The LH and FSH levels showed a decreasing tendency during the treatment. There was no significant change in the prolactin and hydroxycortisone values. The estradiol and progesterone significantly fell, although when Danol was withdrawn or the dose reduced there was a striking elevation in the estradiol levels.

Based on these results, we suggest that danol, although it was previously thought to have antigonadotroph effects, is acting rather on the steroid receptors or as an inhibitor of the steroid synthesis. At the end of the 6-month danol treatment luteinizing hormone-releasing hormone was given intravenously and caused a significant increase in LH levels which seems to support this hypothesis.

Amenorrhea as a Prognostic Indicator in Endometriosis Patients Treated with Danazol

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Initial studies advocating the use of danazol for the treatment of infertile women with endometriosis advised achieving a state of amenorrhea. Despite anecdotal evidence that amenorrhea is a good prognostic sign while on danazol, there are few studies examining the issue. The purpose of this study was to determine if failure to obtain amenorrhea was a significant risk factor for persistent infertility in women with endometriosis. All endometriosis patients were operatively diagnosed; 125 were prescribed danazol in dosages individualized due to a 10% incidence of bothersome side effects. Our therapeutic goal was to achieve 3 months of amenorrhea on no more than 800 mg of danazol daily. Analysis was by frequency analysis using the χ^2 distribution. When type of operation for operative diagnosis was compared, the only difference was the propensity of women treated at laparotomy to have more severe endometriosis than those women treated at laparoscopy ($p = 0.001$). There were no demographic differences between the laparotomy and laparoscopy groups. Of the 67 patients ultimately taking 800 mg of danazol daily, 33 (49%) continued to have breakthrough bleeding or spotting. Seven of 58 patients (12%) who could not advance beyond 400-600 mg daily due to side effects had breakthrough bleeding. Pregnancy rates after 18 months of follow-up were calculated. Pregnancy rates, when analyzed by operation performed and severity of endometriosis, did not significantly differ between the bleeding and non-bleeding patients.

The Role of Unilateral Salpingo-Oophorectomy in the Conservative Surgical Treatment of Endometriosis

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Unilateral salpingo-oophorectomy (USO) has been advocated in the woman with severe unilateral adnexal adhesions and endometriosis, yet little data exists as to the effect of USO on postoperative pregnancy rates. Of 514 patients treated with conservative surgical

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therapy of endometriosis at laparotomy (CSEL) from 1967 to 1984, 141 required USO. These women were enrolled in a historical prospective study, with longitudinal clinical follow-up provided to ascertain pregnancy rates. As expected, USO correlated strongly with severity of pelvic disease ($p = 0.001$); interestingly, extent of endometriosis involvement did not predict the need for USO when compared to dense adnexal adhesions. USO was not associated with an increase in operative complications. When severity of endometriosis was controlled, life table analysis using a variable interval technique failed to demonstrate any significant effect of USO on pregnancy rates ($p = 0.10, 0.60, 0.72$ for mild, moderate and severe endometriosis, respectively). USO conveyed no effect on obstetric outcome - specifically, no increased risk of tubal ectopic pregnancy ($p = 0.16$). USO had no significant effect on the risk of reoperation for recurrent endometriosis. As each pelvic operation for endometriosis is tailored to the operative findings, a prospective cohort study of the role of USO in the surgical treatment of endometriosis would be impossible to conduct. This study with long-term follow-up of a retrospectively identified cohort of women treated by CSEL demonstrates that USO has a definite role in the treatment of severe adnexal endometriosis and adhesions. USO is a pain-relieving procedure in many cases that has no demonstrable deleterious effects on complication rates, prognosis for pregnancy, and risk of recurrence.

Gastrointestinal Endometriosis: Evaluation of Four Treatment Options at Conservative Laparotomy

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The largest collected series of gastrointestinal (GI) endometriosis treated at conservative surgical therapy is presented. From 1967 to 1985, 5,000 women were treated for endometriosis at the Baylor College of Medicine Affiliated Hospitals in Houston, Texas. Of 1,900 women treated with conservative surgery of endometriosis at laparotomy, 152 (8%) were noted to have significant GI tract involvement. The 26 clinicians who participated in this collaborative study have the same approach to the conservative operation for endometriosis, with a notable exception. Four different treatments of GI endometriosis were popular. The purpose of this study was to compare these four techniques for operative morbidity, subsequent pregnancy rates, and risk of recurrent endometriosis.

The four treatment options included expectant management, fulguration of superficial lesions, excision and primary closure, and segmental bowel resection with primary anastomosis. There were 25, 22, 65, and 40 women in each of the groups, respectively. Demographic data and pelvic symptoms did not significantly vary between the four treatment groups. The excision and segmental resection groups had significantly more rectal complaints indicating preoperative colonic evaluation. When severity of endometriosis was held constant, the excision and segmental resection groups had significantly improved pregnancy rates, as well as lower rates of symptomatic recurrence discovered at reoperation. However, the segmental resection group was associated with a greater incidence of febrile morbidity postoperatively. We conclude that surgical treatment of GI endometri