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Approach to Endometriosis Surgery

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Introduction

The widespread health condition known as endometriosis affects many women. It is characterized by the presence of tissue that resembles endometrium outside the uterus and causes a persistent inflammatory response. Peritoneal endometriosis, endometriotic ovarian cysts (endometriomas), and deeply infiltrative endometriosis, often known as Deep Endometriosis (DE), are the three clinical manifestations. Endometriosis that is more than 5 mm below the peritoneal surface is referred to as DE. The uterosacral ligaments, the ovarian fossa, the pelvic peritoneum, the bladder, the rectosigmoid region, the rectovaginal septum, and the vagina are the main locations where it is found. The pelvic anatomy may become completely distorted as a result of DE. The function of a colorectal surgeon in the multidisciplinary treatment of DE is the particular emphasis of this review. Thus, the purpose of this essay is to emphasize the significance of a colorectal surgeon in the multidisciplinary therapy of bowel endometriosis.

Description

During the active reproductive phase, endometriosis develops. Up to 15% of all women who are of reproductive age are thought to be endometriosis carriers. About one-third of women who are unable to conceive have endometriosis. In 3%-37% of cases, endometriosis affects the colon; in 90% of these cases, the rectum or sigmoid colon are also affected. Endometriosis may typically be diagnosed histopathologically with ease. When endometrial-like glands and stroma penetrate the intestinal wall, at least to the subserous fat tissue or nearby subserous plexus, the condition is appropriately referred to as "bowel endometriosis." Pelvic discomfort and infertility are generally the most frequently occurring clinical symptoms that present. Since many women with the disease have no symptoms, the natural history of the condition has never been fully established. Even women with bowel endometriosis may be asymptomatic. Given the benign clinical course observed in these patients, surgical excision is most likely not warranted, particularly in the absence of concomitant infertility. Intestinal symptoms may be seen in women with moderate to severe illness. Depending on the location and menstrual cycle, endometriosis-related intestinal symptoms can change. The lack of specificity in endometriosis symptoms and their significant overlap with other clinical disorders might cause a delay in diagnosis and treatment.

Furthermore, the diagnosis of adolescent females may be hampered by a physical examination that is entirely normal, particularly a vaginal examination. Chronic pelvic pain is the most prevalent symptom of endometriosis, and it is usually worst during menstruation or after ovulation. Changes in bowel habits, including constipation, diarrhea, dyschezia, tenesmus, and infrequently, rectal bleeding, can be caused by involvement of the rectal canal. It is necessary to differentiate between rectal tumors, single rectal ulcer syndrome, and irritable bowel syndrome. Colic endometriosis can cause substantial intestinal blockage, even though it may not show any symptoms at all. It is necessary to distinguish colonic endometriosis from diverticular disease, adhesions, neoplasms, and Crohn's disease. It can be challenging to distinguish endometriosis from Crohn's disease when there are small intestinal implants resulting from the disorder, as there are similarities in the endoscopic and histologic images. Both the colon and an appendix with transmural endometriosis may have intestinal perforation as a result of endometriosis.

The best course of action for endometriosis involving the gastrointestinal system is still up for debate. A preoperative standardized work-up is required to diagnose intestinal endometriosis. It is recommended to schedule a comprehensive laparoscopic procedure in an expert institution beforehand to guarantee appropriate patient counseling. The best method is laparoscopy since it has a shorter recovery period and less pain after surgery.

Additionally, when bowel resection is necessary, the laparoscopic method improves the prognosis for fertility. A precise decision regarding the necessity of a bowel resection or full-thickness disc excision should be made by a skilled colorectal surgeon. We believe that a patient-specific strategy is essential and that the least invasive radical course of action ought to be selected. Future studies should concentrate on improving the long-term results of the multidisciplinary treatment of intestinal endometriosis in terms of symptoms, quality of life, cosmetic results, endometriosis recurrence, and fertility. Preoperative work-up, often performed by the gynecologist, is crucial to the design of a multidisciplinary surgical treatment.

Conclusion

Fundamental with respect to area and degree of bowel endometriosis. For the assessment of bowel endometriosis, with or without inclusion of the rectovaginal septum, transvaginal ultrasonography, barium bowel purge examination, and Attractive Reverberation Imaging (MRI) are the imaging methods of choice. These specialized examinations ought to point to:

Archive the degree of the malady; offer assistance in arranging a multidisciplinary treatment; and guide patients with respect to postoperative complications. Transvaginal ultrasonography may be a non-invasive apparatus, accessible at the gynecological outpatient clinic. DE can be recognized as a heterogeneous, hypo-echoic, and some of the time spiculated mass. Concurring to a later meta-analysis, bowel endometriosis can be analyzed by transvaginal ultrasound with pooled gauges of affectability and specificity of 91% and 98%, separately. In case bowel endometriosis is suspected diagnosis of endometriosis barium enema barium enema is used to determine the extent of endometrial disease. A deep invasion of the intestinal wall occurs as extrinsic matter compresses the intestinal lumen. Fine crenulation in the intestinal mucosa is observed in this particular area. Bowel strictures are also observed at the recto-sigmoid junction. Based on the diagnostic potential, barium enema can provide guidance to the colonorctal surgeon as to the degree of dissection. The exact distance of dissection is not measurable. MRI can be used to diagnose multifocal Endometriosis and to define the anatomical location of the condition. Hemorrhagic foci or hyperintense cavities secondary to endometriosis Hypointense nodule on T2-weighed images, the signal of tissue mass is close to the tissue mass of the pelvic muscles. MRI sensitivity and specificity for the diagnosis of Pelvic endometriosis (Pelvic) is about 90%. Rhomodialysis clonoscopy diagnosis of bowel endometriosis.