FACT SHEET
SURGICAL TREATMENT OF ENDOMETRIOSIS & ADENOMYOSIS

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insight ENDOMETRIOSIS

ENDOMETRIOSIS AT A GLANCE

Endometriosis is a condition where tissue similar to the endometrium (the lining of the uterus) grows elsewhere in the body. This tissue responds to reproductive hormones where oestrogen stimulates patches forming superficial, lesions or endometrioma (ovarian cysts). Inflammation is generally present, and adhesions (scar tissue) can also form in response. Endometriosis within the muscle tissue of the uterus is known as adenomyosis, typically characterised by an enlarged uterus and heavy menstrual flow as well as pain at time of period.

ROLE OF SURGERY

Without a definitive cure, or even an agreement as to the causes or nature of endometriosis, treatments generally aim to reduce or eliminate symptoms, improve quality of life and fertility, if desired.

Some studies have shown that following surgery recurrence can be significantly reducing with a long-term hormonal treatment, which may be a major consideration in the lifetime choice of therapies.

As well as reducing recurrence risk, treatment decisions depend on a range of factors:

- age,
- symptoms,
- clinical history,
- extent of the disease,
- co-morbidities (other co-existing conditions)
- cultural considerations, and
- individual preference and priorities which may include pain/symptom management and/or fertility, and which may change over the lifetime experience of endometriosis

As well as providing a definitive diagnosis, surgery may help with pain and other symptoms due to endometriosis, adenomyosis and adhesions (scar tissue). However, for long-standing pain, central sensitisation pain may have developed, and this may well persist after a successful surgery; an interdisciplinary approach including neuralgia medications may help with this persistent pain.

EXCISION SURGERY

Highly skilled gynaecologists specialising in endometriosis surgery can both diagnose and remove (excise) endometriosis in the same surgical procedure, which aims to:

- remove all endometriosis nodules, tissue and cysts which will then be sent to pathology for assessment
- divide adhesions to free organs and restore anatomy and,
- if fertility is of concern, the patency of the fallopian tubes can be checked with a dye test, with a view to clearing them if blocked.

EXCISION LAPAROSCOPY (KEYHOLE SURGERY)

Excision surgery by laparoscopy is the gold standard of endometriosis treatment. Performed under general anaesthetic by a gynaecologist with specialist surgical skills, laparoscopy is the preferred surgical treatment because the smaller incisions lead to quicker healing and faster recovery time.

During surgery a laparoscope (thin viewing scope) is inserted into the pelvis via a small incision (cut) on the navel (tummy button). Other instruments are inserted into the pelvic/abdominal area via other small cuts. The surgeon will search for any signs of endometriosis deposits, lesions and cysts as well as adhesions (scar tissue). These may be on the pelvic organs including uterus (womb), ovaries, fallopian tubes, bowel, and bladder - and surrounding areas including the peritoneum (membrane lining) and Pouch of Douglas (POD or cul-de-sac). Less commonly endometriosis can be found in more distant locations including the liver, the diaphragm and thoracic (chest) cavity including the heart and lungs.

LAPAROTOMY

A laparotomy involves a larger cut in the abdomen, which may sometimes be necessary. Recovery times are much longer with a laparotomy than laparoscopy.

HYSTERECTOMY

A hysterectomy is not a cure for endometriosis, however it may be suggested for adenomyosis, and is a cure for adenomyosis, if hormonal treatments have proven ineffective. It is important to have a gynaecologist who specialises in endometriosis for this surgery, so concurrent endometriosis can be removed in the same procedure.

Hysterectomy refers to the removal of the uterus (womb) and is performed under general anaesthetic. It can often be completed vaginally using minimally-invasive surgical techniques.

OOPHERECTOMY

Oophorectomy is the removal of the ovaries; the removal of a single ovary is called a 'unilateral oophorectomy', while the removal of both ovaries is called 'bilateral oophorectomy' causing instant and irreversible menopause.

Due to considerable ongoing and long-term risks to health from cardiovascular and bone density issues, an oophorectomy would seldom be considered pre-menopause unless there is also a genetic risk of ovarian cancer. Those who have completed families and who have concerns about ovarian cancers may wish to discuss the option of removing fallopian tubes (salpingectomy) in conjunction with other surgeries.

For further information see the following Insight Endometriosis Factsheets::

- Endometriosis 101
- Endometriosis Symptoms
- Analgesic (Pain Relief) Treatment for Endometriosis
- Hormonal Treatments for Endometriosis & Adenomyosis
- Pain Management for Endometriosis

References:

- Ministry of Health. 2020. Diagnosis and Management of Endometriosis in New Zealand https://www.health.govt.nz/publication/diagnosis-and-management-endometriosis-new-zealand