There are many opinions regarding the treatment of endometriosis. Many of those regard deep, rectovaginal and ovarian disease. However, gynecologists more commonly treat mild stages of this enigmatic disease. There is an ongoing debate about the necessity of excision for early stages. The debate includes clinical response, complications, and the necessity of histological documentation.

An e-pub article by Dr. Martin Healey investigates treatment of endometriosis by coagulation or excision. Dr. Healey was concerned about rectal, bladder, and ureteral involvement and excluded those patients. As a second concern, studies by Dr. Olaf Buchweitz, on the intra-observer variability and confirmation under research and clinical conditions, suggest that histology for the documentation of endometriosis may be useful as a research tool but may not be necessary in clinical use. A third concern is that histology is useful in diagnosing other diseases.

Treatment of Mild Endometriosis

Mild endometriosis was the more common finding in Dr. Frank Ling’s 1999 study, in which 85 percent of patients with moderate to severe chronic pelvic pain for at least six months had endometriosis. The revised American Fertility Society (AFS) classification showed that the majority had minimal or mild endometriosis. Mild endometriosis was also noted in 81 percent of subjects in Dr. Healey’s study.

Dr. Healey randomized subjects to ablation and excision. He found no significant differences in pelvic pain, dysmenorrhea, low back pain, rectal pain, pain with bowel movements or pain with sex. There was a higher AFS stage in the excisional group and Dr. Healey concentrated on minimal and mild endometriosis. He did not attempt to determine if deeply infiltrating endometriosis was better treated with excision than ablation. He concluded that there were no differences in pain response comparing coagulation with excision for minimal or mild endometriosis.

Concerns in the treatment of endometriosis include:

- Treatment of mild endometriosis
- Treatment near the rectum, bladder and ureter
- Histology specifically to confirm endometriosis contrasted with diagnosing other diseases.

Figure 1. Excision removes the lesion to be sent to pathology
Treatment Near the Rectum and Other Organs

Dr. Ling’s study was confirmed and expanded to investigate the results of histology by Dr. Todd Jenkins in 2008. Dr. Jenkins added the concern of perirectal involvement in 43 percent of his patients. Ten percent of Dr. Healey’s patients had rectal, bladder, or ureteral involvement.

Any technique for treatment in these areas can potentially damage them. Damage can be direct when coagulation or excision extends deeper than intended. Damage can be indirect when there are tension tears, subsequent avascular necrosis or secondary ulceration in these areas.

With respect to coagulation, Dr. Bob Wheeless showed 5cm of damage with monopolar electrosurgery. Dr. Jeffrey Phipps subsequently demonstrated up to 15mm of damage and 20mm of thermal spread with bipolar coagulation. Both monopolar and bipolar electrosurgery can be dangerous when coagulating near the rectum, bladder or ureter.

Histology

One advantage of excision is in providing histologic documentation. Although this is useful for documenting diseases other than endometriosis, there is significant debate about whether it is needed to confirm a diagnosis of endometriosis. Although Dr. Buchweitz had an 87 percent confirmation under research conditions; this decreased to 56 percent in clinical use. This is similar to my decrease from 98 percent, in the last six months of a five-year developmental study, to 88 percent in recent combined clinical and academic practice.

Histologic documentation, specifically for confirmation of endometriosis, should be used in research studies but may not be necessary in clinical use. On the other hand, histology for diagnosis of other diseases can be important. Vesicular, fleshy and white nodular lesions have been endometriosis, endosalpingiosis, psammoma bodies, low malignant potential tumor, and cancer. Biopsy of unusual appearances can be important.

Summary

The treatment of mild endometriosis can be reasonably performed using coagulation or excision in locations not near the rectum, bladder and ureter. Although excision has the advantage of providing histologic confirmation, this appears more important in diagnosing other diseases than in confirming endometriosis.

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Figure 2: Vesicles can be endometriosis, endosalpingiosis, psammoma bodies, low malignant potential tumor and cancer
continued from page A3

**Dr. Dan Martin** specializes in gynecological problems and infertility at UT Medical Group and serves as Professor of Obstetrics and Gynecology at the UT Health Science Center. He is certified by the American Board of Obstetrics and Gynecology and has been named to the "Top Doctors" list in the field of gynecology. Dr. Martin cares for patients at UTMG's Germantown, 7945 Wolf River Blvd., Suite 320. Please call 901-347-8320 to make a referral.

**References**


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Researchers Predict Growth in Pelvic Floor Disorders

By 2050, one in three U.S. women may be afflicted with some form of pelvic floor disorder, according to a 2009 Duke University study. Researchers attributed the predicted rise to changing demographics, including the aging of the U.S. population and prevalence of obesity. The study’s results were based on 2010 to 2050 population projections from the U.S. Census Bureau along with data from the 2005 National Health and Nutrition Examination Survey. Researchers estimate significant growth in several areas, including:

- Urinary incontinence: Up 55%
- Fecal incontinence: Up 59%
- Pelvic organ prolapse: Up 46%

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