EDITORIAL
https://doi.org/10.1590/1806-9282.67.01.001

Interpretations on a rare localization of endometriosis: *labium minus*

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Even though endometriosis, a growth of the ectopic endometrial tissue out of the uterine cavity that responds to hormonal stimulation, is a benign condition, its lesions can progress severely. This transformation seldom transpires for cutaneous endometriosis with a malignant degeneration, accounting for 0.3 to 1% for the surgical scar endometrioses. In the upfront surgery setting, a wide surgical excision with or without reconstruction has been recommended for the surgical therapy. It is the gold standard treatment of choice for endometriosis with a safety margin. To this end, some authors recommended a wide excision with at least 1 cm margins for cesarean section and scar endometriomas in order to preclude the recurrence and to avoid its possible transformation[1]. The interval of time from the onset of benign endometriosis to the development of malignancy has been described as a broad variation, ranging from 3 to 39 years with a mean of 17 years, in cesarean section scar endometriosis[2].

Lorenz et al.[3] recommended the surgical resection with 5 mm margins, which is a 'wide and complete' excision of the endometrial tissue, as a standard approach for the surgical treatment of malignant endometriosis in order to avoid recurrence. We also had performed the complete surgical resections with clear margins for our case series of incisional cesarean section endometriosis[4]. Atilgan et al.[5] proposed that a surgeon should avoid unnecessary labia minora dissection for the surgical approach of labium minus endometriosis, due to its specialized and sexually responsive structure with highly vascular folds of the tissue and an abundance of the neural elements. They have also mentioned the preoperative sensory mapping of the labium and clitoral hood in order to refrain from the painful injury, particularly in the regions important in arousal pathways. Herein, they might be reasonable and justifiable for their choice and apprehensions regarding in order not to suggest a wide surgical resection for this kind of endometriosis due to its organ-specific different features.

As a consequence, wide and complete resection with a safety margin, such as the abdominal wall musculature involvement necessitating *en bloc* resection of the myofascial elements, *per se*, is noteworthy, essential, and recommended because it offers the best choice in the management of this disease[4,6]. Of note, we recommend complete surgical resection with a safety margin in order to not be faced with an undesirable recurrence nor a potential malignant transformation in regard to its primary focus. This issue merits further investigation. We thank Atilgan et al.[5] for their remarkable report.

AUTHORS' CONTRIBUTIONS

IS: Conceptualization, Supervision, Writing – Original Draft, Writing – Review & Editing. **DS:** Conceptualization, Supervision, Writing – Original Draft, Writing – Review & Editing. **JMSJ:** Conceptualization, Writing – Original Draft, Writing – Review & Editing.

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Conflicts of interest: the authors declare there is no conflicts of interest. Funding: none.
Received on July 06, 2020. Accepted on October 27, 2020.

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