

Minimal perisigmoidal adhesions in cases with normally appearing peritoneum as a sure sign of superficial peritoneal endometriosis

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Objective To test for the presence of perisigmoidal adhesions in cases with suspected endometriosis (EMS).

Methods A prospective cohort controlled study was performed. Seventy-four women with no clinical or ultrasonic evidence of ovarian cysts or EMS were included in the study. All cases were admitted to undergo laparoscopy for different indications. In all cases, thorough inspection of pelvic peritoneum was done. Then these patients were divided into two groups. Group A had no perisigmoidal adhesions (15 patients) and group B had mild filmy perisigmoidal adhesions. In both groups, documentations of visible endometriotic lesions, bipolar cauterization of selected parts of uterosacral ligaments, ovarian beds and sides of Douglas's pouch and histopathology assessment were done in all cases from suspicious, positive endocoagulation and perisigmoid adhesions.

Results Twenty-seven patients with visible EMS had perisigmoidal adhesions. Thirty-two patients with normal appearing peritoneum with perisigmoidal adhesions had positive electrocoagulation test in one or more pre-selected parts of the pelvic peritoneum. Fifteen patients with normally appearing peritoneum without perisigmoidal adhesions had negative electrocoagulation test (bipolar cauterization turned white).

Conclusion Presence of mild filmy perisigmoidal adhesions causing tenting of the sigmoid colon could be a strong evidence of the presence of at least minimal or subtle EMS and should warrant careful inspection of the peritoneum cavity before exclusion of EMS.

Key words: endometriosis (EMS); perisigmoidal adhesions; laparoscopy; diagnosis; signs

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Endometriosis (EMS), the presence of endometrial tissue growing outside of the uterus, has been estimated to affect 10%–15% of reproduction-age women^[1,2] and 70% of women with chronic pelvic pain^[3,4]. Symptoms related to EMS vary but most commonly include chronic pelvic pain and subfertility. The diagnosis of EMS is traditionally based on laparoscopic visualization, several visual parameters of EMS have been reported. In addition to the typical “powder-burn” bluish-black lesions, red, clear, and white lesions have been reported on the peritoneal and ovarian surfaces^[5-7]. The disease and its treatment recommendations are based on visual assessment of the lesions. Subsequent histological analysis after laparoscopic therapy seldom alters treatment plans^[8]. Ultrasound appears to be useful in confirming ovarian endometriomas but is not helpful in detecting small peritoneal lesions^[9-12]. To date, operative methods are the gold standard to diagnose EMS but may be no more reliable than diagnoses based on clinical findings^[13-15]. Prevalence of pelvic EMS estimated by visual confirmation ranges from 1%–7% in the general female population to 35%–70% in women with pelvic pain, infertility, or both^[13-15]. Pericolonic adhesions is commonly associated with EMS but was not studied before as a sign of EMS. The objective of this study was to test for the presence of perisigmoidal adhesions in cases with suspected EMS. The data and literature regarding this issue are sparse.

Materials & Methods

Study design

All cases were recruited from the Infertility and Gynecology Clinic in El-Shatby Maternity University Hospital, Alexandria University. This study was approved from local ethics committee. The patients were counseled by the surgeon about the research and the need for biopsy. Completely general and gynecological histories of the patients were taken. Informed consents were taken from all patients. Routine laboratory work was done including hemoglobin, liver enzymes, bleeding time, clotting time and prothrombin activity. Patients’ preparations were done according to the standard procedures.

Inclusion and exclusion criteria

Seventy-four women with no clinical or ultrasonic evidence of ovarian cysts or EMS were included in the study. All cases were admitted to undergo laparoscopy for different indications as infertility and pelvic pain excluding deep EMS by experienced laparoscopists.

Laparoscopy was performed by insufflating the abdomen with carbon dioxide through a Verres needle inserted at the umbilicus and then passing a 10-mm trocar into the distended abdominal cavity. When intraabdominal adhesions were expected, an open laparoscopy using a Hassan cannula was performed. In most cases, two other incisions were made, one in the left and the other in the right lower abdomen through which 5-mm trocars were passed under direct vision. Next, with the patient in Trendelenberg position, the peritoneal surfaces, reproductive organs, bowel, and appendix were systematically examined for ectopic endometrium

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