Diaphragmatic endometriotic involvement was documented in literature in about 0.6% of patients who underwent laparoscopy for deep infiltrating endometriosis. Symptomatic involvement of the diaphragm by endometriosis is rare and can cause ipsilateral chest, shoulder, arm and neck pain which can be aggravated during menses.
A retrospective analysis of all consecutive patients affected by diaphragmatic endometriosis treated by complete or incomplete laparoscopic eradication in our Institution from February 2004 to March 2011, was performed.
46 women with diaphragmatic endometriosis were reviewed, over a total of 2180 laparoscopies performed for suspected endometriosis (2%). 70% of diaphragmatic nodules were multiple and 75% of them were defined as superficial; however, in 12 patients (26%) nodules had diameter = 1 cm. Six (13%) patients had hepatic, one (2.1%) pericardial and pleural nodules. Surgical procedures included diathermocoagulation (36.9%), argon plasma coagulation (28.2%), excision (23.9%) and stripping in one case, (2.1%) with conversion to abdominal route because of massive left diaphragmatic, pleural and pericardial involvement. Intra-operative opening of the diaphragm occurred in 5 patients (10.8%), three of which were sutured laparoscopically and two had intrathoracic drainage positioned. Two patients had intraoperative pneumothorax, spontaneously sort out in the early post-operative period.
Diaphragmatic endometriosis is a rare entity, often asymptomatic and mostly present in case of severe pelvic involvement. Laparoscopic surgery, when performed by expert surgeons, can be safe and completely eradicative, with complete resolution of symptoms.

FC.02.5

Endometrioma with broad ligament involvement: comparison between stripping technique with/without peritoneal excision

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To evaluate if surgical endometrioma treatment with resection of posterior broad ligament influences the rate of ovarian recurrence and adhesions formation.
Endometrioma occurs in 17–44% of patients with endometriosis and it often associates with (PBL) adhesion.
Retrospective, two-center, case-control study on 100 consecutive patients affected by endometrioma without other evident localization of disease, who underwent to laparoscopic endometrioma excision by stripping tecnique. Group A (50 patients) underwent to concomitant sistematic PBL resection; group B (50 patients) just underwent to endometrioma excision. Data on patients' characteristics, surgical and anatomopathological findings and follow up were collected
Among group A patients, 49/50 had a posterior broad ligament involvement, which correlates to the presence of preoperative pain symptoms. Endometrioma recurrence occurred in 2 cases (4%) among group A patients and 5 cases (10%) among group B patients. Comparing patients' symptomatology one month and 12 months after surgery, recurrence in term of pain symptoms has been: dysmenorrhea 1/50 (2%) vs. 3/50 (6%); dyschezia 1/50 (2%) vs. 2/50 (4%); dyspareunia 3/50 (6%) vs. 5/50 (10%); dysuria 1/50 (2%) vs. 1/50 (2%); middle cycle pain 7/50 (14%) vs. 3/50 (6%) in group A and B, respectively.
Even if surgical endometrioma treatment with resection of PBL seems to reduce the rate of ovarian recurrence, it has to be taken in consideration the possibility of adhesion formation with subsequent middle cycle pain that can be explained by ovarian adhesion formation after surgery.

FC.02.6

Laparoscopic nerve sparing colorectal resection for bowel endometriosis: surgical outcomes and follow-up

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A prospective study to evaluate the efficacy and the safety of laparoscopic colorectal resection with nerve sparing surgical technique in rectosigmoid obstruction caused by endometriosis.
Rectosigmoid junction is the most common intestinal endometriotic lesion. In these cases can be necessary a bowel resection that can cause a damage of the pelvic autonomic nerves with important consequences on bowel and bladder functions.
Between August 2008 and July 2010, 29 patients underwent laparoscopic colorectal resection with nerve sparing surgical technique for D.I.E. with documented bowel stenosis of 40% or more with a median stenotic intestinal tract length of 3.13 cm. 20 (69%) patients had anterior and lateral parametrial involvment; 7 (24.1%) of them had urinary tract endometriosis.We analyzed changes in gynaecological disorders, non-specific symptoms, bowel and urinary functions by a symptom questionnaire completed befor and after the surgery. We also assessed patients satisfaction, intraoperative and postoperative data and any complications.
20 (68,9%) patients had already undergone at least one surgical procedure for endometriosis.
Median follow up duration after surgery was 21.4 months (range 8–34). A statistically significant improvement in dysmenorrhoea ($p<0.0001$), dysparaeunia ($p<0.0001$), stypsi ($p>0.0006$), diarrhoea ($p<0.0001$), dyschezia ($p<0.0001$) and lower back pain ($p<0.001$) were registered.The patients satisfaction was detected as total in 20 cases (69%), medium in 6 (20.7%), low in 2 (6.9%); no satisfaction was reported in 1 case (3.4%). Major postoperative complications developed in 3 (10,3%) cases, including 1 rectovaginal fistula, 1 ureteral fistula and 1 anastomosis dehiscence.
Colorectal resection with nerve sparing technique in rectosigmoid obstruction caused by endometriosis is a valid and safe procedure.

FC.02.7

Laparoscopy treatment of deep endometriosis

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