

# METHOD OF EXCISION OF DEEPLY INFILTRATIVE RETROCERVICAL ENDOMETRIOSIS LESIONS UNDER TACTILE RECTOVAGINAL CONTROL

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**Key words:** retrocervical endometriosis, tactile rectovaginal control, gynecologic laparoscopy, true pelvis anatomy

**Aim.** To create a safe and efficient method of excision of deeply infiltrative retrocervical endometriosis lesions.

**Material and Methods.** Research includes analysis of 82 cases of deeply infiltrative retrocervical endometriosis surgery, which were performed from October 2014 to May 2018.

**Results and Discussion.** In recent years, due to the improvement of diagnostic methods frequency of detection of retrocervical endometriosis has increased significantly and, according to various authors, comprise 30–34% of all cases of endometriosis (Tarlamazian A. V., Stolyarova U. V., 2016). Gold standard in treatment of this pathology is a surgical method, aimed at a maximal elimination of endometriosis lesions, with consequent hormone-modulating therapy. Excision of retrocervical endometriosis lesions is a technically complicated surgical intervention and requires detailed knowledge of true pelvis anatomy from surgeon. In case of lesions removal under a visual control there is a high risk of vaginal and rectal injuries and incomplete excision is probable. In order to reduce such risks visual control should be complemented with a tactile one. Surgeon with an L-hook electrode in his right hand excises endometriosis lesion within healthy tissues. At a moment of excision he controls posterior vaginal fornix with an index finger of left hand; middle finger, inserted into rectum, serves to assess integrity of its wall. Assistant using endoscopic tool in his right hand provides tension on being removed tissue in a direction of dissection. Due to a different density of surrounding tissues and endometriosis lesion, surgeon controls completeness of excision with his left hand fingers.

**Conclusions.** Tactile rectovaginal control during excision of retrocervical endometriosis lesions contributes to reducing of probability of hollow organs perforation (among 82 cases only one was complicated by perforation of vagina; there were no cases of rectum perforation). At the same time this method provides maximal elimination of endometriosis lesions within healthy tissues.

# SIGNIFICANCE OF LAYERED STRUCTURE OF PUBIC REGION OF ANTERIOR ABDOMINAL WALL IN SUPRAVESICAL EXTRAPERITONEAL CAESAREAN SECTION TECHNIQUE (G. L. DRANDROV'S TYPE)

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**Key words:** supravescical extraperitoneal caesarean section, prevesical fascia, retrovesical fascia, fascial spaces

**Aim.** To study the topographo-anatomic peculiarities of pubic region of anterior abdominal wall for providing an adequate supravescical extraperitoneal approach to a lower uterus segment.

**Material and Methods.** Research was performed using both cadaveric and biopsy material, which is collected during supravescical extraperitoneal caesarean section by G. L. Drandrov's technique. The following methods were used: dissection, intraoperative observation, microscopy of sections, stained with hematoxylin and eosin.

**Results and Discussion.** Deep layers of anterior abdominal wall in a pubic region are presented by transverse, prevesical, retrovesical fasciae and peritoneum. While dissection of cadaveric material it was revealed, that layers of prevesical and retrovesical fasciae, covering urinary bladder from anterior and posterior sides, adjoin transverse fascia laterally. Urachus is situated along the midline of the abdomen between prevesical and retrovesical fasciae. There is a proper prevesical fascial space, which is situated between transverse and prevesical fasciae; and space around urinary bladder between prevesical and retrovesical fasciae is perivesical fascial space. Purulent processes and haematomas can migrate along the ureters to pararenal fat. Retrovesical fascial space is located behind retrovesical fascia. Pathologic contents of this space can propagate to retroperitoneal cellular space. These observations allow us to suppose an uninterrupted transition of pre- and retrovesical fasciae into anterior and posterior layers of renal fascia correspondingly.

**Conclusions.** The main indication for an extraperitoneal caesarean section is a high risk of infection. Safety and absence of complications at such surgeries depend upon a technique of their performance in consideration with topographic anatomy of anterior abdominal wall. Knowing an existence and path of prevesical and retrovesical fasciae will help doctors to perform surgical interventions for pelvic organs with less traumaticity and define the most probable pathways of pus and haematomas propagation at a postoperative period in case of complications.