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Editorial

ENDOMETRIOSIS - DIAGNOSTIC AND THERAPEUTIC CHALLENGE

Endometriosis represents an important health problem, affecting women of reproductive age. It requires often multidisciplinary approach, involving gynecologists, urologists and general surgeons as well.

Endometriosis, the presence of endometrial tissue outside the uterus, affects up to 6%-10% of fertile women, being usually located inside the pelvis[1]. Furthermore, up to 30% of patients have primary or secondary infertility issues related to endometriosis[2]. There are some rare cases of unusual location like pulmonary endometriosis, implying thoracic surgery. Small or large bowel could be a primary location of the disease, as we previously published[3].

Abdominal wall endometriosis is a rare entity, usually developed in the fertile period of women. It means endometriosis outside the peritoneum, located to abdominal wall, related or not to a scar. Parietal endometriosis include, beside abdominal wall endometriosis, perineal endometriosis, related to an episiotomy scar or de novo[4].

Symptoms are typically cyclic, synchronous with menstra. Any symptomatic association with menstrual period should be suspected of this disease.

The treatment of endometriosis could be medical, surgical, or both (combined treatment). Till now, there is no consensus or an optimal established treatment for endometriosis. Resection in healthy tissue, with free margins, seems to remain the best option. Resection could imply multiple organ approach, often in difficult conditions, with organ sacrifice and requiring of reconstruction methods. Intraoperative bleeding of endometrial tissue and dissection difficulties due to lesion infiltration is the rule. All these aspects justify the interdisciplinary approach and collaboration between surgeons of different specialties.

Endometriosis has an old history of referring in the literature. The first historical reference of endometriosis dates back since 1500 BC from a discovery of an ancient

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Egyptian papyrus which described a treatment for a painful disorder of menstruation. In 1690, Daniel Shroen described in his book titled "Disputatio Inauguralis Medica de Ulceribus Ulceri", a more detailed presentation of the peritoneal endometriosis referring to the adhesions and endometriomas as complications of the disease[5].

According to the depth of invasion and anatomic location, endometriosis is usually classified as: ovarian endometriosis, superficial peritoneal endometriosis and the most severe form of endometriosis, deep infiltrating endometriosis. The severest form of the disease is that of deep infiltrating endometriosis involving pelvic organs, such as rectum, urinary bladder, small or large bowel and uterosacral ligaments.

General surgeons, urologists and especially gynecologists should consider the diagnosis of endometriosis when encountering the typical symptoms. It is also important to get trained in a dedicated center for excellence in endometriosis surgery to improve diagnosing and managing the disease or referring the patients to specialized centers where they can get a holistic approach from a multidisciplinary team.

Laparoscopic surgery is considered the first choice for diagnosis and treatment of infertility related to endometriosis[6]*. Laparoscopic adhesiolysis is also very important and constitutes as a part of the treatment*[7].

Bringing together specialists from various fields under the auspices of the endometriotic pathology at the Second National Congress dedicated to this pathology, in Sinaia, between 20th and 22nd of June, this year, proved to be welcomed and the exchange of ideas of high academic level was very useful. The best and most elaborate works are included in extenso in this supplement of the journal.

It would be of great interest to have more consensus conferences and to elaborate practical guidelines for diagnosing and treating this disease.

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