Pre-Treatment Imaging in the Surgical Management of Endometriosis

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Abstract

Background: Preoperative imaging assessment is essential to draw an accurate map of endometriotic lesions. Knowledge of the extension and severity of disease is paramount for the surgical team in order to plan the type of surgery, complete the operating team and properly inform the patient with details of the risks. Material and Method: Transvaginal ultrasound is the first-line imaging technique for ovarian and deep infiltrating endometriosis, but the accuracy of the diagnosis is proportional with the experience of the operator. Respecting the four steps of ultrasound evaluation technique decreases the probability of misdiagnosis. Step 1 include evaluation of the uterus and adnexa, step 2 - evaluation of “soft marker”, step 3 - assessment of the Pouch of Douglas using “sliding sign” and step 4 - assessment of anterior pelvic compartment (urinary bladder, ureteral region and ureters) and posterior pelvic compartment (rectovaginal septum, posterior vaginal fornix, uterosacral ligaments, rectum and sigmoid). MRI is performed as an additional examination in complex cases prior to surgery, in symptomatic patients with negative or equivocal ultrasound findings and it can be useful for diagnosis of multiple sites of deep infiltrating endometriosis. Results: Important information from recent guidelines and relevant literature are highlighted. Ovarian and deep endometriosis diagnosed by ultrasound scan and MRI imaging - case series (personal experience) will be commented. Conclusion: As with cancer pathology, the success of treatment depends on complete excision of the endometriotic lesions. Rigorous imaging investigation avoids „the tip of the iceberg“ mirage and enhances the quality of medical care.

Keywords: endometriosis, preoperative diagnosis, ultrasound, MRI, lesion map, quality of life, EHP-30.
dată preoperator, pentru toate cazurile complexe, la pacientele simptomatice cu examinare ecografică negativă sau echivocă și de asemenea este utilă la pacientele cu noduli endometriozici multipli la nivelul tubului digestiv.

Rezultate: Informații esențiale din ghiduri actuale și literatura de specialitate vor fi evidențiate. Sunt analizate și comentate o serie de cazuri de endometrioza ovariană și endometrioza profundă cu diagnostic ecografic și RMN.

Concluzii: Similar cu patologia neoplazică, succesul tratamentului depinde de excizia completă a leziunilor endometriozice. Examinarea imagistică riguroasă evită mirajul “primei leziuni” pentru și crește calitatea actului medical.

Cuvinte cheie: endometrioză, diagnostic preoperator, ultrasonografie, RMN, hartă lezională, calitatea vieții, EHP-30.

INTRODUCTION

It is essential to map the endometriosis lesions using preoperative imaging evaluation in order to offer to the surgical team details about the extension and severity of the disease. Establishing an accurate diagnosis and preoperative staging, gives the possibility for optimal therapeutic plan, to complete the surgical team with colorectal surgeons or urologists, to inform the patient of foreseeable intraoperative complications and to obtain informed consent for each procedure.

To avoid suboptimal treatment and multiple surgical interventions, patients with severe endometriosis (stage III-IV) must be referred to high volume specialized centers.

Transvaginal ultrasound and MRI are not competing but rather complementary investigations. Ultrasound has the advantage of being readily available, routinely performed, at low cost, with minimal patient discomfort and it’s a real time evaluation with the opportunity to mobilize the uterus and the adnexa. Meanwhile, MRI offers essential details in defining rectal endometriosis nodules (locations, size, stenosis grade, parietal infiltration stage) and also can diagnose endometriotic lesions located above the sigmoid colon.

According to current guidelines, transvaginal ultrasound comes first as recommendation during evaluation of patients with suspected endometriosis. Every patient with dysmenorrhea or dyspareunia that can be related with endometriosis and/or diagnosed with endometrioma should receive the ultrasound protocol of deep endometriosis.

MRI is indicated in selected cases, for example in symptomatic patients with negative ultrasound findings or in suspected cases of deep endometriosis with multiple locations, although there isn’t enough published data concerning the indication of MRI in the evaluation of pelvic endometriosis. In order to obtain a high accuracy diagnosis, both investigations must be performed by experienced specialists in endometriosis.

MATERIAL AND METHOD

Transvaginal ultrasound is useful and highly accurate for endometriomas and deep endometriosis diagnosis.

The menstrual cycle does not influence ultrasound evaluation; emptying the rectum and bowel preparation with contrast medium is adjuvant but not mandatory. High-resolution transvaginal scan is recommended to enhance the quality of imaging in evaluation of the rectum and sigmoid colon.

The IDEEA Group created a protocol for ultrasound evaluation that brings multiple benefits for daily practice: standardization of technique, mandatory evaluation of all pelvic compartments, uniformization of terminology and definitions for endometriotic lesions. This protocol is useful in current practice by increasing the rate of detection of deep endometriotic lesions and facilitates multicenter research.

The protocol calls for a four-step ultrasound evaluation:

- Step one is routinely performed in every ultrasound examination and represents the evaluation of the uterus and adnexa searching for signs of adenomyosis and endometriomas;
- Step two checks the mobility and specific tenderness of the uterus and ovaries, the so-called “soft markers”, using bimanual technique. An ultrasound sign that indicates the presence of
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Step three evaluates the status of the pouch of Douglas (POD) using the „sliding sign“ . A positive sliding sign in the retrocervical region and the level of the upper uterus indicates an unobstructed POD.

Step four aims to identify the presence of endometriotic nodules in the anterior compartment (urinary bladder, uterovesical region) and in the posterior compartment (rectovaginal septum, posterior vaginal fornix, uterosacral ligaments, rectum and sigmoid).

Assessment of the mobility between uterus and posterior region of the bladder is paramount because often bladder endometriotic nodules arise from the uterus. Identifying a hypoechoic wall thickness or nodule with low Doppler signal, involving the muscularis or submucosa of the bladder with a negative „sliding sign“ in the anterior compartment are highly suggestive for the diagnosis of urinary bladder endometriotic nodule11 (Figure 2).

The normal uterosacral ligament is not visible during ultrasound examination, unless it is surrounded by fluid. Pathological uterosacral ligament is visible in the absence of fluid if its proximal region is thickened, nodular and hypoechoic8 (Figure 3).

Transvaginal ultrasound has the great advantage of real-time bimanual examination in detecting adhesions in the posterior compartment. Furthermore, the four separate rectosigmoid wall layers have different echogenicity and this allows staging of parietal infiltration (Figure 4).

The disadvantage of transvaginal ultrasound is that it can’t precisely predict the grade of stenosis because the distention of the bowel cannot be estimated. The distance between the nodule and the anal orifice can be estimated at best taken into consideration that the location of POD is at 7-9 cm from the anal orifice. The gynecologist has the possibility to use a transrectal probe to estimate more precise the distance to the anal orifice, but this method has low compliance among patients12.

Previous published data sustain a high accuracy of transvaginal ultrasound in the diagnosis of endometrioma, peri-adnexal adhesions, POD obliteration and bladder nodules13. Regarding the uterosacral ligament, sensitivity is lower, without major impact on surgical protocol.14 A review that included 10 studies demonstrated a sensitivity of 67-98% and a specificity of 92-100% for bowel endometriotic lesions15.

To conclude, a complete imagistic report consists in describing „hard markers“ - endometriomas (dimensions, number, typical/atypical aspect), „soft markers“, adhesions and the absence of ovarian mobility is “kissing ovaries” sign – this finding indicates an advanced stage of the disease, which can be more frequently associated with Fallopian obliteration (92,6%) and bowel endometriosis. (18,5%)10 (Figure 1).
type of surgical procedure, estimating operating time and the possibility of multidisciplinary involvement during the procedure.

Not so often, these goals are difficult if not impossible to achieve just by using transvaginal ultrasound, this is where MRI brings light in a dark landscape.

„sliding sign”, rectal/sigmoidian colon nodules (dimensions, location, distance from the anal orifice, the depth of wall infiltration, stenosis grade), bladder nodules, ureterohydronephrosis.

This information is extremely important for the surgeon in elaborating the therapeutic plan, choosing the
Magnetic resonance imaging (MRI) is an advantageous technique because it offers multiplanar evaluation, high resolution, lack of radiation and the possibility of abdominal and pelvic complete evaluation in a single scan. Compared to ultrasound, it can visualize in one slide the anatomic relationship of the uterus and recto-sigmoid colon, therefore can easily identify and differentiate a nodule located in the inferior, medium or upper rectum or the recto-sigmoid junction. Ultrasound can only estimate the location of the nodule based on anatomical landmarks: lesions situated below the insertion of uterosacral ligament on the cervix are considered lower (sub-peritoneal) anterior rectal lesions, while nodules located above are considered upper anterior rectal lesions; nodules situated at the level of uterine fundus are located at the rectosigmoid junction and the ones above this limit belong to the sigmoid. The hyper anteverted and/or retroverted uterine position can misleading regarding the correct localization of rectal/ sigmoid nodules.

During ultrasound examination, the distance from the anal orifice is arbitrary evaluated while MRI can directly measure the distance taken into consideration the rectosigmoid curves. It is important for the surgeon to know the exact location of rectal nodules because low rectal resections are more difficult to perform, the need for a temporary stoma may occur and the risk of complications may increase manifold. In the light of the above, patients must express an informed consent for stoma and time should be taken to explain the risks and possible complications.

Endometriosis nodules that infiltrate the rectal muscularis should be completely resected, this implies a certain type of rectal resection. For this reason, it is essential to know the grade of parietal infiltration for choosing the correct surgical technique, and both imaging investigations, ultrasound and MRI, satisfy this purpose. The majority of endometriotic lesions that have penetrated the muscularis and submucosa are found to affect at least 40% of the circumference of the rectal wall.

Predicting the stenosis grade and the dimension of the nodule is mandatory for choosing the correct type of resection - nodulectomy, discoid or segmental bowel resection. MRI and ultrasound are limited in measuring the maximum grade of bowel distention, water enema with a 24 Fr Foley rectal catheter could improve this aspect. Rectal and vaginal opacification with sonographic gel is suggested as an option that could provide better evaluation of POD, the rectovaginal septum, and rectosigmoid endometriosis.

In summary, MRI brings diagnosis reliability, increases the recognition of subperitoneal lesions and the ones covered by adhesions, offers precise data of nodules characteristics and can provide a road map that...
allows presurgical counseling and complete ablation of all possible endometriotic lesions.

RESULTS

Case 1 - A 43 years old woman with one natural labor 10 years prior describing low intensity dysmenorrhea 3-VAS, without dyspareunia, sporadic constipation without rectal bleeding was referred for routine examination.

A 3.97/3.08 cm ground glass adnexal cystic mass suggestive of endometrioma was diagnosed by ultrasound. IDEA protocol for endometriosis was applied – posterior compartment evaluation by angulating ultrasound probe towards the rectum identified a hypoechoic non-homogenous, non-vascularized nodule that infiltrates all the layers of the rectal wall. The mucosa of the rectal wall was intensely retracted resulting in the so-called „Indian headdress sign” (Figure 5). The nodule measured 4.02/1.45/3 cm.

MRI scan confirmed the diagnosis and further evaluated a 50% degree of stenosis at the mid and upper level of the rectum, approximately 15 cm from the anal orifice. The MRI protocol lacked intrarectal gel instillation (T2 sagittal coronal and axial 3.5 mm slices, oblique axial and oblique coronal at the level of the uterus, T1 gradient with saturated fat in axial plane) (Figure 6).

Given the lack of symptoms, expected menopause (FSH=60 mUI/ml) and moderate degree of rectal stenosis, a „wait and see” management was suggested with 6 months ultrasound and MRI reevaluation.

Case 2 - 39-year-old woman with one natural labor 8 years prior describing dysmenorrhea VAS-8, dyspareunia VAS-7, chronic pelvic pain VAS-5, chronic constipation, rectal bleeding during menstrual cycle and overall severe quality of life impairment - EHP-30 score 81.48.

Ultrasound examination demonstrated “kissing ovaries” – both ovaries were located posterior to the uterus with two endometriotic cysts of 6/5.2/4/3 cm and 4.08/3/2.35 cm; negative „sliding sign” at the retrocervical region and at the uterine fundus – completely obliterated pouch of Douglas. In the posterior compartment, at the level of the uterosacral ligaments, a 3.47/2.37 cm well defined hypoechoic nodule that infiltrates all the layers of the rectal wall was visualized (this corresponds to the medium rectum) (Figure 7).

Pelvic MRI after enema and intravaginal and intrarectal gel instillation diagnosed T2 low signal intensity...
Given the pain score, severe quality of life impairment and high degree of stenosis, the patient was referred to a specialized center where she suffered recto-sigmoid resection with termino-terminal anastomosis with no protective stoma. The postoperative course was uneventful and was certified by good EHP-30 score 13.89 – low level of quality of life impairment – dysmenorrhea VAS-3, dyspareunia VAS-2 and chronic pelvic pain VAS-2.

3.8/2.3/1.5 cm rectal nodule at the level of the upper rectum/rectosigmoid junction with 80% stenosis – contrast medium reaches de lower border of the nodule but not more (Figure 8).

The position of the rectal nodule was estimated lower by transvaginal ultrasound because the uterus was hyper antverted. If the uterus held its normal position, the nodule would have been located at the uterine fundus and at the level of the upper rectum/rectosigmoid junction.

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MRI scan revealed a large 5/3/1.6 cm nodule at the level of the upper rectum and rectosigmoid junction (16 cm from the anal orifice). The nodule penetrates all the layers of the rectum determining 90% rectal stenosis and also infiltrates torus uterinus (Figure 10).

The patient was referred for rectal resection. Previous suboptimal treatment permitted the deep lesions to evolve, prevented conception and had a negative psychological impact on the patient that needed constant psychological counsel.

**Case 3** - 39-year-old nulliparous woman with maximal impairment of quality of life shown by EHP-30 score-100 (maximal score), dysmenorrhea and dyspareunia VAS-10, chronic pelvic pain VAS-8, passing stool only with laxatives, no rectal bleeding.

The patient suffered 2 laparoscopic interventions for endometriosis in 2016 and 2018. In 2019, she was started GnRH antagonist medication for symptom control.

A large, well bordered, rectal nodule in contact with the posterior aspect of the uterus was demonstrated by ultrasound (Figure 9).
Pelvic MRI demonstrated several T1 high intensity signal and T2 low intensity signal cystic lesions at the level of right sciatic nerve, anterior and inferior to the piriform muscle, consistent with the presence of an endometriotic nodule (Figure 11).

Sciatic nerve endometriosis implants are very rare extraperitoneal locations and should be taken into consideration in young women with catamenial sciatica associated with gluteal pain and motor deficit. During MRI investigation, high matrix coronal and axial T1 and T2 weighted sequences are recommended to increase the diagnostic rate for this pathology.

Case 4 - 42-year-old referred for routine consultation. In depth anamnesis revealed right lumbar and vertebral pain referred to the posterior aspect of the right thigh and to the heel, pain enhanced by movement and during menstruation and chronic motor deficit. Previous neurology examination and initial MRI examination have stated that the patient suffered from lumbar disk disease and piriformis syndrome.

Barely in the reach of gynecology, the symptoms that worsened during menstruation drawn attention on endometriosis and the patient was referred for further imaging investigations in a specialized center.

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Sciatic nerve endometriosis demands multidisciplinary management and requires highly experienced gynecological surgeons both in endometriosis and neuropelveology.

The patient refused surgical treatment intended to remove all endometriotic lesions and was started on Dienogest. Symptoms improved only after 3 months and at 1-year follow-up, chronic pelvic pain downgraded to VAS-7 to VAS-2 and the motor deficit was minimal. MRI at 1-year has shown 50% decrease of the nodule (Figure 12).

Potential permanent damage to the sciatic nerve is prevented by early diagnosis and appropriate treatment.

**DISCUSSION**

The diagnosis of deep endometriosis is often challenging. Three main elements are required: firstly, we should think and raise clinical suspicion based on a complete anamnesis - questions like when, where, and how intense is the pain on a scale of 0-10; secondly, ultrasound endometriosis specific markers should be identified, and then we must focus on each anatomical compartment in order to lower the rate of false diagnosis.

The delay in establishing the diagnosis is of worldwide concern: for example in Germany and Austria the average time from symptom onset to the positive diagnosis is 10.4 years\(^{26}\), in Spain and U.K 8 and 7,9 years in USA\(^{21,22}\). The main issues for the delay, false negative diagnosis and underestimation of severity may arise from insufficient awareness of endometriosis by both patients and physicians and slow development of diagnosis and therapeutic skills.

The learning curve for transvaginal ultrasound is long, fact observed by Donnez in a study that involved experienced gynecologists that have performed at least 2500 general ultrasound examinations, without specialized experience in transvaginal examinations for endometriosis. After completion of training, the learning curve using the cumulative sum show that the subjects reached the level of proficiency for diagnostic rectal endometriosis after 37-42 patients scans\(^{23}\).

Regarding the MRI learning curve, L. Saba indicated a significant statistical difference in sensitivity regarding detection of recto-sigmoidian endometriotic nodules between first and third analysis: 39,1% versus with 82%\(^{24}\).

**CONCLUSION**

The most important measures for early diagnosis of deep endometriosis are raised awareness for both patients and physicians and routine ultrasound examinations for symptomatic patients. Theoretical and practical training at profile conferences in order to enhance the ability of gynecologists to diagnose deep endometriosis should be encouraged.

Educational programs should be designed for both gynecologists and radiologists to improve collaboration. Feedback with operating room data or images might familiarize the radiologist with subtle surgical and pathology aspects.

Taking into consideration that deep endometriosis is a real public health problem increase efforts are mandatory to improve diagnostic and surgical skills.
Compliance with ethics requirements: The authors declare no conflict of interest regarding this article. The authors declare that all the procedures and experiments of this study respect the ethical standards in the Helsinki Declaration of 1975, as revised in 2008(5), as well as the national law. Informed consent was obtained from all the patients included in the study.

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