Travelling Fellowship Report

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I used the BSGE allocated Travelling Fellowship funding to visit the Endometriosis Centre at Bronovo Hospital, the Hague, Netherlands 29 July – 2 August 2019. My contact for the visit was Mr Jim English.

I found this to be a very informative, thought provoking and interesting visit. I attended 2 all-day and 1 half day theatre lists, with the remaining time being spent in clinic. The hospital has a designated Multi-disciplinary Endometriosis service, which treats approx. 80% of all moderate-severe Endometriosis in the Netherlands. Referral is usually from secondary care. A twice weekly MDT meeting is held on Monday and Thursday mornings to discuss and plan care and surgery for new patients.

The Clinic set-up is comprised of a 30 minute consultation initially with a specialist endometriosis nurse who takes a detailed history, and documents this on a database that can be accessed by the other health professionals in the clinic as well as the patient's GP. The patient then has a 30 minute appointment with the Gynaecologist who examines, performs a detailed transvaginal scan, arranges further imaging if required, and discusses medical or surgical treatment options with the patient and/or relatives. The patient can then be seen by a psychologist or dietician as required, or be referred to the endometriosis special interest colorectal surgeon or urologist.

Patients have 3 appointments before surgery to complete the necessary investigations, other speciality reviews, and achieve an informed consent process. The waiting time for first clinic appointment is 2-3 weeks. The women were afforded ample time to discuss and ask questions. There was no sense of time pressure. There were approximately 10 patients per clinic for 2-3 doctors. By time of surgery, women were very well informed about their procedures, as well as implications and risks, and knew and trusted the team well. Interestingly, and in contrast to the UK, no chaperones are used in the clinic environment. Staff explained that societal norms and the general culture is such, that they are not required. Consultations occur mostly in Dutch medium, although most staff and patients speak English to a high standard.

Theatre sessions were held in Antoniushoeve hospital some 10 minutes drive away. The theatre team were truly excellent in my opinion. Theatre nurses were selected by the surgeons to join the Endometriosis team. They were pre-emptive, clearly interested in the surgery itself, efficient, friendly, and had all necessary equipment readily available. The turnover time was approximately 15 mins between patients, and the lists ended on time. There was food and drink in the theatre common room fridges available for all, meaning that theatre staff did not have to leave the area to obtain lunch from other areas of the hospital, thereby saving time in terms of length of breaks etc.

I observed 2 excisions of endometriois with bowel resections, 1 re-implantation of ureter with urological input, and other complex excisions not requiring other speciality involvement. There is a very low threshold for stenting ureters pre-procedure. This is performed by the Urologist as per Dutch health insurance requirements. The Gynaecologists operate on a buddy system, meaning that at least two skilled, experienced surgeons are present for complex cases, which is of course advantageous for a favourable patient outcome. The patient details, examination and operative findings, as well as procedure are recorded on the Equsum Endo Standards database, allowing for easier collection of data for the purposes of audit and presentation.

Interestingly almost all endometriosis cases are administered an epidural which is in use for 2-3 days post-operatively, allowing for excellent pain management.

I observed the use of the Endo-eye Laparoscopic system, whose anti-fog system makes for a much more efficient and less frustrating surgery.

Some points of interest I picked up were as follows, based on Bronovo's clinical practice and local figures:

Endometriomas greater than 6cm are drained, treated with GnRH analogue and then have an interval cystectomy after 3 months. This is believed to promote ovarian preservation.

The presence of an endometrioma suggests a 50% chance of bowel disease. If rectovaginal disease is present, then there is a 40% chance of appendix disease. 60% of patients with rectovaginal disease also have adenomyosis. Anastomotic bowel leak post resection is 5%. Patients are three times more likely to have symptom eradication if hysterectomy is performed at the time of excision.

Provera 30mg once daily is used widely for the medical treatment of disease. GnRH analogue is used longterm with HRT and 3 yearly Dexa scans.

I found this trip to be extremely interesting and educational and has altered my outlook and treatment approach to endometriosis. It was also novel to have exposure to a healthcare system I have not experienced before. It would appear that the Dutch system can afford a better standard of care to endometriosis patients, than the NHS is currently able to provide, predominantly in terms of waiting times.

Many thanks to the BSGE for the opportunity.