
12TH WORLD
CONGRESS ON
ENDOMETRIOSIS
30 April to 3 May 2014 - Sao Paulo, Brazil

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www.endometriosis.ca/wce2014

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Hubo tres sesiones dedicadas a la cirugía laparoscópica:

* La cirugía laparoscópica en circunstancias difíciles

* Tratamientos quirúrgicos (en general)

* anatomía, energía y nuevas tecnologías para el manejo quirúrgico de la endometriosis

Una conferencia magistral:

Cirugía definitiva: ¿porqué, cuando y como?

…y lo mejor de todo:

* **Sesiones diarias de videos de cirugías…..buenos, regulares y malos, pero todos aportaron algo**

Simposios

Cirugía laparoscópica en casos difíciles

* Disección/hemostasia en cirugía retroperitoneal

* Estrategias quirúrgicas en el caso de útero de gran tamaño y pelvis congelada

Simposios

Tratamiento quirurgico

- Resección vs cirugía conservadora en el manejo de la endometriosis rectal – ENDORE – ensayo randomizado
- La cirugía del endometrioma y los resultados de la FIV
- El método Negar – erradicación laparoscópica de la endometriosis profunda respetando los nervios durante la resección segmentaria rectal y parametral
- Resección parcial de la fascia pelviana extraserosa en el tratamiento de la endometriosis colorectal
- Diez años de seguimiento de una cohorte de pacientes tratadas por endometriosis profunda
- Neurolisis laparoscopica en endometriosis profunda de la pared pelviana y nervios somáticos – estudio retrospectivo de 26 pacientes

Videos

Algunos videos destacados :

- Resección del parametrio infra y supra ureteral
- Tecnica transanal y laparoscópica para los nódulos rectales medios y bajos.
- Nodulo profundo de pared (parahepático) de gran tamaño
- Endometriosis vesical y adenomiosis externa
- Tecnica robótica para el endometrioma
- Ureterolisis izquierda en endometriosis severa
- Shaving y resección segmentaria asociados
- Adenomiomectomía robótica preservando el útero para un futuro embarazo

Comunicaciones

Algunos trabajos provocativos:

IS ADENOMYOSIS AN INDICATION OR CONTRAINDICATION FOR LAPAROSCOPIC SUBTOTAL HYSTERECTOMY?

Krentel H[1]

[1]Medical Director of CEGPA, Peruvian-German Center of Endoscopic Gynecology, Lima, Peru & Head of Department of Obstetrics and Gynecology, St. Anna Hospital, Herne, Germany

In symptomatic patients with bleeding disorders and dysmenorrhea, adenomyosis is the main cause often combined with uterine myomatosis. Especially in this subgroup of young and symptomatic patients the laparoscopic subtotal hysterectomy with electric morcellation is a standard surgical method. The morcellation of the uterus means to shred a histologically unknown variety of tissues in the abdominal cavity. Several publications have shown the correlation between morcellation and postoperative peritoneal endometriosis and adenomyosis. Are we offering a really safe procedure performing a laparoscopic subtotal hysterectomy without knowing if we are morcellating adenomyosis? Do we cause peritoneal endometriosis or adenomyosis? In how many patients? Symptomatic or asymptomatic? After how many years? What does that mean for the informed consent? Do we need a presurgical histology? How can morcellation be safer? How representative is the result of a pathologic report on 500 – 2000 gr of morcellated tissue? This presentation will give some answers. Alternatives and consequences will be discussed.

La histerectomía subtotal en casos de ademoniosis con posterior morcelamiento electrónico conlleva el riesgo de diseminar la enfermedad al peritoneo

Algunos trabajos provocativos:

IMPACT OF SURGICAL AND HORMONAL THERAPY ON ENDOMETRIOSIS

[1]Mettler L, [1]Alkatout I

[1]Kiel, Germany

Introduction: According to patients demand we have to offer different therapeutical strategies in the treatment of endometriosis.
Study Objective: To evaluate 3 therapy strategies: hormone therapy, surgery, and combined treatment.
Design: Prospective, randomized, controlled study (Canadian Task Force classification I).
Methods: Four hundred fifty patients with genital endometriosis, aged 18 to 44 years, before first laparoscopy.
Patients were randomly assigned to 1 of 3 treatment groups: hormone therapy, surgery, or combined treatment.
Patients were reevaluated at second-look laparoscopy, at 2 to 2 months after 3-month hormone therapy in groups 1 and 3 and at 5 to 6 months in group 2 (surgical treatment alone). Outcome data were focused on the endometriosis stage, recurrence of symptoms, and pregnancy rate.
Results: All treatment options, independent of the initial Endoscopic Endometriosis Classification stage, achieved an overall cure rate of 50%. A cure rate of 60% was achieved with the combined treatment, 55% with exclusively hormone therapy, and 50% with exclusively surgical treatment. Recurrence of symptoms was lowest in patients who received combined treatment. Significant benefit was achieved for dysmenorrhea and dyspareunia. An overall pregnancy rate of 55% to 65% was achieved, with no significant difference between the therapeutic options.
Conclusion: In the quest to find the most effective treatment of genital endometriosis, this clinical randomized study shows the lowest incidence of recurrence with combined surgical and medical treatment and improved pregnancy rate in any medically treated patients with or without surgery. The highest cure rate (Endoscopic Endometriosis Classification stage 0) for endometriosis was also achieved in the combined treatment group.
J Minim Invasive Gynecol. 2013 Jul – Aug; 20 (4):473-81

El tratamiento combinado de cirugia laparoscópica seguida por hormonoterapia fue el más efectivo a los fines de mejorar la calidad de vida y disminuir la recurrencia de la enfermedad

Algunos trabajos provocativos:

RADIOFREQUENCY THERMAL ABLATION FOR SYMPTOMATIC UTERINE FOCAL ADENOMYOSIS - PROSPECTIVE PRELIMINARY EXPERIENCE.

Colette Campana1, Stefano Scarperi2, Giovanni Pontrelli2, Marcello Ceccaroni3, Alfredo Ercoli4, Valentino Bergamini5
1 Department of Obstetrics and Gynecology, Policlinico Abano Terme, Abano Terme, Padova, Italy 2 Department of Obstetrics and Gynecology, European Gynaecology Endoscopy School (EGES), Sacred Heart Hospital, Negrar, Verona, Italy 3Gynecologic Oncology and Minimally Invasive Pelvic Surgery Unit. International School of Surgical Anatomy. Sacred Heart Hospital. Negrar, Verona, Italy 4 Department of Obstetrics and Gynecology, Policlinico Abano Terme, Abano Terme, Padova, Italy, 5 Department of Obstetrics and Gynecology, University of Verona, Verona, Italy

Objectives: To evaluate the feasibility and efficacy of laparoscopic radiofrequency thermal ablation of uterine symptomatic focal adenomyosis.
Design: Prospective cohort preliminary study. Setting: four hospitals in Italy.
Materials and Methods: Fifteen women with symptomatic uterine focal adenomyosis underwent radiofrequency thermal ablation under laparoscopic guidance. Gynecological examination and ultrasound evaluation of adenomyosis volume were performed at the baseline and at the postoperative follow-up at 3, 6, 9, 12 months. The impact of adenomyosis related symptoms was assessing using Visual Analogic Scale.
Results: The median number of adenomyosis localization treated per patient was one (1-2). The median baseline volume of the adenomyosis was 60 cm3 (18-128). The median reduction in adenomyosis volume was 32%, 49.4%, 59.6% and 65.4% at 3, 6, 9, and 12 months, follow-up evaluation, respectively. A significant progressive improvement in the symptoms score was observed at three, six, nine, and 12 months follow-up.
Conclusion: In this pilot study, laparoscopic radiofrequency thermal ablation successfully reduced adenomyosis-related symptoms and volume, appearing as a valuable alternative to major surgery, with significant symptoms relief.

La ablación térmica de los nódulos adenomióticos de hasta 60cc de volúmen mediante el uso de la radiofrecuencia dirigida - bajo control laparoscópico – demostró una reducción progresiva del tamaño de los focos (65.4% a 12 meses) y el impacto del dolor asociado

Algunos trabajos provocativos:

COLORECTAL RESECTION VERSUS RECTAL CONSERVATIVE SURGERY IN THE MANAGEMENT OF RECTAL ENDOMETRIOSIS: PRELIMINARY RESULTS OF ENDORE RANDOMIZED TRIAL

Horace Roman1, Jean-Jacques Tuech1, Emmanuel Huet1, Haitham Khalil1

1 University Hospital, Rouen, France

Objectives: To determine whether performing colorectal resection is responsible for a higher rate of postoperative digestive and urinary dysfunction and an increased risk of postoperative complications when compared to rectal nodules excision (shaving or disc excision) through a randomized trial (ENDORE, NCT 01291576).

Design: Prospective in intention to treat randomized trial, enrolling patients with deep endometriosis infiltrating the rectum up to 15 cm from the anus, for whom rectal involvement exceeds 20 mm on length, the muscular layer on depth, and <50% on rectal circumference. Randomization betwwen colorectal resection and conservative procedures.

Materials and Methods: Main outcome : at least one postoperative complaint at 24 months, among severe constipation, defecation pain, frequent bowel movements, anal incontinence and de novo dysuria. Standardized gastrointestinal questionnaires were filled preoperatively and at each postoperative visits (at 6, 12, 18 and 24 months). Thirty patients were required in each arm.

Results: We analyzed 50 women managed in Rouen from 03/2011 to 05/2013 with postoperative follow up > 3 moths. Among the 25 patients enrolled in the arm 1, 10 underwent rectal shaving, 13 disc excision, while 2 patients (8%) had a colorectal resection. The diameter of the disc was 49±12 mm. In women managed by colorectal resection in the second arm, the length of the segment removed (mm) was 92±45, and the height of the colorectal anastomosis (mm from the anus) was 82±42. Women managed by conservative surgery had a significantly lower risk of Clavien 3a complications, and a slightly decreased risk of Clavien 3b complications. Despite the incomplete follow up, the rate of pregnancies among women intending to get pregnant is 67% vs. 46% (P=0.42).

Conclusion: Conservative surgery may be performed instead colorectal resection in 92% of rectal endometriosis with rectal involvement >20 mm, with a decrease of the risk of some postoperative complications. As regards the main outcome, full results will be available in 2016.

La resección discal de 5mm de Ø vs colectomía segmentaria en el trat. de lesiones de hasta 20 mm Ø a más de 15 cm del márgen anal con invasión de hasta la muscularis resultó en una ↓ significativa de las complicaciones postoperatoria y un ↑ de la tasa de embarazo

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Algunos trabajos provocativos:

LAPAROSCOPIC MANAGEMENT OF DEEPLY INFILTRATING ENDOMETRIOSIS: A COHORT PROSPECTIVE STUDY WITH 10-YEAR FOLLOW UP

Jinhua Leng1, Jinghe Lang2, Yi Dai3, Junji Zhang3, Lei Li3
1 Peking Union Medical College Hospital, Beijing, China, 2 Peking Union Medical College Hospital, Department of Obstetrics and Gynecology, Beijing, China, 3 Peking Union Medical College Hospital, Department of Obstetrics and Gynecology, Beijing, China

Objectives: Deeply invasive endometriosis (DIE) is recognized as a special entity responsible for pain symptoms. The aim of this study is to investigate effect of conservative laparoscopicsurgery with long term follow up.
Design: A prospective and 10 year follow-up cohort study began from 2003.
Materials and Methods: There are totally 580 cases of deeply infiltrating endometriosis (DIE) patients and 1000 cases of non-DIE patients pathologically diagnosed were enrolled.Clinical datas of symptoms, operation finding, laparoscopically surgery, medication, pain relief time and relapse rate post-operation were analyzed.
Results: The risk of pain symptoms in DIE patients were significantly increased. The OR for dysmenorrhea, CPP, deep dyspareunia, dyschezia were 6.73, 1.90, 3.09 and 4.903 respectively. The highest incidence of deep dyspareunia was observed in fornix invaded group (72.2%). The longest operative duration (82.00±30.58min) and the postoperative hospitalization (7.67±2.08 days) were observed in rectum invaded group. The median pain relief time was 65 months in the patients with complete excision of DIE lesions, which was significantly longer than that in patients with incomplete excision(25 months). The rate of complication was 2.05%, including one case of colon fistula and relapse rate was 27.6%(at 5-year), 38.5%(at 10-years). Mutivariate analysis demonstrated that only incomplete excision of DIE lesions was a risk factor for shorter pain relief time.
Conclusion: Conservative laparoscopic surgery may effectively treat pain s in DIE patients. The systematisation of strategy is essential to make surgery more reproducible, safer. And patients could gain better life quality after conservative surgery combine with medication. Incomplete excision of DIE lesions was the significant predictor of shorter pain relief time.

Seguimiento a 10 años de 1000 pacientes con endometriosis superficial y 580 con endometriosis profunda infiltrante (DIE). En la DIE la resección incompleta se vinculó a una mayor y más rápida recidiva.

Algunos trabajos provocativos:

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La mayor incidencia de dispareumnia (72%) se verificó en el grupo de invasión profunda de cuerno vaginal

Algunos trabajos provocativos:

LAPAROSCOPIC NEUROLISYS FOR DEEP ENDOMETRIOSIS INFILTRATING PELVIC WALL AND SOMATIC NERVES: A RETROSPECTIVE STUDY ON 216 PATIENTS

Roberto Clarizia1, Giovanni Roviglione1, Francesco Bruni1, Mohamed Mabrouk1, Marcello Ceccaroni1
1 Gynecologic Oncology and Minimally Invasive Pelvic Surgery Unit, International School of Surgical Anatomy, Sacred Heart Hospital, Negrar (Verona), Italy

Objectives: Objective of the present study is to review efficacy and feasibility of laparoscopic neurolysis for cases of endometriosis involving sacral plexus and/or somatic nerves causing ano-genital pain.

Design: Retrospective case-series, single-centre, single-surgeon study on 216 patients. In a 4-year period, we treated by laparoscopic neurolysis of sacral roots and somatic nerves 216 patients with deep infiltrating endometriosis complaining of recurrent sciatica and ano-genital pain in addition to "usual" endometsiosis symptoms (i.e. dysmenorrhea, dyspareunia, dysketia) .

Materials and Methods: Depending from the grade of infiltration, either decompression (resection of disease up to the parietal fascia covering the nerve) or neurolysis (resection of disease together with the affected fascia covering the nerve and with perinevral planes and nevral fibers) was performed.

Results: In all of the patients a surgical whole decompression of nervous structures was performed, where in 41 (18.9%) cases a complete neurolysis was required. Complete relief from neurologic symptoms was achieved in all patients at 6 month after surgery. Neuritis was reported in 42 patients (19.4%) and successfully treated with corticosteroids and pregabalin.

Conclusion: Laparoscopic transperitoneal retroperitoneal nerve-sparing approach to the pelvic wall (the Possover Operation) proved to be a feasible and useful procedure even if limited to referred laparoscopic centers and anatomically experienced and skilled surgeons.

La neurolisis laparoscópica transperitoneal/retroperitoneal de los plexos sacros y nervios somáticos en pacientes con dolor anogenital (método de Possover) es posible en manos experimentadas y tiene excelente resultado en aliviar el dolor

Algunos trabajos provocativos:

SEVERE URETERAL ENDOMETRIOSIS: PRELIMINARY REPORT OF 30 CASES WITH HYDRONEPHROSIS

Marco Puga[1], Joao Alves[2], Rodrigo Fernandes[3], Arnaud Wattiez[3]

1 Clinica Alemana/Fac Medicina UDD, Santiago, Chile, 2 IRCAD / EITS Strasbourg, Strasbourg, Portugal, 3 IRCAD/EITS, Strasbourg, France

Objectives: The objective is to describe perioperative management, complications and outcomes of severe ureteric endometriosis.

Design: Retrospective, descriptive study of patients who had surgery due to deep infiltrating endometriosis with hydronephrosis.

Materials and Methods: Consecutive patients who underwent laparoscopic surgery for hydronephrosis due to ureteral endometriosis (HUE) at the Department of Obstetrics and Gynecology, Strasbourg Hospitals; between June 2004 and June 2013.

Results: Two patients had non-functioning kidneys. Left ureteral lesions were more common (76.9%). Conversion was not necessary. Ureterolysis was performed in 10 patients (33.3%) and segmental resection-anastomosis in twenty (66,7%). All patients had improvement in pain symptoms. There were no intraoperative complications, but five major postoperative complications in four patients (13%).

Conclusion: HUE is a complex subset of patients presenting with a high possibility of ureteral resection and not negligible amount of complications. When managed in specialized team the outcomes are satisfactory, consequently it's critical to diagnose this condition preoperatively in order to offer the best standards of care and safety.

análisis retrospectivo de 30 pacientes con hidronefrosis debida a endometriosis ureteral:
10 ureterolisis laparoscópicas
20 resecciones ureterales segmentarias/reanastomosis laparoscópica
76.9% eran lesiones izquierdas – 13% complicaciones post-op

Algunos trabajos provocativos:

OUTCOMES IN THE LAPAROSCOPIC TREATMENT OF BLADDER ENDOMETRIOSIS: PRELIMINARY REPORT OF 60 CASES

Joao Alves[1], Marco Puga[2], Anne Piton[3], Rodrigo Fernandes[3], Cristina Redondo[3], Arnaud Wattiez[3]

1 IRCAD / EITS Strasbourg, Strasbourg, Portugal, 2 Clinica Alemana/Fac Medicina UDD, Santiago, Chile, 3 IRCAD/EITS, Strasbourg, France

Objectives: To report the performance of the different techniques in bladder endometriosis. Pain scores, complications and recurrence are described.

Design: Retrospective study of patients with bladder endometriosis managed at the University Hospitals of Strasbourg between January 2006 and June 2013.

Materials and Methods: Only cases of deep infiltrating endometriosis (DIE) were included (detrusor invasion). The groups were divided in partial cystectomy (PC) and partial-thickness excision (PTE).

Results: Forty-two patients (70.0%) underwent PC, and the remaining patients underwent PTE. The pain relief was reduced in both groups. No bladder recurrences were found. Major complications developed in 12 PC patients, 11 of them primarily related to bowel resection or ureteral surgery. Of the 12 patients 7 complications were managed surgically.

Conclusion: Laparoscopic management is feasible and associated with reduction of pain and low recurrence rates. As expected, complications were associated with bigger resections and, in our series, only to cases of partial cystectomy. Interestingly, the majority of complications where primarily related to associated procedures.

Pacientes con ivasión del detrusor
70% de cistectomías parciales laparoscópicas (42 ptes.)
30% de resección extraluminal de la pared
Alivio significativo del dolor – no recurrencias
11 complicaciones asociadas a resecciónes ureterales o rectosigmoideas

Algunos trabajos provocativos:

IS OVARIAN ENDOMETRIOMA A MARKER OF THE EXTENSION OF DIE?

Lilian Aragão1, Claudio Crispi1, Marlon Fonseca2, Marco Aurélio Oliveira1, José Anacleto1, Felipe Ventura2
1 UNIFESO, Rio de Janeiro, Brazil, 2 IFF, Rio de Janeiro, Brazil

Objectives: To verify the association between the presence of unilateral or bilateral ovarian endometrioma and the number of areas affected by deep infiltrating endometriosis (DIE).
Design: It is a seccional study
Materials and Methods: 138 women in reproductive age underwent laparoscopic treatment of DIE from 2011 to 2013. They were divided in groups according to side of endometrioma. All visible lesions were considered endometriosis only when confirmed by histopathology. The total number of lesions was obtained by the sum of the affected sites.
Results: Results: The median age of patients was 35.0 years (minimum – maximum: 19-52). Ovarian endometriomas were present in 92 patients (66.7%). In 16 patients (11.6%) they were on the right side, in 21 (15.2%) on the left side and in 55 (39.9%) bilateral.The number of affected sitesby DIE was not statistically different (P .228) between patients with ovarian endometrioma (median5.0 , min-max:1-11) and without ovarian endometrioma (median 4.0 , min-max: 1-12). The number of affected sites by DIE was also not different (P .468) between the groups with unilateral endometrioma (median 6.0, min-max:1-10), bilateral endometrioma (median 5.0, min-max:1-11) and without endometrioma.
Conclusion: Ovarian endometrioma is highly associated with DIE but is not predictive of the extension of the disease.

138 pacientes tratadas por endometriosis profunda infiltrante
En 92 (66.7%) coexistía endometrioma
11,6% a la derecha
15,2% a la izquierda
39,9% bilaterales

Los esperamos para seguir aprendiendo en Vancouver, Canadá, en 2017

Muchas gracias por la atención