

# HOSPITAL PHYSICIAN®

## OBSTETRICS AND GYNECOLOGY BOARD REVIEW MANUAL

### PUBLISHING STAFF

PRESIDENT, PUBLISHER  
Bruce M. White

EXECUTIVE EDITOR  
Debra Dreger

SENIOR EDITOR  
Miranda J. Hughes, PhD

ASSISTANT EDITOR  
Barclay Cunningham

EDITORIAL ASSISTANT  
Melissa Frederick

SPECIAL PROGRAMS DIRECTOR  
Barbara T. White, MBA

PRODUCTION MANAGER  
Suzanne S. Banish

PRODUCTION ASSISTANTS  
Tish Berchtold Klus  
Christie Grams

ADVERTISING/PROJECT COORDINATOR  
Patricia Payne Castle

#### NOTE FROM THE PUBLISHER:

This publication has been developed without involvement of or review by the American Board of Obstetrics and Gynecology.

 Endorsed by the  
Association for Hospital  
Medical Education

The Association for Hospital Medical Education endorses HOSPITAL PHYSICIAN for the purpose of presenting the latest developments in medical education as they affect residency programs and clinical hospital practice.

## Laparoscopy for Endometriosis of the Cul-de-Sac and Rectum; Polycystic Ovarian Syndrome; Collagen Vascular Diseases

### Series Editors:

**Jordan G. Pritzker, MD, MBA, FACOG**

*Assistant Professor, Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, NY, Obstetrics and Gynecology Faculty Practice, Women's Comprehensive Health Center; Long Island Jewish Medical Center, New Hyde Park, NY*

**Adiel Fleischer, MD, FACOG**

*Associate Chairman, Director of Maternal-Fetal Medicine, Obstetrics and Gynecology Faculty Practice, Women's Comprehensive Health Center; Long Island Jewish Medical Center, New Hyde Park, NY*

## Table of Contents

### Chapter 1—Laparoscopic Excision of Deep Fibrotic Endometriosis of the Cul-de-Sac and Rectum . . . . . 2

Contributing Authors: **Harry Reich, MD, FACOG;**  
**Andrea Vidali, MD;**  
**Afshin Fazel, MD**

### Chapter 2—Polycystic Ovarian Syndrome: Case Studies . . . . . 15

Contributing Authors: **Gloria A. Bachmann, MD;**  
**Eckhard Kemmann, MD, FACOG;**  
**Johannes Ramirez, MD**

### Chapter 3—Collagen Vascular Diseases in Pregnant Women: Case Studies . . . . . 26

Contributing Author: **Genevieve B. Sicuranza, MD, FACOG**

Cover Illustration by Jean Gardner

Copyright 2000, Turner White Communications, Inc., 125 Strafford Avenue, Suite 220, Wayne, PA 19087-3391, www.turner-white.com. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, mechanical, electronic, photocopying, recording, or otherwise, without the prior written permission of Turner White Communications, Inc. The editors are solely responsible for selecting content. Although the editors take great care to ensure accuracy, Turner White Communications, Inc., will not be liable for any errors of omission or inaccuracies in this publication. Opinions expressed are those of the authors and do not necessarily reflect those of Turner White Communications, Inc.

# Chapter 1—Laparoscopic Excision of Deep Fibrotic Endometriosis of the Cul-de-Sac and Rectum

## Contributing Authors:

**Harry Reich, MD, FACOG**

*Associate Professor, Clinical Obstetrics and Gynecology  
Columbia University College of Physicians and Surgeons  
Director, Advanced Laparoscopic Surgery  
Columbia Presbyterian Medical Center  
New York, NY*

**Andrea Vidali, MD**

*Assistant Professor  
Department of Obstetrics and Gynecology  
Division of Advanced Laparoscopic Surgery  
and Reproductive Endocrinology  
Columbia University College of Physicians and Surgeons  
New York, NY*

**Afshin Fazel, MD**

*Clinical Fellow, Department of Advanced Laparoscopic Surgery  
Columbia University College of Physicians and Surgeons  
New York, NY*

---

## I. INTRODUCTION

---

Diagnosis and treatment of endometriosis is the most frequent reason for gynecologic operative laparoscopy in the United States.<sup>1</sup> Therefore, the laparoscopist must be thoroughly familiar with the current standards of diagnosis and management of this complex disease.

The most common presentations of endometriosis include pelvic pain, infertility, and adnexal mass. The ovaries, the posterior leaf of the broad ligament, and the cul-de-sac of Douglas behind the uterus are the most common locations of endometriosis, and the left side is more frequently affected than the right, as the rectosigmoid and its mesocolon—both often involved with endometriosis—enter the pelvis from the left side.<sup>2,3</sup> *Extensive endometriosis* refers to bulky deep fibrotic endometriosis deposits that can often be palpated preoperatively as tender pelvic nodules. These nodules consist of endometriotic glands and stroma surrounded by fibromuscular tissue that have accumulated over many years in response to cyclic monthly activation of the endometriosis. They represent a long-standing chronic inflammatory response. Histopathologic examination to document endometriotic glands and stroma

is necessary to substantiate a diagnosis of the endometriosis in any suspect lesion (**Figure 1A–F** [p. 10]).

Extensive endometriosis usually involves the posterior cul-de-sac of Douglas, the area surrounded posteriorly by the anterior rectum, anteriorly by the posterior vagina and cervix, and laterally by the uterosacral ligaments. The lesions can often obliterate the normal anatomy of the cul-de-sac, with the rectum sticking to the posterior vagina, cervix, and uterine fundus. One or both pelvic sidewalls overlying the ureters and the rectosigmoid are often affected. Less commonly involved areas include the anterior cul-de-sac (the area above the bladder and the anterior uterus), the appendix, and the small bowel. Extensive bulky endometriosis may also be present in the uterine muscle itself, where it is called *adenomyosis*.

The revised American Fertility Society classification for endometriosis does not address extensive deep cul-de-sac endometriosis because it does not allow points for intestinal disease. Extensive cul-de-sac disease that does not cause complete obliteration is often classified as stage 1 or 2. This is the same stage often assigned to women with no endometriosis after the surgeon sees the remains of retrograde menstruation, resembling coffee grounds or tobacco stains.<sup>4</sup> No patient should be labeled as having endometriosis without histopathologic confirmation.