

lated and extreme cases, it is possible that in some years they will be part of our daily practice.

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Reply

To the Editors: The correspondents pose the dilemma that has been thrust upon them by a law enacted by the Regione Marche, where their medical school is located in Italy, that warrants the active participation of the pregnant woman in decision making during all stages of labor and delivery *and in the choice of the route of delivery*. This has led some pregnant women to demand cesarean section as an elective procedure to avoid labor in the absence of any obstetric indication for an operative delivery. What is the obstetrician to do in such a circumstance?

Merit may be had in an examination of the balance and difference between negative and positive rights. When a patient refuses an intervention that the caregivers propose as being medically appropriate or even, at an extreme, life-preserving, she is exercising a sacred and protected right to be left alone. This is guaranteed in most ethical constructs on the basis of autonomy, justice, and freedom from unwarranted interference. Thus we usually accept the statement that the competent adult has an almost absolute right to accept or refuse any therapeutic intervention as long as she is fully informed and is not causing harm to another individual of equal standing. A negative right is a very strong right that we would be wont to violate except in the most dire circumstances.¹

However, when the patient actively demands an intervention, she is now exercising a positive right. In most accepted ethical constructs positive rights do not have the same weight or privacy protection as do negative rights. When the patient is demanding an intervention that is against conventional medical practice, her positive right to demand such an intervention can be balanced over and against the autonomy claims of the caregivers to practice their craft on the basis of reasonable and sound medical principles. The issue of distributive justice can also be invoked here in that the patient is demanding a costlier intervention that cannot be justified as medically necessary. The caregiver may also invoke a beneficent interest in avoiding an occasion of harm to the patient by not performing a more dangerous operative procedure in place of a simpler spontaneous delivery. Finally, nonmaleficence would encourage us to "do no harm" and to avoid the more dangerous surgical intervention.

If these measures fail and the caregivers do not feel

justified in acceding to the request from the patient for unwarranted intervention, the option to transfer the care of the patient to another practitioner or another institution willing to accede to the demands of the patient can be exercised.

We hope that the principles outlined here will help resolve the majority of conflicts. Active participation by the patient includes informed decision making with the caregivers recommending what they perceive to be the best alternative courses of action. While serving as patient advocates caregivers should not perform procedures for which there is no clinical justification nor predictable benefit over harm. Ethics consultation, if available, may be helpful if the conflict remains unresolved.

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The preoperative evaluation of ovarian tumors can be improved?

To the Editors: We read with interest the article by Osmer et al. (Osmer RGW, Osmer M, von Maydell B, Wagner B, Kuhn W. Preoperative evaluation of ovarian tumors in the premenopause by transvaginasonography. *Am J Obstet Gynecol* 1996;175:428-34) who investigated the use of simple sonomorphologic criteria. We appreciate the interest of the authors on the crucial role of persistence of the mass to reduce unnecessary surgery in premenopause but, in our opinion, the conclusion that, with the exception of simple ovarian cysts, the cancer should be encountered in all other ultrasonographic groups is misleading, also because it is not supported by an adequate statistical analysis. As a matter of fact, with use of the suggested criteria in a premenopausal population that is characterized by a high rate of endometriomas and dermoid cysts (33% and 14%, respectively),¹ a safe laparoscopy could be never performed. On the contrary, these benign ovarian masses are characterized by very simple ultrasonographic findings not described by Osmer et al. In fact, the presence of a round homogeneous hypoechoic "tissue" of low-level echoes with a clear demarcation from the parenchyma and without papillary proliferations is characteristic of endometrioma,² and areas of focal or diffuse dense echogenicity frequently associated with posterior shadowing were present in dermoid cysts.³ These ultrasonographic findings demonstrated a strong agreement between test result and surgery with both κ values of 0.84.^{1,3} Ovarian cancer in premenopause showed ultrasonographic aspects different from those described as characteristic of endometriomas and dermoid cysts. With these two sim-

ple and reproducible findings we never misdiagnosed an ovarian cancer in the published studies¹⁻³ and in >500 persistent ovarian masses undergoing surgery in our department from 1991. A very low risk of misdiagnosis should be always present but can be further reduced by thorough inspection at laparoscopy characterized by a high sensitivity and by selecting a population with a low risk of ovarian malignancy, such as patients <39 years old. Operative laparoscopy is demonstrated to be safe and to have benefits for the patient undergoing surgery for simple cysts, ovarian endometrioma, and dermoid cyst in the form of reduced postoperative pain, shorter hospital stay, and faster recovery. For these reasons, in premenopausal women with a persistent ovarian mass it is correct to perform operative laparoscopy on those patients in whom preoperative transvaginal ultrasonography identifies the characteristic findings of endometriomas and dermoid cysts.

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Reply

To the Editors: We read with great interest the comment of Guerriero et al. on our article. The authors state that the prevalence of endometrioma and dermoid cysts in premenopausal women with ovarian cysts is 33% and 14%, respectively. This conclusion is based on their own data of 118 patients.¹ However, to our knowledge, there are no published reports on the incidence and prevalence of ovarian tumors in the premenopause. Consequently, no reliable data on the prevalence of dermoid cysts and endometriomas are currently available. In our own study ($n = 1072$) we identified a rate of 11.3% endometriomas and 6.0% dermoid cysts. Although our number of analyzed ovarian cysts is much larger than that of Guerriero et al., we would not claim to have verified the true prevalence of endometriomas and dermoid cysts.

The existing variability of the prevalence of endometrioma is illustrated by the authors themselves, who reported 1 year earlier a prevalence of 24%.² However, dermoid cysts and endometriomas are also regarded in our opinion as common cystic ovarian tumors. Furthermore, Guerriero et al. stated that the presence of a

round-shaped homogeneous hypoechoic "tissue" of low-level echoes with a clear demarcation from the parenchyma and without papillary proliferations is characteristic of endometrioma. We agree with the authors that there is no doubt that an endometrioma can present an ultrasonographic feature as described here. However, in our own data out of 122 histologically verified endometrioma only 43% showed the "typical" ultrasonographic feature of a monolocular cyst with homogeneous internal echos. As many as 38% of the endometriomas did not present any internal echoes. Multilocular cysts with or without internal echos were identified in 24% and cystic solid findings in 16% of analyzed cases. Three endometrioma had been classified ultrasonographically as purely solid. Consequently, we suggest that there is no single "classic" ultrasonographic feature of an endometrioma. Guerriero et al. believe that they have identified a strong correlation between ultrasonography and surgery (κ value 0.84). However, their findings of a sensitivity of 83% and a specificity of 89% were based on 24 documented endometriomas.² Regarding the low incidence of ovarian cancers, we believe that these findings do not support the conclusion that preoperative ultrasonography eliminates the risk to operate on an ovarian cancer. This problem is also illustrated by the data of our study. We have investigated 240 monolocular cysts with homogeneous internal echos that fulfill the ultrasonographic criteria of an endometrioma as stated by Guerriero et al.: 63.8% were found to be functional cysts, only 28.3% retention cysts including endometrioma, 7.5% benign neoplasia, and 0.4% malignancies. There is no doubt that the risk for a malignancy in this group is very low, but it is an existing risk that we have to take in account. The ultrasonographic features of dermoid cysts have nearly the same variability. Nevertheless, we agree that the described "classic" ultrasonographic feature exists in the majority of cases. We found this feature in 88% of the dermoid cysts in our study ($n = 64$). However, 12% of the dermoids may be misdiagnosed.

In conclusion, we agree with Guerriero et al. that the preoperative application of transvaginal ultrasonography is useful. However, to establish ultrasonographically a histologic diagnosis preoperatively means to overstress a method and to accept to be mislead clinically by "typical" ultrasonographic features.

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