Patients or Participants: 63/200 women of with suspected endometriosis have been recruited thus far.

Interventions: Participants underwent a Ca-125 and a 5-domain transvaginal ultrasound by an expert sonologist according to the International Deep Endometriosis Analysis criteria and were assigned a M-UBESS score. All women then underwent laparoscopic surgery within 6 months, with an AGES skill recorded.

Measurements and Main Results: M-UBESS accuracy in predicting a generalist (level I-III) & advanced (level IV-VI) AGES level was 68.25% (p=0.044) & 76.19% (p=0.003) respectively. Ultrasound markers including endometrioma, POD obliteration, uterosacral endometriosis and fixed ovaries predicted ureterolysis in 79.37% (p=0.005), 77.78% (p=0.004), 74.60% (p=0.063) and 53.97% (p=0.137) respectively. CA125 <30 predicted low r-ASRM and generalist AGES level in 73.33% and 46.67% respectively and distinguished between nil disease and r-AMES I-II (sensitivity 75%).

Conclusion: Ultrasound markers (endometrioma, POD obliteration, uterosacral endometriosis & ovarian fixation) and CA-125 improve the prediction of intraoperative ureterolysis and isolated peritoneal disease. Further recruitment is required to determine whether the incorporation of these markers into the M-UBESS model improves UBESS accuracy in predicting surgical complexity.

Plenary 4: Endometriosis (11:00 AM — 12:30 PM)

11:39 AM

Surgical Evaluation and Management of Concomitant Anterior and Posterior Deep Infiltrating Endometriosis

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Study Objective: The objective of this video is to present the evaluation and management of a patient who presents with concomitant anterior and posterior compartment deep infiltrating endometriosis.

Design: Surgical Video.

Setting: The operating room.

Patients or Participants: We present the case of a 34-year-old G0 female who was referred for evaluation and management of biopsy proven bladder endometriosis. The patient reported a long-standing history of chronic pelvic pain, dyspareunia, dysmenorrhea, cyclic hematuria and cyclic dyschezia as well. Of note, she had failed 2 IVF cycles. On pelvic examination, the patient was noted to have a fixed uterus with a scarred posterior cul-de-sac with significant nodularity. Although the patient had known bladder endometriosis, her history and physical exam findings were suggestive of possible rectosigmoid involvement as well. The patient then underwent further evaluation with imaging including a transvaginal ultrasound and pelvic MRI. The transvaginal ultrasound demonstrated hypoechoic nodules in the anterior and posterior compartments, highly suggestive of deep infiltrating endometriosis. The MRI demonstrated anterior compartment disease transmurally invading the urinary bladder as well as posterior compartment disease as well. Given these findings, the patient underwent preoperative planning with a multidisciplinary team including Gynecologic surgery, Urology, and Colorectal surgery.

Interventions: Definitive surgical management.

Measurements and Main Results: The patient underwent a cystoscopy, bilateral ureteric stenting, cystectomy, and excision of endometriosis. In the post operative period, the patient underwent a retrograde cystogram which demonstrated no leakage at the site of repair. Her symptoms improved significantly and she is now attempting to conceive.

Conclusion: A thorough pre-operative evaluation of patients with deep infiltrating endometriosis is of utmost importance. Although the patient was referred for bladder endometriosis, she was incidentally found to have significant posterior compartment disease. As a result, she underwent surgical planning with a multidisciplinary team, which ultimately allowed for the best patient outcome.

Plenary 4: Endometriosis (11:00 AM — 12:30 PM)

11:46 AM

Surgical Management of Inguinal Endometriosis

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Study Objective: To demonstrate surgical management of an inguinal endometrioma.

Design: Stepwise demonstration of surgical techniques with narrated video footage.

Setting: Yale New Haven Hospital, New Haven, CT.

Patients or Participants: A 31-year-old woman with a painful right inguinal endometrioma.

Interventions: The patient underwent diagnostic examination with pelvic MRI, which noted concern for an inguinal endometrioma. Biopsy confirmed endometriosis. She then underwent diagnostic laparoscopy, with resection of intra-pelvic and inguinal endometriosis. The technical steps of management and resection of an inguinal endometrioma have been detailed in the video with an emphasis on anatomic landmarks by utilizing visual illustrations. An incision was made at the inguinal ligament and taken down to the superficial fascia using Bovie cautery. The mass was progressively mobilized from the superficial inguinal ring superiorly, sartorius muscle laterally, and adductor longus muscle medially. Several perforating branches of the femoral vein as well as the round ligament of the uterus, at the level of the external inguinal ring, were ligated and tied off. The mass was removed in full, and the resected bed fulgurated. A drain was placed and the incision was closed in multiple layers.

Measurements and Main Results: Diagnostic laparoscopy revealed intra-pelvic Stage I endometriosis. The right round ligament and internal inguinal ring were without evidence of endometriosis. The 3.1 x 2.8 cm inguinal mass was fully resected. Final pathology confirmed both intra-pelvic and inguinal endometriosis.

Conclusion: Inguinal endometriosis is exceedingly rare, with an estimated incidence of 0.6%. Given the broad differential diagnosis, imaging should be performed. In addition, biopsy can be considered, provided a hernia has been ruled out. Surgical management should entail diagnostic laparoscopy and excisional surgery.

Plenary 4: Endometriosis (11:00 AM — 12:30 PM)

11:53 AM

Sustained Efficacy and Safety of Relugolix Combination Therapy in Women with Endometriosis-Associated Pain: Spirit 52-Week Data

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