Approach to Pouch of Douglas in Deep Endometriosis

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Objective: This video demonstrates how to approach obliterated pouch of Douglas in deep endometriosis.
Design: A case report.
Settings: A women's hospital.

Patients: We present a case of a 31 year old female, Para 2 with known endometriosis. She was found to have a rectovaginal nodule with an oblit- erated pouch of Douglas.
Interventions: At laparoscopy, she was found to have obliterated pouch of Douglas with the rectum and sigmoid adherent to the cervix and upper vagina. We use the Myoma screw for adequate exposure. We started the dissection from the normal area and proceeded toward abnormal anatomy. Complete ureterolysis was then performed until the ureter reached the ure- teric tunnel. The ureter was lateralized away from the fibrotic endometriotic nodule. Next step was para rectal Space dissection. Pararectal space was opened. The avascular plane was identified and developed by traction and counter-traction movements, in addition to spreading the grasper. It is im- portant to note that fat of the rectum should be pushed medially. Rectal and vaginal probes are used to define the outline of the rectal margins and

posterior fornix to create a lateral window and facilitate dissection of the rectum from the nodule and clear the pouch of Douglas. Rectal margins are evaluated repeatedly with the rectal probe and dissected to clear the Pouch of Douglas. Our dissection was limited above the fat. With careful controlled meticulous sharp dissection the Pouch of Douglas is gradually cleared and normal anatomy is restored. Measurements/Results: Results to be presented. Conclusions: Five key steps in approaching the obliterated Pouch of Douglas 1. Adequate exposure; 2. Start the dissection from the normal area to abnormal anatomy; 3. Perform ureterolysis and lateralize the ureters; 4. Pararectal space dissection and creation of lateral window; 5. Use of rectal and vaginal probe