

Congresso Sul Brasileiro de Ginecologia-Obstetrícia
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Conduta no Endometrioma
em
Paciente Assintomática

. César Augusto Cornel
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Endometriose

Prevalência

- 25 – 50% das pacientes com infertilidade tem endometriose
 - 30-50% de pacientes com endometriose tem infertilidade
 - 30 – 80% em pacientes com dor pélvica
 - 5 -10% na população em idade reprodutiva
 - 1a 7%de pacientes submetidas a laquedura tubária
 - 9 a 50% de pacientes submetidas à laparoscopia por infertilidade
-
- Endometriosis and Infertility: a committee opinion (FS, vol 98, Sept 2012)
 - ESHRE guideline set 2013

Endometrioma

17-44% de mulheres com endometriose

(Busacca e Vignali, 2003)

Endometriose

- Lesões peritoneais
- Endometriose profunda
- Endometriomas



Endometriose

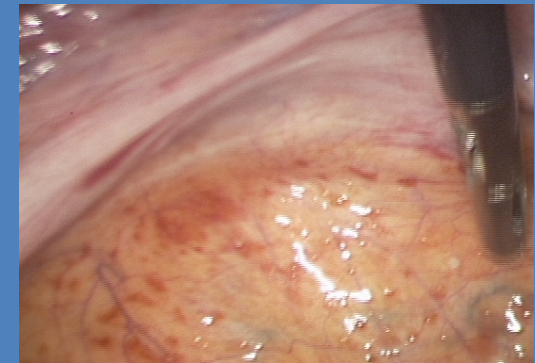
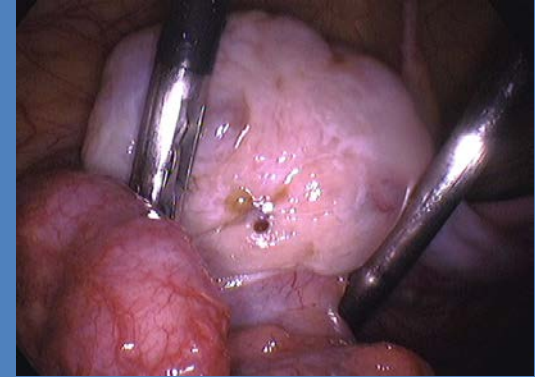
Locais de implantação

54,9% ovariana

35,2% ligamento largo

34,6 FSA

34,0% FSD



Grau de sintomatologia não está relacionada com a gravidade da doença

(Jerkins et al , 1986)

Endometrioma

- Associado com endometriose peritoneal
- Marcador de lesões profundas (Redwine, 1999)
- Multifocal (vaginal, intestinal e ureter) (Chapron, 2009)

Endometriose

Dismenorréia (40%)

Infertilidade (20%)

Dor pélvica Crônica (25%)

Dispareunia (50%)

Irregularidade Menstrual

Alterações Intestinais cíclicas

Alterações Urinárias cíclicas

TPM importante

Endometrioma

Assintomático

Associado à infertilidade

Endometriose Assintomática

- Achado de lesões peritoneais, ovariana ou infiltrativas sem sintomatologia e/ou infertilidade
- Prevalência entre 3 e 45% de mulheres submetidas à laparoscopia para laqueadura tubária

(Gylfason, 2010 e Rawson, 1991)

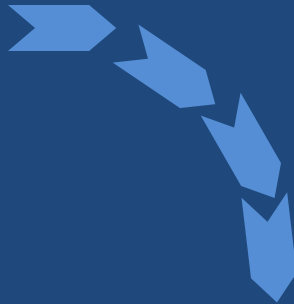
**Porque Tratar?
O Que Queremos Tratar?**



Planejar o Tratamento

Endometrioma em Pacientes Assintomáticas

Porque Tratar?
O Que Queremos Tratar?

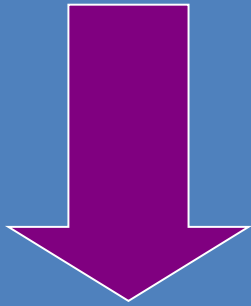


Doença Evolutiva ? baixo risco (Moen e Stokstad, 2002)

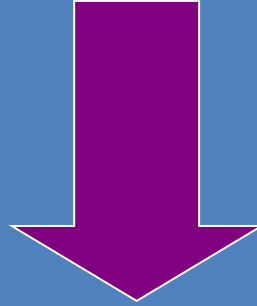
Cancer de ovário ?- sem evidencias (Pearce, 2012)
 sem evidencias (Somigliana, 2006)
 baixo risco (Melin, 2006)

Infertilidade - 17-44% mulheres com endometriose (Busacca, 2003)

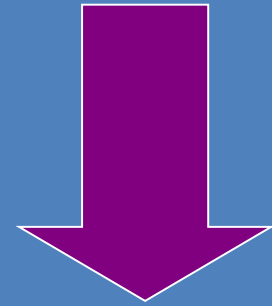
TRATAMENTO



Clínico



Cirúrgico



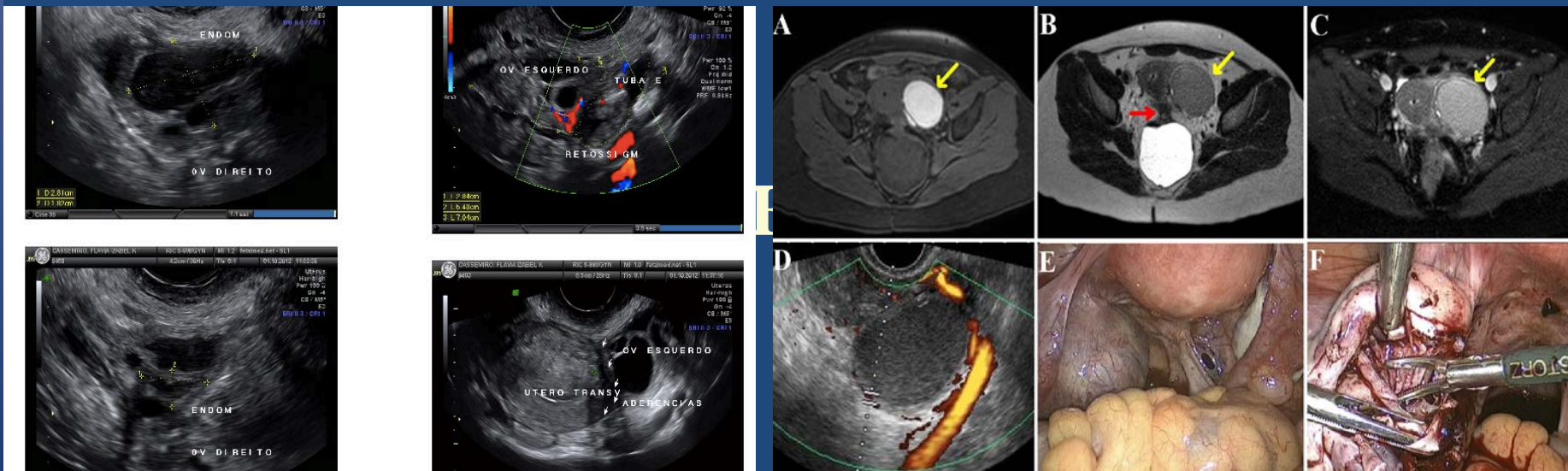
Reprodução Assistida

IMAGING

The accuracy in the diagnosis with the imaging techniques is completely operator dependent



Endometriose



Surgical treatment of ovarian endometriomas: state of the art?

Pascale Jadoul, M.D.,^a Michio Kitajima, M.D., Ph.D.,^b Olivier Donnez, M.D.,^a Jean Squifflet, M.D., Ph.D.,^a and Jacques Donnez, M.D., Ph.D.^a

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TRATAMENTO CIRÚRGICO

FAVOR

CONTRA

+

CA OVÁRIO

RESERVA OVARIANA

+

+

INFECÇÃO

+

CONTAMINAÇÃO OVOCITOS

FERTILIDADE

+

REMOÇÃO DE TEC. OVARIANO

+

ESHRE GUIDELINE 2013



Grades of recommendations	Supporting evidence
A	Meta-analysis, systematic review or multiple RCTs (high quality)
B	Meta-analysis, systematic review or multiple RCTs (moderate quality) Single RCT, large non-randomised trial, case-control or cohort studies (high quality)
C	Single RCT, large non-randomised trial, case-control or cohort studies (moderate quality)
D	Non-analytic studies, case reports or case series (high or moderate quality)
GPP	Expert opinion

ESHRE GUIDELINE 2013

In infertile women with endometrioma larger than 3 cm there is no evidence that cystectomy prior to treatment with assisted reproductive technologies improves pregnancy rates. (Benschop, et al., 2010, Donnez, et al., 2001, Hart, et al., 2008).

A

In women with endometrioma larger than 3 cm, the GDG recommends clinicians only to consider cystectomy prior to assisted reproductive technologies to improve endometriosis-associated pain or the accessibility of follicles.

GPP

The GDG recommends that clinicians counsel women with endometrioma regarding the risks of reduced ovarian function after surgery and the possible loss of the ovary. The decision to proceed with surgery should be considered carefully if the woman has had previous ovarian surgery.

GPP

ESHRE GUIDELINE 2013



In infertile women with ovarian endometrioma undergoing surgery, clinicians should perform excision of the endometrioma capsule, instead of drainage and electrocoagulation of the endometrioma wall, to increase spontaneous pregnancy rates (Hart, et al., 2008).

A

The GDG recommends that clinicians counsel women with endometrioma regarding the risks of reduced ovarian function after surgery and the possible loss of the ovary. The decision to proceed with surgery should be considered carefully if the woman has had previous ovarian surgery.

GPP

In infertile women with AFS/ASRM stage III/IV endometriosis, clinicians can consider operative laparoscopy, instead of expectant management, to increase spontaneous pregnancy rates (Nezhat, et al., 1989, Vercellini, et al., 2006a).

B

ESHRE GUIDELINE 2013

The GDG recommends that clinicians confirm a positive laparoscopy by histology, since positive histology confirms the diagnosis of endometriosis, even though negative histology does not exclude it.

GPP

The GDG recommends that clinicians obtain tissue for histology in women undergoing surgery for ovarian endometrioma and/or deep infiltrating disease, to exclude rare instances of malignancy.

GPP

Endometrioma e qualidade ovocitária

Ovarian endometriomas and oocyte quality: insights from in vitro fertilization cycles

Francesca Filippi, M.D.,^a Laura Benaglia, M.D.,^a Alessio Paffoni, M.Sc.,^a Liliana Restelli, D.Sc.,^a Paolo Vercellini, M.D.,^{a,b} Edgardo Somigliana, M.D., Ph.D.,^a and Luigi Fedele, M.D.^{a,b}

^a Department of Obstetrics and Gynecology, Fondazione Ca' Granda, Ospedale Maggiore Policlinico; and ^b Università degli Studi di Milano, Milan, Italy

Main Outcome Measure(s): Oocyte developmental competence.

Conclusion(s): In women undergoing IVF, the presence of ovarian endometriomas does not affect oocyte developmental competence. (Fertil Steril® 2014;101:988–93. ©2014 by American Society for Reproductive Medicine.)

29 pacientes submetidas a FIV/ICSI

Endometrioma unilateral (1 ou +)

Cisto < 50mm

O endometrioma não afetou a qualidade ovocitária, número e qualidade embrionária e taxa de gravidez

Reprodução Assistida e Endometriose

Endometriosis-related infertility: assisted reproductive technology has no adverse impact on pain or quality-of-life scores

Pietro Santulli, M.D., Ph.D.,^{a,b} Mathilde Bourdon,^a Marion Presse,^a Vanessa Gayet, M.D.,^a Louis Marcellin, M.D., Ph.D.,^{a,b,c} Caroline Prunet,^d Dominique de Ziegler, M.D.,^a and Charles Chapron, M.D.^{a,c}

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Main Outcome Measure(s): VAS pain intensities relative to dysmenorrhea, dyspareunia, noncyclic chronic pelvic pain (NCCPP), gastrointestinal pain, lower urinary tract pain; trends for VAS change between postretrieval and baseline evaluation; FertiQoL score; and statistical analyses conducted using univariate and adjusted multiple linear regression models.

Conclusion(s): Assisted reproduction technology did not exacerbate the symptoms of endometriosis or negatively impact QoL in women with endometriosis as compared with disease-free women. (Fertil Steril® 2016;105:978–87. ©2016 by American Society for Reproductive Medicine.)

102 pac. com endometriose (18 com endometrioma) comparadas com 104 pac. sem endometriose
Pacientes submetidas a FIV/ICSI
Não houve piora dos sintomas em consequência à estimulação ovariana ou ao procedimento

Ovarian damage after laparoscopic endometrioma excision might be related to the size of cyst

Yan Tang, M.D., M.Sc., Shi-Ling Chen, M.D., Ph.D., Xin Chen, M.D., M.Sc., Yu-Xia He, M.D., De-Sheng Ye, M.D., Wei Guo, M.D., Hai-Yan Zheng, M.D., Ph.D., and Xin-Hong Yang, M.D.

Center for Reproductive Medicine, Department of Gynecology and Obstetrics, Nanfang Hospital, Southern Medical University, Guangzhou, People's Republic of China

Main Outcome Measure(s): Antral follicle counts (AFC), number of dominant follicles (follicles ≥ 15 mm), and number of oocytes retrieved.

Conclusion(s): The magnitude of the ovarian damage after laparoscopic endometrioma excision might be related to the size of cyst; the damage to ovaries is more severe when an endometrioma ≥ 4 cm is excised. (Fertil Steril® 2013;100:464–9. ©2013 by American Society for Reproductive Medicine.)

85 pacientes submetidas à FIV/ICSI com LPC prévia (endometrioma unilateral)

Foliculos antrais/ foliculos dominantes/ovócitos obtidos

Endometriomas <4 cm e ≥ 4 cm

Impacto significativo em pacientes submetidas à cistectomia

Comprometimento maior na reserva/resposta ovariana quando cisto ≥ 4 cm

Cistectomia e reserva ovariana

Spontaneous fertility after expectant or surgical management of rectovaginal endometriosis in women with or without ovarian endometrioma: a retrospective analysis

Umberto Leone Roberti Maggiore, M.D.,^{a,b} Carolina Scala, M.D.,^{a,b} Emanuela Tafi, M.D.,^{a,b} Annalisa Racca, M.D.,^{a,b} Ennio Biscaldi, M.D.,^c Valerio Gaetano Vellone, Ph.D.,^d Pier Luigi Venturini, M.D.,^{a,b} and Simone Ferrero, Ph.D.^{a,b}

^a Academic Unit of Obstetrics and Gynecology, IRCCS AOU San Martino—IST; ^b Department of Neurosciences, Rehabilitation, Ophthalmology, Genetics, and Maternal and Child Health, University of Genoa; ^c Department of Radiology, Galliera Hospital; ^d Department of Surgical and Diagnostic Sciences, IRCCS San Martino Hospital and National Institute for Cancer Research, University of Genoa, Genoa, Italy

Main Outcome Measure(s): Crude and cumulative SPRs.

Conclusion(s): Crude and cumulative SPRs are lower in women treated with the use of expectant rather than surgical management. The presence of OMAs decreases SPRs independently from the treatment modality adopted. (Fertil Steril® 2017;107:969–76. ©2017 by American Society for Reproductive Medicine.)

284 pacientes com endometriose (RV c/s endometrioma) com conduta expectante
221 pacientes com endometriose (RV c/s endometrioma) após laparoscopia

Gravidez por ciclo ou acumulativa menor nas pacientes com conduta expectante
Menor taxa de gravidez espontânea no grupo com endometrioma

Cistectomia e reserva ovariana

Impacto da remoção laparoscópica do endometrioma na reserva ovariana

I. Kasapoglu (Uludag University – Bursa –Turquia)

Avaliação da reserva ovariana : FSH, USG (contagem de folículos antrais -AFC) e dosagem de AMH (hormonio antimulleriano)

Laparoscopia – cistectomia / plano de clivagem e mínima cauterização (bipolar)

23 pacientes (25 -31 anos)

11 (52,2%) endometrioma unilateral

12(47,8) endometrioma bilateral

8 (34,8%) apresentavam mais de um endometrioma no mesmo ovario

diâmetro médio dos endometriomas – 41,7 mm

	Pré- lpc	Pós-lpc
FSH	5 UI/L	4,6 UI/L
AMH	2,3 ng/ml	1,93 ng/ml
AFC	4,5	6

Conclusão

Desde que realizada dentro da técnica adequada, a excisão de endometriomas não afeta a reserva ovariana

Cistectomia e reserva ovariana

The impact of laparoscopic cystectomy on ovarian reserve in patients with unilateral and bilateral endometriomas

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operatively and 1 week, 3 and 9 months postoperatively for AMH, and 3 months for other values.

Main Outcome Measure(s): Ovarian reserve based on the comparison of AMH alterations. The secondary end points are changes in FSH, E₂, and AFC.

Conclusion(s): The AMH level decreased and the FSH level increased after laparoscopic cystectomy for endometriomas, especially in older patients and those with bilateral cysts. (Fertil Steril® 2014;101:427–34. ©2014 by American Society for Reproductive Medicine.)

193 pacientes submetidas à cistectomia laparoscópica
AMH/FSH/E2 e AFC antes e 1 semana, 3 e 9 meses após
Diminuição dos valores do AMH nas primeiras semanas e recuperação parcial após 9 meses
FCA pré operatória prejudicada pela presença do endometrioma

Endometrioma em Pacientes Assintomáticas

Infertilidade

Número de cistos
Uni ou bilateral
Ooforectomia prévia
Diâmetro dos cistos

Idade da paciente



AMH
CFA
Número de ovócitos
Número de Embriões
Qualidade embrionária
Índice de gestação
Índice de nascidos vivos

endometriose

Dor pélvica

VLP

Tto clínico

Tto
clínico

VLP

infertilidade

< 35 anos

> 35 anos

G III/IV

GI /II

IIU - FIV

VLP

IIU -FIV

VLP

CONCLUSÃO

Dor pélvica

Progestogênios

Associação Estrogênio/Progestogênios

Análogos do GnRH (mensal/trimestral)

Outros (Antiinflamatórios, Gestrinona, Danazol, Antiestrogênicos,)

TRATAMENTO CIRÚRGICO

Infertilidade

Coito Programado

Inseminação Intra-útero

Fertilização “in vitro”

ASSINTOMÁTICAS SEM INFERTILIDADE

ACOMPANHAMENTO PERIÓDICO

ANTICONCEPCIONAL CONTINUO



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O Que Avaliar para Poder Planejar a Estratégia de Tratamento?



Diagnostic accuracy of physical examination, transvaginal sonography, rectal endoscopic sonography, and magnetic resonance imaging to diagnose deep infiltrating endometriosis

Marc Bazot, M.D.,^a Clarisse Lafont, M.D.,^a Roman Rouzier, M.D.,^b Gilles Roseau, M.D.,^c Isabelle Thomassin-Naggara, M.D., Ph.D.,^a and Emile Daraï, M.D., Ph.D.^b

Services de ^a Radiologie and ^b Gynécologie-Obstétrique, Hôpital Tenon; and ^c Centre Chirurgical Trocadéro, Département d'Endoscopie Digestive, Paris, France

TABLE 2

Locations of deep infiltrating endometriosis diagnosed at surgery and confirmed at histologic examination (n = 92 patients).

Subperitoneal locations	Diagnosis at surgery	Surgical specimens	Confirmation at histology	Isolated locations
Posterior compartment	90 (97.8%)	81 (88%)	81 (88%)	—
Uterosacral ligaments	85 (92.4%)	72 (78.3%)	72 (78.3%)	17 (18.5%)
Vagina	30 (32.6%)	19 (20.6%)	19 (20.6%)	1 (1.1%)
Rectovaginal septum	11 (11.9%)	11 (11.9%)	11 (11.9%)	0
Intestine	66 (71.4%)	56 (60.9%)	54 (58.7%)	4 (4.3%)
Sigmoid colon	6 (6.5%)	5 (5.4%)	5 (5.4%)	2 (2.2%)
Rectosigmoid junction	46 (50%)	39 (42.4%)	37 (40.2%)	1 (1%)
Rectum	14 (15.2%)	12 (13%)	12 (13%)	0
Anterior compartment bladder	3 (3.3%)	3 (3.3%)	3 (3.3%)	0

Bazot. TVS, RES, and MRI for surgery in deep endometriosis. *Fertil Steril* 2009.

TABLE 4

Pelvic endometriosis: correlation of TVS results with surgical and pathologic findings.

TVS	Sensitivity	Specificity	PPV	NPV	Accuracy
USLs	78.3% (65/83)	66.7% (6/9)	95.6% (65/68)	25% (6/24)	77.2% (71/92)
Vagina	46.7% (14/30)	95% (59/62)	82.4% (14/17)	78.7% (59/75)	79.3% (73/92)
RV septum	9% (1/11)	98.7% (80/81)	50% (1/2)	88.9% (80/90)	88% (81/92)
Intestine	93.6% (59/63)	100% (29/29)	100% (59/59)	87.9% (29/33)	95.6% (88/92)

Note: USLs = uterosacral ligaments; RV septum = rectovaginal septum; PPV = positive predictive value; NPV = negative predictive value; TVS = transvaginal sonography.

Bazot. TVS, RES, and MRI for surgery in deep endometriosis. Fertil Steril 2009.

TABLE 5

Locations of deep infiltrating endometriosis: correlation between rectal endoscopic sonography and surgical and pathologic findings.

RES	Sensitivity	Specificity	PPV	NPV	Accuracy
USLs	48.2% (40/83)	44.4% (4/9)	88.9% (40/45)	8.5% (4/47)	47.8% (44/92)
Vagina	6.7% (2/30)	100% (62/62)	100% (2/2)	68.9% (62/90)	69.6% (64/92)
RV septum	18.2% (2/11)	95% (77/81)	33.3% (2/6)	89.5% (77/86)	85.9% (79/92)
Intestine	88.9% (56/63)	93.1% (27/29)	96.6% (56/58)	79.4% (27/34)	90.2% (83/92)

Note: USLs = uterosacral ligaments; RV septum = rectovaginal septum; PPV = positive predictive value; NPV = negative predictive value; RES = rectal endoscopic sonography.

Bazot. TVS, RES, and MRI for surgery in deep endometriosis. Fertil Steril 2009.

TABLE 3

Locations of deep infiltrating endometriosis: correlation of physical findings with surgical and pathologic findings.

PE	Sensitivity	Specificity	PPV	NPV	Accuracy
USLs	73.5% (61/83)	77.8% (7/9)	96.8% (61/63)	24% (7/29)	73.9% (68/92)
Vagina	50% (15/30)	87% (54/62)	65.2% (15/23)	78.3% (54/69)	75% (69/92)
RV septum	18.2% (2/11)	96.3% (78/81)	40% (2/5)	89.7% (78/87)	86.9% (80/92)
Intestine	46% (29/63)	72.4% (21/29)	78.4% (29/37)	38.2% (21/55)	54.4% (50/92)

Note: USLs = uterosacral ligaments; RV septum = rectovaginal septum; PPV = positive predictive value; NPV = negative predictive value; PE = physical examination.

Bazot. TVS, RES, and MRI for surgery in deep endometriosis. Fertil Steril 2009.

TABLE 7

Comparison of the sensitivity, accuracy, LR⁺, and LR⁻ of physical examination, TVS, RES, and MRI compared to surgical and pathologic findings.

Test		PE	TVS	RES	MRI
USLs	Sensitivity	0.73 (0.63–0.82)	0.78 (0.69–0.87)	0.48 (0.37–0.59)	0.84 (0.77–0.92)
	Diagnostic accuracy	0.74 (0.64–0.82)	0.77 (0.69–0.86)	0.47 (0.36–0.56)	0.85 (0.77–0.92)
	LR ⁺	3.3 (0.95–11.1)	2.34 (0.93–5.96)	0.86 (0.45–1.06)	7.59 (1.19–48.3)
	LR ⁻	0.34 (0.22–0.58)	0.32 (0.18–0.60)	1.16 (0.73–3.91)	0.18 (0.10–0.31)
Vagina	Sensitivity	0.50 (0.32–0.68)	0.47 (0.29–0.65)	0.07 (0–0.16)	0.80 (0.66–0.94)
	Diagnostic accuracy	0.75 (0.66–0.84)	0.79 (0.71–0.88)	0.70 (0.60–0.79)	0.84 (0.76–0.91)
	LR ⁺	3.88 (1.85–8.11)	9.64 (3.00–31.0)	—	5.51 (2.94–10.3)
	LR ⁻	0.57 (0.40–0.83)	0.56 (0.40–0.70)	0.93	0.23 (0.11–0.48)
RV septum	Sensitivity	0.18 (0–0.41)	0.09 (0–0.26)	0.18 (0–0.41)	0.55 (0.16–0.75)
	Diagnostic accuracy	0.87 (0.80–0.94)	0.88 (0.81–0.95)	0.86 (0.79–0.93)	0.94 (0.87–0.98)
	LR ⁺	4.91 (0.92–26.2)	7.36 (0.50–109.5)	3.68 (0.76–17.8)	44.18 (4.73–286.8)
	LR ⁻	0.85 (0.64–1.13)	0.92 (0.76–1.11)	0.86 (0.65–1.14)	0.46 (0.32–0.95)
Intestine	Sensitivity	0.46 (0.34–0.58)	0.94 (0.88–1.00)	0.89 (0.83–0.98)	0.87 (0.79–0.96)
	Diagnostic accuracy	0.54 (0.44–0.65)	0.96 (0.91–1.00)	0.89 (0.86–0.97)	0.87 (0.83–0.95)
	LR ⁺	1.67 (0.87–3.19)	—	12.89 (3.54–51.8)	12.66 (3.31–48.37)
	LR ⁻	0.75 (0.54–1.03)	0.06	0.12 (0.05–0.22)	0.14 (0.07–0.26)

Note: PE = physical examination; TVS = transvaginal sonography; RES = rectal endoscopic sonography; MRI = magnetic resonance imaging; USLs = uterosacral ligaments; RV septum = rectovaginal septum; LR⁺ = positive likelihood ratio; LR⁻ = negative likelihood ratio.

Bazot. TVS, RES, and MRI for surgery in deep endometriosis. Fertil Steril 2009.

In conclusion, MRI provides a more reliable map of DIE than physical examination, TVS, or RES. In women with chronic pelvic pain suggestive of pelvic endometriosis, TVS should remain the first-line technique examination, although normal TVS findings do not rule out the diagnosis. Hence, MRI should be used to examine symptomatic women before surgery. The use of rectal endoscopic sonography should be restricted to cases in which a discrepancy is found between physical examination and first-line imaging techniques.

Tabela 3. Correlação dos resultados da ultrassonografia transvaginal com achados cirúrgicos e histopatológicos para ligamento uterosacro

Índice	Estim.	I.C. 95%
Sensibilidade	25,0%	(10,9% ; 39,1%)
Especificidade	92,3%	(77,8% ; 100,0%)
Prevalência	73,5%	(61,1% ; 85,8%)
Acurácia	42,9%	(29% ; 56,7%)
Valor Preditivo +	90,0%	(71,4% ; 100,0%)
Valor Preditivo -	30,8%	(16,3% ; 45,3%)



Tabela 4. Correlação dos resultados da ultrassonografia transvaginal com achados cirúrgicos e histopatológicos para septo ~~retovaginal~~.

Índice	Estim.	I.C. 95%
Sensibilidade	20,0%	(6,7% ; 33,3%)
Especificidade	92,9%	(79,4% ; 100,0%)
Prevalência	71,4%	(58,8% ; 84,1%)
Acurácia	40,8%	(27,1% ; 54,6%)
Valor Preditivo +	87,5%	(64,6% ; 100,0%)
Valor Preditivo -	31,7%	(17,5% ; 46,0%)



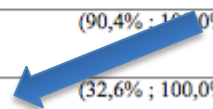
Tabela 2. Correlação dos resultados da ultrassonografia transvaginal com achados cirúrgicos e histopatológicos para endometrioma

Índice	Estim.	I.C. 95%
Sensibilidade	56,3%	(31,9% ; 80,6%)
Especificidade	93,9%	(85,8% ; 100,0%)
Prevalência	32,7%	(19,5% ; 45,8%)
Acurácia	81,6%	(70,8% ; 92,5%)
Valor Preditivo +	81,8%	(69,3% ; 100,0%)
Valor Preditivo -	81,6%	(69,3% ; 93,9%)



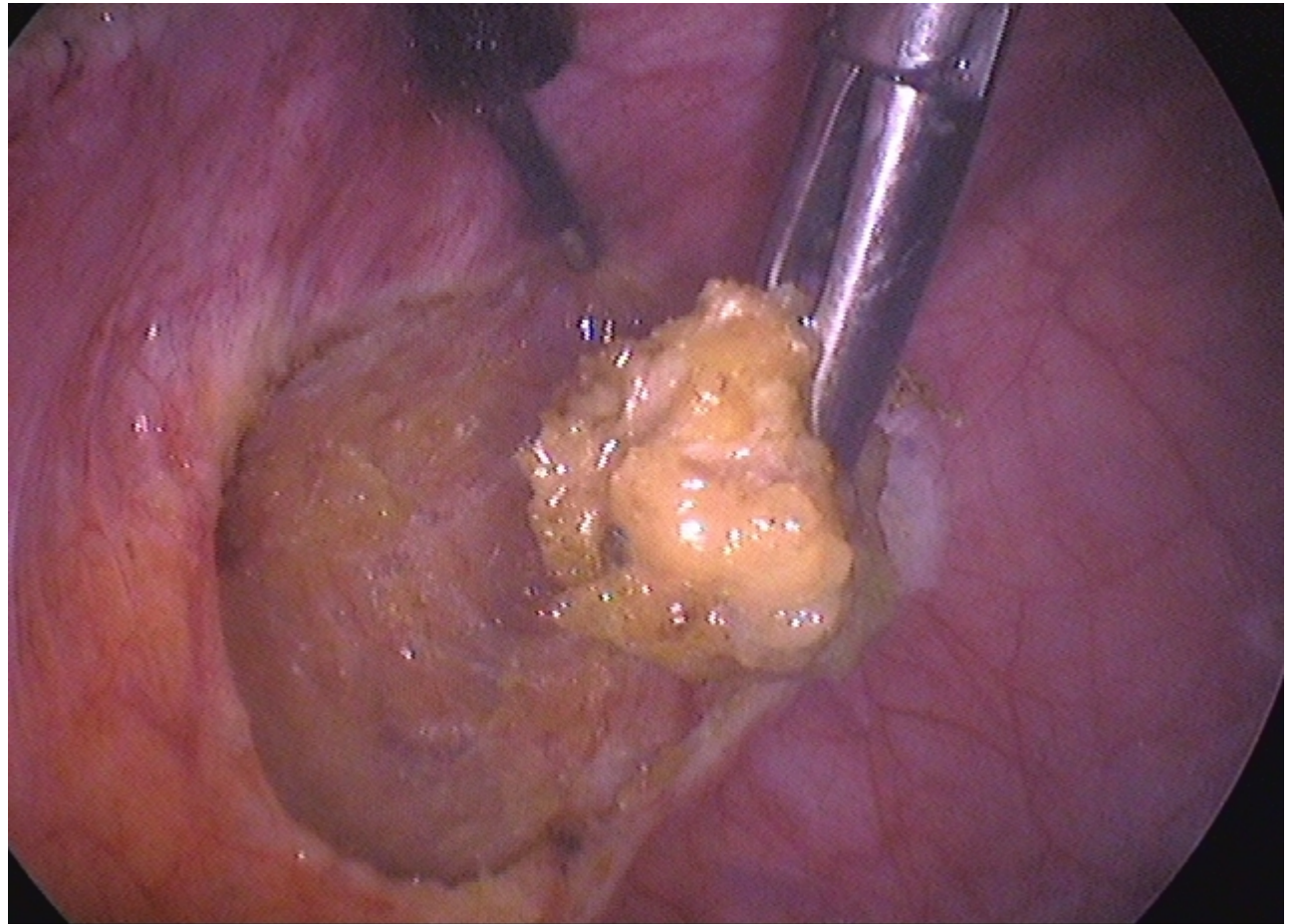
Tabela 6. Correlação dos resultados da ultrassonografia com achados cirúrgicos e histopatológicos para endometriose intestinal

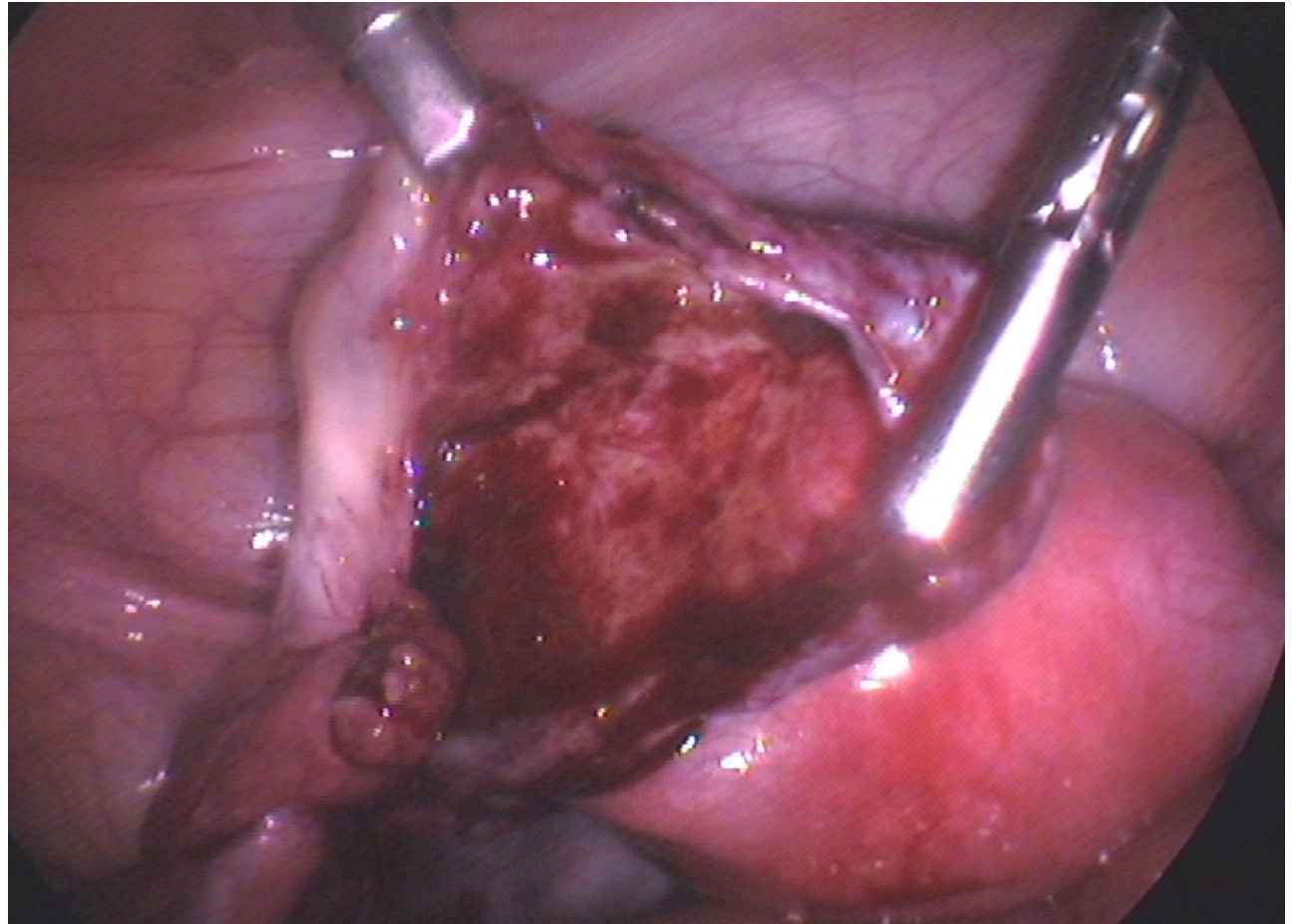
Índice	Estim.	I.C. 95%
Sensibilidade	75,0%	(32,6% ; 100,0%)
Especificidade	97,8%	(93,5% ; 100,0%)
Prevalência	8,2%	(0,5% ; 15,8%)
Acurácia	95,9%	(90,4% ; 100,0%)
Valor Preditivo +	75,0%	(32,6% ; 100,0%)
Valor Preditivo -	97,8%	(93,5% ; 100,0%)

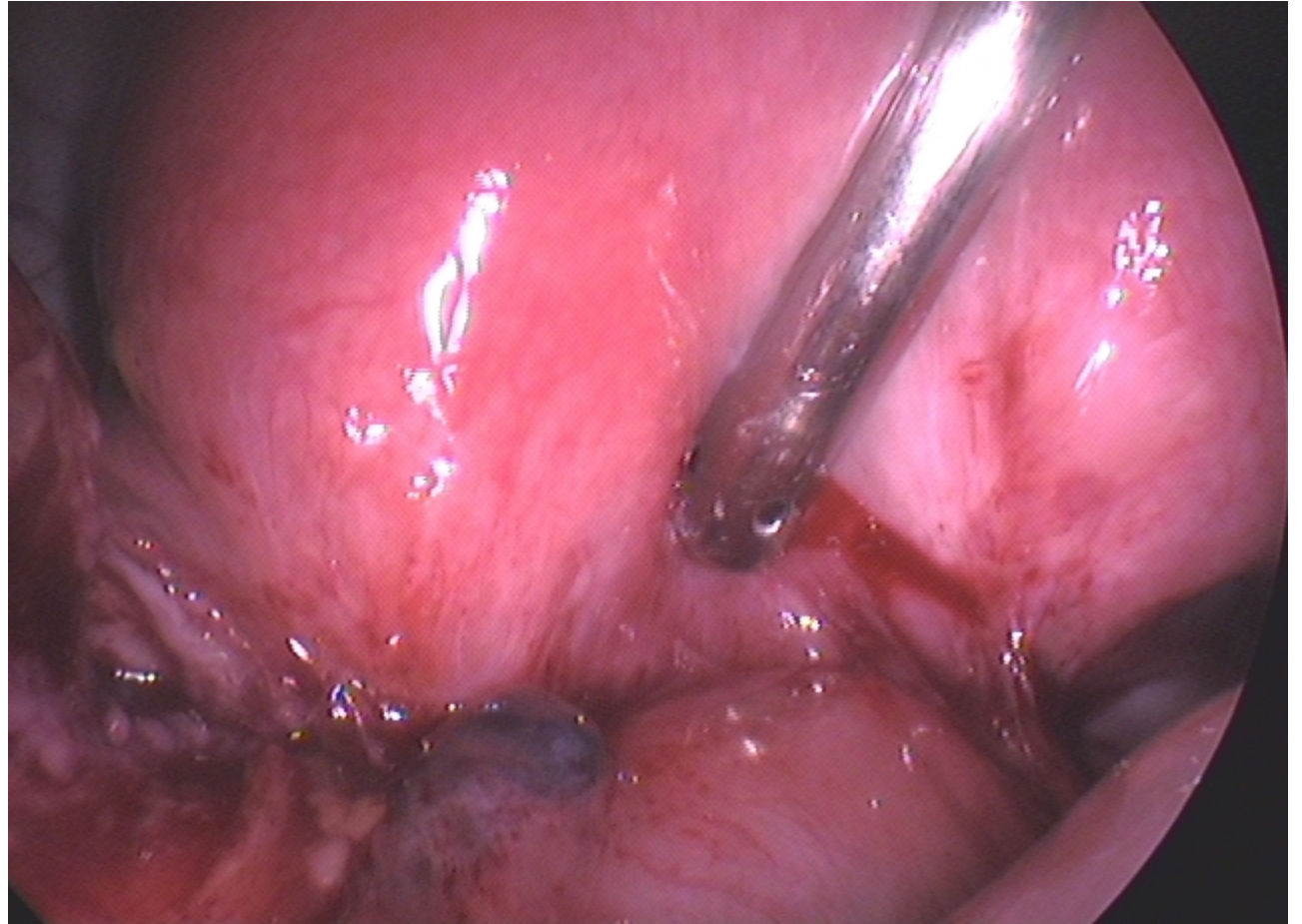


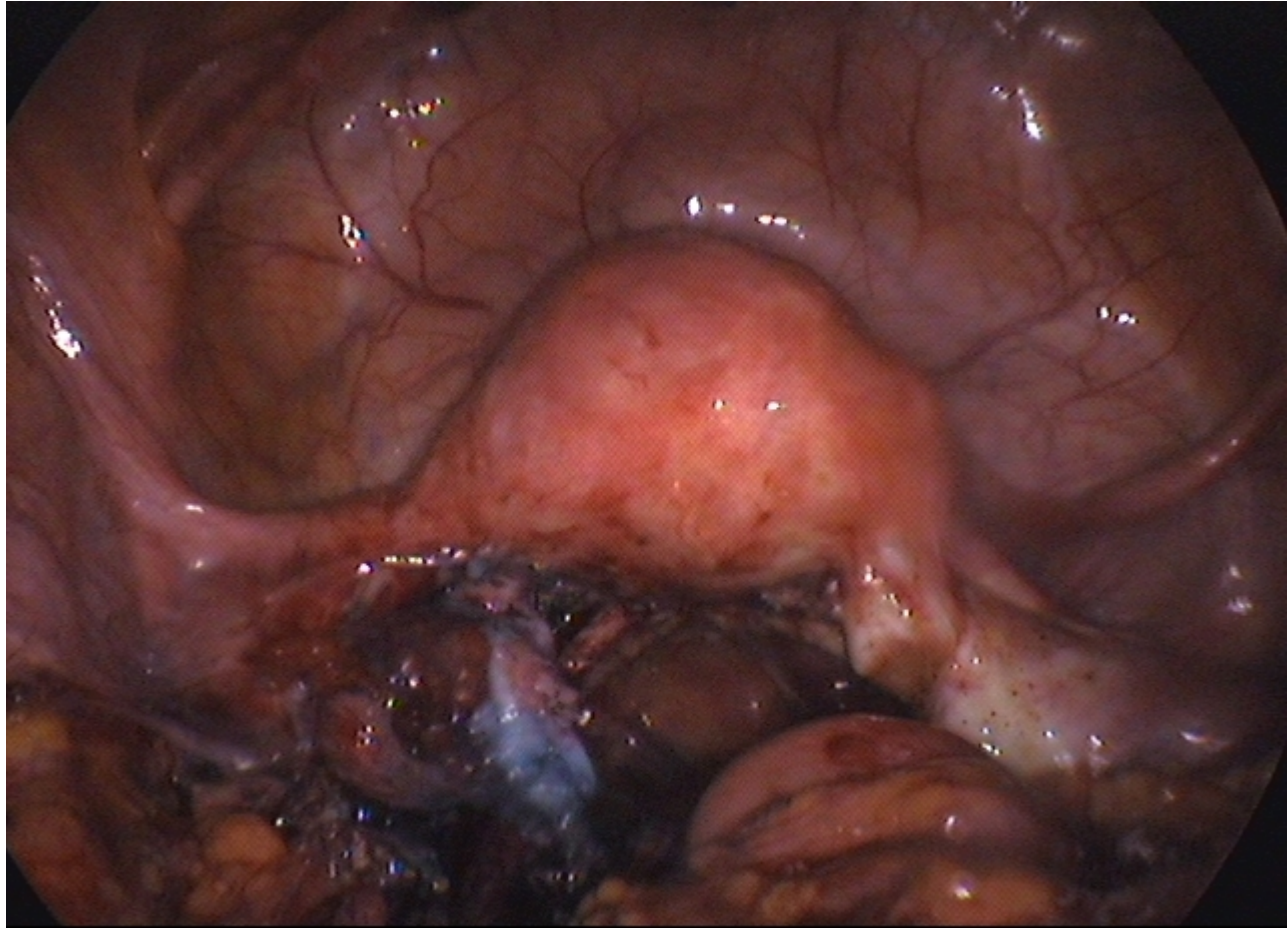
Tratamento Cirúrgico

- Remoção e cauterização das lesões
- Liberação de aderências pélvicas
- Retirada de endometriomas com cápsula









Não houve diferença significativa nos índices de gravidez

Não houve benefício com mais de uma LPC
Risco de comprometimento do capital folicular
Indicação de RA

Não há evidências de melhora no quadro de infertilidade

The impact of endometriosis and its staging on assisted reproduction outcomes: a systematic review and meta-analysis.

Barbosa MA¹, Teixeira DM, Navarro PA, Ferriani RA, Nastri CO, Martins WP.

Abstract

OBJECTIVE: Evaluate whether the presence or severity of endometriosis affect the outcomes of assisted reproductive techniques (ART).

METHODS: In this systematic review all studies comparing the ART outcomes of women with and without endometriosis or at different stages of the disease were considered eligible. We used either risk ratio (RR) or mean difference (MD) and their 95% confidence interval (CI) for comparisons. Our primary outcome was live birth; the secondary outcome was clinical pregnancy. Miscarriage and the number of oocytes retrieved were examined as additional outcomes.

RESULTS: We included 90 studies in the review and 76 in the meta-analysis: 20,167 women with endometriosis were compared with 121,931 women without endometriosis; and 1,703 women with endometriosis III/IV were compared with 2,227 women with endometriosis I/II. The following results were observed for the comparison women with endometriosis vs. women without endometriosis: live birth, RR=0.99 (95%CI=0.92-1.06); clinical pregnancy, RR=0.95 (95%CI=0.89-1.02); miscarriage, RR=1.31 (95%CI=1.07-1.59); number of oocytes retrieved, MD= - 1.56 (95%CI= - 2.05 to -1.08). The following results were observed for the comparison women with endometriosis III/IV vs. I/II: live birth, RR=0.94 (95%CI=0.80-1.11); clinical pregnancy, RR=0.90 (95%CI=0.82-1.00); miscarriage, RR=0.99 (95%CI=0.73-1.36); number of oocytes retrieved, MD= - 1.03 (95%CI= - 1.67 to -0.39).

CONCLUSIONS: Women with endometriosis undergoing ART have practically the same chance of achieving clinical pregnancy and live birth than women with other causes of infertility. No relevant difference was observed in the chance of achieving clinical pregnancy and live birth following ART when comparing endometriosis III/IV with endometriosis I/II. The quality of the evidence for the additional examined outcomes was very low, not

INFERTILITY

MINIMAL AND MILD ENDO

Quality of the oocyte

Toxicity to the embryo

Implantation

*Kondo W, et al. Endometriose e infertilidade: causa ou consequência? JBRA - Jornal Brasileiro de Reprodução Assistida. 2009;13(2):33-8.

Operative laparoscopy + adhesiolysis

Increase pregnancy rates



ESHRE 2013 - Recommendation grade A

Jacobson TZ, Duffy JM, Barlow D, Farquhar C, Koninckx PR and Olive D. Laparoscopic surgery for subfertility associated with endometriosis. Cochrane Database Syst Rev 2010:CD001398.

INFERTILITY

MODERATE AND SEVERE ENDO

Anatomical distortion

Adhesions



PR with expectant management ...

... 25% for moderate and 0% for severe endo

Olive DL, et al. Expectant management and hydrotubations in the treatment of endometriosis-associated infertility. Fertil Steril. 1985 Jul;44(1):35-41.

PR after laparoscopic surgery ...

... 57-69% for moderate and 52-68% for severe endo

Nezhat C, et al. Videolaseroscopy for the treatment of endometriosis associated with infertility. Fertil Steril 1989; 51:237-240.

Vercellini P, et al. Reproductive performance, pain recurrence and disease relapse after conservative surgical treatment for endometriosis: the predictive value of the current classification system. Hum Reprod 2006a; 21:2679-2685.

INFERTILITY

MODERATE AND SEVERE ENDO



Consider operative laparoscopy to increase spontaneous pregnancy rates

Consider ART? ESHRE 2013 – Recommendation grade B

Surgical excision of DIE prior to ART? ESHRE 2013 - Recommendation grade C

ULTRASOUND

Most common imaging technique

Transvaginal ultrasound

Particularly helpful in endometrioma ...

... But also for DIE

ULTRASOUND & DIE

TVUS + DOPPLER + ABDOMINAL US

Accuracy better than MRI

Sensitivity 98% Specificity 95%

... Not exactly a “regular” US

- Experienced team
- Bowel preparation?
- Rectal AND vaginal contrast (US gel)
- Discomfort / pain



Piketty et al. Preoperative work-up for patients with deeply infiltrating endometriosis: transvaginal ultrasonography must definitely be the first-line imaging examination. Hum Reprod. 2009 Mar;24(3):602-7.

Abrao et al. Comparison between clinical examination, transvaginal sonography and magnetic resonance imaging for the diagnosis of deep endometriosis. Hum Reprod. 2007 Dec;22(12):3092-7.

Kondo W et al. Deep infiltrating endometriosis: diagnostic imaging and laparoscopic correlation. J Endometriosis 2011;3(4):197-212.

ULTRASOUND & DIE

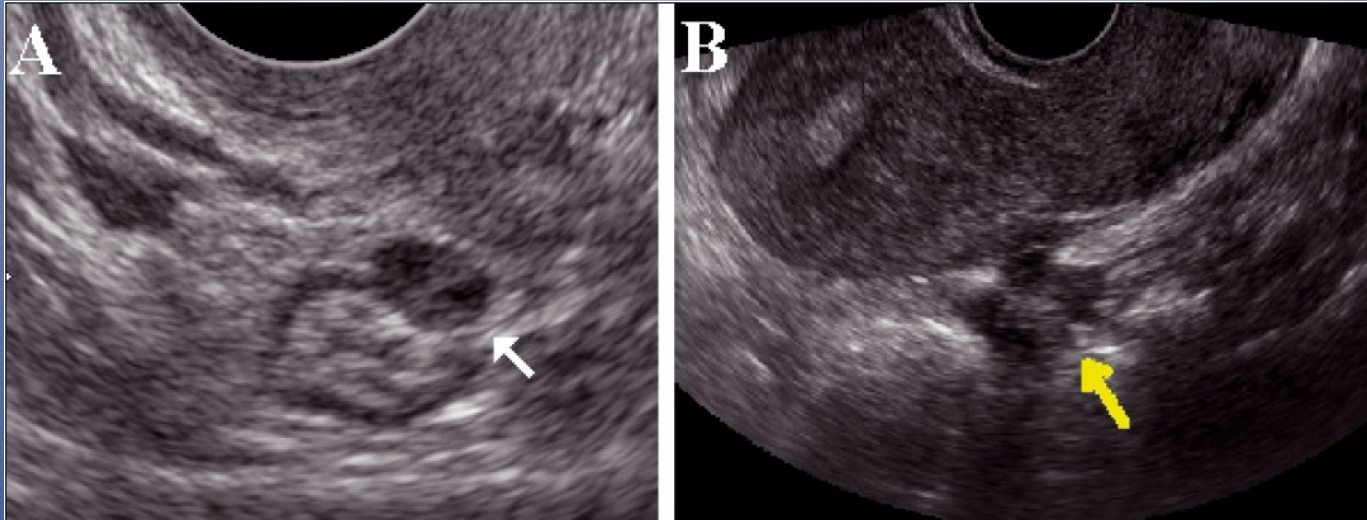


Fig. 3 - (A) Regular and nonretractile endometriotic nodule on the anterior surface of the rectum. (B) Irregular and striated retrocervical endometriotic nodule.

Kondo W et al. Deep infiltrating endometriosis: diagnostic imaging and laparoscopic correlation. J Endometriosis 2011;3(4):197-212.

Considerações Finais

A avaliação detalhada correlacionando a anamnese, exame físico e imagem permite uma programação do tratamento mais adequado

Exames de imagem dependem da experiência do examinador

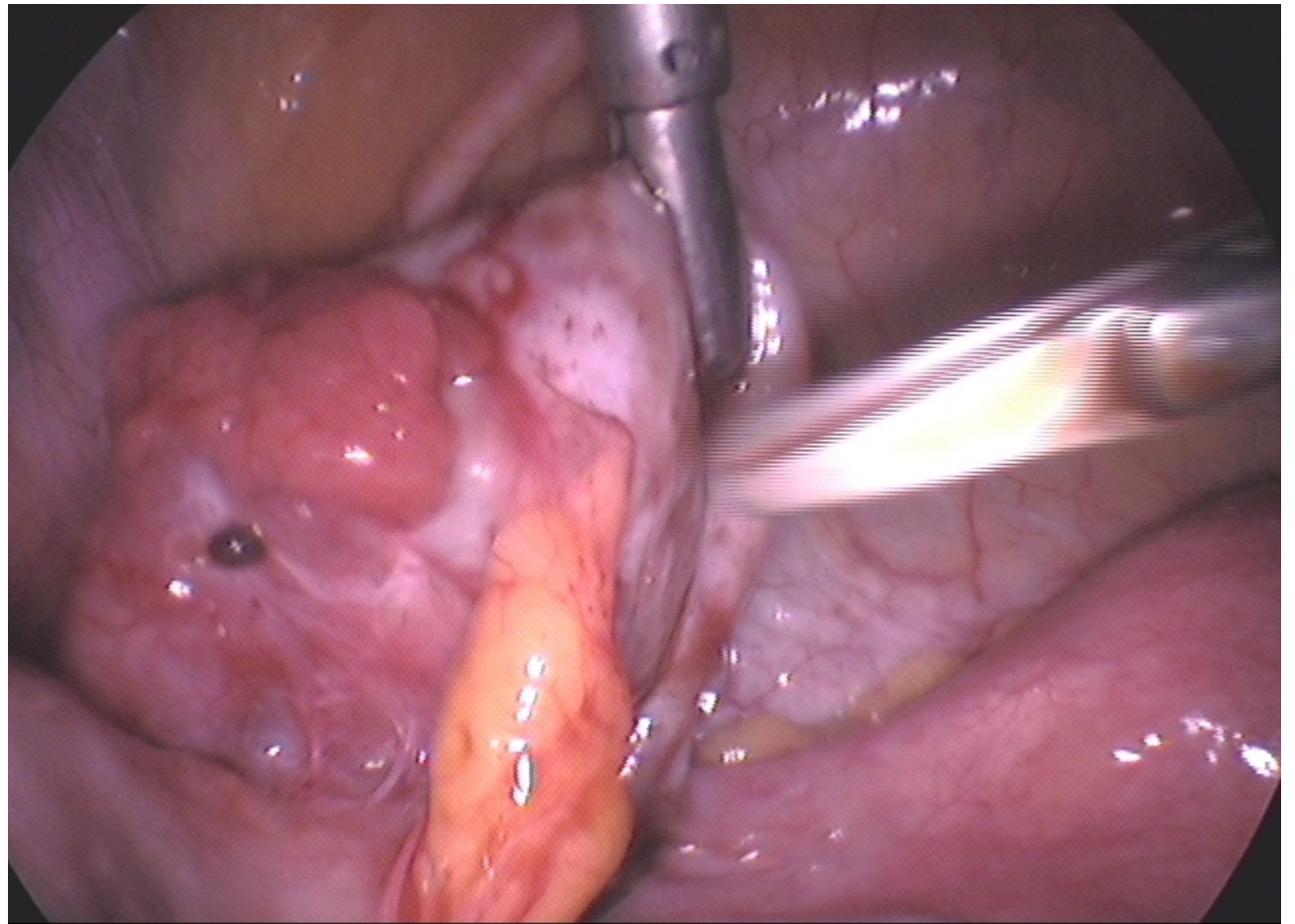
A sintomatologia não expressa necessariamente a gravidade da doença

Os exames de imagem tem maior importância na programação do tratamento

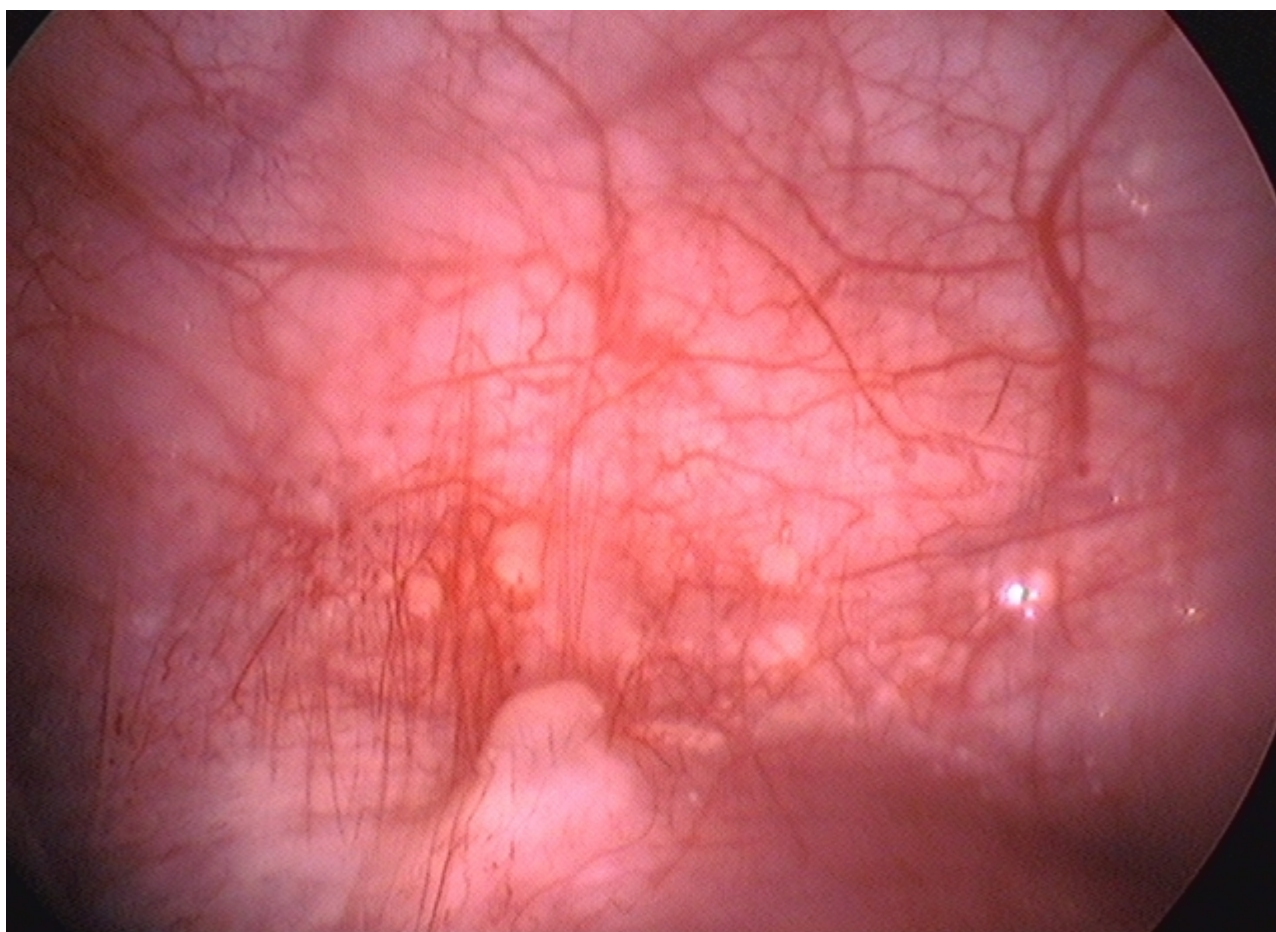
Objetivo final é o bem-estar da paciente

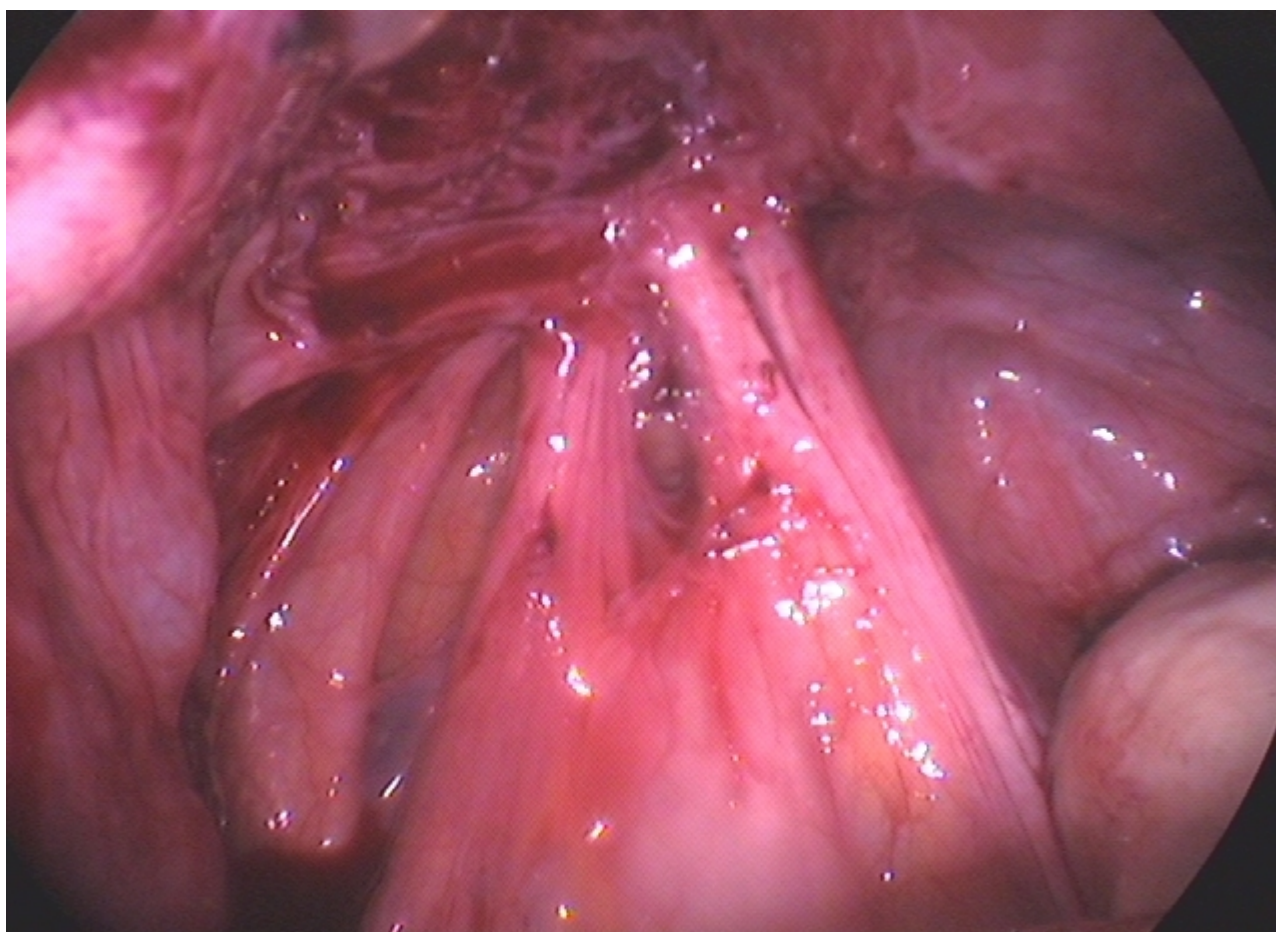
Agradecimentos

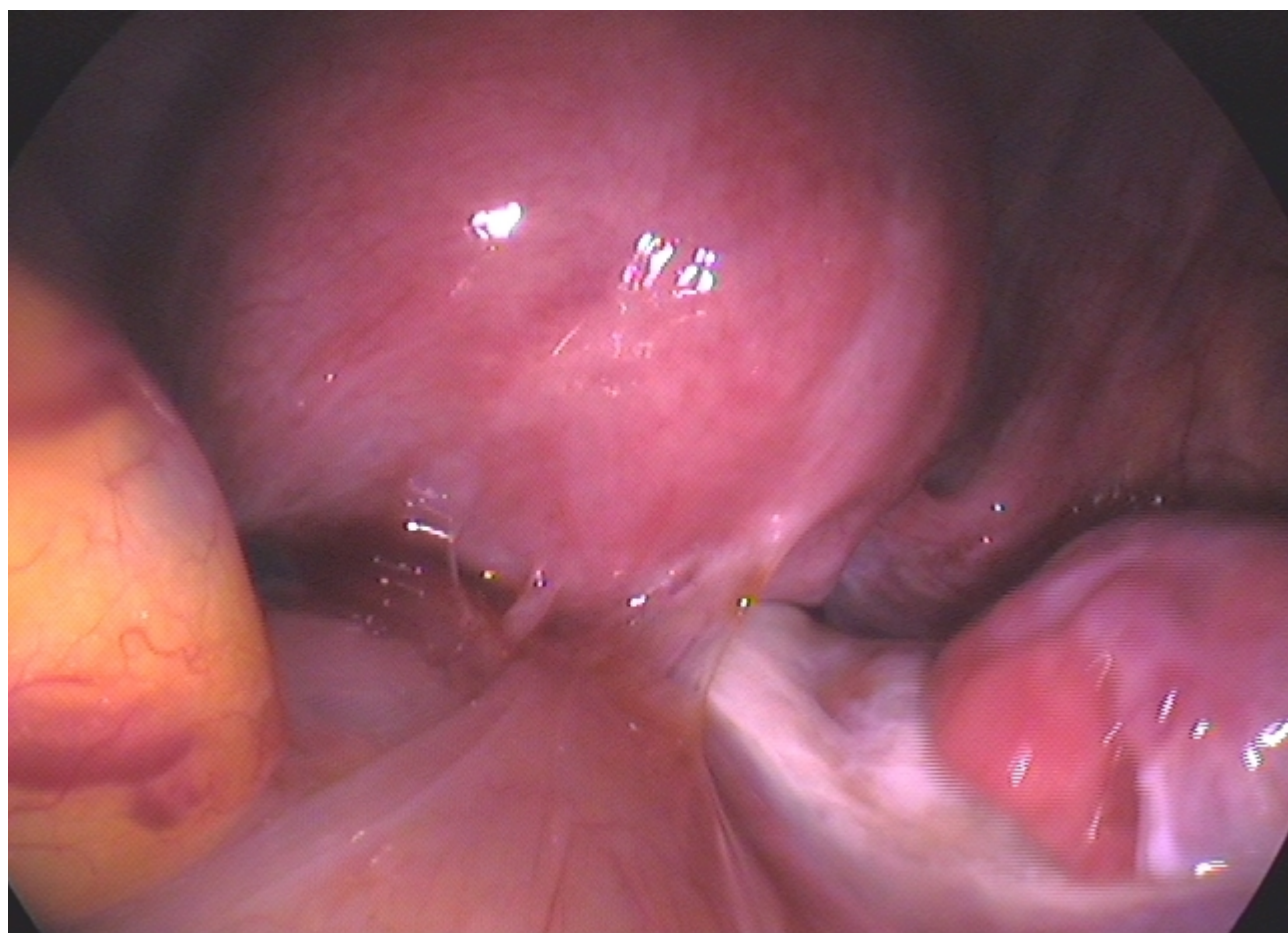
- Dr. Willian Kondo
- Dr. Rafael Bruns
- Dr. Rafael Pazello

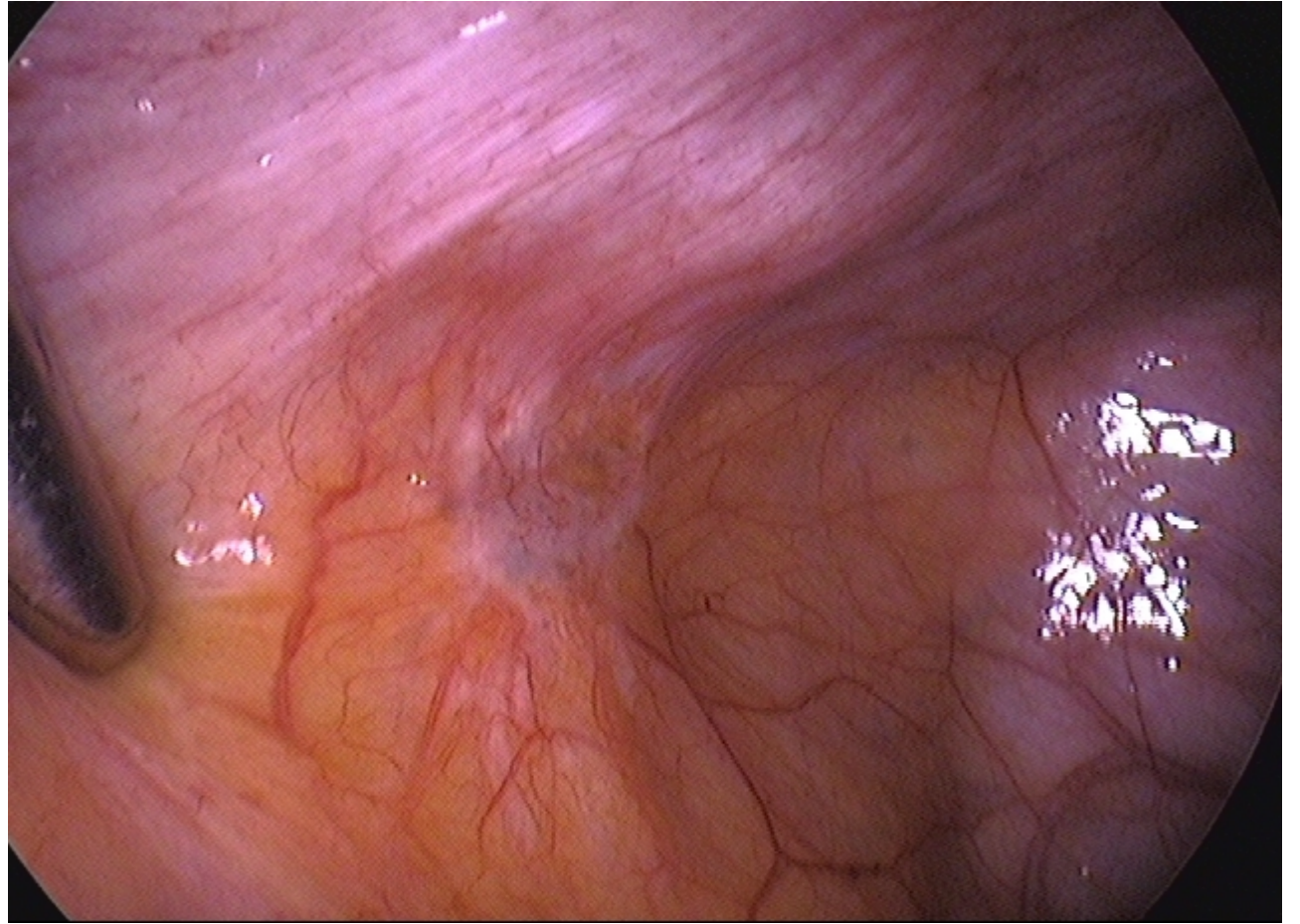


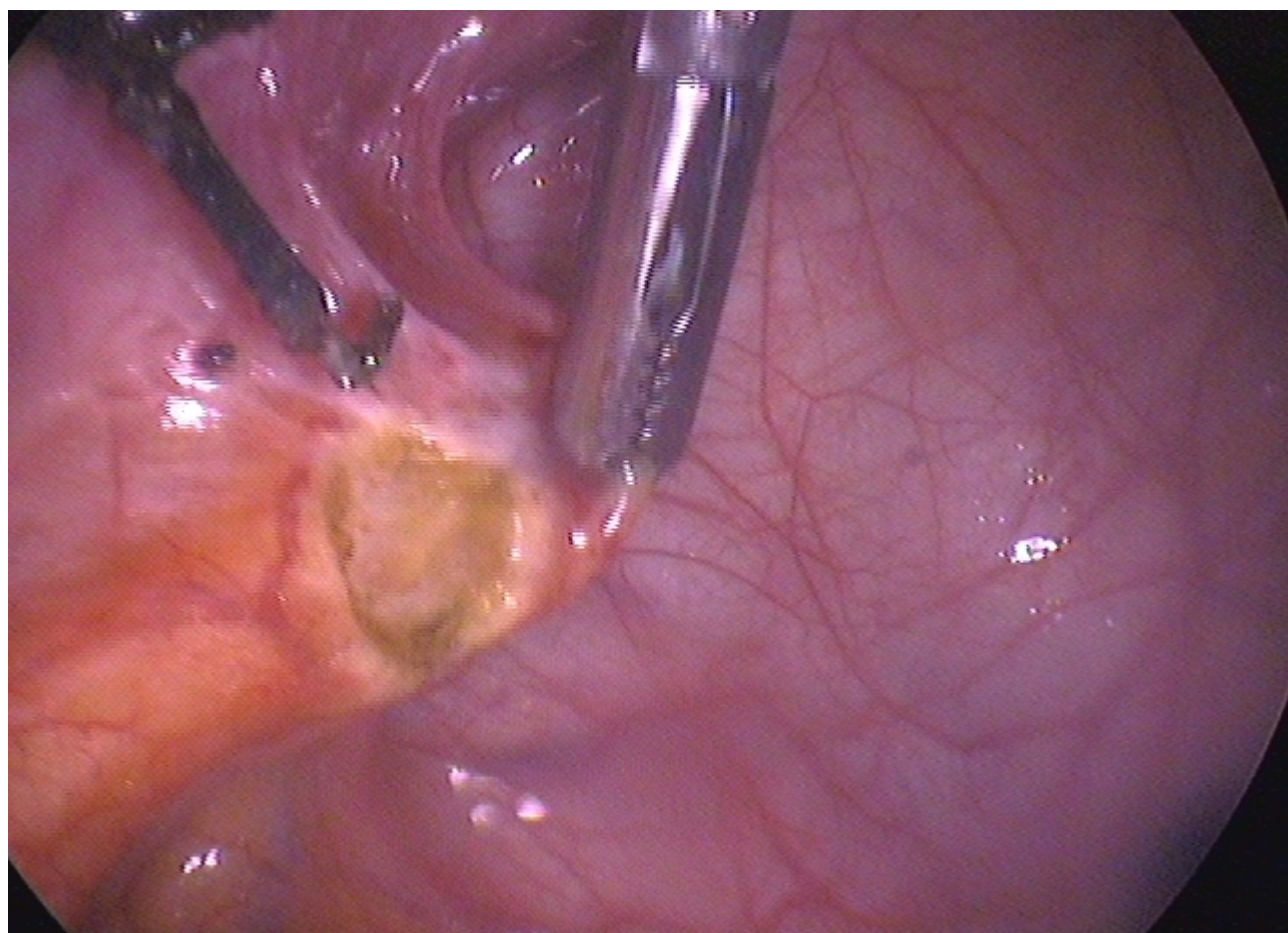


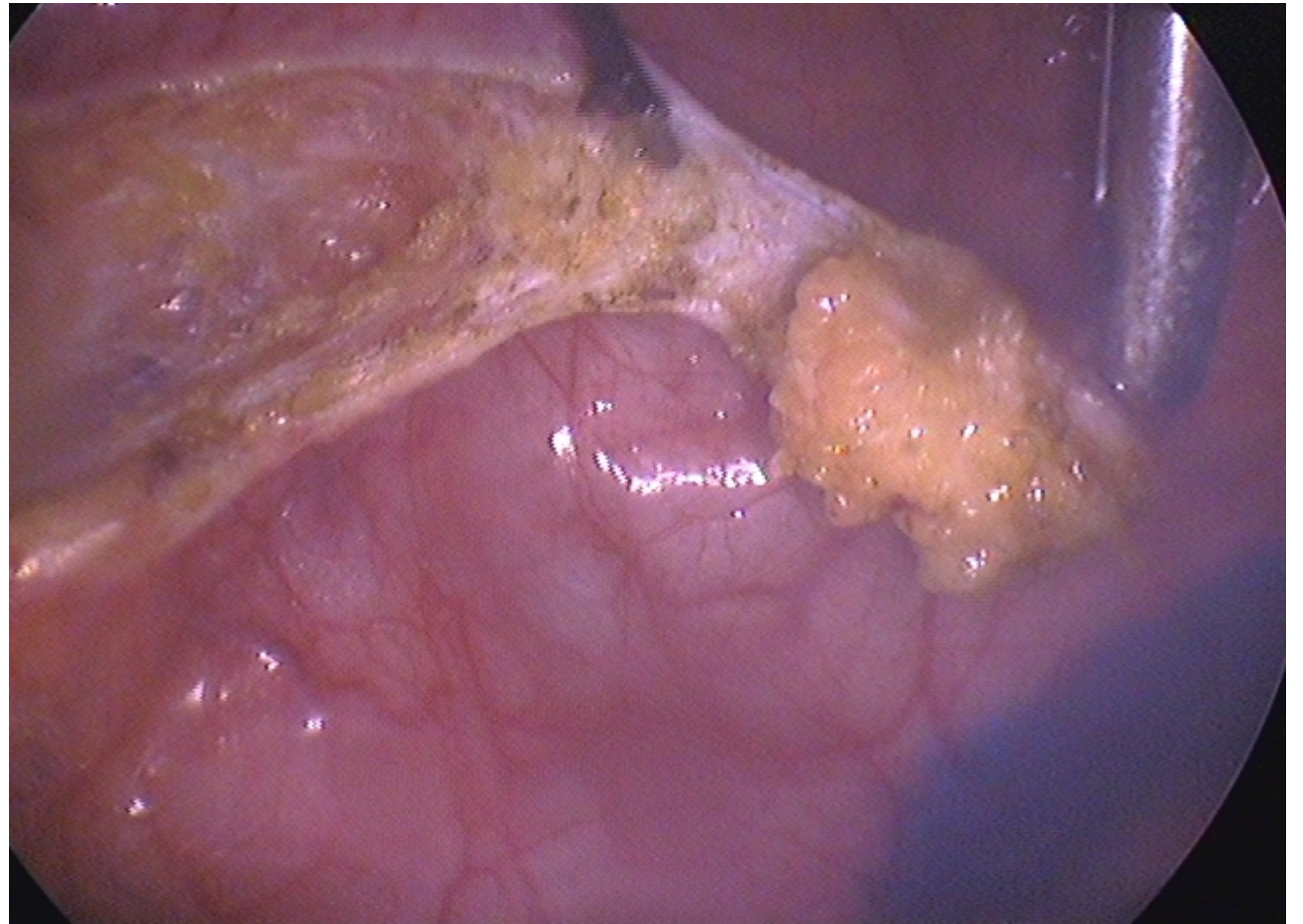




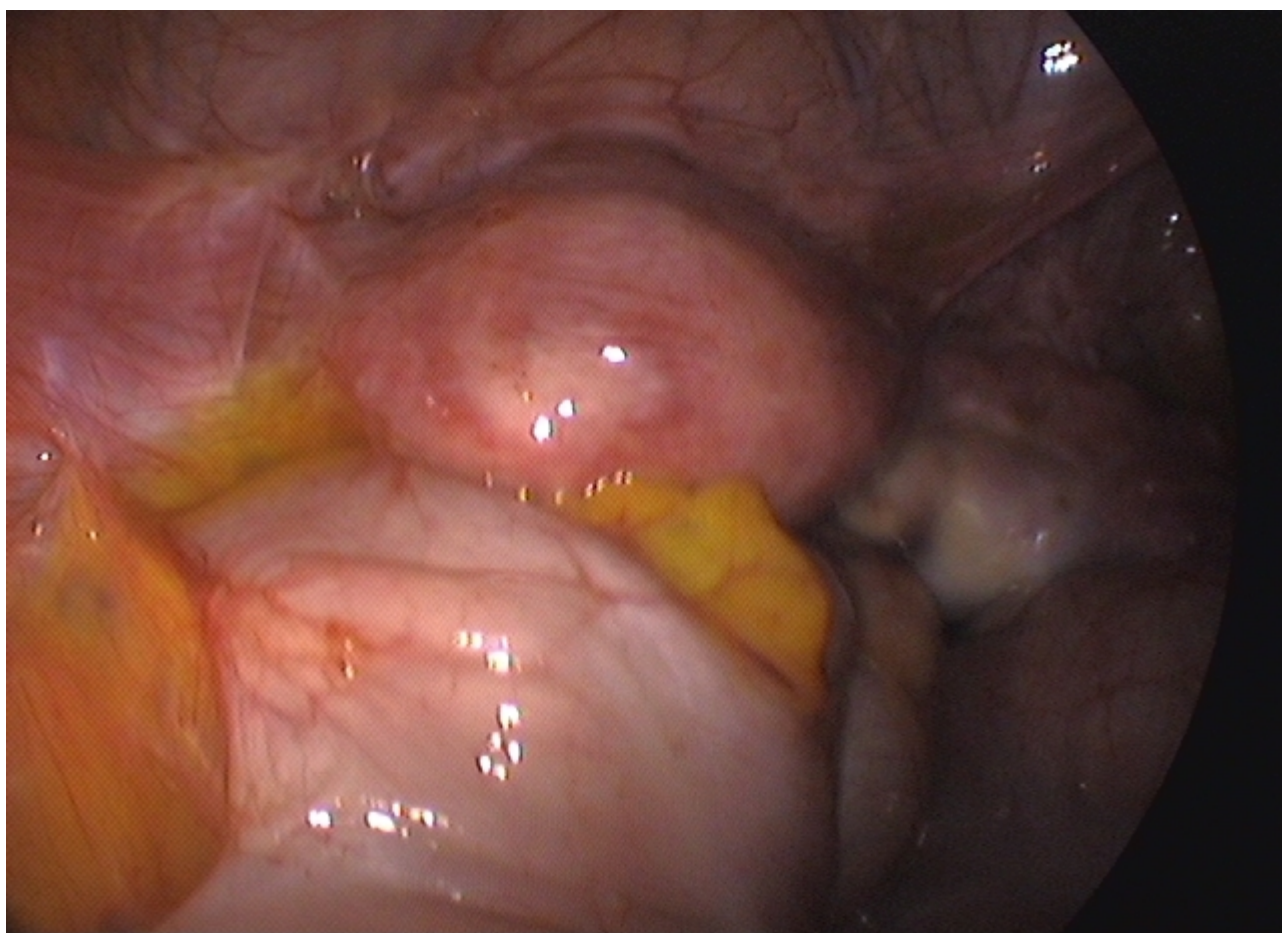


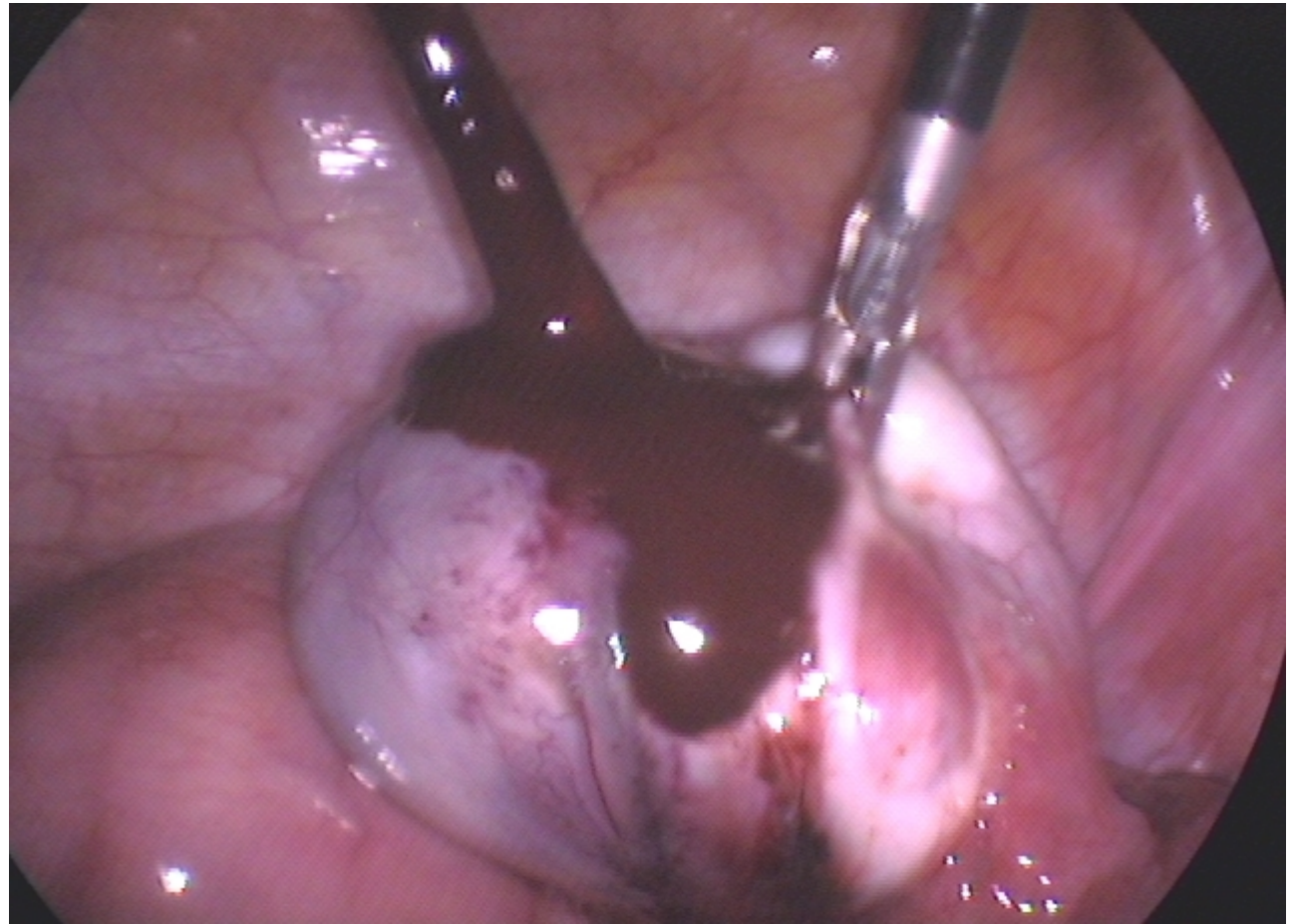


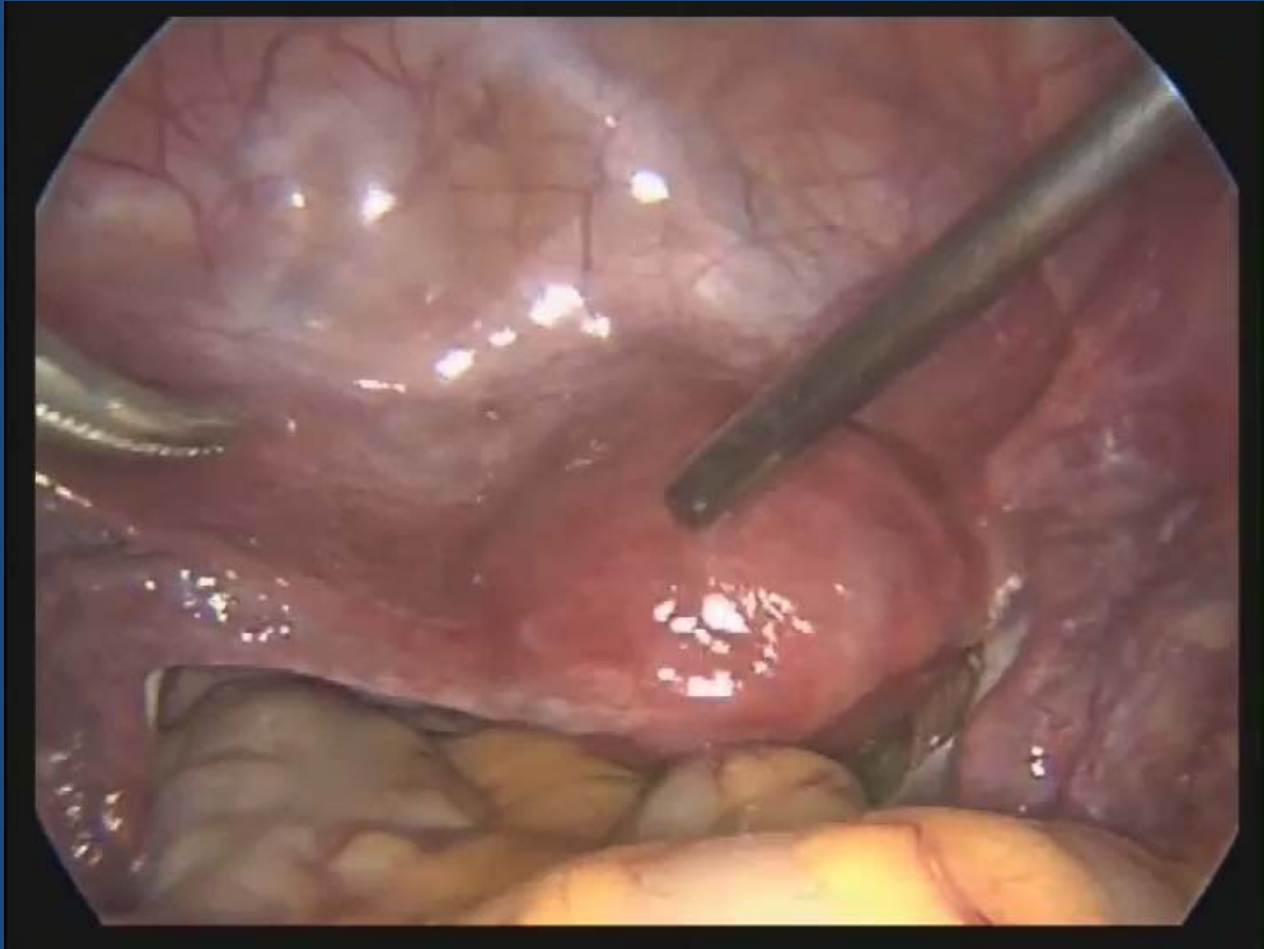














Embryo

CENTRO DE REPRODUÇÃO HUMANA

