

1 Correspondence

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3 Why create a new protocol or a new consensus in the ultrasound diagnosis of  
4 endometriosis?

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7 We read with interest the manuscript entitled: 'Proposed simplified protocol for  
8 initial assessment of endometriosis with transvaginal ultrasound' by Deslandes  
9 and Leonardi<sup>1</sup>. We appreciate their enthusiasm for raising awareness of  
10 **endometriosis in the use of standard ultrasound**. However, we have major  
11 concerns.

12 We do not understand why they consider that the consensus proposed by the  
13 International Deep Endometriosis (IDEA) group is 'only' to be used by experts  
14 or in specialist centers<sup>2</sup>. On the contrary, the IDEA consensus, cited so far in  
15 more than 500 articles, suggests a systematic approach for endometriosis  
16 evaluation, based on four steps (uterine and adnexal assessment; presence of  
17 soft markers; sliding sign; and assessment of deep endometriosis nodules in  
18 anterior and posterior compartments; as well as, added recently, evaluation of  
19 the parametrium); steps that can be used by both expert and non-expert  
20 examiners. In fact, Deslandes and Leonardi<sup>1</sup> introduce the concept of 'simplified  
21 ultrasound', adding to a standard ultrasound examination evaluation of the  
22 uterosacral ligaments (USLs), the upper rectum and the uterine sliding sign for  
23 the pouch of Douglas, but missing entirely the anterior compartment,  
24 parametrium and most of the posterior compartment. **This represents a difficulty  
25 for sonographers, given that, without evidence or proposed learning curves to  
26 seek these lesions, many of them will be missed or misclassified, including the  
27 most prevalent and difficult to assess, the USLs<sup>3</sup>.**

28 In parallel, a recently published article, by Young *et al.*<sup>4</sup>, tries to introduce  
29 another 'augmented' ultrasound protocol, but lacks a systematic approach for  
30 scanning and fails to describe how to interpret normal findings, identify lesions  
31 and measure them. This omission could lead to inaccurate and subjective  
32 evaluations.

33 In particular, the articles by Deslandes and Leonardi<sup>1</sup> and Young *et al.*<sup>4</sup> do not  
34 consider as mandatory the complete evaluation of areas with high prevalence

35 of lesions, such as those involving the rectosigmoid, where ultrasound have  
36 demonstrated a very high accuracy<sup>3</sup>.

37 It is said that time could be a potential cause that prevents us from doing a  
38 comprehensive evaluation. However, Deslandes and Leonardi<sup>1</sup> do not provide  
39 a suggested time for this new approach; nor is there any literature consistent  
40 with these allegations. In addition, the consensus by Young *et al.*<sup>4</sup> suggests that  
41 a routine ultrasound examination takes up to 30–45 minutes, with the addition  
42 of an ‘augmented’ evaluation requiring only 2–5 minutes. We think this  
43 examination time for a routine evaluation is unnecessarily long and, if used,  
44 would be sufficient to incorporate the four steps of the IDEA protocol for a  
45 complete examination, thereby improving the management of the patient and  
46 decreasing the time to diagnosis, by avoiding the expected referral for yet  
47 another ultrasound evaluation.

48 The introduction of an opinion-based article for clinical implementation without  
49 supporting prospective studies prevents its application and reproducibility in  
50 clinical practice. Moreover, we think it could be detrimental to patients affected  
51 by endometriosis.

52 Finally, we would like to stress that the IDEA protocol is not intended only for  
53 experts **but represents the grammar** to any further development. Some studies  
54 have demonstrated that the learning curve for endometriosis recognition is  
55 improved by using the IDEA structured approach<sup>5</sup>. Therefore, we suggest that  
56 we focus all of our strengths on operator training using an established approach,  
57 instead of introducing new protocols for which there is no supporting evidence,  
58 so that patients could finally be provided for an integral evaluation in the same  
59 exam.

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