Laparoscopic Treatment of Endometriosis

Thank you for the opportunity to express my controversial opinions about endometriosis. I encourage AAGL to develop guidelines for its diagnosis and treatment. Extensive endometriosis surgery, often involving the rectum, is the most difficult surgery in gynecology.

I know a lot about this disease. I have been treating it by excisional surgery for over 30 years. I am convinced that what is excised never comes back. My results in over 1000 cases of deep endometriosis excised by laparoscopic surgery confirm that less than 20% of these women will require further treatment.

My diagnostic approach:
1. In most cases of severe endometriosis, the endometriosis, surrounded by scar tissue, can be diagnosed in the office by rectovaginal examination, with elevation of the cervix and palpation through the rectum. These areas are usually tender to palpation, and this tenderness is used to direct the surgeon to the area to be removed. Examination after surgery should be pain free if the appropriate area was excised.
2. Vaginal ultrasound as developed by Professor Mauricio Abrav in Brazil will become a non-invasive procedure to diagnose and follow deep endometriosis, once expertise is obtained.
3. Diagnosis of endometriosis should require a positive biopsy documenting endometriosis glands at laparoscopy. Papers in the literature using visual documentation of endometriosis are worthless!
4. Most women with the diagnosis of endometriosis without biopsy do not have endometriosis! The diagnosis is often made visually by laparoscopy without a biopsy of these “hemosiderin laden macrophages”, white blood cells filled with iron from evacuation of retrograde menstruant.

My therapeutic approach:
1. Enterolysis. Many women with extensive endometriosis have had multiple laparotomies resulting in adhesions of small bowel to the undersurface of the anterior abdominal wall. Thus, the first part of many endometriosis operations is release of these adhesions in order to see the pelvis. Then the rectum must be separated from the posterior vagina and cervix.
2. Separate all pelvic organs including the ovaries, uterus, cervix, upper vagina, and rectum.
3. Excise the endometriosis. Symptomatic endometriosis is surrounded by fibrous scar tissue from a repetitive longstanding inflammatory response. This scar tissue containing the endometriosis glands is excised from inside the ovaries, the posterior cervix and vagina, the rectum, and the uterosacral ligaments (and ureters if necessary).
4. Rectal resection in cases in which the endometriosis penetrates deeply into the rectal/rectosigmoid wall.
5. Various agents to separate operated upon organs during early healing.

Problems in the U.S.:
1. Two distinct groups doing laparoscopic surgery have evolved: a very large cluster doing it for diagnosis and minimal treatment and a much smaller elitist segment doing it for optimum treatment.
2. Poor level of surgical training to deal with endometriosis, despite laparoscopic fellowships. We who do this type of surgery have very few disciples.
3. Poor reimbursement for complex endometriosis surgery despite increased medicoegal risk. Most surgeons who treat extensive endometriosis have problems participating within our managed care insurance system. One may have to do 100 cases to cover malpractice insurance! Office gynecology pays much better. Why get stuck with a complex endometriosis surgical case involving rectum, ureters, and, frequently, small bowel?
4. Many women who undergo multiple “endometriosis” laparoscopies have no disease. The surgeons do an easy diagnostic laparoscopy without biopsy followed by 6 months of GnRH agonist treatment followed by another “diagnostic” laparoscopy, extracting cash from the patient without any long-term benefit.
5. The concept that endometriosis comes back is just a good excuse for poor treatment. What is called recurrent disease is really persistent disease that was not treated in the first place.

If the above sounds depressing regarding the state of endometriosis diagnosis and treatment in the USA, it is! Our lawyers and our health insurance system have contributed.

Fellowship year July 1, 2009 to June 30, 2010 — applications now being accepted!

The Fellowship in Gynecologic Endoscopy, an affiliate of the AAGL and the Society of Reproductive Surgeons of ASRM, is sponsoring fellowships in advanced gynecologic endoscopy. These fellowships were created with the goal of producing a standardized training program. The Fellowship provides an opportunity for gynecologists who have completed their residency to acquire additional skills in minimally invasive gynecologic surgery. This fellowship also aims to further research in the field of minimally invasive gynecology. Fellows are required to complete a scholarly contribution to be presented at the annual meetings of the AAGL and ASRM. The Fellowship in Gynecologic Endoscopy actively encourages applications from postgraduate physicians aspiring to develop their surgical skills in minimally invasive gynecology.

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