

Laparoscopic Appearance of Endometriosis

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Laparoscopic Appearance of Endometriosis was originally published as a set of 52 slides with text in a ring binder.

This web revision incorporates low resolution sides into the manuscript.

Click the image or [\[HRI_**\]](#) for a higher resolution image. The last two digits of the image labels correspond to the slide numbers in the manuscript.

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The reader is advised to carefully examine new information as it is available. The reader is also advised to consider that diagnosis, therapy and management of endometriosis are separate concepts. Techniques discussed in this publication may have been modified or abandoned by the time of publication.

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Laparoscopic Excision

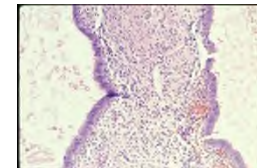
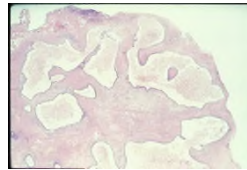
1. The specimens in this set were excised in their entirety and sent for pathology. This mid cul-de-sac cluster of lesions is circumscribed with a CO₂ laser in superpulse by incising through the peritoneum into the loose connective tissue. Repeat pulse superimposed on superpulse gives better control by slowing the process. [\[HRI 01\]](#)
2. After the lesion was circumscribed, it was pulled forward with grasping forceps and the laser was used to incise the loose connective tissue or fat behind the lesion. With the laser in superpulse, the incision is clean, and a distinction could generally be made between loose connective tissue, fat and scarred endometriosis. [\[HRI 02\]](#)



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Black (Dark) Scarred Lesions

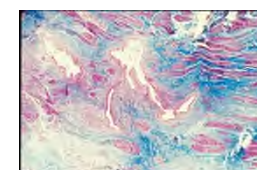
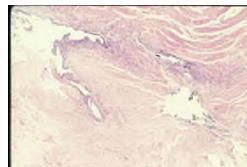
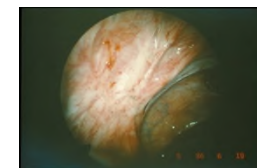
3. Dark (black), scarred (puckered) lesions are the easiest to see and to document by biopsy or excision. These can be histologically confirmed in 87% to 99% of cases under research conditions and 56% to 86% in clinical use. (Martin 1989, Martin, 1990, Buchweitz 2003, Martin 2006) [\[HRI 03\]](#)
4. These lesions generally have a diffuse mixture of glands, stroma, intraluminal debris, fibrosis and muscle. [\[HRI 04\]](#)
5. In these lesions, fibrosis, stroma, hemorrhage and hemosiderin laden macrophages separate the glands that contain old blood. [\[HRI 05\]](#)



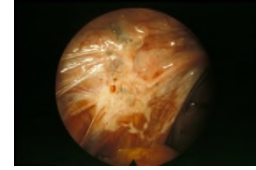
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White Lesions

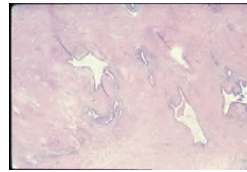
6. Scarred white lesions can be harder to see. This lesion involves almost half of the photographic field of the left broad ligament. [\[HRI 06\]](#)
7. In these white areas, sparse stroma and glands surrounded by a fibrous tissue and muscle is the predominant picture. [\[HRI 07\]](#)
8. Trichrome stain was used to demonstrate the fibrous and muscular components. The muscular portion is likely metaplasia. [\[HRI 08\]](#)



9. These diffuse, predominately white, scarred areas are easier to see in areas when the glands contain hemosiderin residual from intraluminal bleeding. [\[HRI_09\]](#)



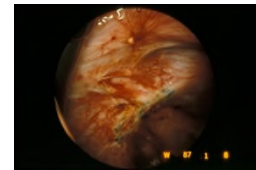
10. These glands are deep in the fibromuscular scar. [\[HRI_10\]](#)



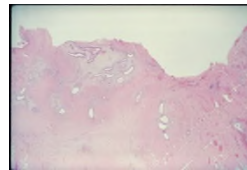
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Red Lesions

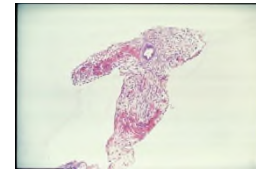
11. When these dark, scarred areas were associated with reddish polyps and reddish reaction, the red polypoid areas were commonly endometriosis. [\[HRI_11\]](#)



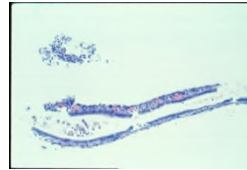
12. Many reddish areas were associated with deeper glands and stroma. [\[HRI_12\]](#)



13. Reddish polyps are predominantly glands and stroma. [\[HRI_13\]](#)



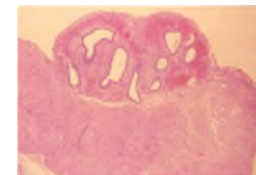
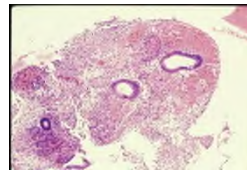
14. The smallest polyp was a single layer gland of about 150 microns in width and 800 microns in length. [\[HRI_14\]](#)



15. These red polypoid lesions are on the surface of a deep scarred perirectal nodule. The largest is about 4 x 7 mm on the surface and blend into the deep fibromuscular scar like slide 12. [\[HRI_15\]](#)



16. Red polyps usually contain glands and stroma with variable degrees of vascularity and hemorrhage. Scarring is uncommon within the polypoid surface, but common beneath the surface. Even when the lesions appear to be on the surface, fibrosis with muscular metaplasia is common as seen in the 1991 *Laparoscopic Appearance of Endometriosis* on page 18 (file page 25). [\[HRI_16\]](#)

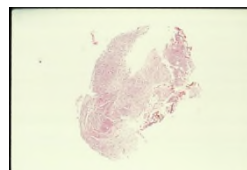


From Laparoscopic Appearance of Endometriosis

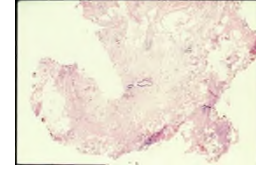
17. Some of the red polyps are so light as to assume a pink or yellow appearance making recognition more difficult. [\[HRI_17\]](#)



18. This polypoid lesion is predominantly stroma. This lesion was cut 6 times to find glands at the base. The 4 cuts through the top of the lesion were stroma only. [\[HRI_18\]](#)



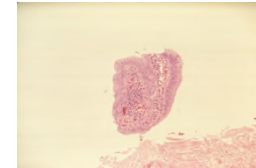
19. On the 5th and 6th cuts, glands and stroma are noted at the base of the lesion. [\[HRI 19\]](#)



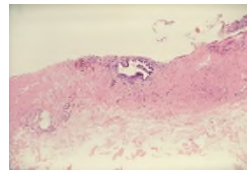
20. Teenagers frequently have small red polyps and white blebs as isolated findings. In this 19-year-old, the largest polyp was 400-micron in size and is the small red polyp toward the center of the slide. The white light reflections toward the left of the slide are 400-micron epithelial lesions with no stroma. [\[HRI 20\]](#)



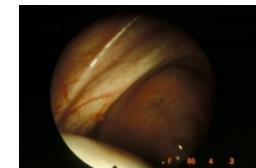
21. The 400-micron polyp in the 19-year-old was a polyp with glands and stroma. [\[HRI 21\]](#)



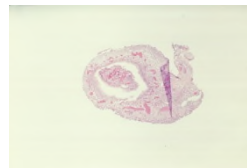
22. The small clear areas were epithelial lesions. The epithelial type of these was compatible with endometriosis. [\[HRI 22\]](#)



23. The youngest patient in this series was 14 years old and had a singular red polyp of the left uterosacral ligament. Reddish stromal endometriosis is seen on slide 25. [\[HRI 23\]](#)



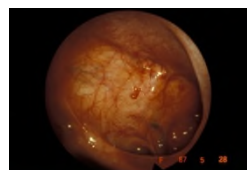
24. Histology confirmed this endometriosis in a 14-year-old. [\[HRI 24\]](#)



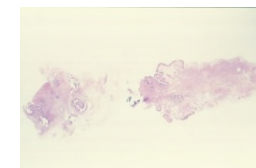
25. Of interest, the same patient, as in slides 23 & 24, had an almost healthy right cul-de-sac with a reddish blush that histologically was stromal endometriosis. If the area had been step sectioned at 5-micron levels, creating about 2,000 sections per cm, glands may have been present. [\[HRI 25\]](#)



26. At a one-year interval, the right cul-de-sac (same patient as slide 25) developed pockets and red polyps. [\[HRI 26\]](#)



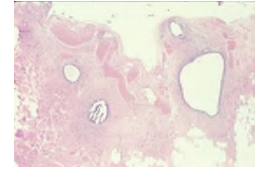
27. The red polyps from slide 26 have glands, stroma and a fibrous stalk. [\[HRI 27\]](#)



28. Hypervascularity associated with white appearing lesions is an uncommon finding. [\[HRI 28\]](#)



29. In this slide, hypervascular surface peritoneum has glands seen beneath this. These glands have little or no stroma and a differentiation between endosalpingiosis, as in this picture, and endometriosis must be made at a histologic level. On a clinical level, there may be no difference in these two diseases. [\[HRI 29\]](#)



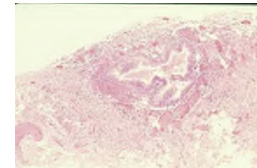
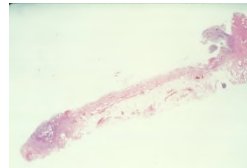
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Clear, White and Brown Lesions

30. A small developing pocket is noted in the right lower cul-de-sac. Immediately above and to the left of the pocket is a small whitish lesion. [\[HRI 30\]](#)

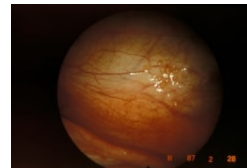


31. A section across the lesions in the rim of this pocket reveal that the whitish lesion is a small area of endometriosis and there may be stroma at the other margin. [\[HRI 31\]](#)

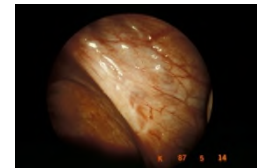


32. Secretion into this glandular structure has glands and scant stroma. [\[HRI 32\]](#)

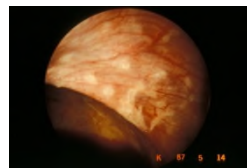
33. White and brown vesicular lesions were more difficult to identify and were usually endometriosis or endosalpingiosis. [\[HRI 33\]](#)



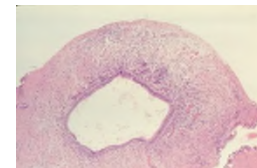
34. The angle of light inflection could be important in identifying lesions. In this slide, whitish looking lesions are difficult to see. The next slide shows a different light angle of this same section. [\[HRI 34\]](#)



35. When the angle of the view was changed (slide 34), more lesions were seen. It is not uncommon that the angle of light on the lesions needs to be changed to see them. [\[HRI 35\]](#)



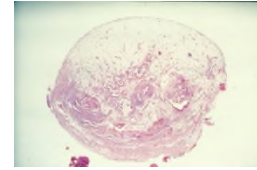
36. Some clear vesicles frequently are dilated glands with scant stroma within fibrosis. [\[HRI 36\]](#)



37. Some sections in the same patient show glands with prominent stroma. [\[HRI 37\]](#)



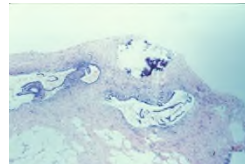
38. An uncommon histologic appearance was stromal edema in endometriosis seen as clear lesions. [\[HRI 38\]](#)



39. Small whitish inclusions are most frequently psammoma bodies. On occasion these hide endometriosis. [\[HRI 39\]](#)



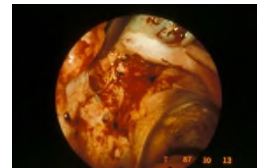
40. A psammoma body is seen on the surface hiding glands and stroma beneath it. The whitish appearance of the calcium deposits is more obvious than the underlying endometriosis. This can represent coexistent disease. [\[HRI 40\]](#)



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Diffuse Infiltration

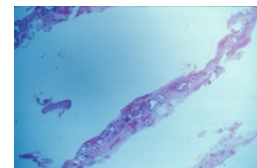
41. This field shows endometriosis and red adhesions covering the entire left broad ligament underneath the left tube and ovary. The left ovary is seen in the upper portion of the field and the left uterosacral at the depth of the field. Blackish areas of endometriosis are noted to the left. Reddish adhesions are noted in the center. Adhesions can hide endometriosis in 40% of the cases. [\[HRI 41\]](#)



42. Due to Sampson's 1921 data that endometriosis was not seen in 10 of 14 adhesions, the area was excised in its entirety by first opening the peritoneum away from the ureter and then pushing the ureter off with a blunt probe. Blunt probes protect the ureter. Fluid dissection is an alternate technique. If the ureter will not bluntly dissect away from the peritoneum, it is assumed that the endometriosis may be infiltrating into the ureter and this is not removed unless the patient has been preoperatively prepared for ureteral implantation. However, in most of the cases, as happened in this one, the ureter pushed away easily, and the broad ligament was excised. [\[HRI 42\]](#)



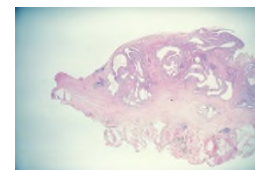
43. In this section of the reddish adherent area, endometriosis is seen infiltrating through the entire field. [\[HRI 43\]](#)



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Deep Infiltration

44. Endometriosis in this case involves the right round ligament and is pulling the tube toward that area. [\[HRI 44\]](#)
45. Dissecting this area with the CO₂ laser is performed and leaves a clean field. However, it is noted that excision went completely through the broad ligament. When tissue is distorted by endometriosis, surgeons must take care not to do damage to deeper levels of tissue. In this circumstance, this was noted during the dissection. Had this not been noted, it would have been easy to damage the ureter if it had been pulled into this lesion. In addition, closing this defect might decrease the chance of internal hernia. [\[HRI 45\]](#)
46. This right uterosacral ligament is interesting in two aspects. The first is that the brownish appearance that may be related to a positive Chlamydia culture from this surface. We can anticipate that endometriosis patients can have active Chlamydia. [\[HRI 46\]](#)
47. The second point regarding this lesion is that it goes much deeper than is apparent. It was palpably about 1 cm in diameter. [\[HRI 47\]](#)
48. After dissection, the dissection plane is almost to the level of the rectum near the lower are of the picture and the vagina in the upper margin. [\[HRI 48\]](#)
49. The size of this lesion is easily noted and had a depth of 7 mm toward both the rectum and vagina. Bipolar and thermal coagulation would have been inadequate to coagulate this lesion unless wide coagulation forceps had been used to completely enclose this lesion in the grasping jaws. Most bipolar and thermal coagulation jaws are not wide enough to completely encircle this lesion. In addition, lasers which coagulate to a depth of no greater than 0.4 to 4.2 mm would have been inadequate to coagulate this lesion. Destruction of this lesion requires vaporization or excision. [\[HRI 49\]](#)
50. Diffuse endometriosis is seen in the cul-de-sac. The dark, fibrotic lesion at the center with a white, scarred appearing base was easily palpable on bimanual exam as a 2 cm nodule extending into the posterior vaginal fornix. [\[HRI 50\]](#)



51. Laparoscopic dissection was taken to the level of the vagina. A probe in both the vagina and the rectum was used for recognition of these areas. The rectum was avoided and the probe in the vagina used so that the dissection could be taken immediately adjacent to the probe around the circumference of the lesion. Once this was well developed, an incision was made directly through the vagina. At this time the pneumoperitoneum was lost, and the lesion was pulled through the vagina. (Martin 1988) [[HRI 51](#)]



52. The left side of the slide is the peritoneum and the right side the vaginal epithelium. Endometriosis is noted infiltrating through the entire fibromuscular scar area. [[HRI 52](#)]



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REFERENCES

- Buchweitz O, Poel T, Diedrick K, Malik E. The diagnostic dilemma of minimal and mild endometriosis under routine conditions. *J Am Assoc Gyneco Laparosc* 2003;10:85-9.
- Martin DC. Laparoscopic and vaginal colpotomy for the excision of infiltrating cul-de-sac endometriosis. *J Reprod Med* 33:806-808, 1988
- Martin DC, Hubert GD, Vander Zwaag R, El-Zeky FA. Laparoscopic appearances of peritoneal endometriosis. *Fertil Steril* 1989;51:63-7.
- Martin DC, Ahmic R, El-Zeky FA, Vander Zwaag R, Pickens MT, Cherry K. Increased histologic confirmation of endometriosis. *J Gynecol Surg* 1990;6:275-9.
- Martin DC, Redwine DB, Reich H, Kresch AJ. *Laparoscopic Appearance of Endometriosis, Second Edition*, 1991, Web Revision. 2017. Resurge Press, Richmond, Virginia <http://www.danmartinmd.com/files/coloratlas1990.pdf>
- Martin D, Webb T, Lazarus E. Histologic confirmation of endometriosis may not be clinically useful (abstract). *J Min Invasive Gynecol* 2006;13:s97.
- Sampson, John A. (1921) Perforating hemorrhagic (chocolate) cysts of the ovary. Their importance and especially their relation to pelvic adenomas of the endometrial type ("adenomyoma" of the uterus, rectovaginal septum, sigmoid, etc.) *Arch Surg* 3: 245-323

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