Society of Endometriosis and Uterine Disorders

DEEP INFILTRATING ENDOMETRIOSIS OF DIAFRAGMA - A Review

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INTRODUTION:

Endometriosis most commonly affects the pelvis. The thorax is a frequent extra-pelvic involvement of endometriosis, the diaphragm being the most common site. The first case of diaphragmatic endometriosis was described in 1954 by Brews. Since then, a limited amount of series of diaphragmatic endometriosis have been reported.

METHODS:

We carried out a systematic review on diaphragmatic endometriosis from 1985 to January 2022 in the main search systems for scientific articles (pubmed, medscape).

RESULTS:

The majority of patients with diaphragmatic endometriosis are asymptomatic. For that reason, all patients with pelvic endometriosis need to have direct exploration of the diaphragms at laparoscopy, in particular along the coronary ligament of the liver.
Symptomatic patients usually experience catamenial chest, upper quadrant, shoulder pain, or a combination of them. There may be a delay of as long as 10 years since the start of the symptoms. Other clinical manifestations are: pneumothorax, hemothorax, diffuse thoracic pain, scapular or cervical pain, the latter (due to phrenic irradiation).
In many cases, the diagnosis is discovered incidentally during the thoracoscopic evaluation of patients with catamenial pneumothorax or hemothorax or during laparoscopy for pelvic endometriosis.

There are no specific guidelines for the treatment of diaphragmatic endometriosis other than surgical excision and suppression of menses, as for endometriosis in any other location.
When the patient present catamenial pneumothorax the indicated treatment is primarily treated with chest tube drainage of pneumothorax followed by secondary prevention of recurrence with blebectomy and pleurodesis and hormonal suppression during 6 to 12 months.
When the patient present catamenial hemothorax due to thoracic endometriosis is primarily treated by definitively managing the presenting feature with chest tube drainage followed by secondary prevention of recurrence with thoracoscopy and hormonal suppression 6 to 12 months.
The presence of lesions should be extirped by minimally invasive surgery.

CONCLUSIONS:

The DIE is rare but disabling and potentially serious for the health of our patients, so we must be aware of the symptoms to avoid delay in diagnosis.
During the follow-up, patient should be followed by a multidisciplinary team with gynecologists, pneumologists, thoracic surgeons.

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