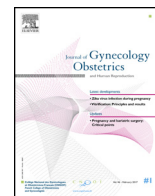




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## Original Article

# Management of deep infiltrating endometriosis of the rectum: Is a systematic temporary stoma relevant?



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## ABSTRACT

**Study objective.** – To assess the value of performing a protective stoma in patients operated for rectal endometriosis.

**Material and methods.** – From June 2009 to December 2011, 47 patients were operated for rectal endometriosis by segmental or discoid resection in 4 different centers. Two groups were formed: one with protective stoma (group S),  $n = 33$  and one without protective stoma (group NS),  $n = 14$ . Data were collected from the CIRENDO database.

**Measurements and main results.** – Postoperative complication rate of group NS was 57% against 48% in group S ( $P = 0.75$ ). There was an increasing trend of the rate of anastomotic leakage in group S as compared to group NS: 21% against 3% ( $P = 0.073$ ). All 3 patients of group NS with an anastomotic leakage were reoperated and the group S patient had medical treatment. In a center, digestive operative time was not necessarily performed in association with a gastrointestinal surgeon. All patients in group S had a restoration of continuity in about 3 months. Two of them had dilation of anastomotic stricture and 3 others showed a transient postoperative ileus during this recovery. Quality of life was assessed by the MOS SF-36 and significantly improved in both groups thanks to the intervention.

**Conclusion.** – Temporary digestive stoma in patients operated for rectal endometriosis has to be considered because in our study, it seems reducing complications such as anastomotic leakage. This must be confirmed with studies with larger numbers.

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## Introduction

Endometriosis is defined as the presence of endometrial mucosa (endometrial glands and stroma) in heterotopic position/abnormally implanted [1]. One distinguishes surface endometriosis defined as the presence of endometrial tissue located on the peritoneum or the pelvic organs while deep infiltrating endometriosis is defined as the infiltration of endometrial tissue in the peritoneum at least 5 mm deep [2]. There are several types of deep lesions, involving for instance uterosacral ligaments (Us), rectosigmoid, vagina and bladder. Gastrointestinal involvement corresponds to 13% of deep lesions with consequent symptoms from pelvic pain with rectal bleeding and constipation till intestinal obstruction syndrome in case of severe lesions. In 70% to 93% of cases, gastrointestinal involvement would concern the rectum and the rectosigmoid hinge [2–4].

When the patient is symptomatic and medical treatment ineffective, management of such endometriosis is surgical [5]. For some authors, it should be as radical as possible, just like cancer surgery [5,6], and involve segmental rectal resection [7–9]. For others, conservative treatment by shaving (i.e. excision of the endometriosis nodule in contact with the intestinal serosa without opening the rectal lumen) or discoid resection should be preferred to minimize any functional sequelae related to movement [10–12].

Any type of rectal resection and its anastomosis run the risk of anastomotic leakage. In the literature, the role of the stoma in the prevention of this complication is controversial. For some authors, the realization of a stoma would not prevent anastomotic leakage in cases of low rectal resection and should not be performed routinely [14–17]. Conversely, for others, it is clear that this complication was significantly higher in patients who had no protective stoma [18,19].

In young and healthy patients with endometriosis, some risk factors of anastomotic leakage are immediately eliminated. Thus,

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the role of the stoma in preventing this complication deserves to be evaluated in this population.

In the context of the surgical management of deep infiltrating endometriosis with rectal resection (discoid segmental resection), we wished to assess surgical site and morbidity by comparing a group with protective stoma with another group without protective stoma.

## Material and methods

This retrospective multicenter case-control analysis was conducted using the prospective data collection of the CIRENDO study (Appendix 1).

We included all women with rectal endometriosis requiring surgery and responding to questionnaires of the CIRENDO study. Detailed gastrointestinal symptoms or the iconographic record specifying the location, size and infiltration of deep infiltrating endometriosis lesions were not studied.

Preoperative and postoperative self-questionnaires at 1 year of the CIRENDO study were analyzed and the medical records allowed to retrieve the perioperative data.

Patient characteristics were collected through self-administered questionnaires (surgical history, symptoms and chronicity, impact on quality of life). In the medical records, the following variables were extracted: type of rectal opening and location, colpotomy, omental flap/omentoplasty, general and specific – i.e. anastomotic leakage – perioperative complications, intraoperative bleeding, duration of response and length of hospital stay, time to recovery of gastrointestinal continuity and complications during recovery.

For the evaluation of postoperative morbidity, we chose to use the definition of “anastomotic leakage” as is described in the articles by Rahbari et al. [20], Matthiessen et al. [19], Tan et al. [21] and Ruffo et al. [22]: a defect in the integrity of the intestinal wall on the site of the colorectal or coloanal anastomosis due to a communication between the intraluminal and extraluminal compartment. Pelvic abscesses located near the anastomosis are also considered as anastomotic leakage. Thus, on the clinical level, all patients with the postoperative following signs were considered as having anastomotic leakage: intestinal gas, pus or faeces outflow at the drain end, pus outflow from the rectum, peritonitis, perianastomotic abscess, and rectovaginal fistula. Only radiologically confirmed anastomotic leakages were taken into account.

From this collection of data, two groups of patients were formed and compared:

- group S: patients with rectal opening protected with a stoma;
- group NS = “No Stoma”: patients with rectal opening without stoma.

No surgical procedure was imposed on operators and the decision to make a stoma and its type (ileostomy or colostomy) were left to the discretion of the surgeon as based on local habits and intraoperative conditions.

A stoma could be considered in four situations:

- in the case of a discoid resection by Stapled transanal resection of the rectum (STARR) procedure after anal dilatation and rectal externalizing at the anal margin. The resection and anastomosis were performed at the same time under laparoscopic control. The discoid resection by transanal route could also be carried out using a PCEA 31 clamp;
- in the case of a segmental rectal resection with endo GIA (section clamp and stapler) and mechanical end-to-end or end-to-side anastomosis by transanal route using PCEA (stapling clamp);

- in the case of an electrocautery discoid resection by intraperitoneal route and manual suture in one or two planes;
- in the case of performing a wound with opening of the rectal mucosa during a shaving with a manual suture in one or two planes.

## Statistical analysis

Statistical analysis was performed using SAS software version 9.2 (SAS Institute Inc., Cary, NC 25513).

A value of  $P < 0.05$  was considered statistically significant.

The results are presented as median, mean and standard deviation for quantitative variables and as frequency (percentage) for qualitative variables.

The normal distribution of quantitative variables was tested by the Shapiro Wilks test and non-parametric tests were retained.

To complement the descriptive analysis, a comparative analysis of groups with or without stoma was performed using the Chi<sup>2</sup> test for qualitative variables or Fisher’s exact test if the theoretical sample was small and a Mann-Whitney test for quantitative variables. Comparison of preoperative and postoperative variables was made by a paired Wilcoxon test.

## Results

From the anonymized CIRENDO file, via the keyword “digestive gesture”, 134 patients were selected from June 2009 to December 2011. After reading the operative reports, 74 patients who underwent a rectal shaving alone were excluded. Of the remaining 60 patients, 2 patients had small bowel resection and 11 had a sigmoidectomy. These 13 patients were also excluded.

Four types of rectal opening were distinguished:

- segmental rectal resections;
- discoid rectal resection by transanal route using the STARR technique;
- discoid rectal resections by intraperitoneal route with electrocautery;
- rectal wounds when performing a shaving.

These different data are summarized in Fig. 1.

Forty-seven patients from 4 different centers (29 from Rouen university hospital, 5 from Lille university hospital, 12 from Caen university hospital, 1 from Saint-Hilaire clinic in Rouen) were included from June 2009 to December 2011. Eight surgeons from 4 different centers participated in the study.

Of the 47 patients, 33 patients, i.e., 70% had a stoma and 14 patients i.e. 30% did not. Group S:  $n = 33$ ; group NS:  $n = 14$ .

## Epidemiology

The preoperative and epidemiological characteristics are summarized in Table 1.

In both groups, the painful symptomatology was predominant with rates of dysmenorrhea respectively evaluated for group S and group NS at 97% and 100%.

In addition, 93% of patients in each group complained of dyspareunia ( $P = 0.7$ ); 72% of patients in group S had pain outside menstruations and 71% in group NS ( $P = 1$ ).

The intraoperative led to precisely locate the gastrointestinal involvement:

- in group S, 70% of patients had a single lesion in the rectum, 18% had a lesion of the rectosigmoid and 12% had a bifocal lesion (rectum and sigmoid);

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