Ileocaecal endometriosis, a marker of advanced disease: to treat or not to treat?

V Mijatovic
Amsterdam UMC, Amsterdam, the Netherlands

Linked article: This is a mini commentary on L Marcellin et al., pp. 1600–1608 in this issue. To view this article visit https://doi.org/10.1111/1471-0528.15901

Published Online 13 October 2019.

The main finding of the large retrospective cohort study by Marcellin et al. (BJOG 2019;126:1600–8) is the high prevalence of ileocaecal endometriosis (ICE) of 25.6%. In previous surgical series, the reported prevalence of ICE is lower, with rates up to 10.2%. In contrast, the study’s interesting finding that ICE is associated with severe deep endometriosis and higher American Society for Reproductive Medicine stages is in line with previous reports indicating that ICE is a marker of advanced disease.

Usually, a pelvic evaluation by magnetic resonance imaging (MRI) is the technique of choice for presurgical mapping of bowel endometriosis. However, MRI lacks accuracy in the diagnosis of ICE, although some have suggested that it is suitable for diagnosis of ICE when right ureteral endometriosis lesions are detected preoperatively on pelvic MRI (Girmonet et al. Abdominal Radiol 2016;41:2404–10). Clinically, ICE may overlap with symptoms of rectosigmoidal endometriosis including pelvic pain and cyclical pseudo-obstruction. However, it may also be asymptomatic.

The unusually high prevalence of ICE in this study is largely explained by routine surgical exploration of the ileocaecal junction followed by resection of all macroscopic abnormalities in that area. This surgical approach reveals a considerable number of occult ICE lesions that otherwise would not be detected and treated. Decisions about whether surgical treatment of bowel endometriosis is indicated are usually based on symptomatology related to the bowel lesion. Nevertheless – as also highlighted by the authors – there are no specific questions to help to identify ICE-related symptoms preoperatively among women with endometriosis who are undergoing colorectal resection. Because all the ICE-positive women in the study by Marcellin and colleagues were asymptomatic with respect to ICE, the rationale for routinely treating all ICE lesions may be questionable.

The authors justify ileocaecal resection by pointing out that otherwise painful symptoms may persist or higher rates of recurrence may occur because of incomplete surgery. This claim remains to be proven. The study, however, shows neither increased postoperative complications, nor impaired long-term functional results due to additional ileocaecal surgery in women with ICE, which is reassuring.

For the time being, one should be careful in the implementation of routine exploration of the ileocaecal junction and resection of ICE lesions when associated with rectosigmoidal endometriosis. Further investigation and validation of this surgical approach are needed in prospective, preferably randomised, studies with surgical and functional end-points to explore its true clinical value and to overcome any bias and potential overtreatment. Therefore, in line with the recommendation of Marcellin et al., this kind of complex endometriosis surgery should be performed in only multidisciplinary referral centres and research settings where its effectiveness and safety are continuously evaluated.

Disclosure of interests
VM reports receiving fees for travel and speaking, as well as research grants from Guerbet. This does not relate in any way to the content of the mini commentary. A completed disclosure of interest form is available to view online as supporting information.