

SURGICAL MANAGEMENT OF ENDOMETRIOSIS

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SUMMARY

The two laparoscopic techniques (destruction and resection) for the treatment of superficial endometriotic lesions are effective (LE2). For endometriomas of at least 3 cm in diameter, percelioscopic intraperitoneal cystectomy is superior to drainage followed by destruction of the cyst wall (LE1). Surgery to remove deep endometriosis lesions of the rectovaginal septum with or without rectal involvement allows a significant improvement in endometriosis pain (LE4). Percelioscopic partial cystectomy is technically easier for dome injury than for basal injury (LE4). Simple conservative hysterectomy

exposes a high risk of pain failure (LE4). Recurrences may occur with hormone replacement therapy despite castration (LE2). The highest rates are observed in the management of deep endometriosis (LE2). These specific serious complications are part of the information to be provided to patients. It is desirable to explain that the improvement in pain is observed in nearly 80% of cases, whether complete or partial (professional consensus).

INTRODUCTION

the surgical management of endometriosis is one of the most delicate situations in gynecology because of the difficulty in establishing the correct indications for operation, the requirement of sometimes difficult surgery, the risk of complications inherent in this surgery and the uncertainty of its functional results in terms of pain or fertility.

Choice of the first route**Place of laparoscopy in the treatment of ovarian and superficial peritoneal endometriosis**

Laparoscopy has become in recent years the gold standard for the treatment of ovarian endometriosis cysts and therefore superficial peritoneal lesions usually associated with these

endometriomas. Laparoscopy is the standard treatment for ovarian endometriomas and superficial peritoneal endometriosis (NP2).

Place of laparoscopy in the treatment of deep endometriosis

The feasibility of laparoscopic surgery for the treatment of deep endometriosis has been demonstrated by several studies, whether it concerns rectovaginal endometriosis of the uterosacral ligaments, digestive or vesicoureteric lesions. The feasibility of laparoscopy has been demonstrated, in expert hands, for all forms of deep endometriosis (LE3). If complete lesion removal is the objective, complete surgery by laparotomy is always preferable to incomplete surgery. by laparoscopy (professional consensus) The exclusive vaginal route has no place in the treatment of deep endometriosis (professional consensus).

Surgery for superficial peritoneal endometriosis

Superficial peritoneal implants can be removed either by a destruction technique or by an excision technique. These implants are usually associated with more or less extensive pelvic adhesions, the role of which in pain symptoms is currently impossible to apprehend on an individual scale. The release of these adhesions can be done by laparoscopy, either by laser vaporization, or by monopolar or bipolar coagulation then section.

What is the best surgical technique for treating superficial peritoneal endometriosis ?

The two laparoscopic techniques of destruction and resection of superficial endometriotic lesions are effective in the treatment of endometriosis (LE2). No therapeutic trial has compared these different techniques.

Surgical treatment of endometriomas

The rationale for treating endometriomas is linked to the pain associated with it, whether it is dysmenorrhea, dyspareunia or non-cyclical pelvic pain, to the infertility with which they are associated and, more exceptionally, to the risks of complications such as rupture or malignant transformation.

The puncture under ultrasound control

Ultrasound-guided puncture is not the first-line treatment even if this technique can be used in the context of ART (LE3).

Simple drainage by laparoscopy

Simple percelioscopic drainage is insufficient because it does not prevent recurrence (LE2)

Intraperitoneal cystectomy or drainage then destruction of the cystic wall

Percelioscopic intraperitoneal cystectomy (KIP) consists of cleaving the pseudoparoi from the rest of the ovarian parenchyma by divergent traction between two grasping forceps. The objective is to perform the complete excision of the wall while macroscopically preserving the ovarian parenchyma in its entirety.

Surgery for deep subperitoneal lesions**Deep endometriosis lesions with involvement of the rectovaginal septum without digestive involvement**

Removal of rectovaginal septum nodules involves removing a mass of endometriotic tissue that preferentially invades the thickness of the vaginal wall and occasionally the adjacent rectosigmoid wall.

Surgery to remove deep endometriosis lesions of the rectovaginal septum without rectal involvement improves endometriosis pain in 60 to 100% of patients (LE4).

The surgical technique for bladder endometriosis

Percelioscopic partial cystectomy is technically easier for dome injury than for basal injury (LE4).

Transurethral resection has no place in the surgical treatment of bladder endometriosis (LE4). Resection of the superficial myometrium adjacent to the nodule decreases the risk of recurrence of symptoms of bladder endometriosis (LE4).

Hysterectomy and adnexectomy

Simple conservative hysterectomy exposes a high risk of pain failure (LE4).

Ovarian conservation is associated with a significantly increased risk of recurrence (LE4).

But the place of surgical castration cannot be specified in the absence of data.

Recurrences may occur with hormone replacement therapy despite castration (LE2).

The major complications of endometriosis surgery

The major complications of surgery for endometriosis are ureteral, bladder, intestinal and vascular wounds. The presence of endometriotic implants on the bladder, ureter and intestine, the absence of a cleavage plane, anatomical distortion due to adhesions and fibrosis and reduced ureteral mobility, make these complications more frequent in interventions for endometriosis than in other gynecological procedures.

CONCLUSION

The two laparoscopic techniques (destruction and resection) for the treatment of superficial endometriotic lesions are effective (LE2). For endometriomas of at least 3 cm in diameter, percelioscopic intraperitoneal cystectomy is superior to drainage followed by destruction of the cyst wall (LE1). Surgery for resection of deep endometriosis lesions of the rectovaginal septum with or without rectal involvement allows a significant improvement in endometriosis pain (LE4).

Links of interest: the authors have no link of interest with this article.

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