

Ureter endometriosis

Abstract

Ureter endometriosis is a rare clinical condition that can present itself as a silent kidney loss. This condition should be suspected in rectovaginal endometriosis treatment. This treatment is feasible by laparoscopy with ureterolysis, end-to-end anastomosis or re-implantation.

Keywords: endometriosis, ureter, laparoscopy

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Introduction

Ureter endometriosis is a rare clinical condition with up to 12% of women with endometriosis affected in the urinary tract.^{1,2} The proportion of involvement of bladder, ureter and kidney is said to be 40:5:1.^{3,4} Of special concern ureteral endometriosis is a silent disease with most patients without specific symptoms (related to the ureter) and, more commonly with pelvic pain (dysmenorrhea and dyspareunia) that affects most patients with endometriosis. In patients without pain symptoms the diagnosis of endometriosis can be delayed leading to silent loss of kidney function.^{5,6} Ureteral endometriosis can be intrinsic or extrinsic to the ureteral wall.^{7,8} Extrinsic type is considered the most common.⁹

Surgical treatment is feasible and safe.^{10,11} Ureter endometriosis can be treated either by ureterolysis, segmental ureterectomy with end-to-end anastomosis or ureteroneocystostomy. The surgical strategy published by Wattiez et al.,¹² starts with retroperitoneal inspection of ureters. Dissection of the ureter may need to begin at the pelvic brim and always strats in sano. We use bipolar forceps and scissors or the blunt tip of an aspirator to the dissection aiming to free the ureter from the endometriosis tissue. After ureterolysis the ureter is evaluated to check for wall stenosis, vascular compromise or with residual tissue. If one of this happens then resection with end-to-end reanastomosis or ureteroneocystectomy may be needed. In either case we use the double J stent keeping it in place until 6-8weeks after ureter resection doing a CT urogram at this time. If only ureterolysis the JJ stent is kept until 2weeks after surgery.

Conclusion

Even if ureteral endometriosis is considered a rare disease it should be always suspected in deep endometriosis patients as part of the surgical strategy. The main advantage is to isolate the rectovaginal nodule from the ureter keeping it safe during the surgery but also to rule out endometriosis involvement of the ureter that is most often without specific symptoms. Laparoscopic management of ureter endometriosis is feasible and surgeons should consider ureterolysis and if after that the ureter is compromised the either ureter partial resection with end-to-end anastomosis or ureteroneocystostomy.

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Conflict of interest

The author declares no conflict of interest.

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