A Multidisciplinary Approach to the Patient with Deep Infiltrating Endometriosis

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Abstract

Endometriosis is a prevalent condition that affects women’s health-related quality of life worldwide and deep infiltrating endometriosis represents a subset of these patients who are most severely affected. Due to the complex nature of deep infiltrating endometriosis (DIE) a preoperative suspicion for the condition allows for coordination of a multidisciplinary approach to surgical planning, a key to successful surgical resection. We describe three patient cases to highlight the importance of preoperative planning and the added benefit of imaging with an MRI protocol specific for DIE that includes vaginal and rectal contrast. Additionally, we emphasize the importance of appropriate referral to surgical subspecialists to allow for coordination of care during pre-operative planning to improve outcomes of patients with deep infiltrating endometriosis.

Keywords

Chronic pelvic pain, Deep infiltrating endometriosis, Appropriate imaging evaluation MRI

Abbreviations

DIE: Deep infiltrating endometriosis; EBL: Estimated blood loss; LEEP: Loop electrode excisional procedure; IUD: Intrauterine device; MRI: Magnetic resonance imaging; UTI: Urinary tract infection; TVUS: Transvaginal ultrasound; RES: Rectal endoscopic sonography

Introduction

Endometriosis is a prevalent condition that affects women’s health-related quality of life worldwide. Deep infiltrating endometriosis (DIE) represents a subset of these patients, estimated to affect up to 20% of endometriosis patients [1]. DIE is defined as lesions penetrating at least 5 mm deep to the peritoneal surface and could have genital or extragenital manifestations, including involvement of the uterosacral ligaments, the rectosigmoid colon, the vagina, the bladder, and the small and large bowel [2,3]. In advanced cases, large full-thickness lesions need to be resected from the vagina, bowel, bladder and ureters, resulting in extensive surgeries. For this reason, it can have a profound clinical impact and diagnosis and treatment can be challenging. While patient symptoms and anatomic sites of DIE do correlate, physical exam has limited value in assessing the extent of the disease which frequently requires imaging by ultrasound or MRI, as well as multidisciplinary consultations [4]. The complex nature of DIE mandates taking preoperative suspicion seriously in surgical planning and patient counseling [5,6].

Beyond a thorough pelvic examination, imaging is the modality to fully assess the extent of disease in or-
laparoscopic resection of endometriosis seven years prior, with operative report describing stage 4 endometriosis and significant bowel adhesions. Moreover, she was noted to have biopsy proven endometriosis adjacent to and possibly involving the rectal lesion which was not resected as it was not anticipated pre-operatively and as a result, surgical back up for a colorectal surgeon was not arranged. Her symptoms transiently improved after her first surgery but returned several years later and were not responsive to medical management with combined oral contraceptives. Limited exam in the office due discomfort demonstrated a 14-week globular uterus adherent to the anterior abdominal wall with no other significant findings. Pre-operative MRI with intravenous contrast demonstrated bilateral endometriomas as well as T1-hyperintense implants along the surface of the uterus, cervix, and posterior to the bladder (Figure 1).

The MRI did not show evidence of intestinal endometriosis, nor did a subsequent colonoscopy when performed pre-operatively. Despite this negative gastrointestinal work up, given the patient’s complaints and the report of possible bowel involvement in her last surgery, an outpatient general surgical consultation was obtained, and patient was consented for possible rectosigmoid resection. Finally, pre-operative cystoscopy was performed due to persistent urinary complaints, which was negative for evidence of endometriosis. The patient was extensively counseled, and the plan was made to perform robotic assisted total laparoscopic hysterectomy with bilateral salpingo-oophorectomy and resection of endometriosis.

Exam under anesthesia demonstrated a fixed rectum and uterosacral ligaments. Digital rectal exam was notable for a palpable 2-centimeter lesion on the upper rectum. Inspection of the vagina identified a 2-centimeter nodule in the posterior fornix and a 1 cm anterior vaginal wall nodule halfway between the introitus and apex. Intraoperatively, presence of bilateral endometriosis...

Figure 1(A,B,C): Axial, sagittal, and coronal T2-weighted MR images demonstrate an enlarged uterus with a markedly thickened junctional zone and subcentimeter T2 hyperintense foci throughout the myometrium; findings consistent with adenomyosis. Evaluation of the rectouterine space demonstrates infiltrative T2 hypointense signal abnormality which is inseparable from the anterior rectum, representing DIE with rectal involvement (yellow arrows).
the vagina and the rectosigmoid. The biopsy of the small bowel, also, was positive for endometriosis. The appendix contained subserosal fibrosis with hemosiderin-laden macrophages but no overt endometrial glands and stroma was reported. In light of the bowel involvement that was not described on imaging preoperatively, the MRI images was re-reviewed with radiology, and rectal involvement was retrospectively appreciated (Figure 2).

**Case 2**

41-year-old G4P0040 with a 15-year history of chronic pelvic pain with symptoms of dysmenorrhea, dyschezia, constipation, dysuria, and abnormal uterine bleeding failed previous management with hormonal suppression. Her history was significant for irritable bowel syndrome, depression, alcoholism, and a prior laparoscopic excision of endometriosis and appendectomy.

Given her bladder and bowel symptoms, pre-operatively the patient was seen by both urology and general surgery. Colonoscopy noted a 3-centimeter non-obstructing lesion protruding into but not all the way through mucosa with negative mucosal biopsies. Pre-operative cystoscopy was negative.

On exam in the office, she was noted to have a 10-week sized uterus with mobility limited by posterior cul-de-sac lesion with a 2-centimeter posterior fornix lesion tethered to a rectal lesion. The MRI, which this time was performed with intravenous, oral, rectal, and vaginal contrast, reported deep pelvic endometriosis with mass like T2-hypointense process in the rectovaginal septum, with gross invasion into the anterior rectal wall. The endometrial mass appeared to invade full thickness of the rectal wall, extending into the rectal lumen (Figure 3 and Figure 4). MRI also demonstrated adenomyosis and thickening of the right fallopian tube and right proximal round ligament.

Pre-operatively, both general surgery and gynecology surgeons had extensive discussions with the pa-
Post-operative course was complicated by post-operative urinary retention, presumably secondary to disruption of the parasympathetic plexus during the deep endometriosis resection for which she required intermittent catheterization with timed voids.

Case 3

Case 3 is a 33-year-old G1P1001 with past history significant for a cesarean section, LEEP, history of chlamydia, and CopperT IUD in place. She had presented as a referral from urology for chronic pelvic pain and an endometriosis bladder lesion that was seen on outpatient cystoscopy. The plan was for a combined procedure. The patient complained of dysmenorrhea and chronic pelvic pain with urinary symptoms; bladder irritation, dysuria, urinary frequency, and frequent urgent visits for UTI symptoms with negative urine cultures. Her chronic pelvic pain was cyclical. Exam in the office was unremarkable. Pre-operative office cystoscopy demonstrated no stones or diverticula but identified a blue hue endometrial nodule covered with bladder mucosa pushing into the bladder posteriorly in the midline. Bilateral ureteral orifices visualized with clear efflux of...
no vaginal involvement. The bladder defect was closed and confirmed to be water-tight, right ureteral stent was removed but the left ureteral stent was left in place due to its proximity to the suture line. Final pelvic and abdominal survey confirmed little to no residual disease with adequate hemostasis and an EBL 150 cc (Figure 7). Post-operative course was complicated by a urinary tract infection which responded to antibiotics. Pathology confirmed histologic evidence of endometriosis in all excised tissue. Two weeks post-operative, the patient had normal CT cystogram and office cystoscopy and the left ureteral stent was removed without difficulty.

Conclusions

These three cases highlight the importance of extensive preoperative planning by a multidisciplinary surgical team to achieve optimal surgical resection of DIE. Each case demonstrates the value of appropriate preoperative imaging, subspecialty consultation, coordination of care, and an individualized comprehensive work up including colonoscopy or cystoscopy.

While transvaginal ultrasound, cystoscopy, and rectosigmoidoscopy, have been studied and used for the preoperative evaluation of symptomatic endometriosis, MRI may provide an added benefit of mapping deep le-
sions with greater accuracy than other modalities [9]. Bazot, et al. demonstrated that MRI had a sensitivity of 90.3% and NPV of 89% for DIE which appeared as a hyperintense foci and/or hypointense areas on T1- and T2-weighted MR images, respectively. Similarly, Hottat, et al. reported a sensitivity of 96.3% and NPV of 93.3% [4,9,10]. The use of T1 and T2 weight sequences in mapping lesions has become an integral step in surgical planning for DIE as was demonstrated in the above cases. More importantly, the cases above support the utility of adding vaginal and rectal contrast to the protocol for MRI when evaluating for DIE. Chasong, et al. demonstrated that opacification of the vagina and rectum with ultrasound gel improved the sensitivity of MRI for the detection of DIE and allowed for improved visualization and delineation of the vagina and rectovaginal septum, allowing for better delineation of the pelvic organs [11]. Endometriotic lesions have an MRI signal intensity similar to their surrounding fibromuscular structures, since they are fibromuscular structures. Vaginal and rectal distension and opacification with ultrasound gel can help to delineate the cervix, vaginal fornices, vaginal wall, rectum, and rectosigmoid colon junction [12]. Endelarae, et al. was also in favor of using vaginal and rectal distension to detect and localize, with better accuracy, endometriotic lesions, and to identify conditions either developing inside the lumen of cavities or coming from the outside [13]. For our case 1, DIE discovered intra-op was not seen pre-operatively by MRI most likely because of the lack of vaginal and rectal contrast when obtaining this MRI. After this case the vaginal and rectal contrast was added to the protocol. In case 2, where vaginal and rectal contrast was used for the MRI protocol, DIE was seen involving the rectovaginal septum, with gross invasion into the anterior rectal wall. This allowed for preoperative planning with general surgery and plan for segmental rectosigmoidectomy and anastomosis. These cases prompted the development of a collaborative relationship with radiology and the establishment of formalized reporting system and endometriosis-specific MRI protocol when evaluating for DIE, allowing clinicians to order correct studies and for radiologists to report their findings in a standardized fashion. The inclusion of a radiologist that specializes in MRI is crucial to the multidisciplinary team approach.

When approaching bowel endometriosis, Abrao, et al. describes several considerations critical to surgical planning: The number of DIE lesions, multifocality, lesion size (with lesions over 3 centimeters typically requiring a segmental resection while smaller lesions are often amenable to discoid resections), the extent of bowel surface involvement, and lesion depth [14]. In case 2, the general surgery team identified a greater than 5 centimeters lesion on the upper and medial rectum. Given its size, the lesion was not amenable to shaving or a discoid resection, but rather demanded a segmental resection. In comparison, in case 1 the rectosigmoid lesion was smaller and therefore amenable to a discoid resection. A collaborative relationship with joint meetings to review patient cases was created with general surgery, radiology, and minimally invasive gynecology to improve patient care. As a result, recognition in the community was established and increased referrals were seen, giving us reassurance that patients have better access to comprehensive surgical teams and are avoiding incomplete surgical debulking.

These three cases highlight the importance of thorough preoperative planning and the added benefit of MRI in preoperative planning with a protocol that includes vaginal and rectal contrast. In addition, we emphasize the importance of referral to subspecialty surgeons to allow for coordination of a multidisciplinary approach to surgical planning to improve treatment and outcomes of patients with deep infiltrating endometriosis. Finally, patients with deep infiltrating endometriosis would benefit from a center with multispecialty providers that can work in conjunction to coordinate patient care and surgical planning.

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