CHRONIC ABDOMINAL PAIN Endometriosis

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Endometriosis is a common inflammatory condition and is diagnosed by the presence of endometrium-like tissue in extrauterine sites. The most commonly a ff ected sites are the pelvic organs and peritoneum, although distant sites such as the lungs are occasionally a ff ected (resulting in symptoms such as recurrent haemoptysis at the time of menstruation or recurrent pneumothoraces) (Figure 87.11). The exact pathognomonic mechanism remains elusive, but it is widely believed that most endometriotic lesions develop from retrograde menstruation. It is estimated to a ff ect 5–10% of women, mainly of reproductive age, with the incidence reported to be higher in certain subgroups, e.g. women with a history of infertility . Endometriosis may be associated with a number of symptoms, but the predictive value of any one symptom or set of symptoms remains uncertain as each can have other causes (e.g. irritable bowel syndrome or interstitial cystitis), with a significant proportion of a ff ected women remaining asymptomatic. The most common symptom is pain. Other symptoms include: cyclical and non-cyclical pain; dysmenorrhoea (pain related to menstruation); deep dyspareunia (pain during intercourse); dyschezia (pain on opening the bowels); and dysuria. Many women also su ff er from fatigue, haematuria, chronic pelvic pain, infertility and rectal bleeding (haematochezia). The extent of the disease varies from a few small peritoneal lesions on otherwise normal pelvic organs to deep endometri - osis and large ovarian endometriotic cysts (endometriomas). tion of endometriomas has been synonymous The identifica with deep disease. There can be extensive fibrosis in structures), and adhesion such as the uterosacral ligaments (Figure 87.12 formation causing marked distortion of the pelvic anatomy (Figure 87.13). Disease severity can be assessed by describing the operative findings, or quantitatively using various classifica - tion systems, but there is little correlation between such systems and the type or severity of symptoms experienced. Endometriosis typically appears as superficial ‘powder burn’ or ‘gunshot’ lesions on the ovaries, serosal surfaces and luish puckered lesions, peritoneum – black, dark brown or b nodules or small cysts containing old haemorrhage surrounded b y a variable extent of fibrosis. Atypical or ‘subtle’ lesions are also common, including red implants (petechial, vesicular, polypoid, haemorrhagic, red flame-like) and serous or clear vesicles. Other appearances include white plaques or scarring and yellow-brown discoloration of the peritoneum. Ovarian

Figure 87.11 Endometriosis seen on the peritoneal surface of the diaphragm. Figure 87.12 Endometriosis seen on the uterosacral ligament. Figure 87.13 Bilateral ovarian endometriosis with pelvic adhesions.

been reported in 17–44% of women with endometriosis. They are distinguishable from simple haemorrhagic ovarian cysts because typically they are densely adherent to the peritoneum of the ovarian fossa, fallopian tube and posterolateral aspect of the uterus. The surrounding fibrosis may

also involve the bowel. Deep endometriosis represents another disease type. This is defined by the presence of endometrium-like tissue 5 /uni00A0 mm beneath the peritoneum, with growth seen in the utero sacral ligaments, vagina, bowel, bladder or ureters; when such lesions grow into the vagina they may be visible on speculum e xamination as ‘blue-domed’ cystic lesions in the posterior for nix. Lesions infiltrating the bowel may mimic cancer in their presentation. The gold standard for making a diagnosis of endometriosis is through laparoscopy with histological confirmation; non-invasive diagnostic tools, such as ultrasound scanning (transvaginal and transrectal), can r eliably detect only severe forms of the disease, i.e. endometriomas or deep endometriosis of the pelvis. MRI can detect haemosiderin deposits in abdominal organs to suggest deep endometriosis. A sigmoidoscopy may also provide additional information on the level of disease involvement in cases of deep endometriosis involving the bowel. The distance between the inferior border of a bowel lesion and anal verge can impact on the proposed surgical intervention and degree of associated risks. Excision of low rectal lesions (5–8 /uni00A0 cm from the anal verge) has been associated with a higher risk of anastomotic leaks and transient neurogenic bladder dysfunction. Finding pelvic tenderness, a fixed retroverted uterus, ten der uterosacral ligaments or enlarged ovaries on examination is suggestive of endometriosis. The diagnosis is more certain if deeply infiltrating nodules are found on the uterosacral lig aments or in the pouch of Doug las and/or visible lesions are seen in the vagina or on the cervix. A digital rectal examination should also be conducted to assess for disease involving the rectosigmoid ar ea, as well as lateral and dorsal extension of the disease suggesting involvement of the hypogastric vessels and/ or nerves. The findings may , however, be normal. The treatment options are limited because the cause is uncertain. These include: conservative management; medical management (simple analgesia or hormonal drugs to suppress ovarian function [progestogens, the levonorgestr intrauterine system, gonadotropin-releasing hormone agonists in conjunction with add-back hormone replacement therapy]); and surgical management (ablation or excision of endometriotic lesions). Women may require multiple admissions for surgery and/or prolonged treatment with costly drugs that can have problematic side e ff ects. Surgical planning needs to be aware of the proximity of the disease to the ureter and the risk of ureteric stricture leading to hydronephrosis and renal dysfunction. The surgical risks include those for any laparoscopic procedure, including damage to the bowel, bladder and ureters (2 in 1000 women); the risks are increased if deep endometriosis is present secondary to anatomical displacement of structures such as the ureter, as well as in repeat surgical cases where repeated Thomas Hodgkin , 1798–1866, curator of the museum and demonstrator of morbid anatomy , Guy’s Hospital, London, UK. repeated bowel shavings can reduce the integrity of the bowel wall increasing the risk of fistula formation. Bow el resection or injury increases the risk of faecal peritonitis. Bowel integrity can be assessed by stretching the bowel over a rectal manipulator to identify thinned areas, filling the pelvis with fluid and then pushing air into the rectal lumen whilst looking for bubbles or injecting methylene blue in the rectum and looking for leaks. - Consideration should be given to ureteral stent insertion in cases of bladder endometriosis close to the trigonum which can usually be removed after approximately 6 /uni00A0 weeks. A catheter - will be needed for 8–10 days postoperatively , followed by a cystogram checking for suture integrity prior to removal. Rarely , infection in an endometrioma will result in the formation of a tubo-ovarian abscess. For a woman who has completed her family , hysterec - tomy plus bilateral salpingo-oophorectomy with total excision of endometriotic disease o ff ers a good chance of cure. Sur - gical treatment, however, in a woman who wishes to retain her fertility needs to be as conserva tive as possible, ensuring that ovarian function is preserved. The aim is to remove the endometriotic tissue while restoring the pelvic anatom y . The preferential method to retain ovarian function is ovarian drain - age with directed spot ablation (electrocoagulation, thermal coagulation,

laser or plasma energy) over cystectomy . Coun - selling needs to include the increased risk of recurrence with cyst drainage versus a cystectomy , as w ell as consideration for preoperative oocyte cryopreservation, especially in the pres - ence of bilateral ovarian disease. Furthermore, bowel shaving - versus bowel resection is associated with the risk of incomplete disease resection. Several classification and staging systems hav e been pro - - posed for the diagnosis, management and prognosis of endo - metriosis. Currently , there is a need for an internationally accepted system. The endometriosis fertility index has demon - strated good predictive value in the determination of fecundity after endometriosis surgery . Endometriosis is also associated with an increased risk of o varian cancer (endometrioid and clear-cell types) and non-Hodgkin’s lymphoma, adding to the burden of the disease. el

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