon solely on this basis.
11. **Has the surgeon done follow-up on his or her prior surgeries and for how long after the surgeries?** Ask detailed questions about the results related to pain relief and infertility. Again, be cautious, since numbers are extremely difficult to interpret in this field.
12. **How does the hospital, surgical center, and surgeon guarantee enough time for a case if it turns out to be a difficult one?** If enough time isn't allotted by either the hospital or the surgeon, the surgeon may feel great pressure to skip some of the endo or leave other loose ends (figuratively speaking) so that the next surgeon can get into the operating room. Or your own surgeon may need to get on to the next case or back to the office where patients are waiting. As Dr. David Redwine notes, "A typical case can take from one to four hours to accomplish, and a busy obstetrical practice can interfere with the time needed to treat endometriosis well."
13. **Does the surgeon provide the patient a written report, photographs, and/or a copy of a video of her surgery, and how complete is that video?** Be aware that most videotapes of surgeries are likely to be incomplete and/or edited. Still, a video record of the extent of the disease and procedures performed is a protection for you – you will be able to see the disease for yourself, see it treated for yourself, and have a permanent record for comparisons in the future.
14. **What measures does the surgeon take to help prevent adhesion formation?** See the article on adhesions at the end of the chapter in association's second book, *The Endometriosis Sourcebook*.

Talking to your doctor PART 2

If you have preliminarily chosen a surgeon based on satisfactory answers to your questions, continue to evaluate the surgeon as you move along toward surgery:

1. **Did you feel the prospective surgeon listened carefully to you?** If not, you cannot be sure that he or she has clearly heard all symptoms and made notes on what those symptoms might mean surgically or understood completely your fertility wishes, concerns related to future treatment, or desires related to going on to (or not going on to) laparotomy in case of disease the surgeon may not be able to handle through the laparoscope.
2. **Did the prospective surgeon do a very thorough pelvic exam?** If not, you have to wonder if he or she is as concerned about deep nodules as you are or will be prepared to address them if found.
3. **Was your prospective surgeon as gentle as possible?** Despite the need for thoroughness, it is possible to be reasonably gentle in the pelvic exam. Of course, with endo and tender nodules, it *will* hurt, but a distinction can be made between this and a sloppy, roughshod approach. If the latter is used, you might well wonder if similar rough handling of tissues might occur during surgery, leading to more adhesion potential.
4. **Where does the surgeon think the endo is in your case and how would he or she handle it?** Pay particular attention to the manner in which the surgeon addresses sensitive areas such as the bladder, uterosacral ligaments, and the bowel. If endo is present on the bowels, does the surgeon work with a bowel surgeon if the endo goes deep: What kind of preliminary work-ups will be done to determine if the endo does go deep or to determine the nature of endo in sensitive areas?

Name _____ Date _____