



SIGNIFICANCE OF ULTRASOUND IN RECTOVAGINAL ENDOMETRIOSIS

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Abstract:

Endometriosis is one of the most important problems of modern gynaecology due to the steadily increasing morbidity, affecting women of young age, high frequency of infertility and difficulties in diagnosis and treatment. Verification of diagnosis in advanced endometriosis is still the prerogative of scientific centres and large federal medical institutions.

Keywords: Diagnosis of Retrocervical Endometriosis, Diagnostic Algorithms For Retrocervical Endometriosis

INTRODUCTION:

Endometriosis ranks third in the structure of gynaecological diseases after pelvic inflammatory diseases and neoplasms of the female reproductive organs. Studies show that endometriosis is most common in women of reproductive age, ranging from 2 to 27% (10-15% on average). One of the most severe forms of endometriosis is deep infiltrative endometriosis (DIA) with intestinal involvement (5-12% of all endometriosis cases). The rectum (13-53%) and intestine (18-47%) are most frequently affected, while other organs are less frequently involved: small intestine (2-5%), appendix (3-18%), etc. The most common manifestations of endometriosis are pelvic pain, infertility and symptoms of compression of adjacent organs (bowel, ureter, bladder).

CLASSIFICATION

- Stage I - endometrioid foci are located within the rectovaginal tissue;
- Stage II - infiltration of endometrioid tissue into the cervix and vaginal wall with the formation of small cysts and into the serous membrane of the rectosigmoid region and rectum;
- Stage III - spread of the pathological process to the sacro-uterine ligaments, serous and muscularis recta;
- stage IV - involvement in the pathological process of the rectal mucosa with the process spreading to

the peritoneum of the recto-uterine space with the formation of adhesions in the uterine appendages. Of course, the true severity of the disease is determined by the clinical picture that characterises the course of a particular variant.

If deep infiltrating endometriosis is localised in the posterior uterine space or sacroiliac ligament, patients report sharp pain that radiates to the vagina, rectum, perineum, hips, and is worse when sitting and when defecating (dyschezia).

Ultrasound diagnosis of infiltrative forms is difficult and often requires differential diagnosis with pelvic cancer. Radiological methods are uninformative for this pathology. Retrocervical endometriosis is characterised by a solid mass, situated in the rectovaginal tissue under the cervix or eccentrically to it, with an average size of 0.5-4.5 cm. The echogenicity of the lesion also varies: hypoechogenicity in 63% of women, moderate echogenicity in 20%, and increased echogenicity in 17%. In the majority (86%) of cases, endometrioid heterotopias of this localization have irregular contours and only 14% have smooth contours. Clear internal boundaries were found in 18% of patients and indistinct boundaries in 82%. A significant number of cases showed an indistinct inner contour of the mass. Often, retrocervical endometriosis spreads to the cervix, and the infiltration is so pronounced that it is almost no longer visible as a separate anatomical



entity. According to surgical data, the infiltration of endometriosis into the wall of the rectum is detected in 15% of patients. This is manifested on scans as a semilunar or longish-oval zone 0.3-1.9 cm wide and 1-4.5 cm long in the location of retrocervical endometriosis foci in the intestinal wall. The involvement of the rectosigmoid colon in the pathological process is also evidenced by the absence of displacement of its wall when pressing on the affected area with a vaginal probe.

In some cases, compression and overgrowth of the ureteral wall can be observed, leading to megaureter and hydronephrotic transformation of the kidney. The present data indicate that transvaginal echography is highly informative in the diagnosis of retrocervical endometriosis: the sensitivity in a prospective analysis was 95.8%, and the specificity was 92.6%. The accuracy in determining the presence or absence of retrocervical endometriosis averaged 94.2%. Difficulties can sometimes be encountered in differentiating between a small, low-lying myoma and retrocervical endometriosis. If the mass on the scans has a round shape, clear borders and a homogeneous internal structure with reduced echogenicity, the probability of myoma is higher than that of retrocervical endometriosis. It is often difficult to distinguish retrocervical endometriosis from sacroiliac ligament endometriosis in the clinical picture.

CONCLUSIONS:

Therefore, sacroiliac ligament endometriosis cannot also be detected on echography but can only be suspected by exclusion. If retrocervical endometriosis is not detected on echography, but there is significant pain when a vaginal probe is applied to the sacro-uterine ligament area, this may be a sign of this pathology. The most difficult to differentiate between retrocervical endometriosis and rectal infiltration and malignancy requires a high degree of specialist skill. MRI scans show the following features, which are characteristic of rectovaginal endometriosis:

- Pathological tissues (foci, masses) in the rectovaginal space of heterogeneous structure, similar to endometrial tissue, without clear contours, connecting the posterior cervical wall and the anterior wall of the adjoining colon, with MP-characteristic changes in the endometrium during the menstrual cycle. It is most appropriate to compare MP patterns obtained during I (day 10-13) and II (day 16-19) phases of the menstrual cycle
- The absence of clear borders between these pathological tissues, the anterior wall of the rectum, and the posterior wall of the cervix and uterine body, with possible extension of the process to the uterine ligament apparatus and

subcutaneous fatty tissue of the posterior parametrium.

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