

# Bowel occult microscopic endometriosis in resection margins in deep colorectal endometriosis specimens has no impact on short-term postoperative outcomes

Horace Roman, M.D., Ph.D.,<sup>a,b</sup> Clotilde Hennetier, M.D.,<sup>a</sup> Basma Darwish, M.D.,<sup>a</sup> Alexandra Badescu, M.D.,<sup>a,c</sup> Marie Csanyi, M.D.,<sup>d</sup> Moutaz Aziz, M.D.,<sup>d</sup> Jean-Jacques Tuech, M.D., Ph.D.,<sup>e</sup> and Carole Abo, M.D.<sup>a</sup>

<sup>a</sup> Department of Gynecology and Obstetrics, Rouen University Hospital, Rouen, France; <sup>b</sup> Research Group 4308, Spermatogenesis and Gamete Quality, IHU Rouen Normandy, IFRMP23, Reproductive Biology Laboratory, Rouen University Hospital, Rouen, France; <sup>c</sup> University of Medicine and Pharmacy of Târgu Mureș, Târgu Mureș, Romania; <sup>d</sup> Department of Pathology and <sup>e</sup> Department of Surgery, Rouen University Hospital, Rouen, France

**Objective:** To evaluate the impact of bowel occult microscopic endometriosis (BOME) implants on postoperative outcomes in patients treated with colorectal resection for deep infiltrating digestive endometriosis.

**Design:** Prospective series of consecutive patients with deep colorectal endometriosis managed by colorectal resection in our department from June 2009 to November 2014 and enrolled in the CIRENDO database (NCT02294825).

**Setting:** University tertiary referral center.

**Patient(s):** 103 patients managed by colorectal resection for deep infiltrating endometriosis.

**Intervention(s):** Histologic examination of colorectal resection specimens.

**Main Outcome Measure(s):** Patient characteristics, preoperative and 1-year postoperative symptoms and intraoperative findings were compared between women with and without BOME on specimen resection margins.

**Result(s):** In 15 cases, BOME was found in one (nine cases) or both resection limits (six cases). No statistical significance was found between BOME and height of colorectal anastomosis, length of the resected bowel specimen or depth of rectal wall infiltration. One patient with BOME underwent a second colorectal resection 5 years later for rectal recurrence. Comparison between the rates of dyschezia, diarrhea, constipation, bloating and overall values of GIQLI and KESS scores 1 and 3 years postoperatively showed no statistical significance between women with and without BOME.

**Conclusion(s):** BOME was found in 14.6% of specimen resection margins. No impact on either pelvic or digestive symptoms was observed after 1-year follow-up postoperatively.

**Clinical Trial Registration Number:** NCT02294825. (Fertil Steril® 2015; ■:■-■. ©2015 by American Society for Reproductive Medicine.)

**Key Words:** Bowel occult microscopic endometriosis, colorectal resection, endometriosis, microscopic implants, recurrence, resection margins

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**D**eep endometriosis infiltrating the rectum is a severe disease that may be diagnosed in young women. It is usually responsible for digestive symptoms, which may be

associated with deep dyspareunia, infertility, and significant impairment of quality of life. Surgical management of colorectal endometriosis follows the principles of two main philosophies or

approaches: radical and conservative (1, 2).

The radical or oncologic-like approach is the systematic use of colorectal resection to attempt complete

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Reprint requests: Horace Roman, M.D., Ph.D., Department of Gynecology and Obstetrics, Rouen University Hospital-Charles Nicolle, 1 rue de Germont, 76031 Rouen, France (E-mail: [horace.roman@gmail.com](mailto:horace.roman@gmail.com)).

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removal of all macroscopic and microscopic implants present in the digestive tract. Historically, deep endometriosis was treated with conservative techniques (3, 4), but a progressive increase in the rate of bowel resections has been recorded. At present, management of the majority of colorectal endometriosis patients worldwide follows the radical philosophy (5).

The conservative or symptom-guided philosophy focuses on relieving symptoms rather than complete removal of microscopic digestive foci (2, 6). This approach relies on surgical techniques that allow selective retrieval of macroscopic colorectal deep endometriosis nodules (i.e., bowel shaving and disc excision), with preservation of the mesocolon and mesorectum. The conservative approach is supported by three major arguments: [1] evidence that colorectal resection may engender postoperative functional digestive symptoms for which management is challenging (7), [2] a higher risk of postoperative complications when the bowel is opened (8), and [3] the unlikelihood of achieving complete excision of endometriotic foci, as indicated by the existence of occult microscopic endometriosis (OME) (9). The concept of OME is based on detection of microscopic endometriosis implants in visually normal peritoneum, with an estimated prevalence of up to 15% in patients managed for endometriosis (9). The question remains as to whether residual microscopic implants are truly inactive, as has been proposed by both older and more recent reports (10, 11), or whether they may become symptomatic and even develop into macroscopic endometriosis lesions.

Anaf et al. (12) demonstrated endometriosis foci on specimen margins in 9.7% of patients managed by colorectal endometriosis; most of these foci were in close contact with nerves. Not long after, Remorgida et al. (13) investigated the completeness of full-thickness disc resection in the treatment of deep endometriotic bowel lesions and found residual OME in the digestive tract in 43.8% of cases. Other reports that have focused on histologic analysis of colorectal resection specimen margins with the goal of estimating the completeness of the radical approach have suggested that colorectal OME may be left behind in up to 19% of cases (14, 15). Using data prospectively recorded in a large endometriosis database (NCT02294825) (16), we have estimated the rate of bowel occult microscopic endometriosis (BOME) from histologic analyses of colorectal resection specimen margins and investigated its impact on postoperative outcomes.

## MATERIAL AND METHODS

We included all patients managed by bowel resection for colorectal endometriosis in our department from June 1, 2009, to November 24, 2014. Inclusion criteria were [1] symptomatic deep endometriosis infiltrating at least the muscular layer of the rectum or the sigmoid colon, [2] laparoscopic management by colorectal resection, and [3] enrollment of patients in the North-West Inter Regional Female Cohort for Patients with Endometriosis (CIRENDO) database. The database comprises a prospective cohort, financed by the G4 Group (the university hospitals of Rouen, Lille, Amiens, and

Caen) and coordinated by one of the authors (H.R.). All French-speaking patients managed for endometriosis have been entered since June 2009 (16).

A detailed preoperative questionnaire was used to obtain each full patient clinical history. Standardized gastrointestinal questionnaires were routinely used to assess preoperative and postoperative digestive function: the Gastrointestinal Quality of Life Index (GIQLI) (17), the Knowles-Eccersley-Scott-Symptom Questionnaire (KESS) (18), the Fecal Incontinence Quality of Life index (19), the Wexner score (20), and the Bristol stool scale (21). Data recording, contacts, and follow-up evaluations were performed by a clinical research technician. The prospective recording of data was approved by the French Advisory Committee on Information Processing in Healthcare Research (CCTIRS), and the study was approved by the institutional review board.

All women referred for deep endometriosis to our department underwent a clinical examination by a senior surgeon experienced in endometriosis (H.R.) and an MRI examination. When deep endometriosis was confirmed, an endorectal ultrasound was performed to diagnose rectal involvement and to estimate the depth of rectal wall infiltration. In cases with colorectal involvement, computed tomography-based virtual colonoscopy was prescribed to look for digestive tract stenosis and associated digestive tract localizations, and to allow measurement of the distance from the anus to colorectal nodule inferior limits. Complementary examinations such as cystoscopy and unenhanced helical computed tomography were performed in women with associated involvement of the urinary tract. The operative strategy was first discussed with both the patient and the digestive surgeon before a decision was preoperatively taken concerning the type of surgical procedure to be performed (i.e., rectal shaving, disc excision, or segmental bowel resection). The decision for colorectal resection rested on various parameters: patient age and pregnancy intentions, size and height of rectal infiltration, digestive complaints, and risk of further occlusion.

As a general rule, arguments for colorectal resection concern large infiltrations of the rectum responsible for stenosis, large nodules involving the upper rectum (above the 10-cm feasibility limit of the combined laparoscopic-transanal disc excision using the Rouen technique) (22), multiple nodules with short, intermediate, disease-free bowel segment, and young patients with intentions of future pregnancy. Conversely, colorectal resection is not performed in older patients with no pregnancy intentions and the possibility of postoperative uninterrupted amenorrhea (rectal shaving is preferred), in young patients with large low and midrectum nodules (disc excision using the Rouen technique is preferred), for upper rectum nodules with diameter not exceeding 3 cm (where disc excision using end-to-end anastomosis circular transanal staplers is feasible) (22), for multiple nodules separated by disease-free bowel segment >5 cm (multiple excisions are preferred), and in young patients who are unable to spontaneously conceive and who will be postoperatively referred for assisted reproduction treatment (for whom conservative surgery can be followed by uninterrupted medical treatment).

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