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THE PRESIDENT'S MESSAGE

Another beautiful theory slain by ugly facts?

Professor Hans Evers
WES President

At least 836 different explanations exist for the way in which minimal endometriosis causes infertility. All cytokines, most steroid and many protein hormones, prostaglandins and leukotrienes, and a host of other soluble substances in the blood, the peritoneal fluid and the follicle have been incriminated, as have macrophages, natural killer cells, B cells, T cells, altered uterine and tubal activity, endometrial wave-like movements, ovum capture disturbances, fimbrial, oocyte and fertilization factors, tubal milieu, endometrium and implantation, and immune processes to name but a few. Not to forget disorders of sperm transport, failed capacitation, disturbed folliculogenesis and/or ovulation, reduced oocyte and/or embryo quality, and of course apoptosis and reactive oxygen species. However, since Ken Muse published his landmark paper "How does mild endometriosis cause infertility?" (Fertility & Sterility 1982; 38:145-52), people have also been wondering about the appropriateness of the *"How"* in the paper's title: does mild endometriosis really affect fertility at all?

One way to look at this problem is to study data from (inter)national IVF registries and compare the outcome of IVF in endometriosis patients with that in patients with unexplained infertility. If we accept that patients with unexplained infertility are characterized by a normal outcome of their complete fertility work-up (including normal semen, regular ovulation, patent tubes), and patients with mild endometriosis have exactly that, *plus* some endometrial implants on their pelvic peritoneum, then the difference in outcome between these two would allow us to obtain an impression of the effect of endometriosis on fertility. The 1998 US ART registry shows 2338 live births in 9063 cycles (25.8%) in endometriosis patients compared to 1362 in 5364 cycles (25.4%) in unexplained infertility patients (Fertility & Sterility 2002;77:18-31). Comparable figures were reported in the subsequent years, up to and including the most recent report, from December 2009, when 34.3% of endometriosis patients conceived by IVF and 31.8% of patients with unexplained infertility (CDC US National ART Registry 2007). Canadian figures, from 2005, showed similar outcomes: 39.2% pregnancies in endometriosis patients and 34.4% in unexplained infertility patients (Fertility & Sterility 2009;91:1721-30). No indication whatsoever that these spots of endometrium that you happen to find on the peritoneum at laparoscopy might decrease fertility.

But, you will object, ovarian hyperstimulation may correct unidentified fertility impairing factors in endometriosis patients and not –– or less so – in unexplained infertility patients. Wrong again, studies of IVF in the (modified) spontaneous cycle show the same difference, endometriosis patients do not do any worse than controls. For example, a study from The Netherlands (Pelinck et al, Human Reproduction 2006;21:2375-83) showed 7/62 endometriosis patients conceiving (11.3%) by IVF in a spontaneous cycle, as compared to 21/323 unexplained infertility controls (6.5%). Omland and co-workers, from Norway, reported a 10.4% clinical pregnancy rate per initiated cycle in endometriosis patients following natural cycle IVF, compared to 2.6% in unexplained infertility (Human Reproduction 2002;17:1926-27).

So, next year, in Montpellier, on 4 September, we will have another "Research Priorities" workshop, chaired by Peter Rogers, preceding the 11th World Congress on Endometriosis. The outcome may very well be that we will have to cancel the whole world congress. Come to Montpellier, you may witness the end of a beautiful dream!

In this issue of the WES e-Journal

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A WORD FROM THE EDITOR

Gauntlet: from Old French *gantelet*, diminutive of gant, *glove*

Dr Luk Rombauts
WES e-Journal Editor

I am pleased to bring you our next WES e-Journal issue for October 2010. Most of you have returned to work following the summer holidays. For some October means preparing for hibernation mode: short days, miserable weather and lots of chocolate to fend off SAD (seasonal affective disorder). For me, an antipodean now, October means spring time. Gardens are waking up all around Melbourne, after a wetter than usual winter. It's a most welcome thought after a drought that has been devastating in recent years.

In the previous issue Bernard Hedon also referred to *la retour* (the return), in particular in reference to its significance for the region of Montpellier (Hedon B, 2010). This year his to do list was a little bigger on his *retour*. Bernard and his team have prepared the latest guest editors' digest. In addition, he has added another teaser for the World Congress on Endometriosis in Montpellier next September. This time he points out several of the exciting cycling options around Montpellier for the fit and not so fit.

But it won't all be fun and games in Montpellier. It may be perhaps a timely reminder that you should urgently plan any studies or experiments in preparation for the congress. We are now calling for the first abstracts. You can find all the details on page 6.

Our President, Hans Evers, opens this issue with another thought-provoking piece. If this doesn't result in any feedback from our readers, I honestly don't know what will. In a provocative way he is essentially suggesting that all our research and clinical efforts have been a waste of time. I am sure he doesn't quite believe that himself, but the case he puts forward is indeed puzzling. He pointed out this very issue to me in question time after my IFFS 2010 plenary lecture on the role of ART in women with endometriosis. I thought: 'Nice curve ball, Hans'. I hit it back with as much top spin as I could muster and didn't think he would return the ball. Well ... he is back with a smart drop-shot.

I expect that many self-respecting researchers will not let this opportunity to send a rebuttal pass by. This journal presents a fantastic opportunity to have your opinions published quickly and unedited. Philippe Koninckx recently pointed out in an opinion piece (Koninckx et al, 2010) that vigorous debate is stymied in scientific journals. I have no problem with journals maintaining methodological rigor, but the discussion section often gets over-editorialised in my opinion. This is, I believe, the strength of a forum like the WES e-Journal. Out of the box thinking and controversial perspectives, both long and short, can find a place here, at no cost. Show us that this society is still alive and kicking.

The President has thrown down the gauntlet; take it up!

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Hedon B. WCE2011 is now only 12 months away.... what do the inhabitants of Montpellier do in September? WES e-Journal 2010;12(4):8-9.

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UPCOMING MEETINGS

39th Annual Meeting of the AAGL
8 - 12 November 2010
Las Vegas, USA

Reproductive surgery in the 21st century and beyond (RCOG / ESHRE / ESGE)
1 - 2 February 2010
London, United Kingdom

Annual Scientific Meeting of the SGI
16 - 19 March 2011
Miami Beach, USA

ESHRE Campus: Endoscopy in Reproductive Medicine
24 - 26 November 2010
Leuven, Belgium

The 10th International Symposium on GnRH: The Hypothalamic-Pituitary-Gronadal-Axis in Cancer and Reproduction
6 - 8 February 2011
Salzburg, Austria

>> COMPLETE CONGRESS SCHEDULE

Endometriosis surgery before infertility treatment

Professor Bernard Hédon, Dr Lionel Reyftman, Dr Clotilde Dechanet, and Dr Sofie Deutch
Equipe de Médecine de la Reproduction, Département de Gynécologie-Obstétrique, Pôle Universitaire Naissances et Pathologies de la Femme, Academic Hospital A. De Villeneuve, University Montpellier Sud de France Medical School
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Professor Bernard Hédon

Barri et al (2010) recently published a fairly large series. The aim of this retrospective and observational study is to evaluate fertility in patients suffering from severe endometriosis (stage III-IV and endometriomas) after treatment with surgery and/or IVF.

The rate of pregnancy is high in the group treated with "surgery and IVF" (65.8% of patients fell pregnant). In comparison, for patients left untreated the rate of spontaneous pregnancy is 11.8% only. After surgery alone, the rate of pregnancy is 54.2%, suggesting that surgery is an efficient treatment to induce spontaneous pregnancy. In this group, patients without pregnancy have been treated by IVF and the rate of pregnancy was 30.4% per retrieval. Thus, a combined strategy of surgery and IVF allowed 66% of patients to get pregnant and these results are close to those observed in previous studies (Coccia et al, 2008; Pagidas et al, 1996).

In the group "IVF only", the rate of pregnancy was 32.2 per retrieval and was similar as the rate observed in patients treated by surgery and IVF (30.4% per retrieval). When comparing IVF parameters between patients treated by surgery before IVF and patients treated with IVF only, a higher dose of FSH was required and a lower number of oocytes and embryos was obtained. However, the pregnancy rate between these two groups is similar. This suggest a deleterious effect of ovarian surgery on ovarian reserve and response to controlled ovarian stimulation. However, the high rate of spontaneous pregnancy after surgery and the IVF pregnancy rate observed encourage the use of surgery as a first treatment and, in case of failure, IVF.

In this study, the interval between surgery or IVF and pregnancy was also analysed. The mean delay to obtain a pregnancy after surgery was 11.2 months. To date, no consensus is established concerning an optimal delay between surgery and IVF. Moreover, endometriosis is a chronic disease and recurrence is not uncommon. In this study, IVF was efficient in patients who were not previously treated by surgery and in patients with recurrent endometriosis, suggesting that IVF could improve fertility in patients suffering from recurrent endometriosis. However, the optimal timing of IVF after surgery remains to be elucidated.

On the one hand, a short interval may not leave enough time to obtain a spontaneous pregnancy, questioning the utility of surgery. On the other hand, a long interval may increase the risk of recurrent endometriosis. It may also worsen the effect of increasing female age and lower ovarian reserve, and thus lower the IVF prognosis. This was borne out in this study with the analysis of results according

Endometriosis-associated infertility: surgery and IVF, a comprehensive therapeutic approach
Reprod Biomed Online 2010;21(2):179-185

Barri PN, Coroleu B, Tur R, Barri-Soldevila PN, Rodríguez I

Infertility is a common problem presented by patients with endometriosis. At present, whichever treatment is chosen, half of patients with advanced stages of the disease will remain infertile afterwards. This observational study looked at the reproductive outcome achieved after treating a group of 825 patients aged between 20 and 40 years with endometriosis-associated infertility during the period 2001-2008. Of the 483 patients who had surgery as the primary option, 262 became pregnant (54.2%). Among the patients who did not become pregnant, 144 underwent 184 IVF cycles and 56 additional pregnancies were obtained (30.4% clinical pregnancy rate per retrieval). It is notable that, before any treatment, patients with endometriosis had a poorer ovarian reserve than the control group. The combined strategy of endoscopic surgery and subsequent IVF led to a total of 318 pregnancies, which represents a combined clinical pregnancy rate of 65.8%. This percentage is significantly higher than that obtained with surgery alone ($P < 0.0001$), with 173 patients who were not operated on and who went to IVF as the primary option ($P<0.0001$) and with 169 patients who had no treatment and achieved 20 spontaneous pregnancies ($P<0.0001$)

to the age of the patients showing that the rate of spontaneous pregnancy after surgery and success of IVF are lower in patients aged more than 35 years.

The second paper we highlight is a very interesting study which will increase the awareness of the dangers of surgery for ovarian endometriomas when fertility is at stake and IVF potentially a necessity. The evidence is consistent that ovarian reserve is affected after surgery of the ovary. The damage inflicted by surgery may be due not only to stripping and removal of healthy ovarian tissue, but also to the local inflammation and/or vascular injury secondary to electrosurgical coagulation. The main information brought by this study by Benaglia et al (2010), is the risk of ovaries becoming unresponsive to ovarian stimulation after ovarian surgery for an endometrioma.

This retrospective study included 93 women who have been operated for monolateral endometriomas and who underwent IVF. Ovaries were considered like severely damaged when no follicles with a mean diameter >or= 11 mm were observed at the time of hCG administration. This study found a decrease of 42% of the number of follicles in the operated ovary compared with healthy controlateral ovary observed at the time of hCG administration during IVF stimulation. A complete absence of follicular growth was observed in 12 operated ovaries.

This study is comparative between the operated ovary and the controlateral ovary, each patient being its own control, and both ovaries receiving the exact same amount of stimulus. This is an elegant way to be able to evaluate the negative impact of surgery. Knowing that the main inclusion criteria was previous laparoscopic excision of one or more unilateral endometrioma, the number of cases included in this study remains relatively important.
The present study has certain limitations that need to be taken into account:

- The data exclusively refer to the first IVF cycle and perhaps some follicular growth may have been observed in subsequent cycles or with higher doses of gonadotrophins.
- The size and location of each endometrioma and the type of surgery were not mentioned. Only information on the mean diameter of the excised cyst (4.2±1.8 cm) was mentioned.
- Selection bias may also exist. The selected population only included infertile women who failed to get pregnant following surgery and the results need to be confirm in a unselected population. The inclusion of women with recurrent endometriomas probably selected specifically infertile women for whom surgery has failed.

The take home message from this study is that the rate of ovaries remaining silent after endometrioma surgery is 13% (12/93).

The third study we will discuss deals with bowel surgery. The debate about whether or not patients with deep infiltrative endometriosis involving the bowel should be exposed to aggressive surgical management is still ongoing.

Is it ethical to propose a potentially life threatening treatment to a young patient experiencing the symptoms of a benign condition? The decision to offer colorectal resection to a patient affected with endometriosis should only be made on an individual basis, and the information given to the patient should include the likelihood of complications as well as success. The use of evidence based medicine should be derived from the literature as well as from our own clinical experience and rate of gastrointestinal complications. If a team feels confident with a laparotomy approach and has a low rate of severe pre- or postoperative complications, there should not be any reason why the operators should shift to laparoscopy just to follow the accepted trends. However, if the rate of complications decreases with laparoscopy (which is frequently the case for colorectal procedures) and the literature supports

Rate of severe ovarian damage following surgery for endometriomas
Hum Reprod 2010;25(3):678-682

Benaglia L, Somigliana E, Vighi V, Ragni G, Vercellini P, Fedele L

BACKGROUND: There is growing and consistent evidence showing that ovarian reserve is affected following surgical excision of ovarian endometriomas. Of particular concern is the risk of severe ovarian damage leading to unresponsiveness to ovarian hyperstimulation. In this study, we aimed to determine the rate of this complication.
METHODS: Ninety-three women underwent surgery for monolateral endometriomas were recruited. Patients who underwent IVF were selected and, in all cases, follicular growth was monitored by serial transvaginal ultrasonography. The main outcome measure was the rate of ovaries remaining silent when stimulated after surgery for endometriomas.
RESULTS: Absence of follicular growth was observed in 12 operated ovaries although this event never occurred in the contralateral gonad ($P < 0.001$). The frequency (95% confidence interval) of severe ovarian damage following surgery was 13% (7-21%).
CONCLUSIONS: Severe ovarian damage, occurring in gonads operated on for ovarian endometriomas, is not a rare event.

the use of laparoscopy for fertility preservation, the question should be re-assessed.

Darai et al demonstrate here, in a very elegant and rigourous way that laparoscopy is not inferior to laparotomy for this radical type of surgery if the team is trained for this special skill. They use the appropriate tools for their assessment: randomisation; validated pain and quality of life questionnaires; the Dindo and Clavien classification for surgical complication and cumulative tables for pregnancy rates. Furthermore, the author has published extensively in that field and we were very eager to see the results of a prospective randomised study with a long term follow up. The literature only offers retrospective studies comparing the two surgical routes, whereby numerous biases exist concerning patient selection, the laparotomy cohort usually being the most severe cases. Their results are in line with common sense - laparoscopy offers a better ability to achieve haemostasis compared to an open route; patients experience less post operative pain; the post operative course is simpler and their fertility is improved after treatment. The latter is attributed to disease excision and that laparoscopy induces less adhesions than laparotomy.

Nevertheless, serious limitations exist with this study. The sample was calculated for a non-inferiority trial and only 52 patients were enrolled. The team is highly specialised in laparoscopic advanced surgery (laparoscopic treatment only increases the duration of their procedure by 40 mins) and their results should not be extrapolated to any surgeon. Future larger multi-centre studies with less experienced teams could potentially ascertain whether increased fertility rates are due to superior surgical techniques or methodology. Darai et al does not mention the rate of protective colostomy, although it was conducted every time they performed concomitant vaginal and rectal opening. In addition, their discussion of the amplified benefit of hysterectomy in terms of pain relief compared to non-radical surgery seems too narrow, as many other factors are implicated, such as the persistence of menstruation, dysmenorrhoea and psychological factors.

In summary, this paper contributes to an important debate that is far from being closed: all patients with colorectal endometriosis should certainly not be operated, but if they are and if the surgeons have the mandatory training and skills, laparoscopy should definitely be considered.

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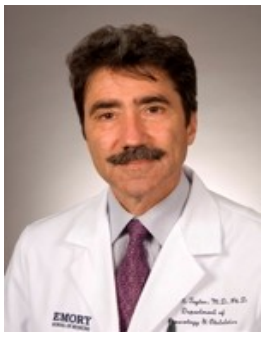
Randomized trial of laparoscopically assisted versus open colorectal resection for endometriosis: morbidity, symptoms, quality of life, and fertility

Ann Surg 2010;251(6):1018-23

Daraï E, Dubernard G, Coutant C, Frey C, Rouzier R, Ballester M

OBJECTIVE: We report the first randomized trial of laparoscopically assisted versus open colorectal resection for endometriosis focusing on perioperative complications, improvement in symptoms, quality of life, and fertility.
SUMMARY OF BACKGROUND DATA: Bowel endometriosis is one of the most severe forms of endometriosis. Although laparoscopically assisted surgery is a validated technique for colorectal cancer, there are serious concerns about its appropriateness for endometriosis in young women wishing to conceive because it is almost invariably a traumatic procedure.
METHODS: We conducted a noninferiority trial and randomly assigned 52 patients with colorectal endometriosis to undergo laparoscopically assisted or open colorectal resection. The median follow-up was 19 months. The primary end point was improvement in dyschesia.
RESULTS: Overall, a significant improvement in digestive symptoms (dyschesia $P < 0.0001$, diarrhea $P < 0.01$, and bowel pain and cramping $P < 0.0001$), gynecologic symptoms (dysmenorrhea $P < 0.0001$ and dyspareunia $P < 0.0001$), and general symptoms (back pain $P = 0.001$ and asthenia $P = 0.0001$) was observed. No difference in the symptom delta values and quality of life was noted between the groups. Median blood loss was lower in the laparoscopic group ($P < 0.05$). Total number of complications was higher in the open surgery group ($P = 0.04$), especially grade 3 ($P = 0.03$). Pregnancy rate was higher in the laparoscopic group ($P = 0.006$), and the cumulative pregnancy rate was 60%.
CONCLUSION: Our findings support that laparoscopy is a safe option for women requiring colorectal resection for endometriosis. Moreover, laparoscopy offers a higher pregnancy rate than open surgery with similar improvements in symptoms and in quality of life.

Partnership grant focuses on workforce diversity in women's health and reproductive research



Professor Robert Taylor

Professor Robert N Taylor, WES board member and vice-chair for research at the Emory University department of gynaecology and obstetrics, and Dr Winston Thompson of Morehouse School of Medicine will lead the Atlanta Center for Translational Research in Endometriosis (ACTRE).

Emory University and Morehouse School of Medicine (MSM) have been awarded a five-year, nearly $3 million, partnership grant to promote workforce diversity and education in the reproductive sciences and women's health. This is the first time this grant has been awarded and it is one of only two in the nation to be funded by the National Institute of Child Health and Human Development (NICHD), a part of the National Institutes of Health. ACTRE represents a partnership between strong reproductive research programmes at both Emory University and Morehouse School of Medicine. ACTRE will recruit, support and train under-represented minority college students throughout Atlanta to study the health implications and biology of endometriosis taking a unique "bedside to the bench" approach.

"We are honored to have received this cooperative research grant from the NIH and look forward to working with Morehouse School of Medicine," says Robert Taylor. "The goal of this grant is to introduce minority students to translational human reproductive research, demonstrating how cellular and molecular biology bridge the way to clinical reproductive medicine."

Abstract submission for the 11th World Congress on Endometriosis is now open

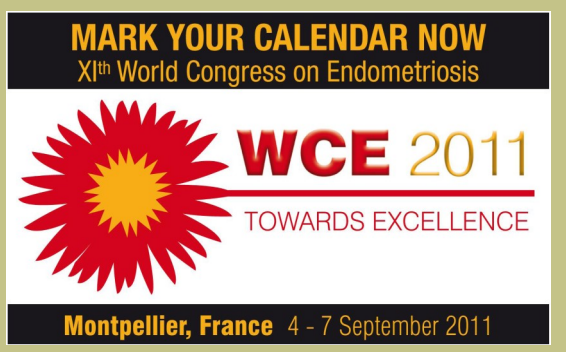
The WES world congresses on endometriosis are "abstract driven" meetings, which allows as many clinicians and scientists as possible to present their research in plenary sessions. At WCE2011 the following topics will be included:

- **Environmental factors***
- **Endometrium***
- **Communication**
- **Prevention and recurrence***
- **Deep endometriosis***
- **Pathophysiology / Aetiology**
- **Cancer**
- **Pain***
- **Quality of life / sexuality***
- **Pregnancy***
- **Diagnosis***
- **Infertility***
- **Counselling**
- **ART**
- **-omics***
- **Surgery***
- **Medical treatment**
- **Genetics**
- **Epidemiology**
- **Screening***
- **Other**

For each of the main topics (marked by *), the five best abstracts will be selected for presentation in one of the 10 plenary seminars. Additional topics will be covered in our "free communication" sessions, and as posters.

We encourage you to share your work in endometriosis with your colleagues at the global event on endometriosis in 2011 and invite you to submit your abstract(s): **www.wce2011.com**

Deadline for abstract submission is 31 March 2011



Update from the Argentinean Endometriosis Society

Dr Marcelo Bergamasco

This has been a very busy year for the Argentinean Endometriosis Society (SAE) in its 9th consecutive year of hard work in the field of continuous medical education and public awareness on endometriosis.

Sadly, on the eve of our international symposium *Una visión actualizada de la endometriosis* ("An updated vision on endometriosis"), our vice-president, Dr Marcelo Bergamasco passed away in an unthinkable nautical accident. Trying to overcome our collective shock, and keeping up high the premise that "the show must go on", the meeting was held in memoriam of one of the most dedicated founding members of our society.

Too young not to be still on our side, Marcelo had a prominent and protagonist role in the building and development of our society. A good friend, an active worker, an excellent physician and outstanding laparoscopic surgeon, Dr Bergamasco will be always remembered by his never ending smile and intensive participation in all matters related to SAE.

Two foreign speakers, Hans Evers and Carlos Sueldo, members of the boards of WES and the World Endometriosis Research Foundation (WERF), were our friendly guests. Although Dr Sueldo was born and educated in Argentina (where he practices reproductive medicine part time), he developed his outstanding career in the United States. Hans Evers is an "all time" friend of Argentina, known here not only for his knowledge on endometriosis, but – as well – for his love for our country and our people. To make it clear: both of them are "frequent speakers" in Argentina, with thousands of miles gained locally.

The introductory conference was given by Dr Rosa Inés Barañao, undoubtedly the most prolific basic science author in our country. With a high number of international publications, the original investigations by the group she coordinates at the CONICET in Buenos Aires, allowed her to master her speech: *In vivo* evaluation of new possible therapies for endometriosis.

Professor Evers excelled in the two topics assigned to him: Understanding endometriosis and Treating Endometriosis. professor Sueldo made an excellent proposal on how to apply investigation on endometriosis to clinical practice, and later presented some controversies on the treatment of the endometriosis related infertility.

On the subject, Dr Alberto Valcarcel, Director of the Reproductive Laboratory at the IFER – Instituto de Ginecología y Fertilidad (Buenos Aires), exposed his extensive personal experience on the impact of endometriosis at the time of In Vitro Fertilization.

Finally, Professor Ricardo Buquet, President of the Argentinean Endometriosis Society and Head of the Minimally Invasive Surgery Department. at the Buenos Aires University School Hospital, gave us detailed information about new therapeutical options for endometriosis.

This memorable symposium was followed by a very exciting Tango Dinner and Show at the Querandí Restorán – a landmark in our city; and not more and not less than a relaxing Sunday boat tour and riverside lunch in the wonderful delta of the Paraná River on board of the "Josefina", my sailboat.

Later in June, at the XXVIII International Congress on Obstetrics and Gynecology held by SOGIBA (Society De Obstetricia y Ginecología de Buenos Aires) a meeting attended by more than 8,000 participants, SAE was responsible for the symposium on endometriosis.

We had the honour and the pleasure of receiving this time, as international speaker, our friend Mauricio Abrao, also a member of the WES Board, and close neighbour from Sao Paulo, Brazil. He gave an outstanding lecture on imaging in the diagnosis of endometriosis. His contribution to the field of rectovaginal adenomyosis is well known all over. His new diagnostic proposal, using low cost simple ultrasound equipment is undoubtedly a landmark that deserved to be presented at this important congress. He later gave another memorable main lecture on this issue at this meeting.

NEWS FROM NATIONAL SOCIETIES

Dr Susana Vighi, one of the most re-known specialised gynecological pathologists in Argentina, introduced us to the new diagnostic tools her specialty has nowadays developed. The chair, Professor dr Luis Augé, an SAE founding member and past president, lectured on adenomyosis related infertility, and I proposed different and personal points of view on the current controversy: should recurrent endometriomas be operated when treating infertility?

In August, the Annual International Congress of the Sociedad de Ginecología y Obstetricia de Cordoba was held at the City of Cordoba (our second largest metropolis). Once again, the SAE was in charge of the symposium on endometriosis.

With the participation of several founding members of our Society (Dr Luis Augé, Dr Humberto Dionisi, Dr Carlos Coria, Dr Rosa Inés Barañao, Dr.José Miguel Curto, and myself), the following topics were addressed: recent updates, new possible therapies, surgical treatment, and the special treatment of endometriosis related pain.

We now look forward for the Annual Meeting of FASGO (Federación Argentina de Sociedades de Ginecología y Obstetricia) next October, at the beautiful colonial city of Salta, in our northwest, were we will be in charge of all endometriosis related conferences, and the Annual OBGYN Meeting of SOGBA (the Buenos Aires Province Ob. Gynaecological Society), at Mar del Plata, in December this year, where – once again – our society has been called upon to manage all issues pertaining to endometriosis.

As you can see, the importance of a national society, from our view, is that sooner or later you will be called upon in order to organise and run all matters associated to endometriosis – which is good since in this way you can expand nationally what WES does internationally. Please take this message home: create local societies and seek rapid and intensive participation in all local meetings, carrying always the word from our mother organisation, the World Endometriosis Society!

Edgardo D Rolla MD
Founding Member, WES, SAE
Past-Vice President, SAE
In charge of Inter-institutional Relations, SAE

WES secretary general honoured at 4th Pan-Hellenic Endometriosis Congress

The Hellenic Endometriosis Society has made WES secretary general, Lone Hummelshoj, an honorary member in recognition of her contribution to the field of endometriosis. The ceremony took place at the 4th Pan-Hellenic Endometriosis Congress in Heraklion (Crete, Greece) on 16-17 October this year, where its president, Professor Ioannis Matalliotakis, paid tribute to her work.

The Hellenic Endometriosis Society was founded in 2000, and was first chaired by Professor Koumantakis. The society has now successfully conducted four pan-Hellenic endometriosis congresses, which each have been attended by more than 200 physicians and nurses from across Greece, demonstrating the high level of interest in the disease – matched also by many publications from those active in the Hellenic Society!

Lone Hummelshoj, Professor Aydin Arici and Professor Ioannis Matalliotakis

The two other honorary members are the late Professor Rodolphe Maheux, co-founder of WES, and Professor Aydin Arici from Yale University, who were both honoured at the society's 2nd congress in 2006.

WCE 2011 MONTPELLIER TEASER

Cycling, biking, walking, running, swimming, climbing, trekking: there is so much to do before, during and after the World Congress of Endometriosis (Montpellier, France, 4-7 September 2011)

In this issue I would like to draw your attention to the many fantastic cycling opportunities:

Level 0

Visit Montpellier with the public bike rental system. There are numerous bike stations. You leave the bike and after your visit you take another one from any station. One hour, half a day, a full day, depending on your availability, desire and curiosity, not to say your fitness. Because Montpellier is not exactly flat. *Mons-pelliensis* means "the hill".

Level 1

20 km to the beach by independent cycling routes: you start from the Corum congress centre and you take the direction "Carnon" or "Palavas". You will come accross horses and wild bull meadows, but will remain safe on your side of the fence. Even the non-regular bike users will reach the beach because, unless there is a strong head wind: no climb in view, and a good rest on the beach!

Level 2

40 km: you need a good bike from a local rent-a-bike. You will turn yourself towards the so-called "back country", heading north. Crossing typical Languedoc villages such as Valflaunès, Saint Jean de Cuculles, Notre-Dame de Londres, you will cycle around the local mountain: the pic Saint Loup, 600m high, a stunning view from all the way along. Of course, this route is meant to include some good climbings. This is the typical Sunday morning route on a sunny day with your good friends. Just above two hours of cycling; far less if you are a competitor.

Level 3

80 km (or more!): this is probably the most gorgeous cycling tour you can imagine. After a warm-up on small country roads, you enjoy a descent to the Herault gorges and you follow the river going up-stream. Soon you understand you have to give back the gradient you have already taken. Then you can stop at the most charming 3-star touristic village of Saint Guilhem le Désert before ending your tour at a lower speed because your legs are aching and you need a good refreshment to bring up your blood glucose level.

I hope you will extend your visit to Montpellier next year to explore the beautiful surroundings by bike.

Bernard Hedon
President of WCE 2011