bowel DE lesions at other sites, such as in the ileum and cecum, there are important technical considerations. The site of the lesion may not be as important as its depth of invasion, notwithstanding the smaller lumen of the terminal ileum, which may prove problematic. LRSD is ideal for lesions affecting only the muscularis without submucosal and mucosal involvement because the technique takes advantage of the submucosal plane, where dissection follows submucosal injection. For LRSD at other gastrointestinal sites, it is important to note that we use a rectal probe when performing LRSD for rectosigmoid lesions that could not be used for more proximal lesions. The rectal probe provides a platform to stabilize the nodule, but most importantly makes the mucosa under the nodule predictably conform to its rounded surface. If a nodule is lifted without a rectal probe, the mucosa below the nodule would adopt a tented, irregular configuration that makes it difficult to anticipate its exact position, risking a breach of the mucosa and entry to the bowel lumen.

The usual recommended size of lesion appropriate for rectal shaving is ≤3 cm, which will result in a muscularis defect much larger than the nodule itself. The size of the resultant muscularis defect will also be affected by the depth of the nodule and the amount of tethering around the lesion. We agree that the size of the muscularis defect is important, because it may affect postoperative bowel function. Previous work suggests that a segmental bowel resection is preferable when the muscularis defect after a disc excision is >50% of the bowel circumference or when the muscularis defect is >7 to 8 cm long [3]. Our technique is likely to provide equal or improved functional outcome compared with full-thickness disc excision. A study of 18 patients with full-thickness rectal excision who underwent postoperative magnetic resonance imaging demonstrated a posterior rectal pouch but no significant impact on digestive outcomes at 12 months [4]. Similarly, when a double circular stapler technique for rectosigmoid endometriosis lesions of up to 4.2 cm was reported in 11 patients, no significant postoperative bowel dysfunction was reported [5]. This is likely to be a similar situation to when a large muscular defect is repaired, as in our technique where the 4-cm rectal nodule resulted in a 7-cm-long muscularis defect. After its repair transversely, we have not encountered any functional problems to date.

The training period for LRSD for surgeons who are already comfortable performing rectal shaving would be minimal because this technique makes traditional rectal shaving easier, especially for colorectal surgeons. We would highly recommend performing a simulation of LRSD on a surgical specimen from a segmental bowel resection for DE. This will provide a clear understanding of the effects of submucosal injection on the layers of bowel wall and familiarize the surgeon with the submucosal dissection required along the submucosal plane.

There are no data to determine the outcome of an inadvertent mucosal perforation during LRSD; however, we suggest that a small mucosal suture repair with LRSD is likely to confer a low risk of complication, similar to that of the traditional rectal shaving technique. This is compared with the higher risk of complication rates after either a disc excision or a segmental bowel resection.

Our dietary management after LRSD is as per the Enhanced Recovery After Surgery protocol, namely, to allow our patients diet as tolerated. Patients are typically discharged on day 2 with some choosing to be discharged on day 1.

Finally, we agree that long-term data are required and that LRSD is inappropriate for large lesions with deep mucosal invasion or when neoplasia is suspected.

References


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Regarding “Comparison of High-intensity Focused Ultrasound and Conventional Surgery for Patients with Uterine Myomas: A Systematic Review and Meta-analysis”

To the Editor:

We read the study by Tsai et al [1] published in the *Journal of Minimally Invasive Gynecology* with great interest.
The authors performed a systematic review and meta-analysis to evaluate the effectiveness and safety of high-intensity focused ultrasound treatment compared with conventional surgery for patients with uterine myomas. We would like to congratulate the authors for writing an informative article with novelty. Nevertheless, we have some suggestions to communicate with the authors regarding the model used in the methods section.

The authors mentioned that EMBASE, PubMed, and Cochrane Library were searched in this study, without any language restrictions. However, it would have made the results more convincing if the authors had included other databases such as NLM Gateway, clinicaltrials.gov, Wanfang, Scopus, and BIOSIS previews to obtain more literature. Our other concern is the high degree of heterogeneity in the outcomes. Based on the Cochrane Handbook for Systematic Reviews, a high degree of interstudy heterogeneity could not lead to definitive conclusions. To our knowledge, a more robust model was introduced in the research of Doi et al [2], called the Inverse Variance Heterogeneity (IVhet) model. Doi et al [2] investigated improved alternatives to the random-effects model for meta-analysis of heterogeneous studies. It was shown that the known issues of underestimating the statistical error and spuriously overconfident estimates with the random-effects model could be resolved by the use of an estimator under the fixed-effects model assumption with a quasi-likelihood-based variance structure—the IVhet model [2]. Thus, we subsequently used the IVhet model to reanalyze the outcomes in this meta-analysis. Most of the reanalysis outcomes were consistent with the authors; however, no statistically significant difference was detected for the incidence of transfusion between the groups (rate ratio = 0.13, 95% confidence interval, 0.00 −5.36) (Fig. 1). Overall, Tsai et al [1] analyzed a valuable issue. High-quality studies with larger sample sizes are still needed in the future to confirm these conclusions.

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The authors would like to appreciate Cui et al for taking an interest and commenting on our article [1]. We read their comments on the databases and the statistical model we used in our study.

Cui et al mentioned that it would have made the results more convincing if we had included other databases such as NLM Gateway, clinicaltrials.gov, Wanfang, Scopus, and BIOSIS previews to obtain more literature. However, the databases we used, namely EMBASE, PubMed, and Cochrane Library, contained the most reliable and quality literature for worldwide-adopted surgical procedures. An extension of databases is unnecessary unless the articles of interest are always kept in such databases.

As for the statistical model, Cui et al mentioned that it would have made the results more convincing if we had included other databases such as NLM Gateway, clinicaltrials.gov, Wanfang, Scopus, and BIOSIS previews to obtain more literature. However, the databases we used, namely EMBASE, PubMed, and Cochrane Library, contained the most reliable and quality literature for worldwide-adopted surgical procedures. An extension of databases is unnecessary unless the articles of interest are always kept in such databases.

Author’s Reply

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As for the statistical model, Cui et al suggested that by using an estimator under the fixed-effects model assumption with a quasi-likelihood-based variance structure, the Inverse Variance Heterogeneity (IVhet) model could resolve the known issues of underestimating the statistical error and spuriously overconfident estimates with the

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