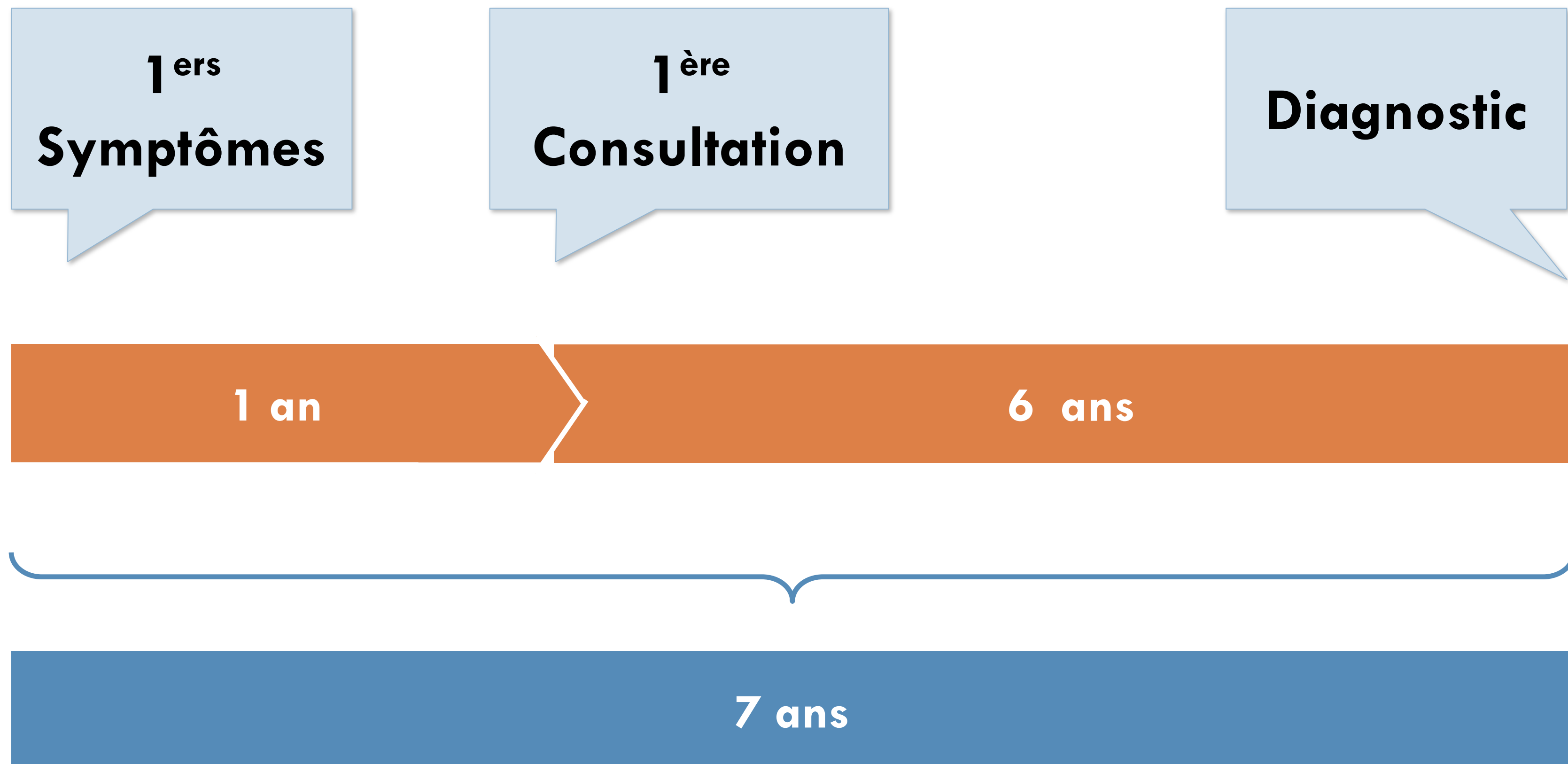


Délai de diagnostic



Nnoaham et al 2011



C H U | U V C
B R U G M A N N
P E R I N E O L O G I E

Diagnostic delay according to the revised ASRM stage

	rAFS stage				
	Stage I (n = 30)	Stage II (n = 23)	Stage III (n = 15)	Stage IV (n = 12)	Advanced stage IV (n = 15)
Diagnostic delay (years)	3.5 ± 3.4	6.7 ± 5.8	5.5 ± 5.0	6.3 ± 4.6	14.4 ± 5.7 ^a

Note: Stage IV defined as revised ASRM score ≤70 and advanced stage IV as revised ASRM score >70. All data are expressed as mean ± SD (years).

^a $P < .0001$ versus stage I, $P < .003$ versus stage II, $P < .003$ versus stage III, $P < .005$ versus stage IV.

Matsuzaki. Diagnostic delay of endometriosis. Fertil Steril 2006.



C H U | U V C
B R U G M A N N
P E R I N E O L O G I E

Endométriose - Adolescence

Incidence : 62% (543/880)

880 adolescentes – douleur chronique

- Douleur pelvienne chronique résistante au traitement médical
 - 75% (237/314)
- Dysménorrhée primaire
 - 70% (102/146)
- Douleur pelvienne chronique non nécessairement résistante au traitement médical
 - 49% (204/420)



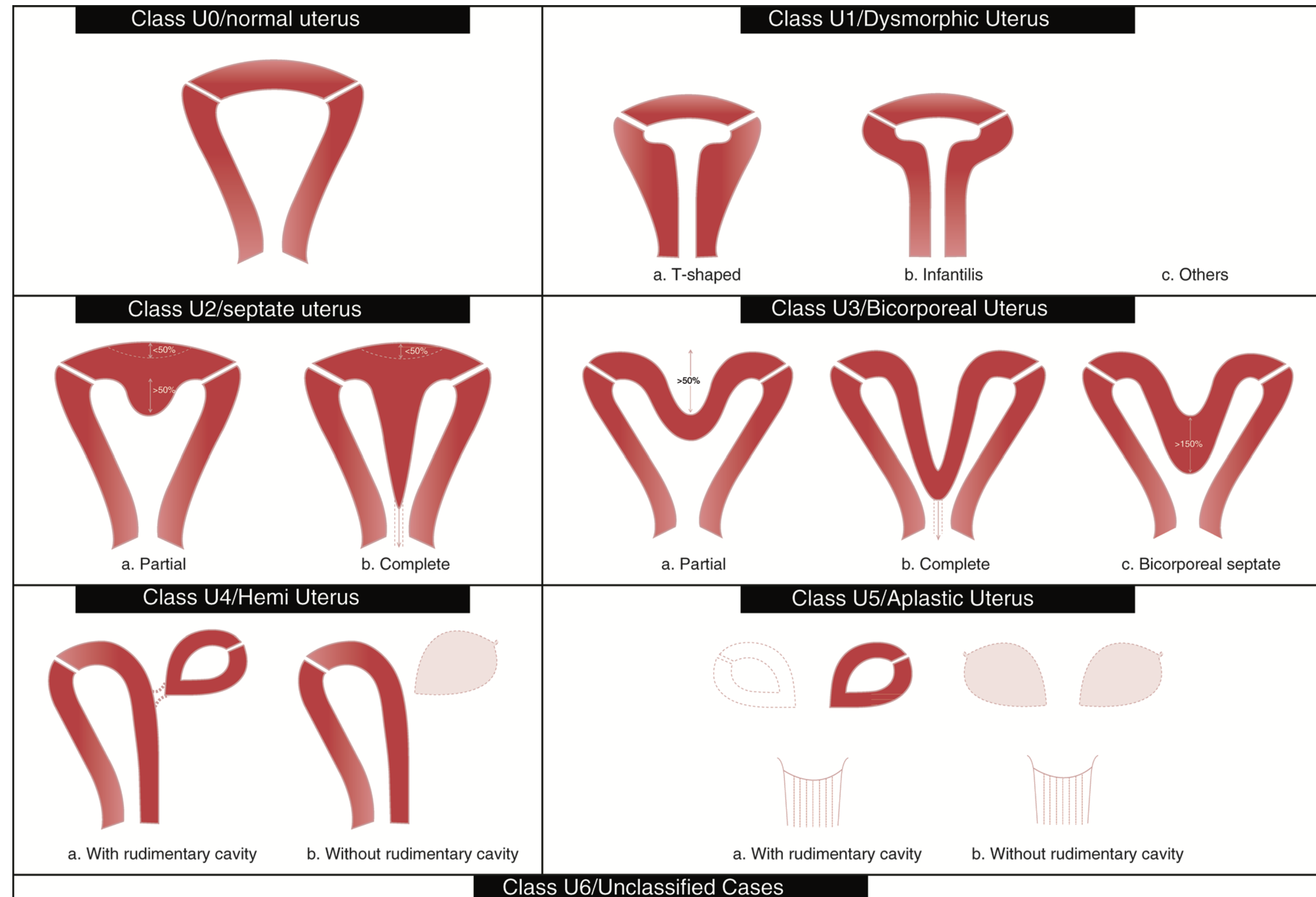
Sévérité de l'endométriose à l'adolescence

Études récentes: > 2000

	Nb	Age	Stage I	Stage II	Stage III	Stage IV
Bai (2002)	39	14-21	10%	44%	28%	18%
Ventolini (2005)	28	12-18	14%	39%	43%	4%
Vicino (2010)	38	15-21	18%	13%	34%	34%
Roman (2010)	20	14-20	40%	45%	5%	10%
Yang (2012)	63	12-20	8%	3%	52%	37%



The ESHRE/ESGE consensus on the classification of female genital tract congenital anomalies





ESHRE/ESGE classification
Female genital tract anomalies

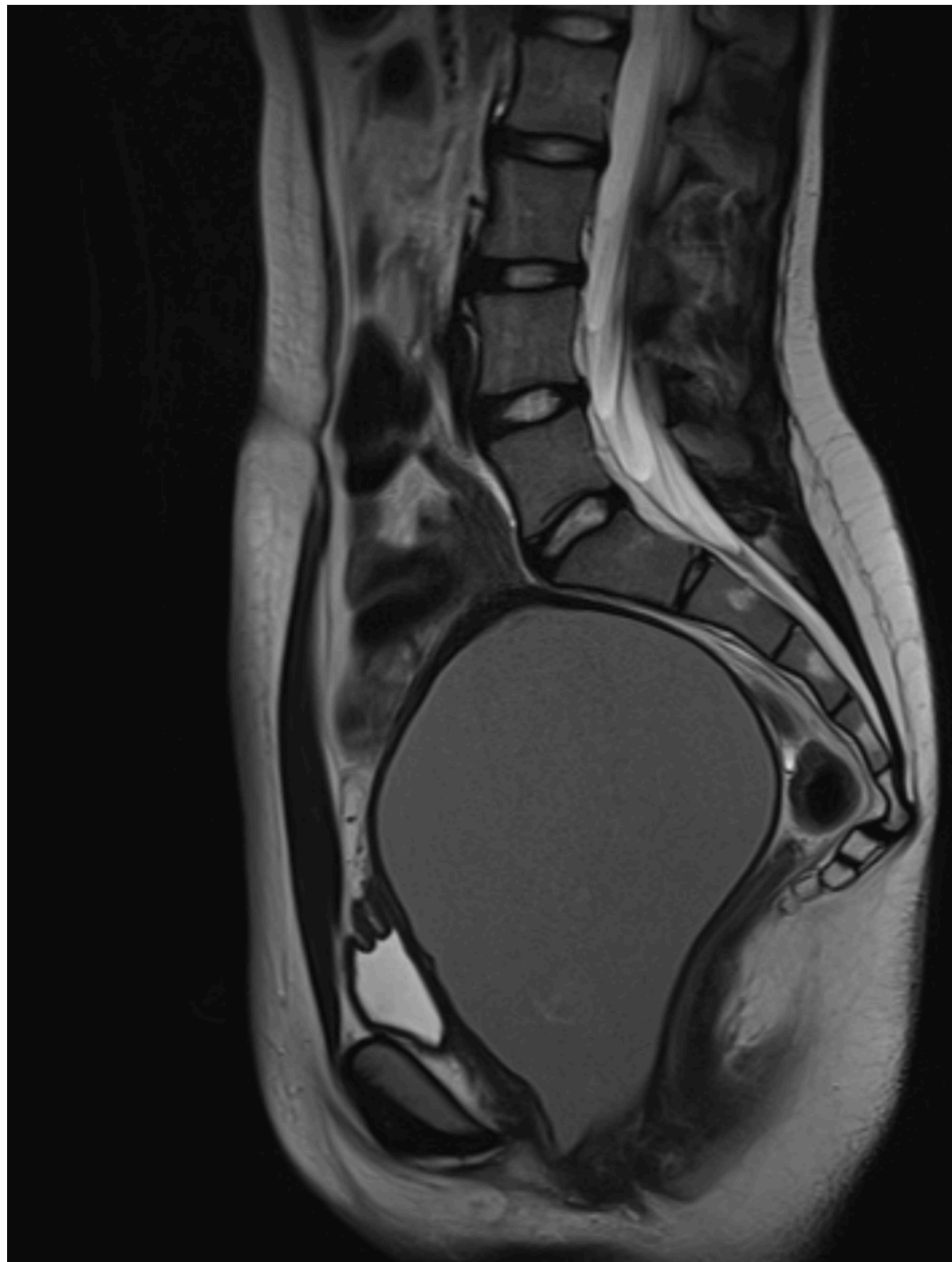


Uterine anomaly			Cervical/vaginal anomaly	
<i>Main class</i>	<i>Sub-class</i>		<i>Co-existent class</i>	
U0	Normal uterus		C0	Normal cervix
U1	Dysmorphic uterus	a. T-shaped	C1	Septate cervix
		b. Infantilis	C2	Double ‘normal’ cervix
		c. Others	C3	Unilateral cervical aplasia
U2	Septate uterus	a. Partial	C4	Cervical aplasia
		b. Complete		
U3	Bicorporeal uterus	a. Partial	V0	Normal vagina
		b. Complete	V1	Longitudinal non-obstructing vaginal septum
		c. Bicorporeal septate	V2	Longitudinal obstructing vaginal septum
U4	Hemi-uterus	a. With rudimentary cavity (communicating or not horn)	V3	Transverse vaginal septum and/or imperforate hymen
		b. Without rudimentary cavity (horn without cavity/no horn)	V4	Vaginal aplasia
U5	Aplastic	a. With rudimentary cavity (bi- or unilateral horn)		
		b. Without rudimentary cavity (bi- or unilateral uterine remnants/ aplasia)		
U6	Unclassified malformations			
U			C	V

Associated anomalies of non-Müllerian origin:

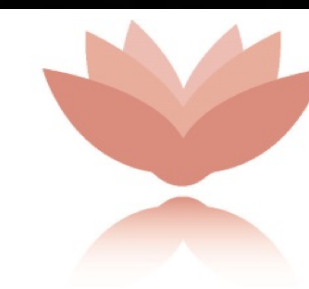
Drawing of the anomaly

Hematocolpos

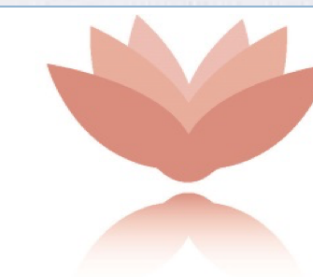
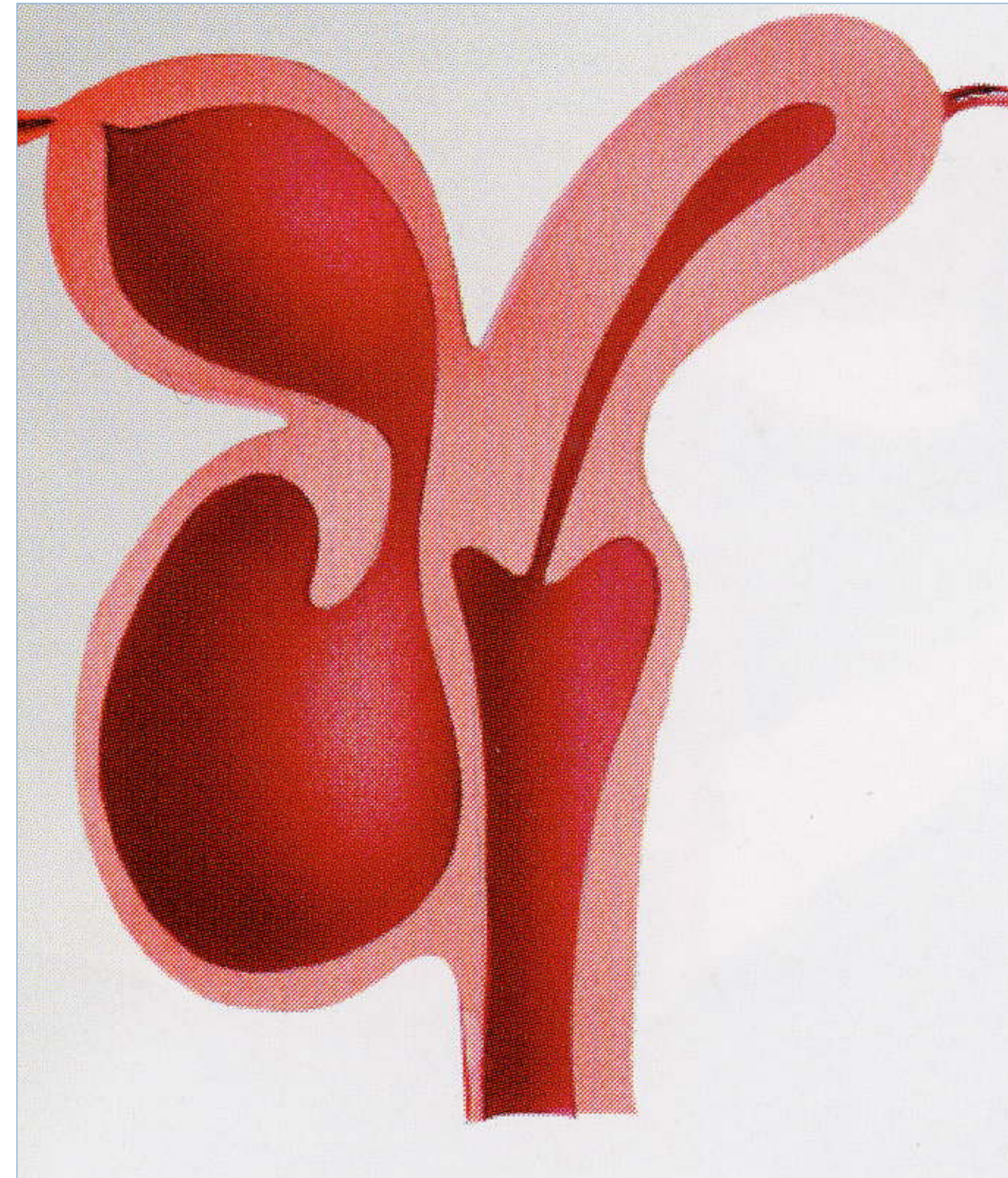
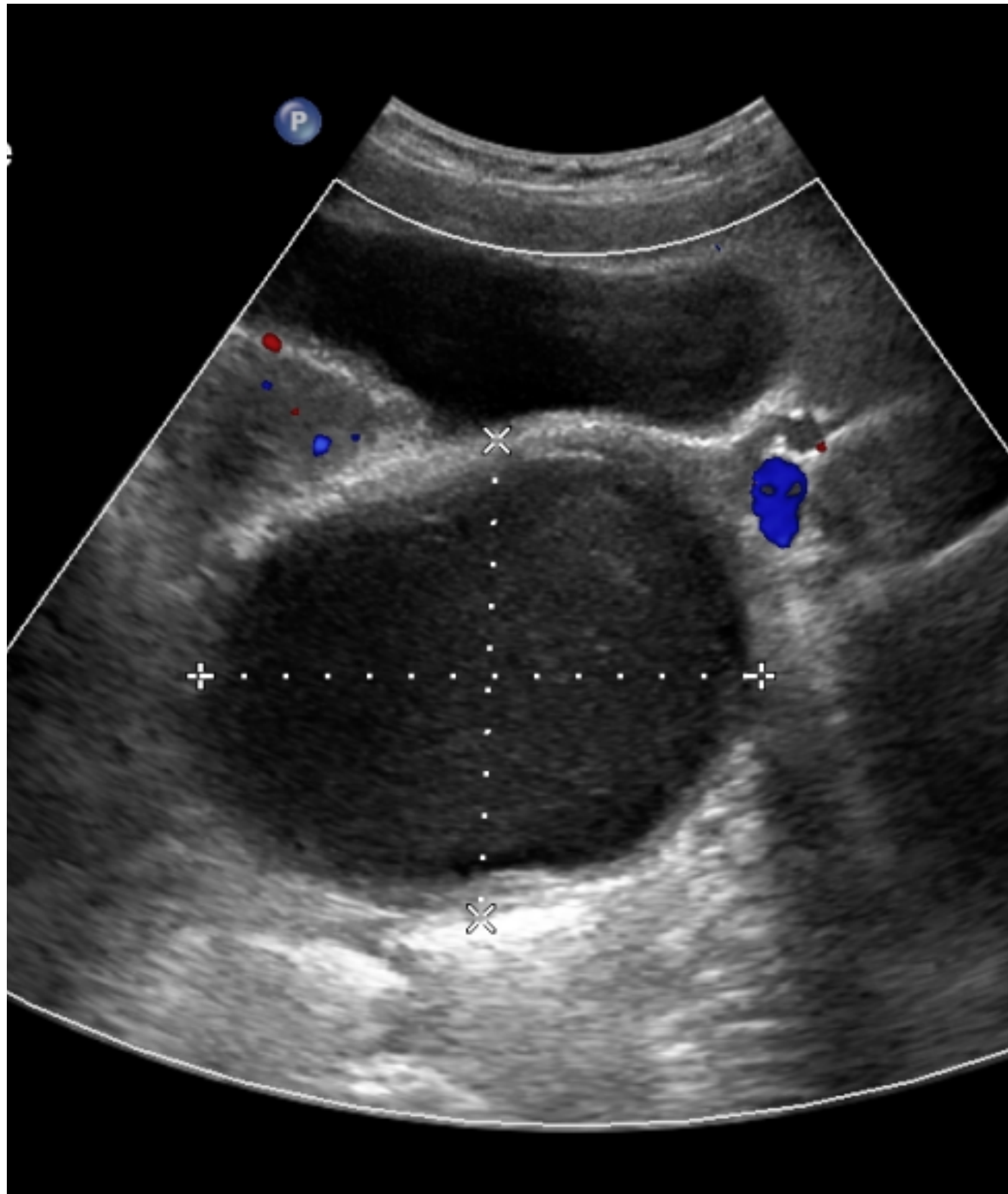


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Drainage hématoocolpos et Coelioscopie



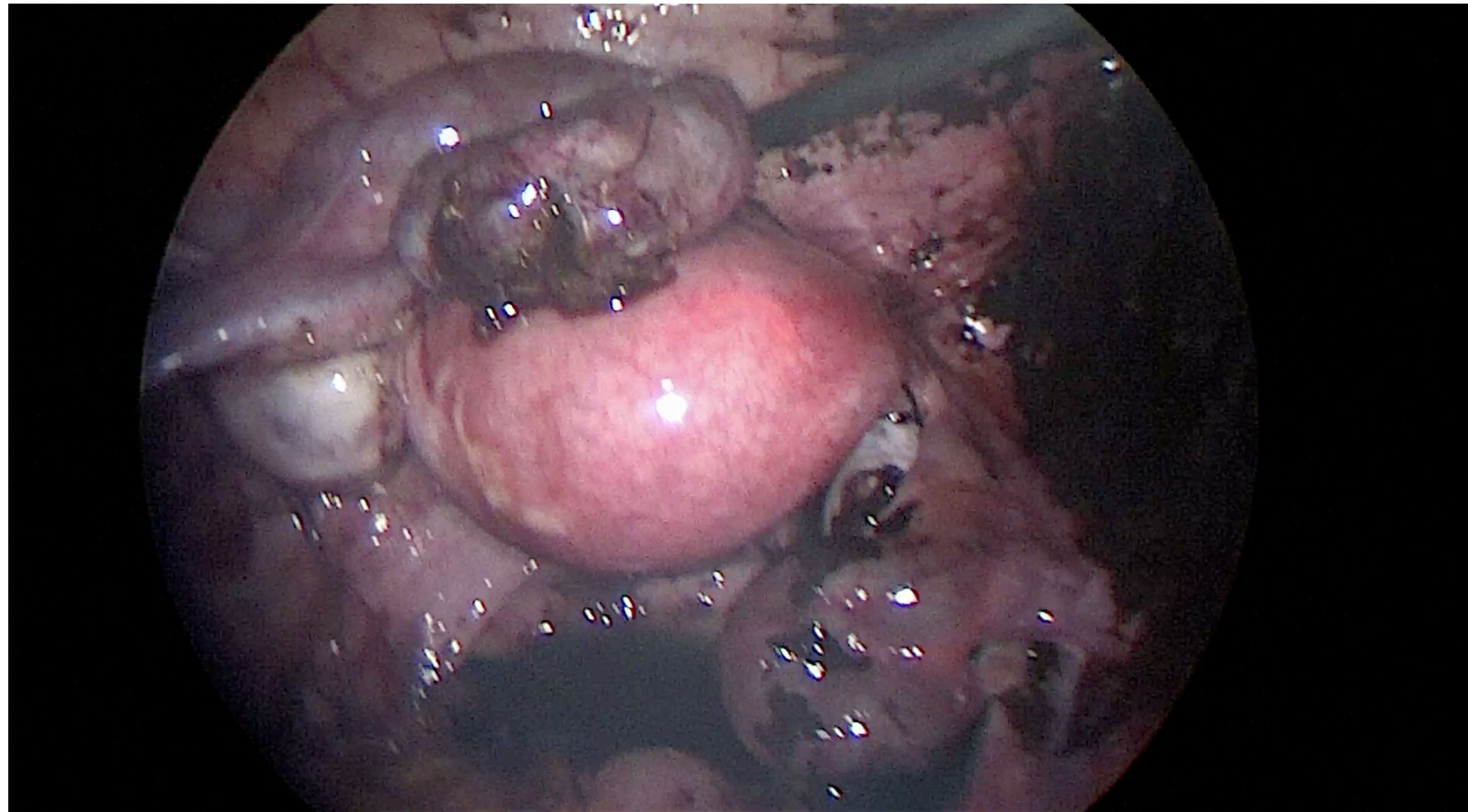
Hémi-vagin borgne



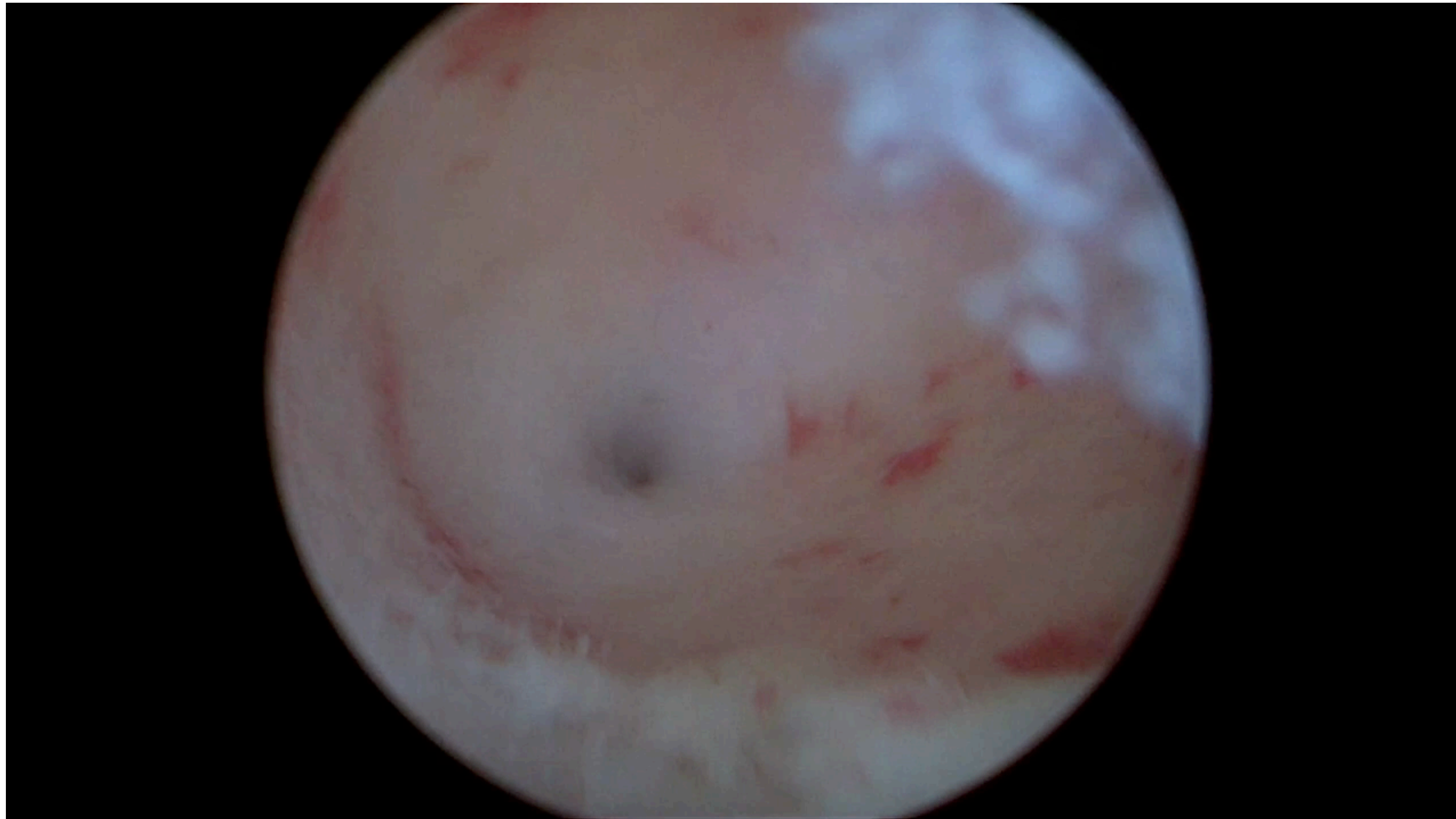
Hémivagin borgne et agénésie rénale ipsilatérale



Répercussion d'une anomalie obstructive



Congenital anomaly U4a,C0,V0



Autres symptômes

Davis et al ; J Adolesc Health 1993

Douleur cyclique : 67%

Douleur non cyclique : 39%

Constipation/ Diarrhée : 67%

Absence d'infertilité et de dyspareunie



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Traitement médical de l'endométriose de l'adolescente

Contraception oestro-progestative

Efficace pour réduire dysménorrhée primaire

Pas évaluée pour endométriose

Progestatifs

Dienogest 2mgr/j : VISADO

- Réduction scores douleurs liées à endométriose (VAS : 64 → 9)
- Faible diminution DMO après 52 sem mais réversible 6 mois après arrêt du traitement
- N : 111 patientes (1 coelio - 13 imagerie)

Agonistes de la Gn-RH

Efficacité DPC chez adolescentes

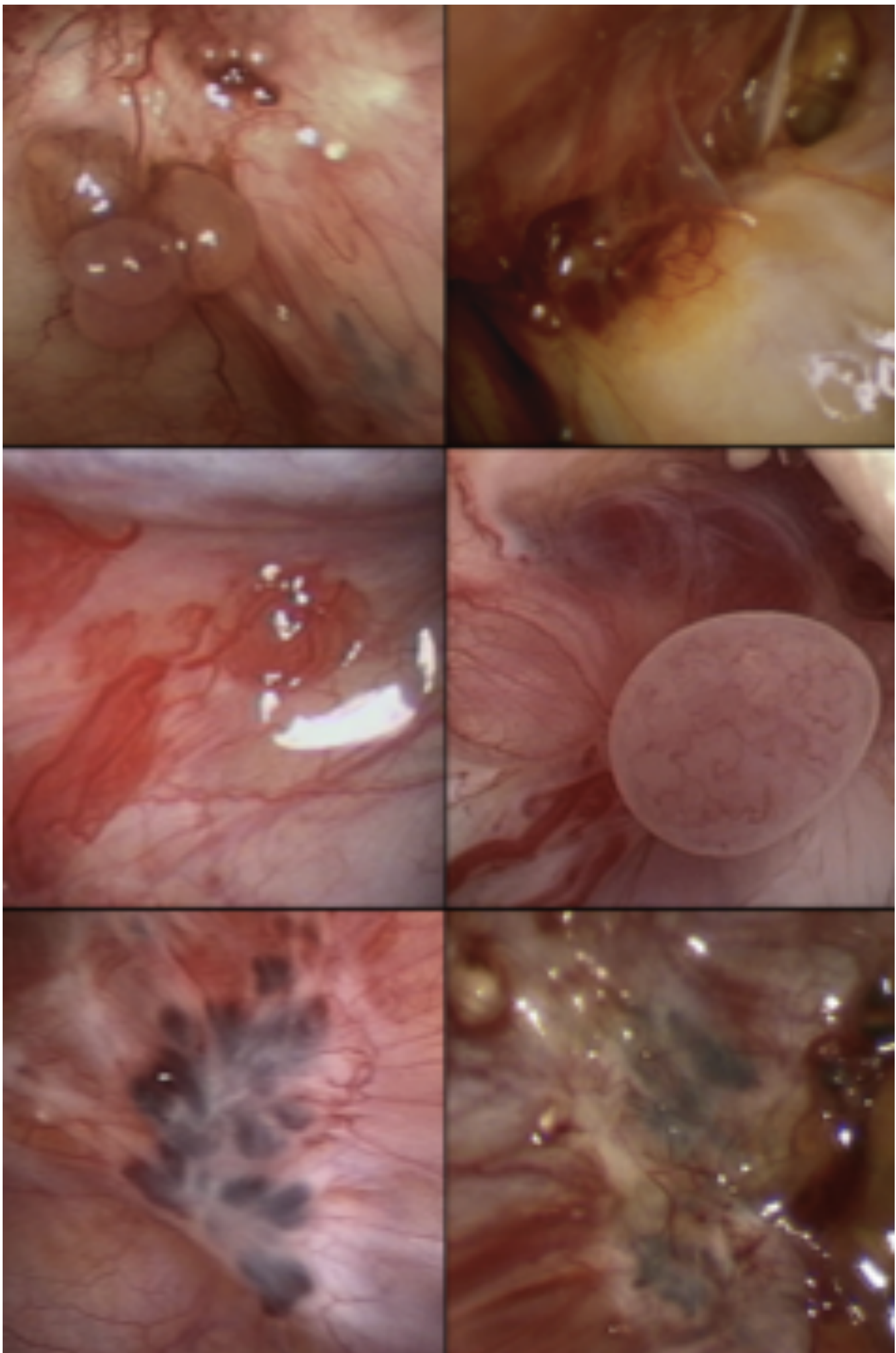
Add-back thérapie : P-OE

- QOL et DMO améliorées si OE



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Coelioscopie exploratrice



Preferential localization and types of lesions of endometriosis according to age groups		
Age group	Localization	Type of lesions
Adolescent	Peritoneum	Angiogenesis, subtle
	Ovarian surface	Endometrioma
Adult	Peritoneum	Typical, adhesions
	Ovary	Endometrioma
	Rectovaginal septum	Deep adenomyoma
Postmenopausal	Ovary	Endometrioma
	Extrapelvis	Obstructive

Occult microscopic endometriosis: undetectable by laparoscopy in normal peritoneum

Nisolle M et al Fertil Steril 1990

Balasch J et al Hum Reprod 1996

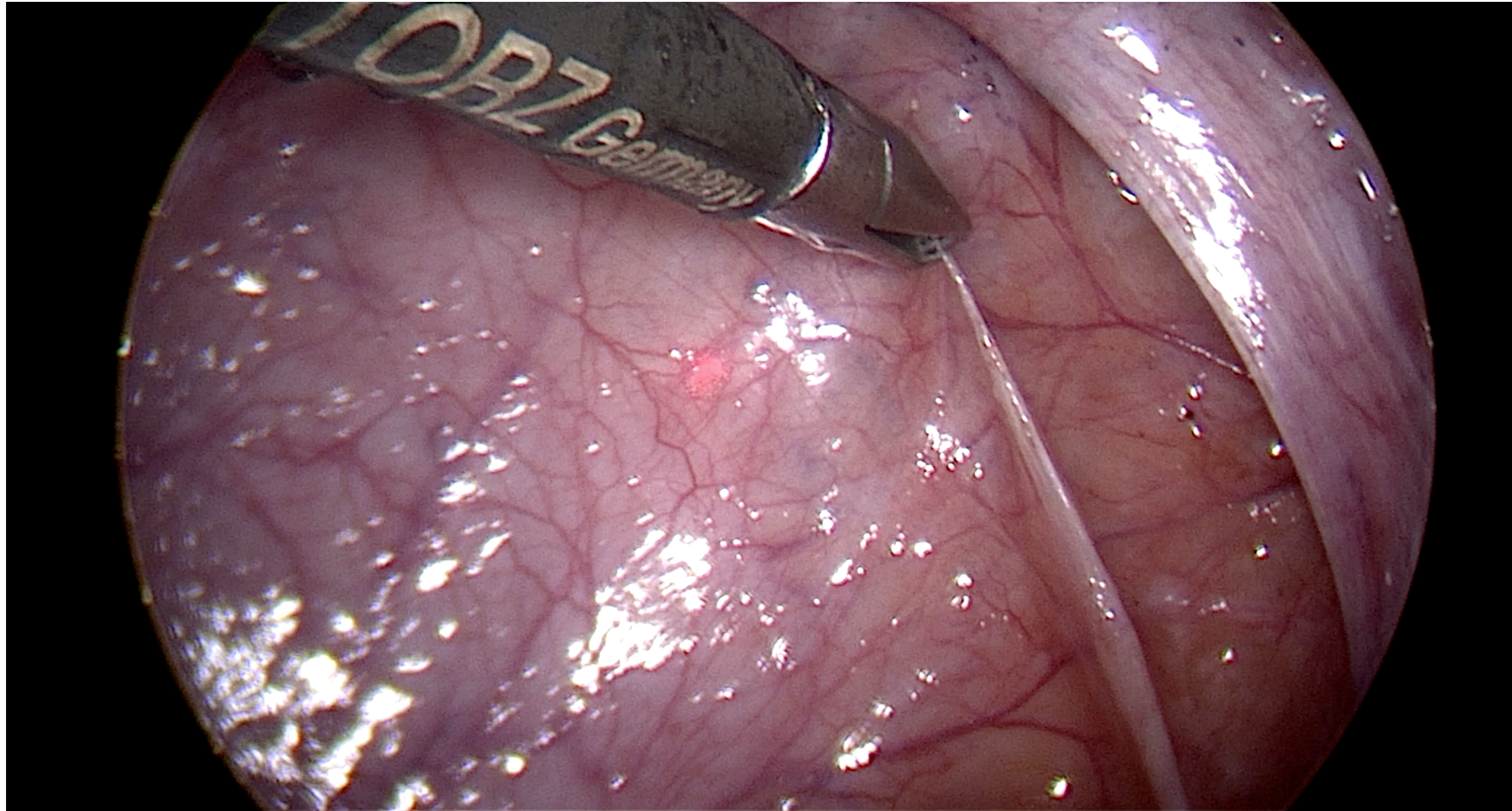
Khan K et al Hum Reprod 2014

Confirmation of previous results

It may contribute to the recurrence or occurrence of endometriosis after ablation or excision of visible lesions by laparoscopy

Khan K et al Hum Reprod 2014

Adolescent patient - Endometriosis



Endometriosis in adolescents is a hidden, progressive and severe disease that deserves attention, not just compassion

I. Brosens^{1,*}, S. Gordts¹, and G. Benagiano²

ABSTRACT: Endometriosis in the adolescent has, in recent years, been discovered to be a challenging problem in gynaecology. Although the pain may start at a young age, even before the onset of menstruation, the diagnosis by laparoscopy is almost always postponed for several years, by which time destructive lesions have affected the tubo-ovarian structures and severely compromised fecundability. Several factors may play a role, but one important reason for this disease progression is likely to be the delay in diagnosis. Therefore, transvaginal ultrasounds and transvaginal access with a less invasive needle endoscopy are recommended for exploration of the pelvis, diagnosis of endometriosis and treatment at an early stage before severe lesions develop.

Key words: endometriosis / adolescence / adult / pathogenesis / laparoscopy



Trans Vaginal Laparoscopy

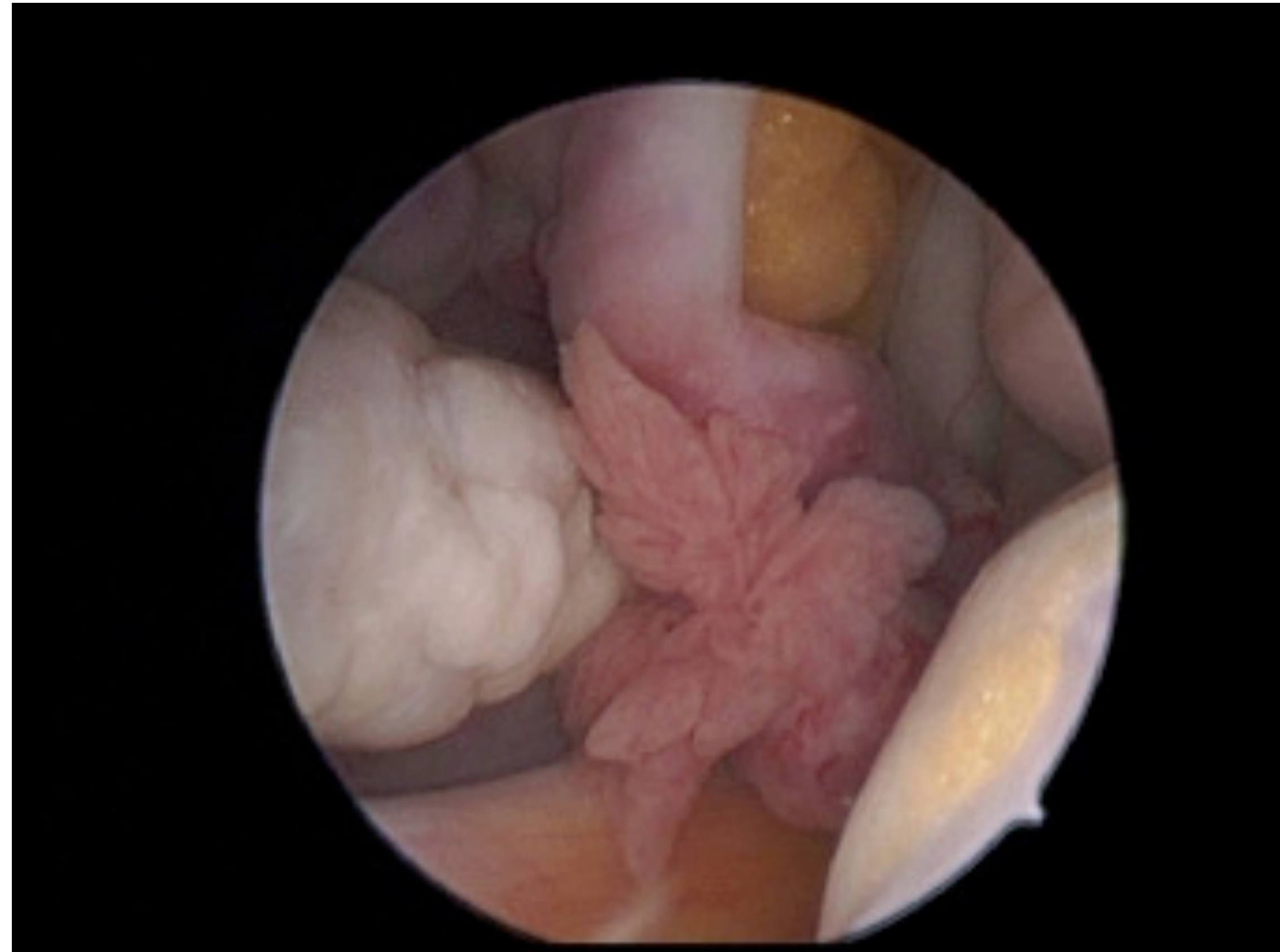
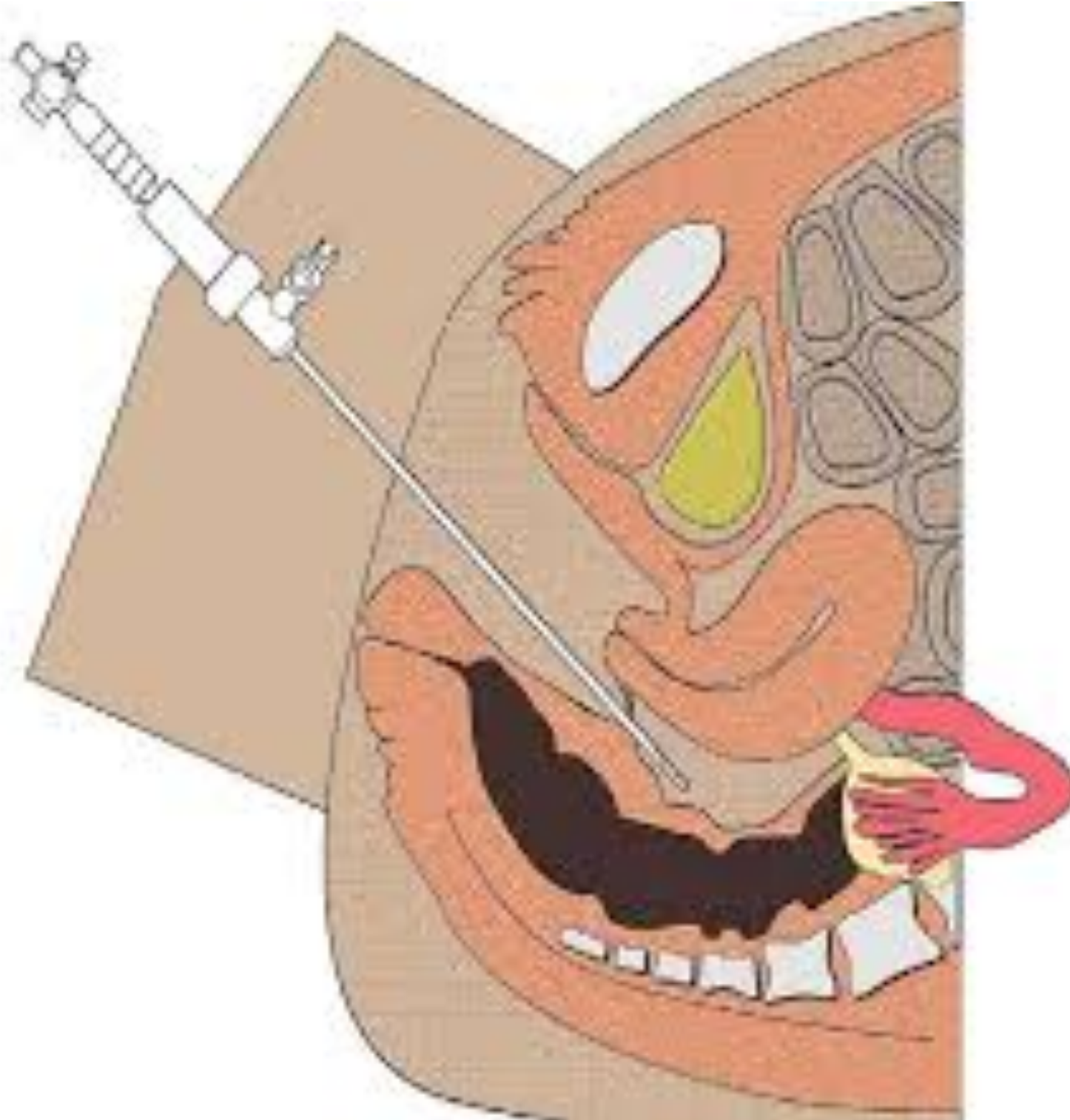


Table 2 – Phenotype of adolescent versus adult endometriosis.

Adolescent endometriosis	Adult endometriosis
Symptoms	Symptoms
Severe primary dysmenorrhoea	Moderate dysmenorrhoea
Frequently resistant to oral contraceptive pill and non-steroidal anti-inflammatory drugs	
Peritoneal	Peritoneal
Red, clear or vesicular implants	Black intraperitoneal implants
Minimal fibrosis	White, fibrotic
Ovarian endometrioma	Ovarian endometrioma
Cortex	Cortex
Angiogenic adhesions	Dense adhesions
Stigma of inversion with implant	Stigma of inversion with implant
Invaginated cortex	Invaginated cortex
Marble white	Dark pigmented
Thin angiogenic mucosal lining	Endometrial tufts
Medulla	Thickened by fibrosis
Stretched	Medulla
	Smooth muscle metaplasia
	Fibrosis and devascularization
Deep endometriosis	Deep endometriosis
Seldom	Adenomyoma
	Microendometrioma
Concomitant pathology	Concomitant pathology
Obstructive genital tract anomalies	Rectal and bladder endometriosis
	Uterine adenomyosis

Based on [Hughesdon \(1957\)](#), [Janssen et al. \(2013\)](#) and [Brosens et al. \(2013b\)](#).

Conclusions

Importance de l'anamnèse

Détecter les adolescentes à risque

Proposer un traitement précoce

Traitement hormonal

SIU- LNG ?

Endoscopie transvaginale

Frein sur évolution ?

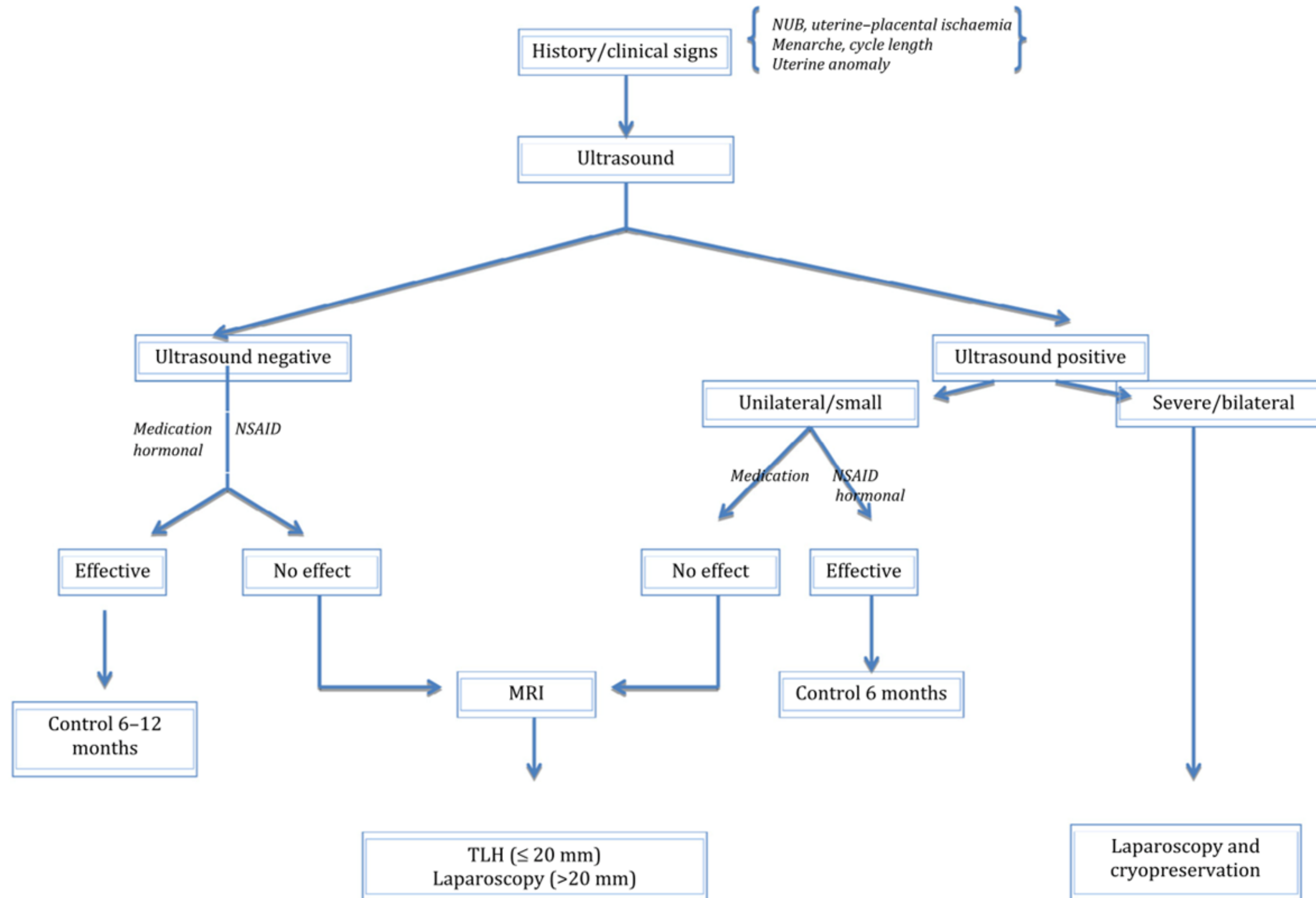
réduction de la morbidité de la chirurgie?

limiter risque d'infertilité?

- Effet délétère endométriose sur réserve ovarienne

Amélioration de qualité de vie

Conclusions





Merci