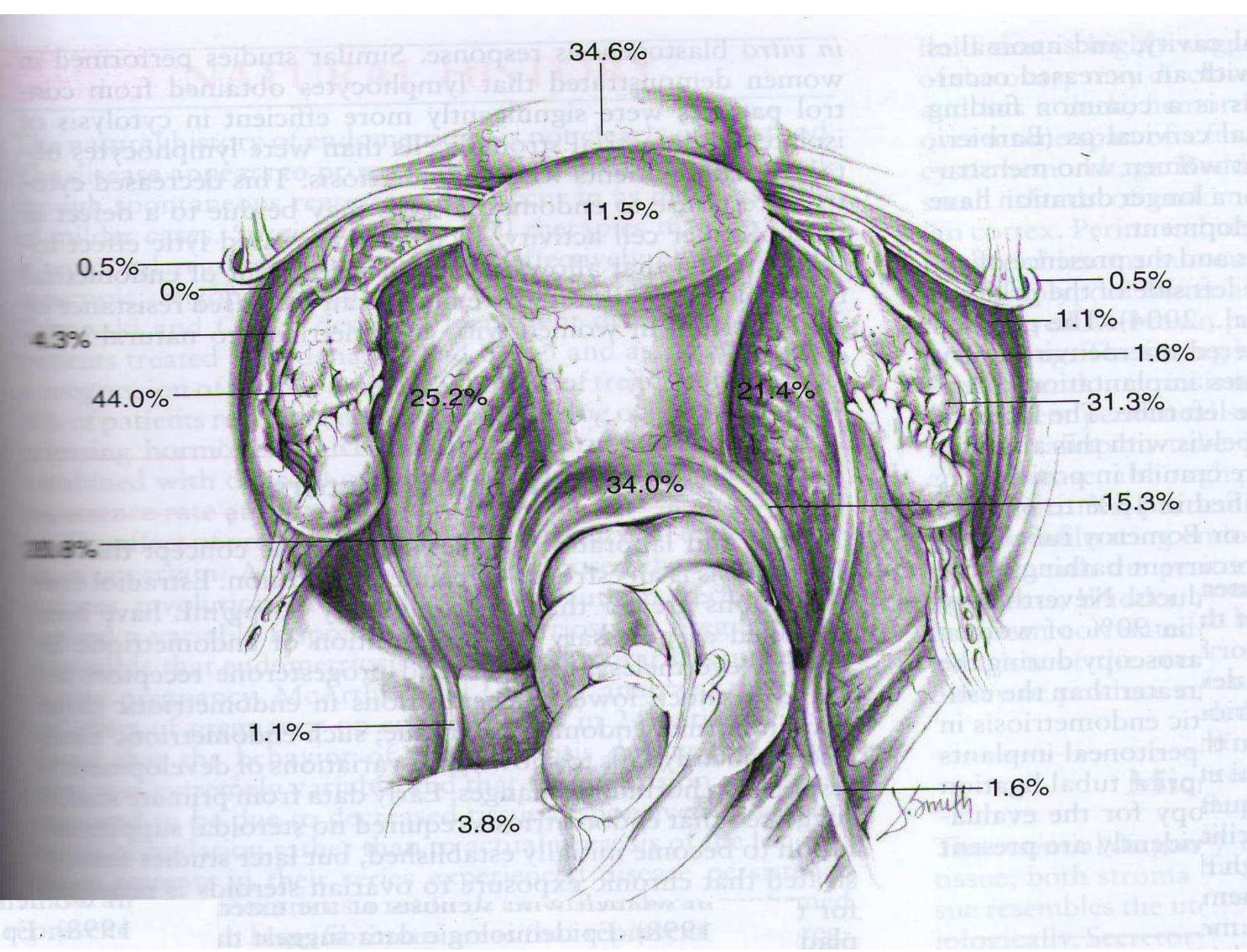
BOWELL ENDOMETRIOSIS

DR.SAMAN MOHAMMADIPOUR
COLORECTAL SURGEON


34.6%
11.5%
0.5%
0%
4.3%
44.0%
25.2%
21.4%
0.5%
1.1%
1.6%
31.3%
34.0%
15.3%
1.1%
3.8%
1.6%

- Endometriosis affects up to 10% of all reproductive-aged women, and affect
- The bowel is the most common site of extra-genital endometriosis and is most frequently seen along the rectum, rectovaginal septum, and sigmoid colon.
- Surgical management is recommended for symptomatic patients with bowel endometriosis who have failed medical therapy, or in whom medical therapy is not indicated

SITES OF ENDOMETRIOSIS

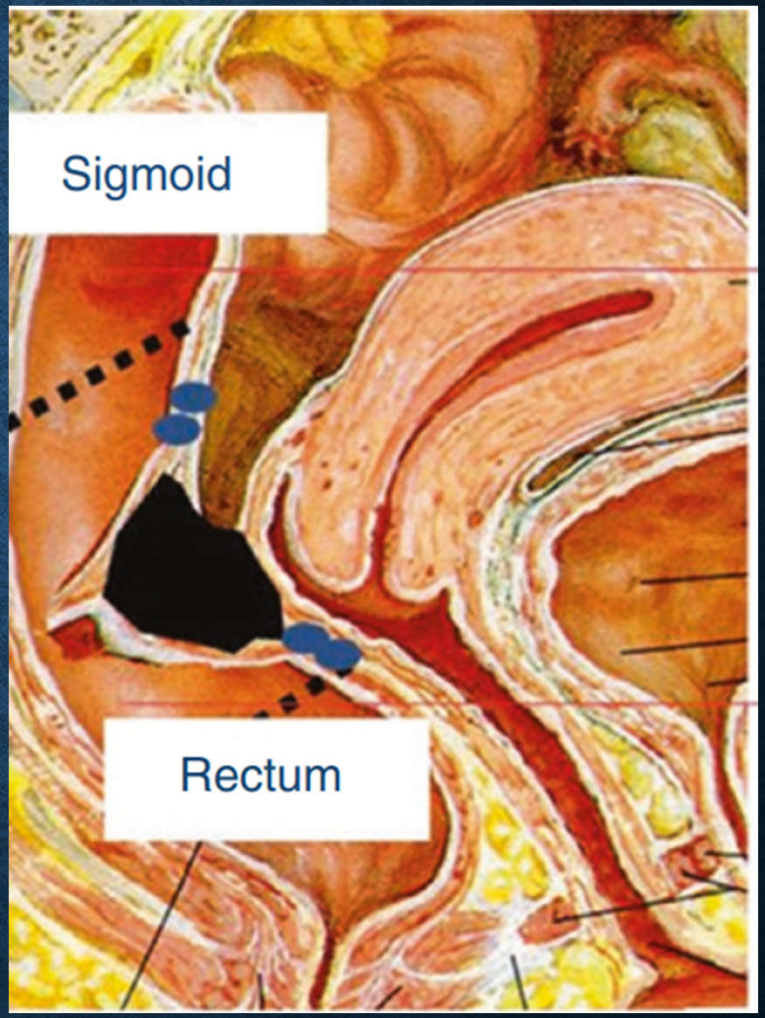
- ***Pelvic***
  - Ovary
  - Cul de sac
  - Uterosacrals
  - Posterior surface of uterus
  - Posterior broad ligament
  - Rectovaginal septum
  - Tubes and round ligaments
- ***Extrapelvic sites***
  - Intestines (rectosigmoid,
  - Lungs & thorax
  - Urinary tract
- ***Less common sites***
  - Cervix
  - Hernial sacs
  - Umblicus
  - Laparotomy/episiotomy sites
  - Tubal stumps after sterilization
- ***Rarest***
  - Extremities

Bowel involvement

affecting 3.8–37%

rectum and rectosigmoid 65%
Sigmoid colon 17%
appendix 6% - 20%
cecum and ileocecal
junction 4% (only)

8% of associated ileocecal endometriosis



ENDOMETRIOTIC LESIONS
VARIABLE APPEARANCE

Peritoneum

Typical

Superficial

- Early red lesions
- Powder burn or gunshot
- Black, dark brown or bluish puckered lesions
- White plaques
- Adhesions –flimsy,vascular,dense

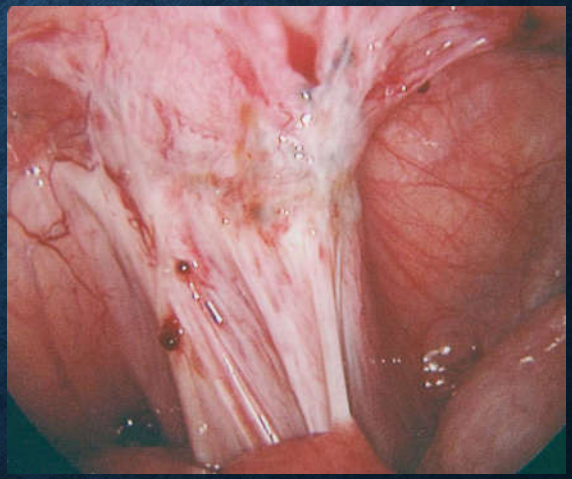
(DIE) Deeply Infiltrating Endometriosis , >5mm depth

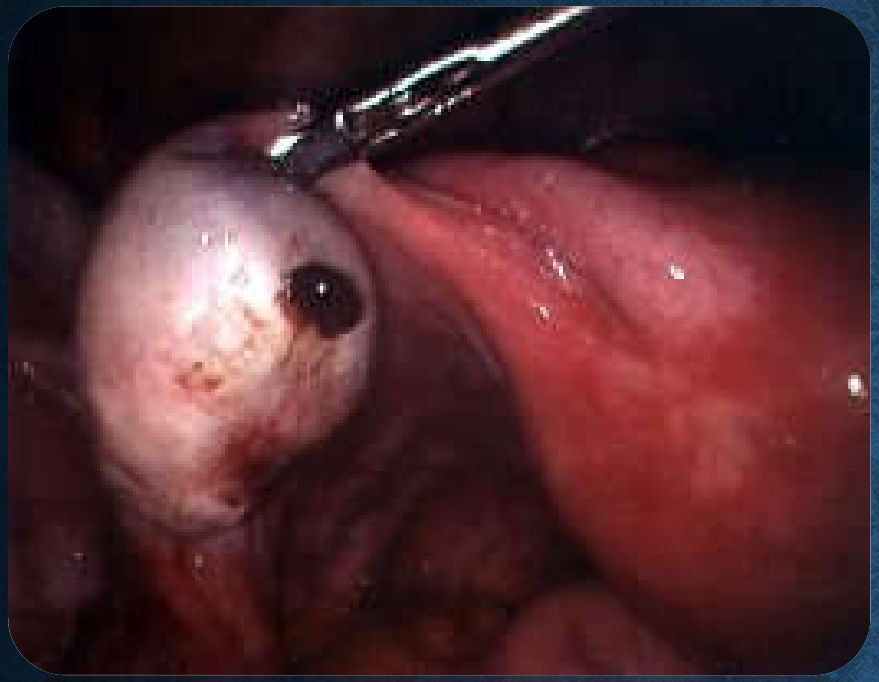
Atypical or subtle lesions

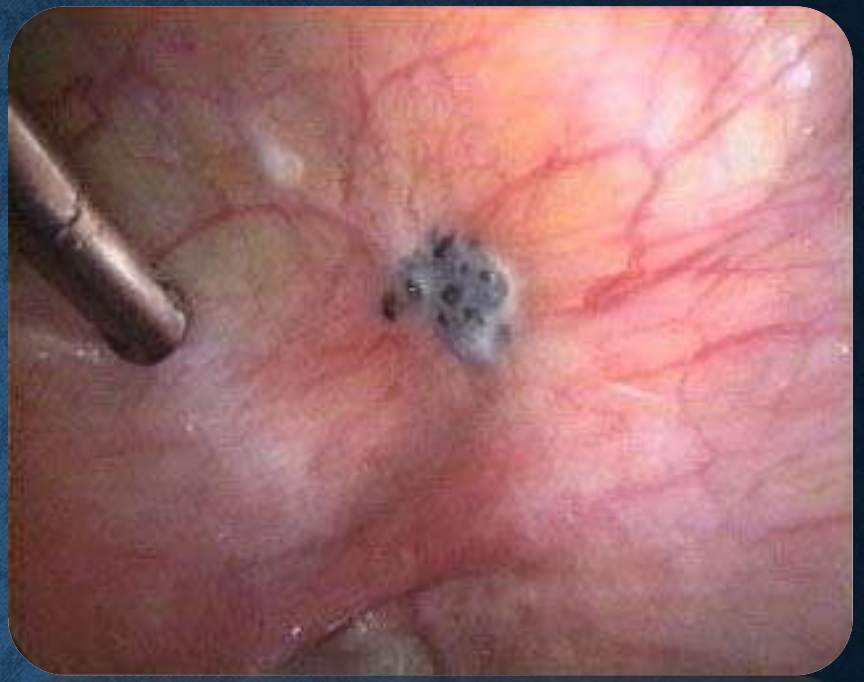
- Serous / clear vesicle
- Yellowish discoloration

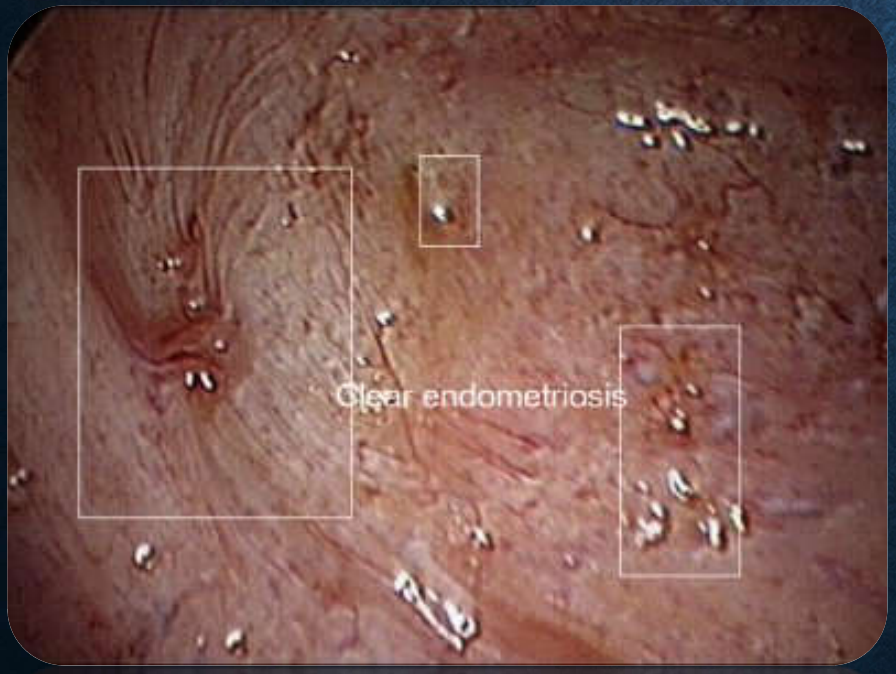
Ovaries

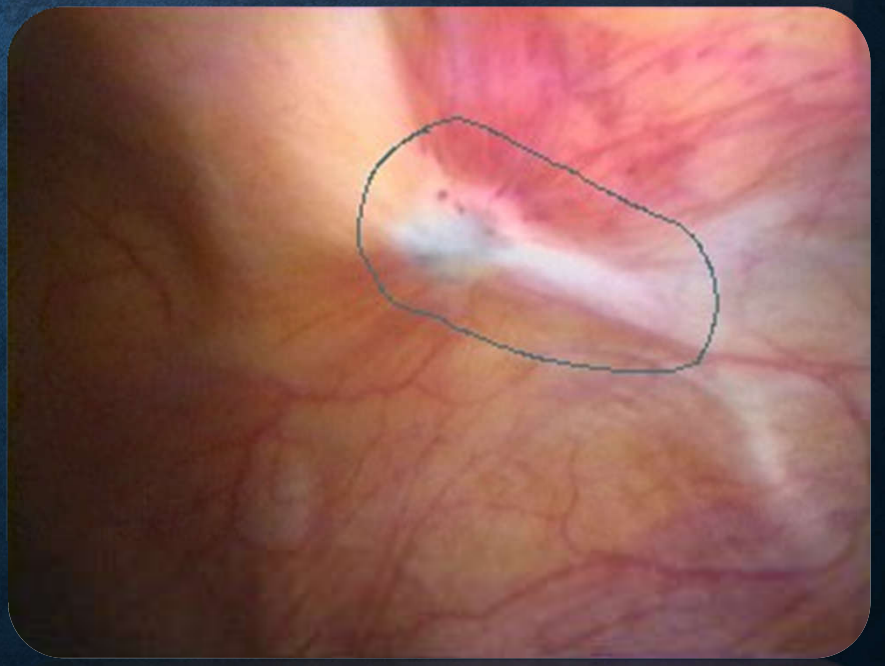
- Superficial
- Subovarian adhesions
- Endometriomas

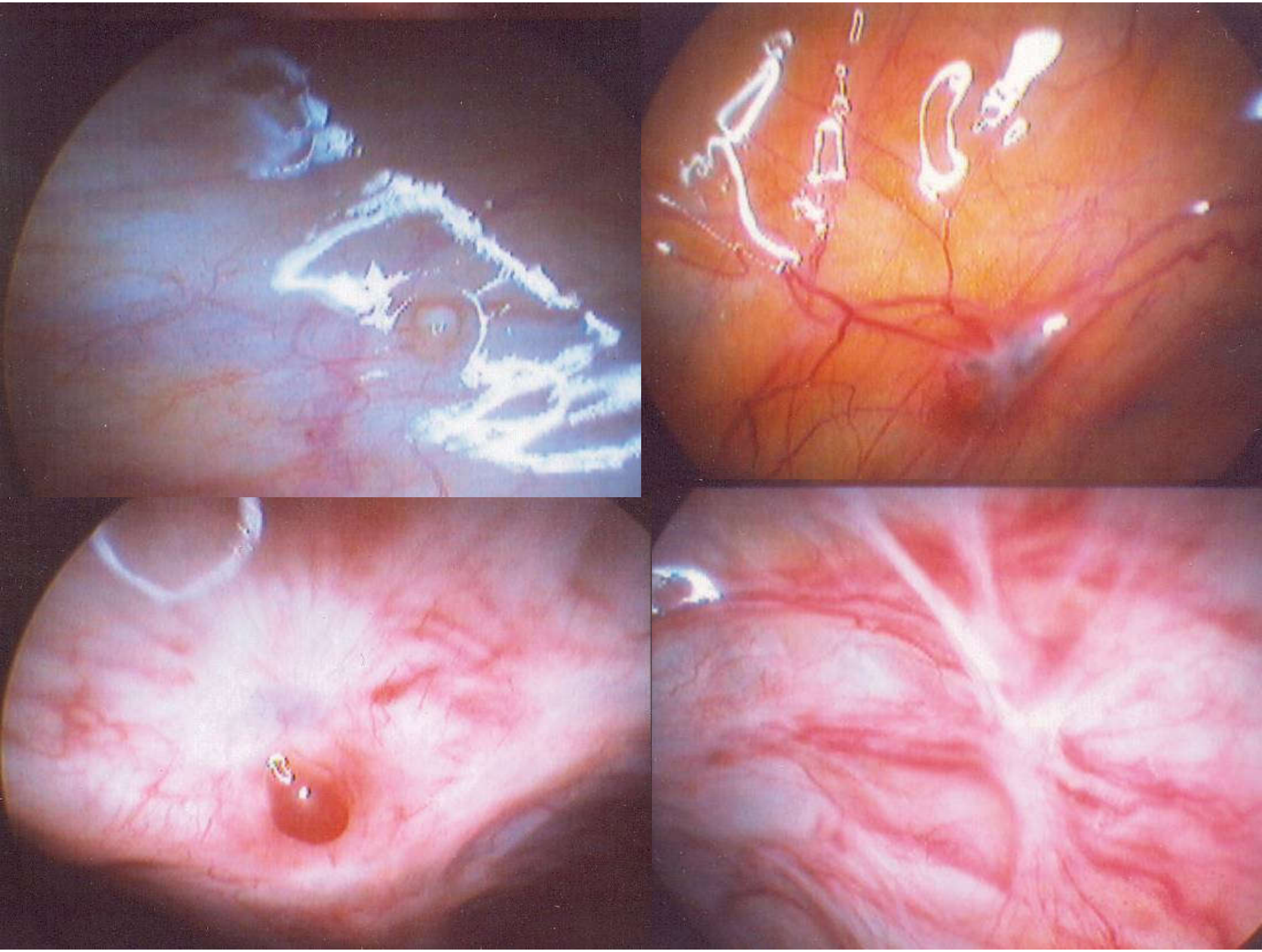







Clear endometriosis





CLINICAL PRESENTATION

Severe dysmenorrhoea

Deep dyspareunia

Chronic pelvic pain

Ovulation pain

Perimenstural pain/bleed

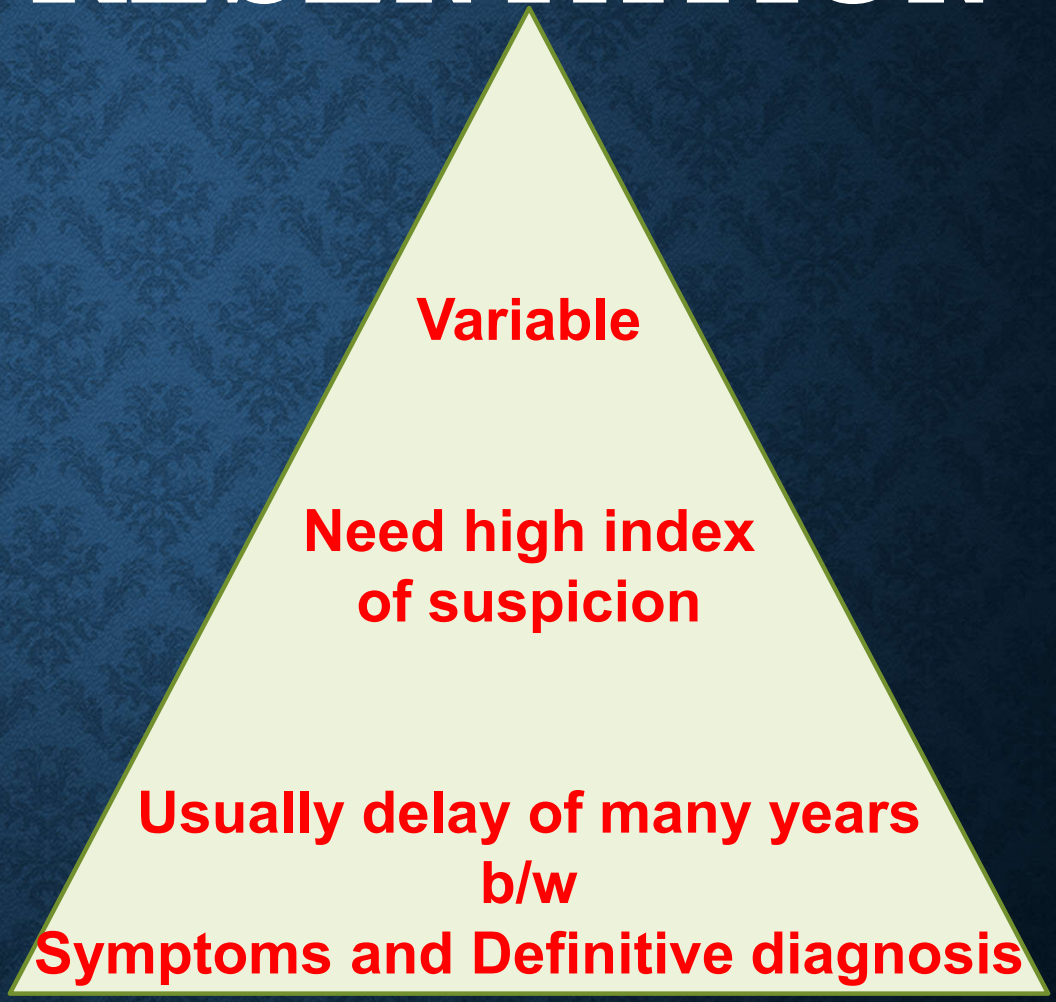
Infertility

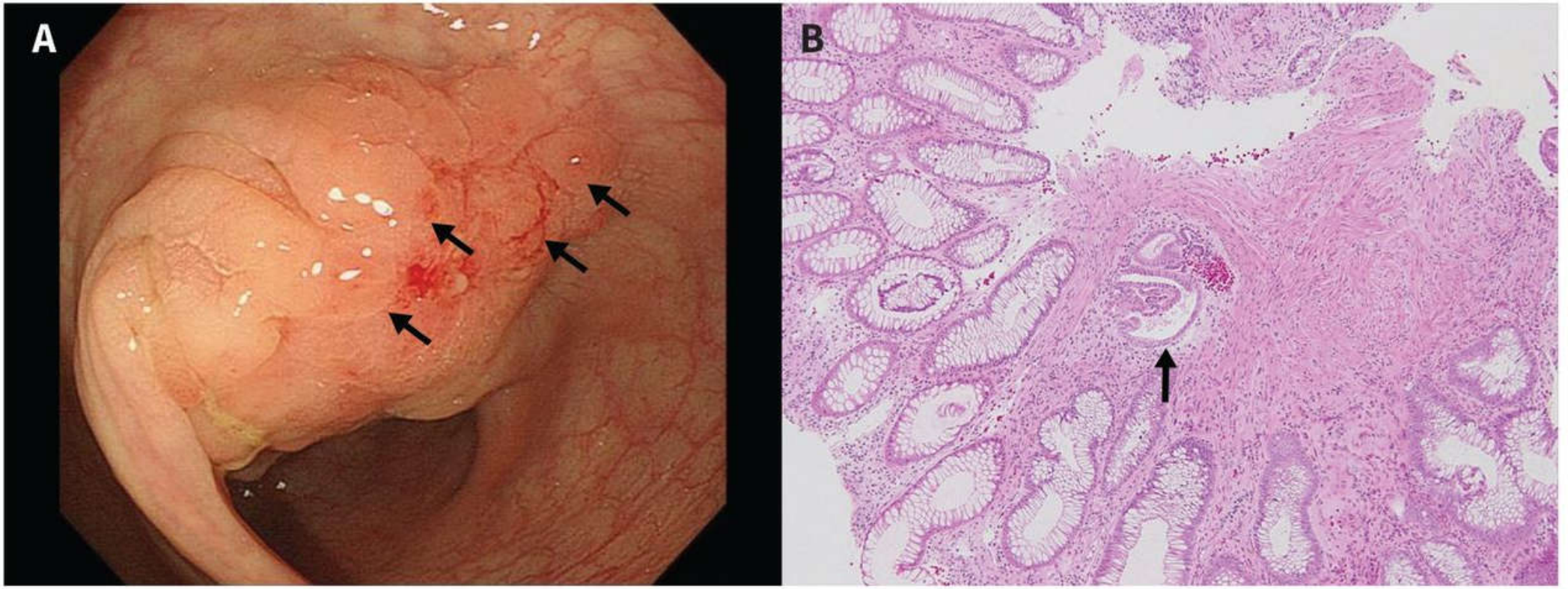
Chronic fatigue

Pain during defecation

Constipation

Rectorrhagia

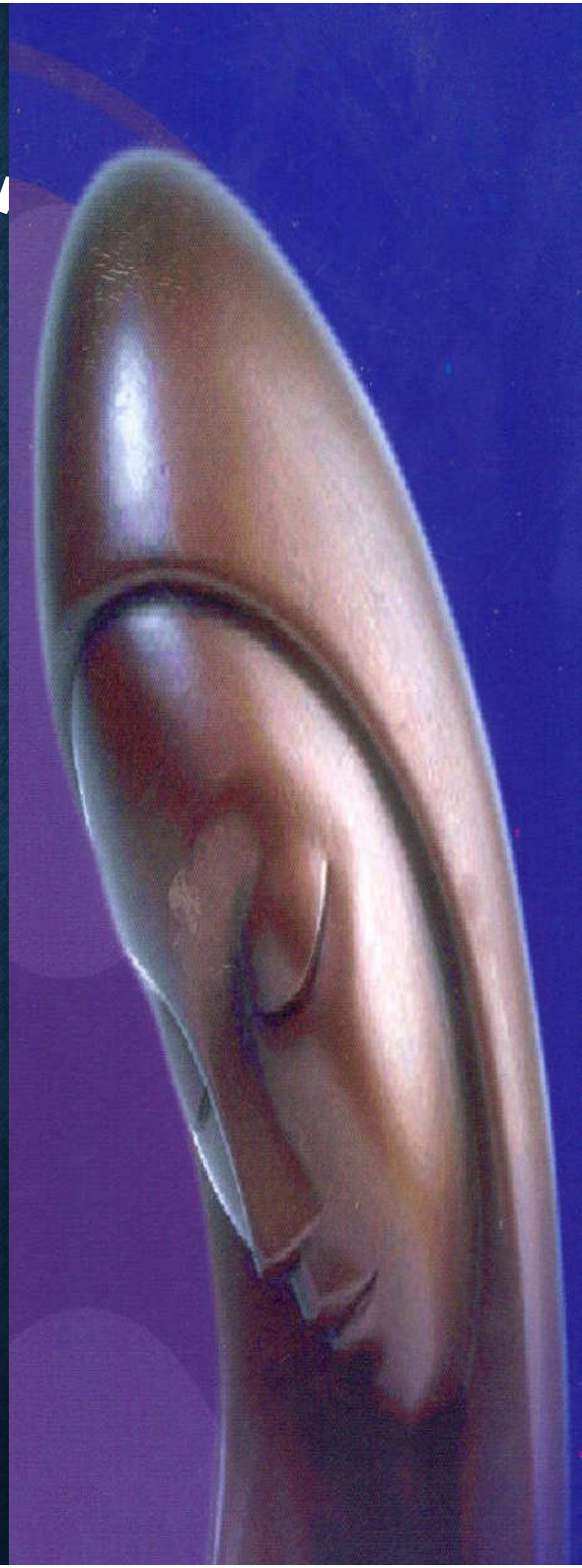



A
B

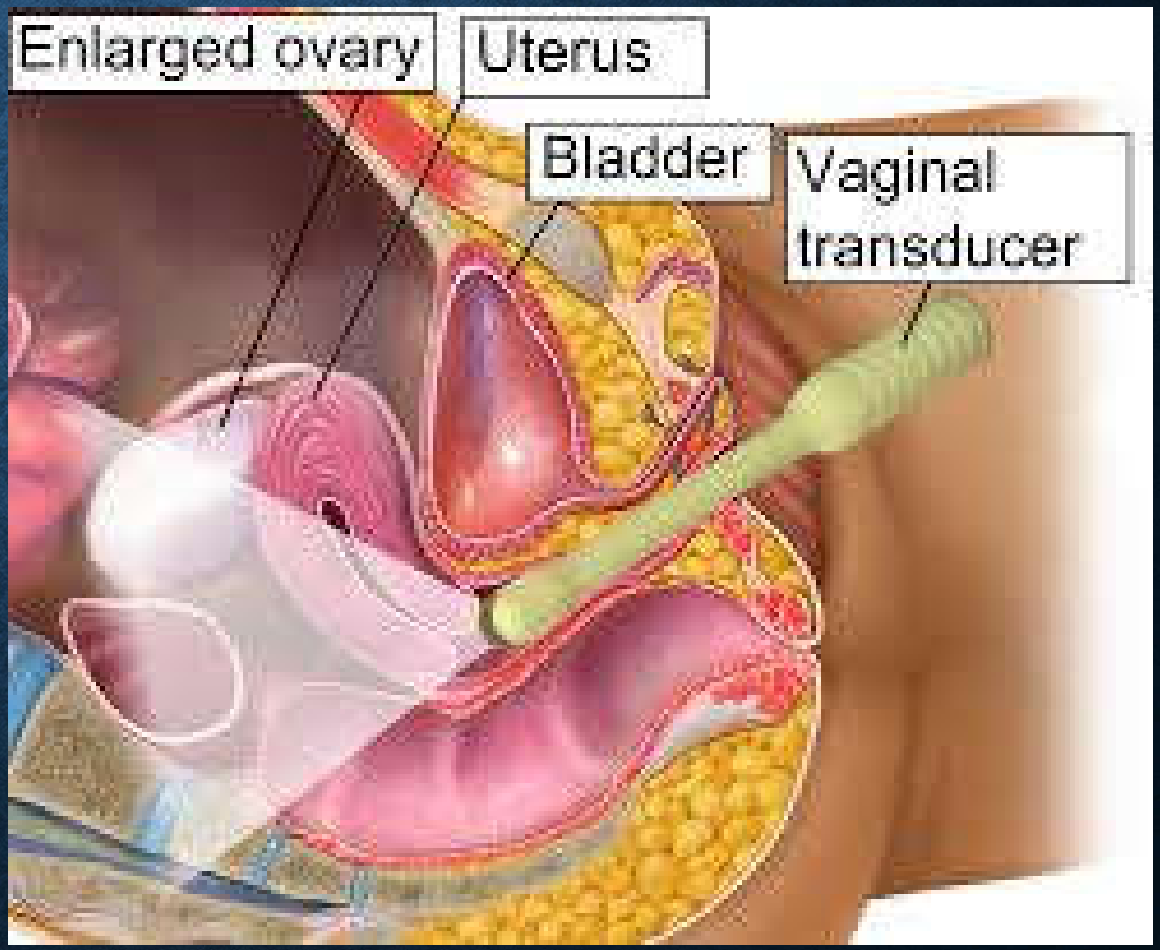
TREATMENT OP

- **Medical Therapy**
  - NSAIDs and Cox2 inhibitors
  - COCs
  - Progestogens
  - Anti progestins
  - GnRH agonists and antagonists
  - Aromatase inhibitors
  - Selective Estrogen Receptor Modulators
  - Selective Progesteron Receptor Modulators

- **Surgical Treatment**
  - Conservative Surgery
  - Definitive Surgery



Transvaginal ultrasound (TVUS)
TRANS RECTAL
PHYSICAL EXAMINATION



- mimic that of irritable bowel syndrome
- inflammatory or ischemic colitis,
- radiation colitis
- Diverticulitis
- malignancy,
- pelvic inflammatory disease

INDICATION

- Pain
- Infertility
- Bleeding
- Obstruction or constipation
- cancer

LAPAROSCOPY – GOLD STANDARD

- Diagnose the **extent** and **severity** of disease.
- **Should not be performed within 3 months** of hormonal therapy to avoid under diagnosis.
- **Methodical approach required**. Thoroughly inspect the lateral sidewalls, all ovarian surfaces, both sides of broad ligament, bladder, bowel serosa and inferior aspects of the cul de sac.
- **Uterine manipulation** helps in visualizing POD and recto vaginal septum
- **Photography** and video recording of the findings should be done ideally.

SURGICAL MANAGEMENT :

LAPAROSCOPIC trained gynecologic surgeon
gastrointestinal surgeon familiar with endometriosis

- Extensive dissection not advisable

SURGERY FOR PAIN RELIEF

- Drug therapy may relieve inflammation and reduce pain in early superficial disease but corrective surgery +/- drug therapy is preferable (Padwick 1999)
- Rectovaginal, rectal and uterosacral lesions always need surgery
- Endometriomas always need surgery
- Abnormal Anatomy and adhesions always need surgery

Deep Infiltrating Endometriosis

Classification	*Operative procedure*
A Anterior DIE	
A1: Bladder	***Laparoscopic partial cystectomy***
P: Posterior DIE	
P1: Uterosacral ligament	***Laparoscopic resection of USL***
P2: Vaginal	***Laparoscopically assisted vaginal resection of DIE infiltrating the posterior fornix***
P3: Intestinal	
P3a: Solely intestinal location	
- without vaginal infiltration (V-)	***Intestinal resection by laparoscopy or by laparotomy***
- with vaginal infiltration (V+)	***Laparoscopically assisted vaginal intestinal resection or exeresis by laparotomy.***
P3b: Multiple intestinal location	***Intestinal resection by laparotomy***

RECURRENT ENDOMETRIOSIS

- Spontaneous resolution occurs in about 20% of endometriosis stage I-II.
- **Residual disease-** persistence of symptoms or reappearance of symptoms within 3 months .
- **Recurrence** usually appears after 3 months .
- Incidence-6-30% in various studies.
- Depends on- age, stage of disease, prior treatment, completeness of surgery, extent of peritoneal disease.
- Usually presents as chronic pelvic pain , dysmenorrhea

RECURRENT ENDOMETRIOSIS

- Diagnosis- rising CA-125,TVS, MRI, laparoscopy.

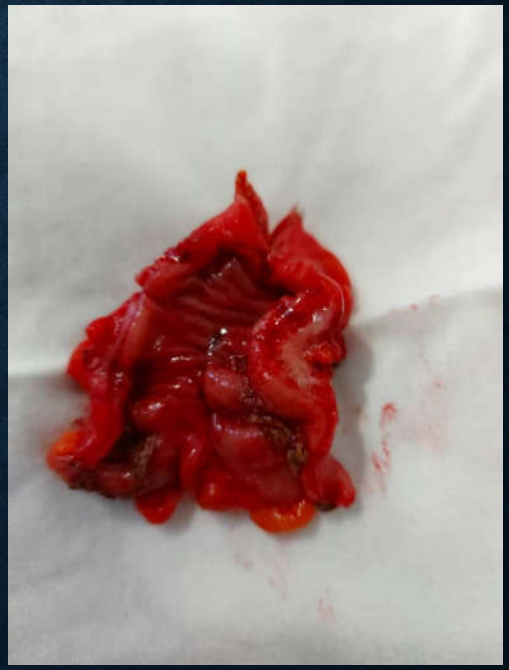
Treatment-

- Pain killers
- Hormones- progesterones, OCPs, GnRH analogues
- **Conservative surgery-**
  - Indicated if medical therapy fails or contraindicated or intolerable side effects.
  - Cystectomy/ adhesiolysis may be an option after IVF fails..
- Postoperative hormone therapy delays recurrence but does not reduce the recurrence.
- **LNG IUCD-** reduces recurrences post surgery & role is being studied in recurrent disease.
- **Hysterectomy with bilateral salphigo oophorectomy**

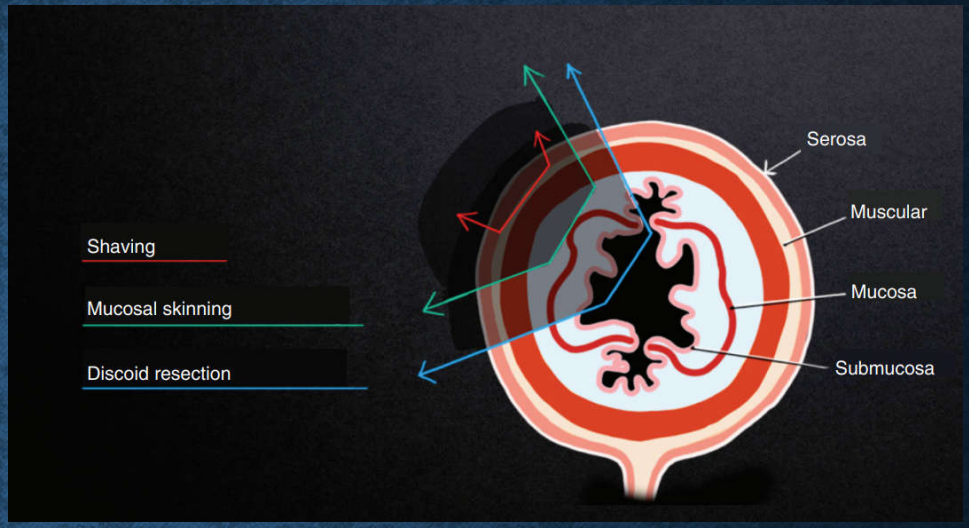
- Acute obstruction due to bowel endometriosis is rare and should generally be managed with segmental resection.

- Bowel resection has been performed to treat bowel endometriosis since the early 1900's.17 Eve

- conservative approaches including
  1 shaving excision
  2 disc resection
  3 bowel resection

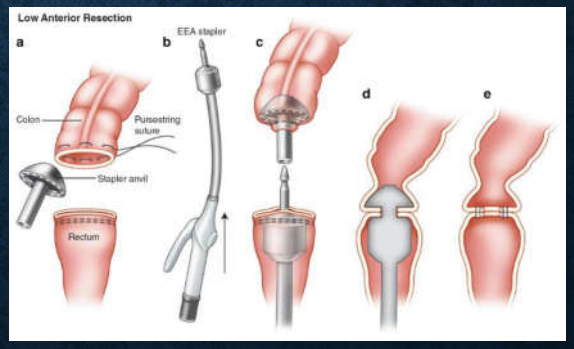


Shaving resection
Disc resection

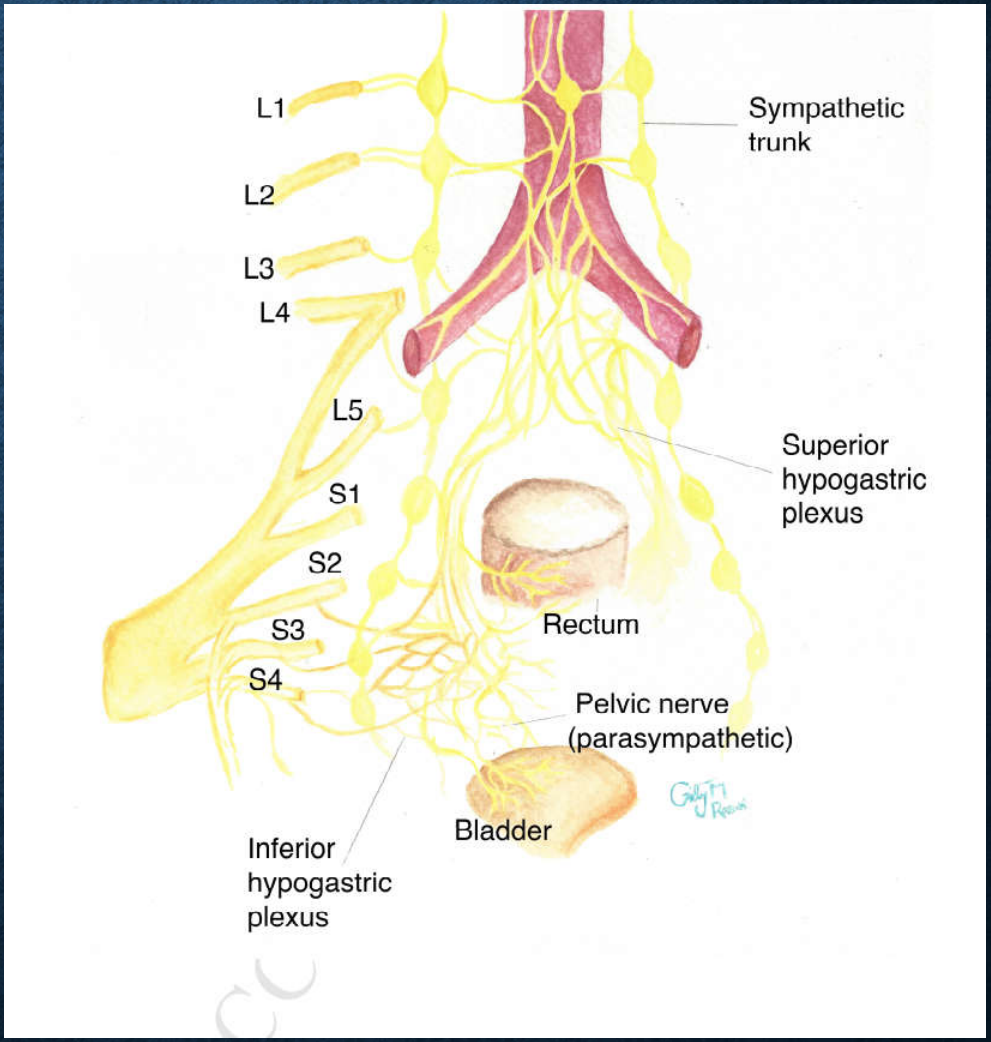


Segmental

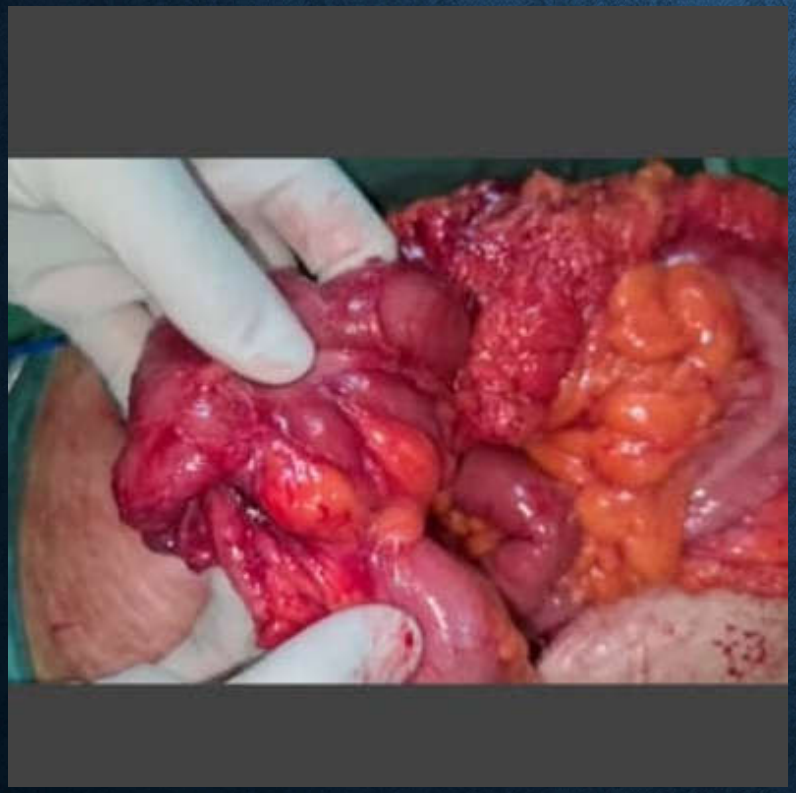
- multifocal,
- greater than 3cm,
- involve more than 2/3rd of the bowel lumen

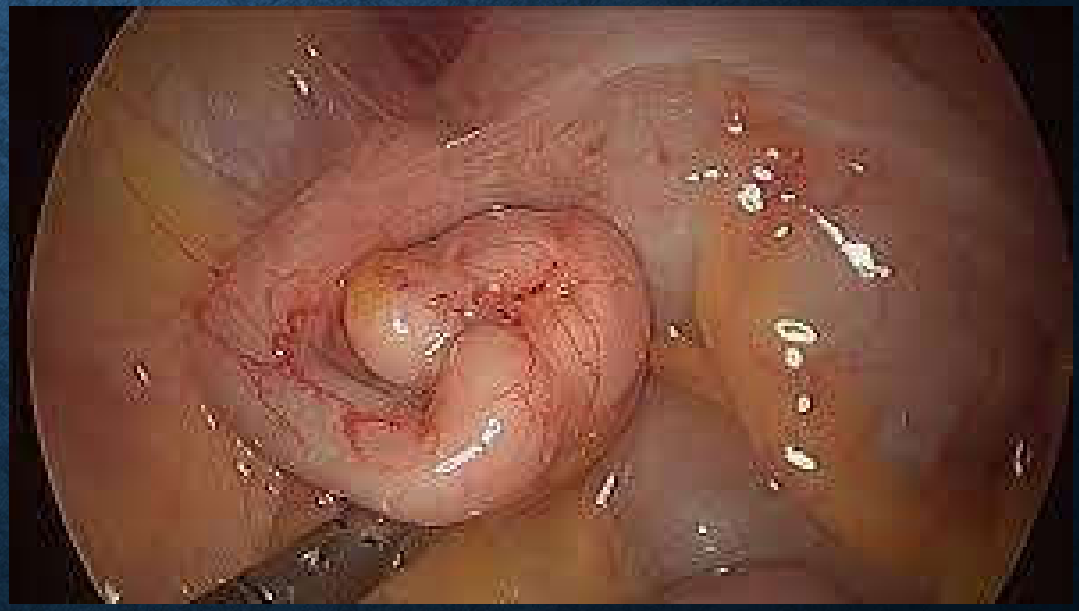


splanchnic nerves



- APPENDECTOMY RECOMMENDED IN MOST .
- MOSTLY MICROSCOPIC INVOLVEMENT





- CONSTIPATION
- Ostomy
- Laparoscopic v/r open
- Complication