THE SCOPE MEETS... PROFESSOR HORACE ROMAN

The Scope met keynote speaker Professor Horace Roman at the recent BSGE/RCOG Benign Abdominal Surgery Meeting. Horace is Professor in the Department of Gynaecology and Obstetrics at Rouen University Hospital. He focuses on minimally invasive gynaecologic surgery, and particularly on the surgical management of endometriosis. He spoke about everything from complex endometriosis to coffee as well as covering training, scanning, nerve sparing surgery and what continues to drive him professionally.

The Scope: Thank you very much for the excellent talk at the Benign Abdominal Surgery meeting. We all enjoyed that. Can you tell our readers a bit about your typical day at work? How do you fit it all in 24 hours?

Professor Roman: First I am a surgeon and after that I am a professor. Three days a week I spend all the day in the operative room, so from 8 o'clock in the morning to 5 o'clock in the afternoon. On those days, I come to the hospital at 6 or half past 5 because spontaneously I wake up very early. I spend this time on clinical research, so all the residents or PhD students who work with me know that they have to wake up early. Once a month we meet 6 o'clock in the morning to check the progression of their work. The hospital is quiet, nobody calls me, the phone does not ring. I think it is the best part of the day when you can work-and have coffee of course!

Two days a week I start at 9 o'clock because I bring my daughters to the school. I never finish earlier than 6 o'clock or 7 o'clock in the evening because in France, the problem of a professor is overcrowded, they have to accomplish administrative tasks, university tasks and from clinical tasks.

The Scope: We were talking earlier about your surgical workload. What do you think is the minimum number of rectovaginal endometriosis cases a surgeon should do in a year to progress and maintain their skills?

Professor Roman: That is a very good question. When I started the surgery of deep endometriosis in 2005, I felt comfortable with this disease after 50 or 60 cases. So, I think that a surgeon who does not perform at least 15 cases of colorectal endometriosis a year cannot be called a skilled surgeon in this area. If you consider the need for training others, you will have to add another 15 or 20 to this. The truth is, as you said at the meeting today, we don't treat nodules or disease but patients. The patient's characteristics may change our strategy, even though the nodule has the same localization in different patients.

The Scope: How many procedures for advanced endometriosis do you do in a year?

Professor Roman: I usually schedule two patients with colorectal endometriosis each day and I have three operative days a week and I can add a third patient with a small endometriosis, so usually I manage 6-7 patients a week, except for weeks when I am at congresses, meetings or on holiday. In total, I manage around 200-240 patients a year and the majority are colorectal endometriosis. I work with a team of four young surgeons. They perform small endometriosis procedures, so if I see a patient with small endometriosis I refer them to one of my colleagues. If they see a patient with colorectal endometriosis that they are comfortable to manage by themselves, they will. If they are not, they refer it to me. Usually I only see women with deep endometriosis involving the rectum, the ureter or the bladder both in my public and private consultations.

The Scope: For complex endometriosis it's necessary to work together with other specialties, particularly with colorectal surgery and urology. In France, do other surgeons get exposure to endometriosis during their specialty training?

Professor Roman: Certainly not. The colorectal surgeons are not trained in endometriosis surgery during their residency. They never use shaving or disc excision in the treatment of other diseases and that is why they are most likely to perform only colorectal resection every time they are called to help manage a woman with colorectal endometriosis. The same with the urologists because they are not trained in the treatment of endometriosis, each time we call them, they propose a ureteral re-implantation into the bladder because they are not used to doing ureterolysis or short resections with end-to-end anastomosis. This is the strength of an expert centre; the management strategy can be more varied and adapted to each patient. This is because the other specialists consider their gynaecology colleague, who is expert in endometriosis, and are willing to listen to advice.

The Scope: In the UK, we don't have enough people who can do ultrasound scanning to the level that can diagnose rectovaginal endometriosis. Is this a problem in France as well?

Professor Roman: In France, all the residents in Obstetrics and Gynaecology have to accomplish a training in ultrasound and this training is very difficult. However, 90% of this training concerns Obstetrics. So, the number of gynaecologists or radiologists who are able to diagnose deep endometriosis with vaginal ultrasound is very low. That is why I am much more comfortable when the patient has an MRI and brings me the disc, because I can read it and diagnose the patient myself. Properly training gynaecologists in ultrasound in endometriosis is a major concern and may be the way to improve the early diagnosis of deep endometriosis.

The Scope: When somebody finishes residency in France what level are they at, what kind of endometriosis can they deal with laparoscopically?

Professor Roman: It strongly depends on the hospital where the resident was trained. At some centres, like ours, residents will have attended many cases of deep endometriosis and are able to dissect the pararectal space, then resect small uterosacral nodules. After one year, they are able to schedule on their own programme of colorectal endometriosis. Residents, who are trained in other departments may be unable to do to this but may be more skilled in other pathologies like oncology or urogynaecology.

The Scope: Let's get to the question of nerves. Endometriosis of the pelvic nerves and the sacral nerve roots is a relatively new subject. Do you think it's an area for development or nonsense?

Professor Roman: That's a very challenging question because during the last twelve years, I have seen that the endometriosis in the patients I manage has become more and more severe. I am sure that some of patients I treat today, I could not have managed in 2010. At that time, I had not seen such large nodules. Since 2014 I have started to treat big, deep endometriosis lesions with contact on the pelvic wall and pelvic nerves. I manage one or two patients a month, where the complete resection of the nodules requires a full dissection of sacral roots. Today, I have a series of 25-27 patients with full dissection of sacral roots and shaving or even dissection into the sacral root.

The Scope: Thank you very much for a fascinating talk at the meeting and for sharing your thoughts, knowledge and experience with readers of The Scope.

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Editor's Notes

Another year is drawing to close as our eighth issue of The Scope goes to press. As I reflect on the first edition, the newsletter really has gone from strength to strength (even if I say so myself!) It has improved communication, attracted attention and helped to demonstrate the vibrant face of the society. Putting each issue together involves an enormous amount of work from a team of people. The trainee representatives, the WebComms subcommittee, Dominic and the Portfolio Chairs and of course, Jane Gilbert who does a fantastic job putting it all together with the help of Atia and Sally Anne, our graphic designer. You can see many of their pictures on the back page. I'd like to thank them all for their diligence and attention to detail.

I was pleased to see that the members' survey showed that you value the BSGE's communication in general, and the website and The Scope, in particular. I'd like to encourage even greater member engagement. We live in the age of social media and we need to use these capabilities to get closer to some of the BSGE's aims, including improving training and sharing experiences with like-minded colleagues. The new Facebook page has been an immediate success, with more than 200 colleagues signed up. There have been many animated discussions and we would like to make it even more active, so can I encourage you all to register. If you're concerned about privacy, then consider setting up a private account so that no one can see your family pictures, or see Tereza's article later in The Scope for details on how to ramp up your security settings.

You can also join the debate by following @TheBSGE on Twitter, there's lots of comment and controversy from members, fellow professional societies and patient representative groups. At The Scope, we always welcome articles, stories and opinion pieces from members, so please get in touch on TheScope@BSGE.org.uk, it's your society, so you should shape the news.

May I wish you all a happy and successful 2018.

Shaheen Khazali
S.Khazali@me.com