Endometriosis with Bowel Involvement

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Dr. Daniell: "We're here in Montreal at the ISGE meeting, and we have an opportunity to talk to one of the researchers who has been doing some excellent work in the treatment of severe endometriosis involving the bowel. Those of you with endometriosis and those of you who are physicians dealing with endometriosis are aware of the difficulty of dealing with rectosigmoid disease, or bowel endometriosis. In Australia, down under, one group has been doing some fascinating work, and we have one of the authors from this group who actually presented this paper this morning with us, Dr. Solmandi. Dr. Solmandi, would you give us some background on your work there in Melbourne and your research in this area?"

"I was an endosurgery fellow with Professor Peter Maher in Melbourne last year in Townsley, and the pelvic surgery fellow at Prince Albert Hospital in Sydney. This paper involved 169 patients with severe endometriosis who had colorectal involvement of endometriosis."

"The really bad type."

"That is right. They were all Stage III or Stage IV endometriosis cases, and these women with quite debilitating diseases, severe pain and rectal symptoms had presented to previous gynecologists, but symptoms persisted. As I had said in the paper, 87% of these women had previous laparoscopies, and 25% have had up to seven previous laparoscopies, but all continued to have persistent symptoms until they were presented to us. So in the majority of these women we dissected the rectum of the vagina and the posterior uterus, and there were 27 of these patients who had had segmental resection of the rectum, or the rectosigmoid, with quite good postoperative results."

"I want to ask you, did you always have bowel preps, of course, and did you have a colorectal surgeon physically in the room with you? Or did you have them on stand-by for these cases? How did you work that, logistically?"

"In the majority of cases, we worked with a colorectal surgeon who is skilled in laparoscopic surgery, just as all of the gynecologists on the team are. He was there with us, especially for the segmental resections, but we did do the retroperitoneal dissections, and we did shave off the endometriosis and put the stitches in the rectum if we needed to. But the segmental resection was done by the surgeon, per say."

"So you keep the division between the surgeons and the gynecologists traditional?"

"That's right. It's actually a team approach, so we do work together. The surgeons learn about endometriosis, we learn about dealing with the bowel, and we feel more comfortable dealing with that, so it's quite a good approach to this disease."
"You had a very large number of cases - 169, I believe - over a 5-year period. That reflects, I guess, a large referral base throughout all of Victoria and South Australia?"

"It does. Not only Australia, but we also get referrals from, obviously, Professor Maher, and the other consultants get international referrals as well."

"I was really impressed with your long-term results, the over-one-year results, and the re-operation rate. Can you just briefly tell our audience about the long-term outcomes, which is what really counts, as far as pain relief?"

"I can also talk about the main group of patients who did not have the bowel resection. Just over one-third of them required further surgery."

"Only one-third?"

"For surgery due to persistent symptoms, yes, and we found that 75% of them did not have any endometriosis. This is quite a good figure when you are looking at the group of women who had the bowel resection at three-year follow up, and the majority of them did not have the surgery. There were about 15% of them who did require further surgery at that stage."

"You also had the unique opportunity to get a second-look laparoscopy in some of these patients, and I was very impressed with the small number of patients who had a recurrence of endometriosis in your second-look laparoscopies after these extensive procedures. That is very good data. My take on this is that, in the hands of a team approach with good skills, severe endometriosis can be managed in many cases by avoiding laparotomy, and good long-term results can be the outcome. One person alone without a bowel prep and without any experience should not mess with these extensive procedures, though - they should go to a big referral center, such as the group in Melbourne. So thank you for your time and for giving us a report on this excellent work in the area of endometriosis."

"Thank you very much."

"Thank you very much, Dr. Solmandi."

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