LETTER TO THE EDITOR
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Letter to: Endometriosis of the rectosigmoid colon mimicking gastrointestinal stromal tumor

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Dear Editor,

We would like to congratulate the authors for publishing such an informative and interesting article (1). We totally agree with the authors to proceed with various modalities and evaluation in this patient who presented with pelvic pain and abdominal bloatedness as it is not easy to diagnose rectosigmoid endometriosis solely by history and physical examination (2,3). However, we believe that there are few issues that can be highlighted in the article to further enhance the visibility of the article value. We value if further detailed gynaecology history could be included namely cyclical pain, dysmenorrhoea, dyschezia and also her fertility status. Physical examination such as tenderness at the pouch of Douglas and thickening of the uterosacral ligament might also give a clue to the preoperative diagnosis of endometriosis as in this patient. In addition, we believe that the readers are keen to know the findings of the transvaginal ultrasound prior to surgical intervention as it has high sensitivity and specificity (4).

The authors stated that the frozen section was performed prior to anterior resection. We were wondering what type of tissue was submitted for the section as intraoperative findings were not described. As we are concerned, gastrointestinal stromal tumor arises from the submucosal tissue, hence we wonder whether the authors performed laparoscopic cytology of the submucosal mass or biopsy of the peritoneal tissues. Commonly, the assessment involved in gastrointestinal pathology of the submucosal lesion is via endoscopic biopsy (5).

In malignant cases, usually, a clinical assessment that shows perforation, bleeding and obstruction warrant a colonic resection or diversion (6). We were wondering about the decision for surgical resection in this case as the reasons were not described in detail. Furthermore, since it is a benign diagnosis following the frozen section, we believe that any lesion above 5-8 cm from the anal verge as in this case, is better to be managed with conservative management such as hormonal suppression rather than surgical resection to decrease the risk of short- and long-term complications (7).

Lastly, since this is a collaborative effort between general surgery, radiology, obstetrics and gynaecology as well as anatomic pathology until eventual diagnosis, we believe that the involvement of the latter 2 disciplines is crucial as part of the authorship in making this article valuable. In addition, the authors could acknowledge those aforementioned disciplines in the acknowledgement section if they were not involved much in manuscript preparation. We hope that this practice can be improved in the future.

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