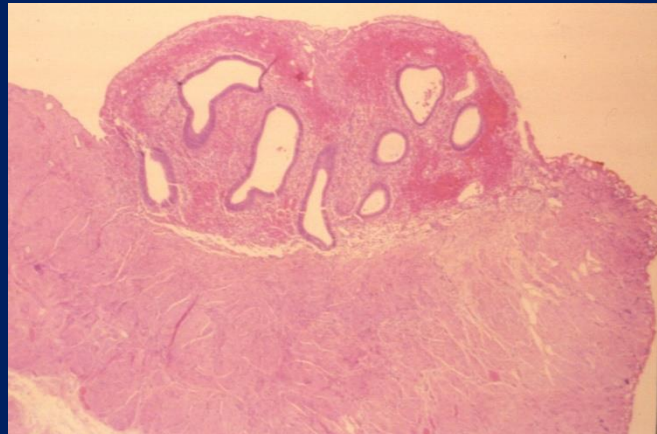


Laparoscopic Appearance of Endometriosis



Dan C. Martin

Laparoscopic Appearance of Endometriosis

Dan C. Martin, M.D.

Slide set ©1988

Web Revision with slide images, 26 December 2018, ©2108

This is periodically updated at

www.danmartinmd.com/files/lae1988.pdf

Laparoscopic Appearance of Endometriosis uses images that were originally published in 1988 as a set of 52 slides with text.

This web revision incorporates low resolution sides into the manuscript to link to higher resolution images in the cloud.. Click the image or the slide designator [*HRI_***] for the higher resolution image. The last two digits of the slide designator correspond to the slide numbers in the manuscript.

Additional Resources:

1990 Color Atlas: www.danmartinmd.com/files/coloratlas1990.pdf

1991 Lecture Slide Series images: www.danmartinmd.com/files/lae1991.pdf

Downloads: <http://www.danmartinmd.com/sitemap.html>

Endometriosis Concepts: <http://www.EndometriosisConcepts.com/>

Copyright ©1988, ©1989 Fertility Institute of the Mid-South, Inc, Memphis
Web Revisions, Copyright ©2018, Dan C. Martin, MD, Resurge Press, Richmond

Notice: Our knowledge in clinical sciences is constantly changing. As new information becomes available, changes in treatment and surgery become necessary. The author and the publisher of this volume have taken care to make certain that the standards of diagnosis are correct and compatible with the standards generally accepted at the time of publication.

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.

All materials contained in these volumes are covered by copyright. Any or all sections may be adapted or duplicated for use in training or educational events as long as proper citation as illustrated below is given. If large-scale reproduction or distribution of any portion of the volume is desired, prior written permission from The Resurge Press is required. If you wish to include any material in any other publication for sale, please send your request and proposal to The Resurge Press.

The following statement must appear on all reproductions:

*From Martin DC, Laparoscopic Appearance of Endometriosis
The Resurge Press, Richmond*

Copyright 1988 and 1989 by the Fertility Institute of the Mid-South, Inc,
a nonprofit, tax-exempt [501 (c) (3)], educational and research organization.

Copyright 2018, Dan C. Martin, MD, Resurge Press

All rights reserved. No part of this book can be reproduced in any form or by any electronic or mechanical means including information storage and retrieval systems without permission in writing from the publisher, except by a reviewer who may quote brief passages in a review.

Published by the Resurge Press, 201 Wakefield Road, Richmond, VA 23221
(901) 761-4787
danmartinmd@gmail.com

Published 1988, 1989
2018 Web Revisions, Sept 23, Oct 29, 1 Nov 1, Nov 23, Nov 24

ISBN: 0-9616747-2-5

Printed and bound in the United States of America.

Table of Contents

	Slides	Page
<u>Laparoscopic Excision</u>	1 - 2	1
<u>Black Lesions</u>	3 - 5	1
<u>White Lesions</u>	6 - 10	1
<u>Red Lesions</u>	11 - 29	2
<u>Clear, White and Brown Lesions</u>	30 - 40	4
<u>Diffuse Infiltration</u>	41 - 43	5
<u>Deep Infiltration</u>	44 - 52	5
<u>References</u>		6

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. [\[HRI 02\]](#)

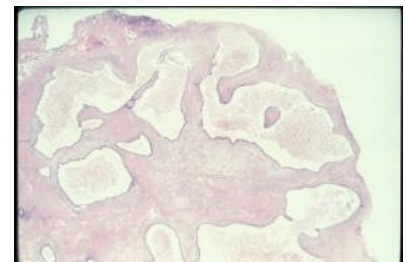


Black (Dark) Scarred Lesions

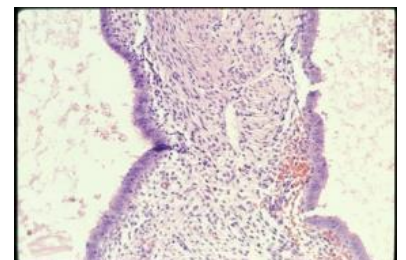
3. Dark (black), scarred (puckered) lesions are the easiest to see and to document by biopsy or excision. These can be histologically confirmed in 87% to 99% of cases under research conditions and 56% to 86% in clinical use. (Martin 1989, Martin, 1990, Buchweitz 2003, Martin 2006) [\[HRI 03\]](#) Satellite lesions of 1-mm to 3-mm were noted years later while reviewing the images. [\[HRI 03b\]](#)



4. These lesions generally have a diffuse mixture of glands, stroma, intraluminal debris, fibrosis and muscle. [\[HRI 04\]](#)



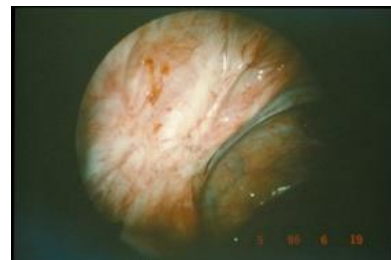
5. In these lesions, fibrosis, stroma, hemorrhage and hemosiderin laden macrophages separate the glands that contain old blood. [\[HRI 05\]](#)



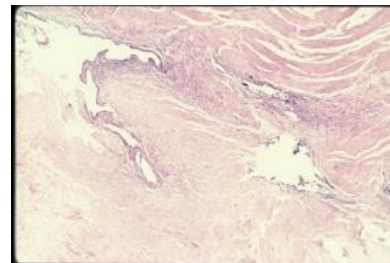
[Table of Contents](#)

White Lesions

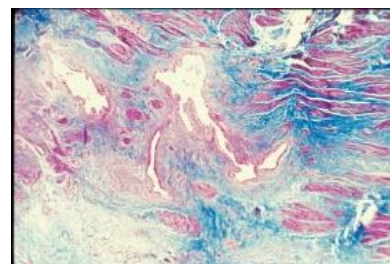
6. Scarred white lesions can be harder to see. This lesion involves almost half of the photographic field of the left broad ligament. In the high resolution, linked picture, carbon from inadequate laser vaporization is seen. A better picture of carbon is on page 27 (file page 34) at <http://www.danmartinmd.com/files/coloratlas1990.pdf> [[HRI_06](#)]



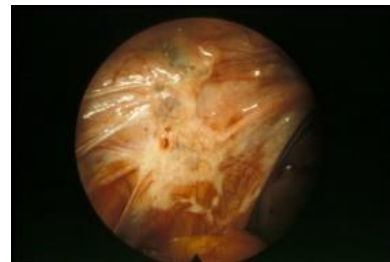
7. In these white areas, sparse stroma and glands surrounded by a fibrous tissue and muscle is the predominant picture. [[HRI_07](#)]



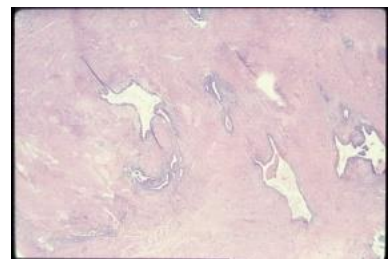
8. Trichrome stain was used to demonstrate the fibrous and muscular components. The fibrous component is likely reactive and the muscular portion metaplastic. [[HRI_08](#)]



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



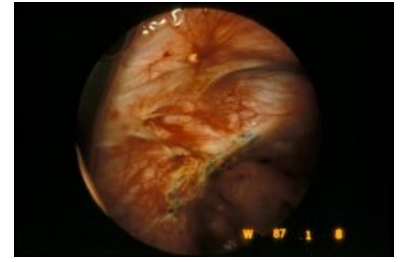
10. These glands are deep in the fibromuscular scar. [[HRI_10](#)]



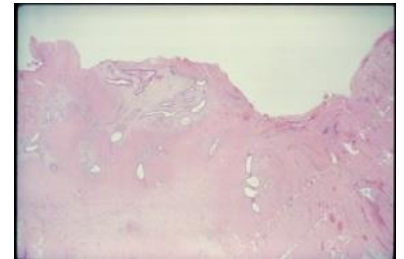
[Table of Contents](#)

Red Lesions

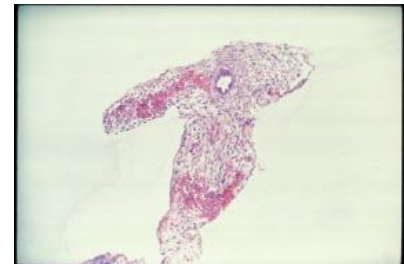
11. When these dark, scarred areas were associated with reddish polyps and reddish reaction, the red polypoid areas were commonly endometriosis. [\[HRI_11\]](#)



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. [\[HRI_14\]](#)

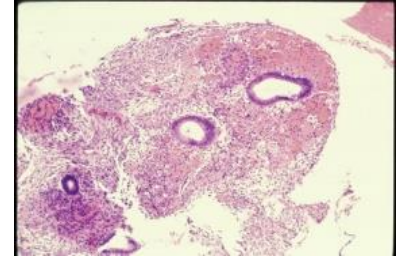


15. These red polypoid lesions are on the surface of a deep scarred perirectal nodule. The largest is about 4 x 7 mm on the surface and blend into the deep fibromuscular scar like slide 12. [\[HRI_15\]](#)

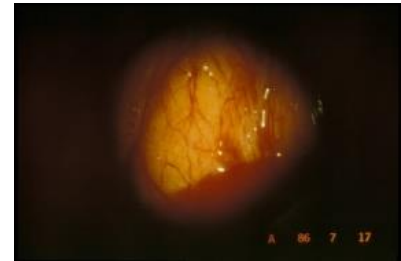


[Table of Contents](#)

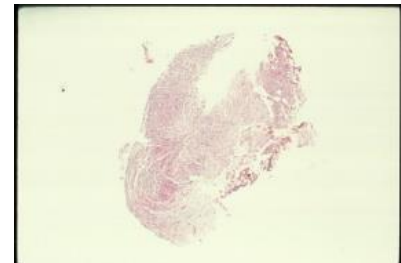
16. Red polyps usually contain glands and stroma with variable degrees of vascularity and hemorrhage. Scarring is uncommon within the polypoid surface, but common beneath the surface. [\[HRI_16\]](#)



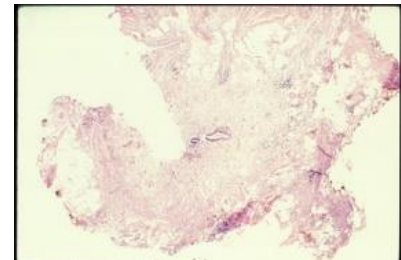
17. Some of the red polyps are so light as to assume a pink or yellow appearance making recognition more difficult. [\[HRI_17\]](#)



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. [\[HRI_18\]](#)



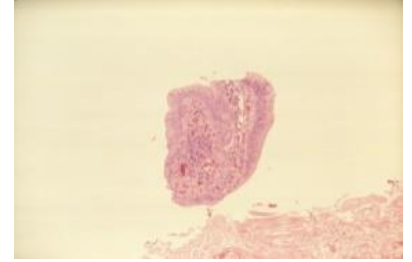
19. On the 5th and 6th cuts, glands and stroma are noted at the base of the lesion. [\[HRI_19\]](#)



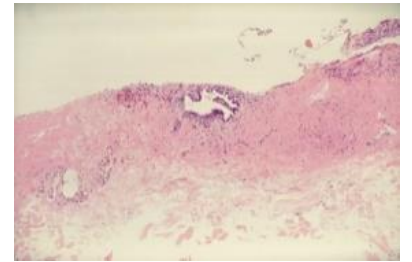
20. Teenagers frequently have small red polyps and white blebs as isolated findings. In this 19-year-old, the largest polyp was 400-micron in size and is the small red polyp toward the center of the slide. The larger blebs were 200-micron epithelial lesions with no stroma and there are smaller blebs that may be 100-micron or less. [\[HRI_20\]](#), [\[HRI_20b\]](#), & [\[HRI_20c\]](#)
The smaller blebs were noted 30 years later after reviewing Badescu (2016 & 2018) and Roman (2016).



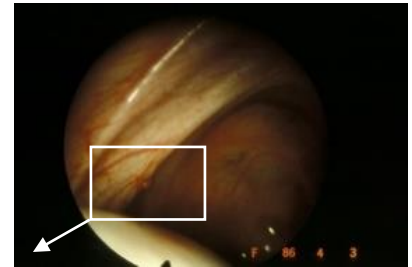
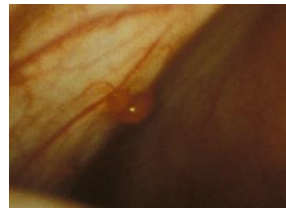
21. The 400-micron polyp in the 19-year-old was a polyp with glands and stroma. [\[HRI 21\]](#)



22. The small clear areas were epithelial lesions of 200-micron or less with no stroma. 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. [\[HRI 23\]](#) & [\[HRI 23b\]](#)



24. Histology confirmed this endometriosis in the 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 serially sectioned, glands may have been found as in Slide 19. Sectioning a 1-cm lesion at 5-micron would create about 2,000 sections. [\[HRI 25\]](#)



[Table of Contents](#)

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



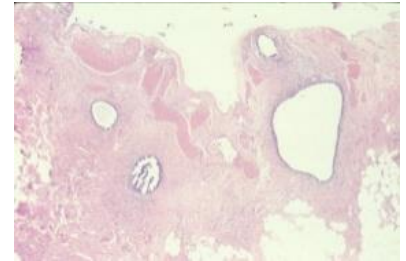
27. The red polyps from slide 26 have glands, stroma and a fibrous stalk. [\[HRI 27\]](#)



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. [\[HRI 29\]](#)



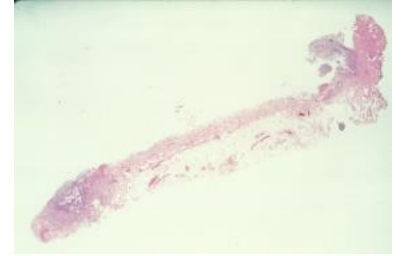
Clear, White and Brown Lesions

30. A small developing pocket is noted in the right lower cul-de-sac. At the upper and lower left of the pocket is are small clear lesions. [\[HRI 30\]](#) & [\[HRI 30b\]](#)

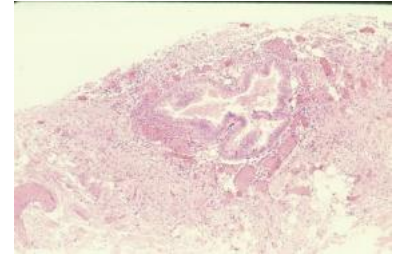


[Table of Contents](#)

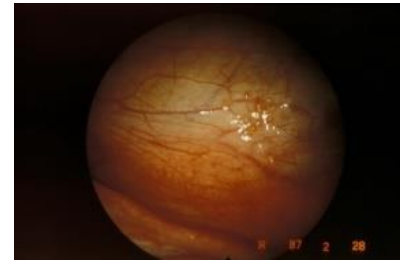
31. A section across the lesions in the rim of this pocket reveal that the whitish lesion is a small area of endometriosis and there may be stroma at the other margin. [\[HRI 31\]](#)



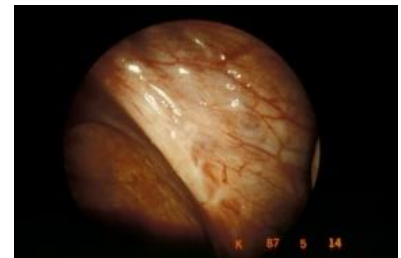
32. Secretion into this glandular structure has glands and scant stroma. [\[HRI 32\]](#)



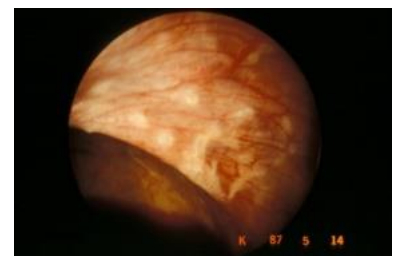
33. White and brown vesicular lesions were more difficult to identify and were usually endometriosis or endosalpingiosis. [\[HRI 33\]](#)



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. [\[HRI 34\]](#)

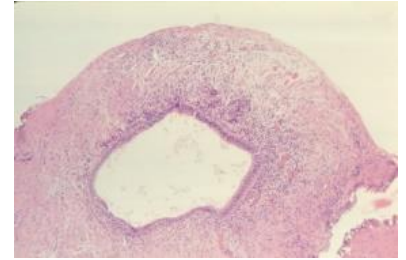


35. When the angle of the view was changed (slide 34), more lesions were seen. It is not uncommon that the angle of light on the lesions needs to be changed to see them. [\[HRI 35\]](#)

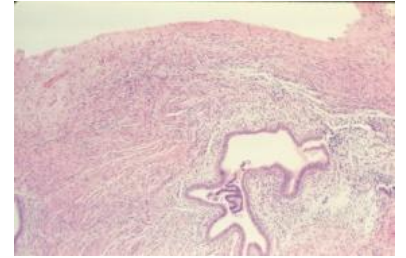


[Table of Contents](#)

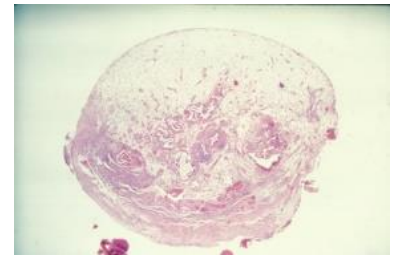
36. Some clear vesicles frequently are dilated glands with scant stroma within fibrosis. [\[HRI 36\]](#)



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



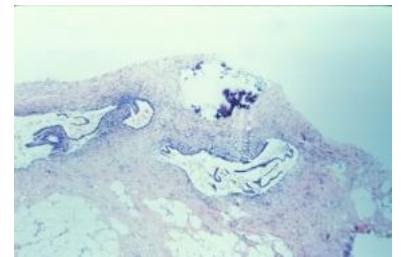
38. An uncommon histologic appearance was stromal edema in endometriosis seen as clear lesions. [\[HRI 38\]](#)



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. [\[HRI 40\]](#)



[Table of Contents](#)

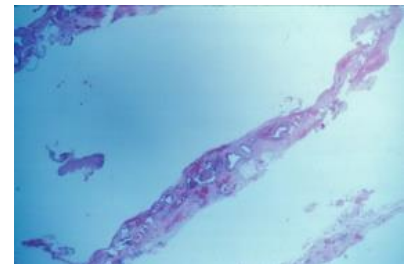
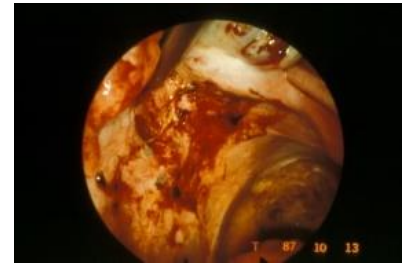
Diffuse Infiltration

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. [\[HRI 43\]](#)

[Table of Contents](#)

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. [\[HRI 46\]](#)



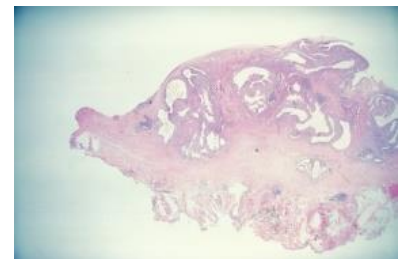
47. The second point regarding this lesion is that it goes much deeper than is apparent. It was palpably about 1 cm in diameter. [\[HRI 47\]](#)



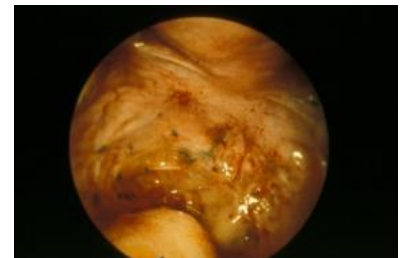
48. After dissection, the dissection plane is almost to the level of the rectum near the lower are of the picture and the vagina in the upper margin. [\[HRI 48\]](#)



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. [\[HRI 49\]](#)

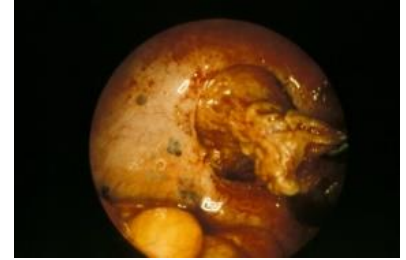


50. Diffuse endometriosis is seen in the cul-de-sac. The dark, fibrotic lesion at the center with a white, scarred appearing base was easily palpable on bimanual exam as a 2 cm nodule extending into the posterior vaginal fornix. [\[HRI 50\]](#) and [\[HRI 50b\]](#)

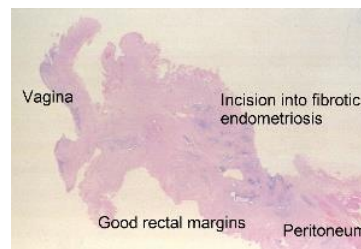
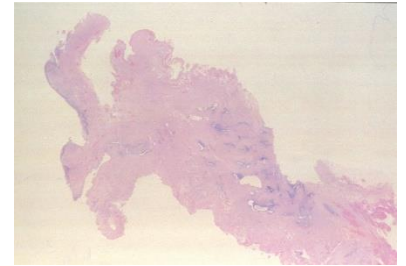


[Table of Contents](#)

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. Dissection into healthy fat separated the rectum. The lesion extended to the cervix and the lesion was entered along the cervical margin. Once this was 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 vaginal epithelium and the right is peritoneum. Endometriosis is noted infiltrating through the entire fibromuscular scar area. The area of the incision into the cervical margin is labeled. [\[HRI 52\]](#) and [\[HRI 52b\]](#)



REFERENCES

- Badescu A, Roman H, Aziz M, Puscasiu L, Molnar C, Huet E, Sabourin JC, Stolnicu S. Mapping of bowel occult microscopic endometriosis implants surrounding deep endometriosis nodules infiltrating the bowel. *Fertil Steril* 2016, 105:430–4.
- Badescu A, Roman H, Barsan I, Soldea V, Nastasia S, Aziz M, Lucan M, Puscasiu L, Stolnicu S. Patterns of Bowel Invisible Microscopic Endometriosis Reveal the Goal of Surgery: Removal of Visual Lesions Only. *J Minim Invasive Gynecol* 2018, 25(3):522-527.e9
- 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.

Roman H, Hennesier C, Darwish B, Badescu A, Csanyi M, Aziz M, Tuech J-J, Abo C. Bowel occult microscopic endometriosis in resection margins in deep colorectal endometriosis specimens has no impact on short-term postoperative outcomes. *Fertil Steril* 2016;105:423–9.

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

[Table of Contents](#)