

(abdomen vs thorax)? In addition, how many specimens from the lung parenchyma and the diaphragm had histology-confirmed endometriosis?

- (3) Combined laparoscopic and thoracoscopic treatment of thoracic and abdominal endometriosis has been reported by Nezhat et al [3–6] and others before, and the references should reflect this.

We congratulate the authors for assisting this patient and educating the community about the surgical management of endometriosis.

Robert A. Roman, MD^a
Atena Asaii, MD^a
Anupama Rambhatla, MD^a
Michael White, MD, PhD^b
Farr Nezhat, MD^c

^aPalo Alto, California, ^bMineola and New York, New York, and ^cNew York and Stony Brook, New York

References

1. Liu L, Seckin S, Goldstein K, Seckin T. Dual compartment surgery for pulmonary endometriosis. *J Minim Invasive Gynecol.* 27559–560.
2. Sonoda A, Jeudy J, White CS, et al. Pleurodesis: indications and radiologic appearance. *Jpn J Radiol.* 33241–245.
3. Nezhat C, Main J, Paka C, Nezhat A, Beygui RE. Multidisciplinary treatment for thoracic and abdominopelvic endometriosis. *JSLs.* 18:e2014.00312.
4. Nezhat C, Lindheim SR, Backhus L, et al. Thoracic endometriosis syndrome: a review of diagnosis and management. *JSLs.* 23:e2019.00029.
5. Nezhat C, King LP, Paka C, Odegaard J, Beygui R. Bilateral thoracic endometriosis affecting the lung and diaphragm. *JSLs.* 16140–142.
6. Nezhat C, Seidman DS, Nezhat F, Nezhat C. Laparoscopic surgical management of diaphragmatic endometriosis. *Fertil Steril.* 691048–1055.

<https://doi.org/10.1016/j.jmig.2020.04.043>

Author's Reply

To the Editor:

We are pleased that our colleagues Roman et al [1] are reading our article with great interest, and we appreciate their comments that raise valid questions.

Our purpose was simple: Sharing images of multicentric endometriotic foci of thoracic and abdominal compartments as an epiphenomenon of extensive pelvic disease in the “Images in Gynecologic Surgery” section of the journal [2].

What prompted us to present this case was that for the first time in our experience we visualized multiple bullae, or blebs along with endometriosis implants, of the alveolar parenchyma in 3 separate lobes of the lung.

Regarding the indication for pleurodesis, we do not routinely use it in our practice. However, we fired 3 Endo GIA staplers (Medtronic, Minneapolis, MN) for triple-wedge lobectomies and 1 for diaphragm resection,

resulting in 4 stapler applications in the thoracic cavity. Additional wide excisions on the parietal pleura of the chest wall were then followed by mechanical pleurodesis after confirming the absence of any residual endometriosis implants. Overall, our decision to perform pleurodesis was an intraoperative judgment call led by an experienced thoracic surgeon who is part of our surgical team. Supporting this view, the review by Nezhat et al [3] after our publication reported that pleurodesis reduced the recurrence rate of pneumothorax after video-assisted thoracoscopic surgery by 20% to 25% compared with cases in which pleurodesis was not performed at the time of surgery. Prospectively collected data from 22 patients from Italy, published again after our report, advise pleurodesis whenever there is a risk of recurrence [4].

Regarding clarification about the detailed histopathology and origin of the samples, we removed a total of 13 samples: 8 were collected from the thoracic cavity and 5 from the pelvic cavity. Two out of the 3 lung wedge-lobectomy specimens, all 3 pleural excisions, and 1 out of 2 diaphragm excisions were positive for endometriosis. In total, 6 out of 8 samples from the thoracic cavity were confirmed for endometriosis.

There were 5 specimens excised from the pelvis. Except for 1 nodule from the anterior rectum, the remaining 4 specimens were positive for disease. These were bilateral adnexa with ovarian endometrioma, and a deeply infiltrating nodule anterior to the external iliac artery, and sigmoid.

We agree that the references should have included the article by Nezhat et al [5], whose scholarly work is widely recognized and respected by us.

Elevating the quality of the surgery and seeking perfection in our craft is our primary objective—it is what the patients deserve! We want to thank the authors for giving us the opportunity to clarify their constructive comments.

Tamer Seckin, MD
New York City, New York



References

1. Roman RA, Asaii A, Runhatla A, White M, Nezhat F. Regarding “dual compartment surgery for pulmonary endometriosis”. *J Minim Invasive Gynecol.* 2020;27:1650–1651.
2. Liu L, Seckin S, Goldstein K, Seckin T. Dual compartment surgery for pulmonary endometriosis. *J Minim Invasive Gynecol.* 2020;27:559–560.
3. Nezhat C, Lindheim SR, Backhus L, et al. Thoracic endometriosis syndrome: a review of diagnosis and management. *JSLs.* 2019;23:e2019.00029.
4. Viti A, Bertoglio P, Roviglione G, et al. Endometriosis involving the diaphragm: a patient-tailored minimally invasive surgical treatment. *World J Surg.* 2020;44:1099–1104.
5. Nezhat C, Main J, Paka C, Nezhat A, Beygui RE. Multidisciplinary treatment for thoracic and abdominopelvic endometriosis. *JSLs.* 2014;18:e2014.

<https://doi.org/10.1016/j.jmig.2020.05.030>