Laparoscopic Excision of Rectovaginal Endometriosis at Croydon Endometriosis Centre: a single centre prospective cohort study

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Introduction
Deeply infiltrating endometriosis has an estimated prevalence of 1% in women of reproductive age, of which 90% have rectovaginal lesions. Depending on the women’s wishes and symptom control, management can be conservative, medical and/or surgical. Our objective was to examine the effectiveness of laparoscopic excision of rectovaginal endometriosis at Croydon University Hospital Endometriosis Centre. Specifically, we aimed to ensure our outcome data relating to symptom severity, quality of life and surgical complications were in line with national data recently published by the BSGE.

Methodology
- Women undergoing laparoscopic excision of rectovaginal endometriosis requiring dissection of the pararectal space at Croydon Endometriosis Centre completed a ISGE Pelvic Pain Questionnaire at first presentation, 6 months, 12 months and 24 months following surgery.
- Data was collected prospectively on the BSGE database.
- Secondary analysis of quality of life (QoL) and symptom severity responses was performed.
- Women must have given written consent for data collection.
- Women with inadequate follow up data, defined as less than 50% of all recommended fields, were excluded.

Grading of Symptoms
- Clinical symptom severity was recorded on a 0–10 point Likert scale.
- Bowel function was assessed using graded answers between 0–4, corresponding to frequency of occurrence.
- Dichotomous data (yes or no) were collected for use of analgesics: paracetamol, NSAIDs and opiates.

Assessment of Quality of Life
- Patient-reported QoL data were collected using the EuroQol 5-Dimension (EQ-5D) and EuroQol Visual Analogue Score.
- The five domains of the EQ-5D–3L questionnaire were combined to compute a single weighted index score (as used by NICE for assessing quality-adjusted life years (QALYs)).
- In this EQ-5D index score, 1 represents full health and 0 represents death.
- There are some health states that are assigned negative values (ie. worse than death).

Results
- 29 patients had complete data collection.
- 2 patients were excluded due to lack of follow up data.
- This left a total of 35 women.

Complications
- 2 women had intraoperative complications – 1 had primary repair of a small bowel injury, and 1 required laparotomy and defunctioning colostomy following rectal perforation during vaginal resection of an endometriotic nodule. Both women had been counselled and gave consent for stoma formation.
- There were no recorded postoperative complications.

Analgesic Requirements

Comparison to National Data: QoL

EQVAS numeric (Visual Analogue Scale out of 100)

<table>
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<th>Presurgery</th>
<th>6 months</th>
<th>1 year</th>
<th>2 years</th>
<th>Change (0 vs 2 years)</th>
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EQSD Index (score between -1 and 1)

<table>
<thead>
<tr>
<th></th>
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<th>2 years</th>
<th>Change (0 vs 2 years)</th>
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Conclusion
The reduction in pain and increased QoL observed at 6 months following surgery was maintained at 2 years, and all types of pain and bowel symptoms improved following surgery. When comparing the figures to the BSGE’s data including 51 Endocentres nationally1, Croydon Endometriosis Centre had a greater improvement at 24 months for premenstrual, menstrual, and lower back pain, faecal frequency, urgency and incomplete emptying sensation. Croydon patients self-reported a higher standard of health at presentation, and a similar standard of health at 24 months. Using the EQSD Index (calculated from the EuroQoL-5D–3L), patients from Croydon had greater improvement in QoL at 24 months postoperatively. We attribute this success to excellent multidisciplinary team working.

References