



CENTER FOR WOMEN'S CARE AND REPRODUCTIVE SURGERY

Gynecologic Endoscopic Surgery

Endometriosis

Management of endometriosis has always been based on relief of symptoms. Despite the fact that voluminous research has been performed in order to find a noninvasive cure, management remains centered around the use of surgical removal with medical placation.

Although extensive efforts have been made in attempts at improving prospects of pregnancy for patients with the disease, results remain marginal. Neither medical therapy nor surgery alone or in combination produces significant improvement in pregnancy rates.

However, for relief of pain both medical and surgical therapies have been employed with success although cure rates are not available. For invasive (Type III) disease and large endometriomas, surgical therapy appears to be the only solution as medical therapy has demonstrated no efficacy in these areas.

Surgical therapy revolves around three basic techniques:

- Vaporization
- Coagulation;
- Excision

Of these techniques, excision is by far the most appropriate. If the surgeon has significant expertise in the recognition of endometriosis, at times vaporization or coagulation can be used but in most cases excision is the wiser choice. Excision offers two basic advantages:

- Pathologic Confirmation
- Adequate removal of the lesion

Because endometriosis may extend several millimeters into the tissue and because epithelial cancers can mimic this disease it is always wise to have a histologic confirmation of the diagnosis.

Laparoscopy has been defined as the gold standard in surgical treatment of endometriosis for several reasons:

- Minimally invasive approach
- Superior visualization - microscopic
- Superior access - posterior pelvis
- Microsurgical accuracy of excision
- Less scarring
- Ability to repeat the surgery without compromising results

The surgical approach to endometriosis should be aggressive. Most patients should be bowel prepped and counseled appropriately preoperatively. A single stage approach is preferable if the clinical picture warrants this type of surgery.

*1140 Hammond Drive, Bldg. F-6230
Atlanta, GA 30328
770-352-0037 or
Toll free 888-545-0400*

Pain mapping (i.e. determining the location of the pain) should be performed preoperatively using a systematic regimen.

Intraoperative mapping may be used under conscious sedation in order to better target excisional therapy. Ovarian preservation is possible in a large percentage of patients and, despite using an aggressive surgical approach, hysterectomy is rarely necessary. If significant adenomyosis or uterine corpus disease is present, however, uterine removal is required.

Laparoscopic surgery seems to be the most appropriate method of therapy for individuals with pain, rectovaginal disease, or bowel involvement secondary to endometriosis. Risk is low with this approach although the technical demands are prodigious. Surgical therapy of invasive endometriosis remains one of the most difficult tasks for the gynecologic surgeon.

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