Accuracy of Documentation of Staging of Endometriosis at the Time of Laparoscopic Surgery

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Introduction

Endometriosis is an oestrogen-dependent, chronic inflammatory condition which is associated with pelvic pain and subfertility. It is a complex disease and presents many challenges with respect to documentation and classification due to it's various presentations in regard to type, appearance, location and the extent of disease found in the pelvic and abdominal cavity during laparoscopy/laparotomy.[3]

There is a lack of consensus on it's classification owing to the many aspects of the disease. In 2014, representatives at the World Endometriosis Society's (WES) 12th World Congress worked to establish consensus statements on Endometriosis[1].

Before a majority consensus statement on classification can be established, the WES proposes the use of a classification toolbox which utilizes the revised American Society for Reproductive Medicine (r-ASRM) classification.

Purpose

The lack of uptake of surgical staging systems for documentation of endometriosis can lead to incomplete, inconsistent and inaccurate recording of the nature and severity of the lesions. This subsequently impacts on surgical planning, patient safety, future management and patient counselling.

This practice also makes data collection more onerous for future audit and research.

Objective

To determine the accuracy of documentation of endometriosis found at time of laparoscopy by gynaecologists.

Results

Number of operation reports reviewed	334
• % with endometriosis	72.8% (243/334)
• % without endometriosis	27.2% (91/334)
In patients with endometriosis confirmed	
• % of reports with ANY description of Endometriosis	62.9% (153/243)
% of reports with following information included	
• An accurate ASRM staging	42.4% (65/153)
• Over –description of endometriosis seen	46.4% (71/153)
• Under-description of endometriosis seen	13.0% (20/153)

Noted:
- 5 reports (2%) included documentation of nodule size and the extent of obliteration of the posterior cul de sac.

Figure 3. Depicting the r-ASRM classification[2].

(a) REVISED AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE CLASSIFICATION OF ENDOMETRIOSIS 1985

Patient's Name _____ Date: _____

Stage I (Minimal) 1-5 Laparoscopy_____Laparotomy_____Photography_____
Stage II (Mild) 6-15 Recommended Treatment _____
Stage III (Moderate) 16-40 _____
Stage IV (Severe) >40
Total _____ Prognosis _____

	ENDOMETRIOSIS	< 1 cm	1 – 3 cm	> 3 cm
Peritoneum	Superficial	1	2	4
	Deep	2	4	6
Ovary	R Superficial	1	2	4
	Deep	4	16	20
	L Superficial	1	2	4
	Deep	4	16	20
	POSTERIOR CULDESAC OBLITERATION	Partial 4		Complete 40
	ADHESIONS	< 1/3 Enclosure	1/3-2/3 Enclosure	> 2/3 Enclosure
Ovary	R Filmy	1	2	4
	Dense	4	8	16
	L Filmy	1	2	4
	Dense	4	8	16
Tube	R Filmy	1	2	4
	Dense	4	8	16
	L Filmy	1	2	4
	Dense	4*	8*	16

*If the fimbriated end of the fallopian tube is completely enclosed, change the point assignment to 16.
Additional Endometriosis: _____ Associated Pathology: _____

To Be Used with Normal Tubes and Ovaries

To Be Used with Abnormal Tubes and/or Ovaries

Methods and Materials

A retrospective cohort analysis was performed on operative records of patients who underwent laparoscopic diagnosis and/or treatment of endometriosis from April 2014 to December 2018, at a tertiary referral centre.

The revised American Society for Reproductive Medicine classification of Endometriosis (ASRM) was used to retrospectively stage the endometriosis.

All reports were scored and the accuracy of the surgeon's description of endometriosis was compared with the ASRM scores.

Conclusions

89/153 (59.4%) of operative reports were inaccurately assessed by the general gynaecological surgeons.

All of the reports lacked pertinent negative findings and all of the reports demonstrated inconsistent anatomical description and disease severity.

This audit clearly shows that better documentation of endometriosis is needed and a proforma guiding the surgeon on how to stage endometriosis will greatly benefit the patient and aid as a valuable surgical tool.

By standardising documentation , the aim would be to allow the findings to be translated to any staging system as currently the r-ASRM poorly correlates with the patient's pain symptoms and future fertility prognosis.

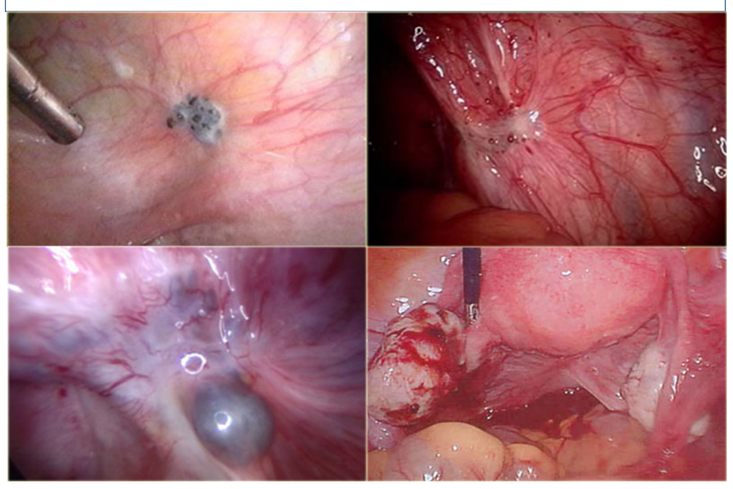

Figure 1. Laparoscopic findings of endometriosis

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