

Endometriomas: their ultrasound characteristics.

[Ultrasound Obstet Gynecol.](#) 2010 Jun;35(6):730-40.

[Van Holsbeke C](#), [Van Calster B](#), [Guerrero S](#), [Savelli L](#), [Paladini D](#), [Lissoni AA](#), [Czekierdowski A](#), [Fischerova D](#), [Zhang J](#), [Mestdagh G](#), [Testa AC](#), [Bourne T](#), [Valentin L](#), [Timmerman D](#).

Source

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Abstract*Objectives*

To describe the ultrasound characteristics of endometriomas in pre- and postmenopausal patients and to develop rules that characterize endometriomas.

Methods

All patients included in the International Ovarian Tumor Analysis (IOTA) studies were used in our analysis. Patients with an adnexal mass were scanned by experienced sonologists using a standardized research protocol. The gold standard was the histology of the surgically removed adnexal mass. The gray-scale and Doppler ultrasound characteristics of the endometriomas were compared with those of other benign and malignant masses. Based on decision-tree analysis, the existing literature and clinical experience, ultrasound rules for the detection of endometriomas were created and evaluated.

Results

Of all 3511 patients included in the IOTA studies, 713 (20%) had endometriomas. Fifty-one per cent of the endometriomas were unilocular cysts with ground glass echogenicity of the cyst fluid. These characteristics were found less often among other benign tumors or malignancies, or among the small set of endometriomas (4%) that were found in postmenopausal patients. Based on the decision-tree analysis, the optimal rule to detect endometriomas was 'an adnexal mass in a premenopausal patient with ground glass echogenicity of the cyst fluid, one to four locules and no papillations with detectable blood flow'. Based on clinical considerations, the following rule: 'premenopausal status, ground glass echogenicity of the cyst fluid, one to four locules and no solid parts' seems preferable.

Conclusions

Several rules had a good ability to characterize endometriomas. The ultrasound characteristics of endometriomas differ between pre- and postmenopausal patients. Masses in postmenopausal women whose cystic contents have a ground glass appearance have a high risk of malignancy.

Prospective multicentre randomized controlled trial to evaluate factors influencing the success rate of office diagnostic hysteroscopy.

[Hum Reprod.](#) 2005 Jan;20(1):258-63.

[Campo R](#), [Molinas CR](#), [Rombauts L](#), [Mestdagh G](#), [Lauwers M](#), [Braekmans P](#), [Brosens I](#), [Van Belle Y](#), [Gordts S](#).

Source

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Abstract*Background*

Diagnostic hysteroscopy is not widely performed in the office setting, one of the reasons being the discomfort produced by the procedure. This randomized controlled trial was

performed to evaluate the effects of instrument diameter, patient parity and surgeon experience on the pain suffered and success rate of the procedure.

Methods

Patients were randomly assigned to undergo office diagnostic hysteroscopy either with 5.0 mm conventional instruments (n=240) or with 3.5 mm mini-instruments (n=240). Procedures were stratified according to patient parity and surgeon's previous experience. The pain experienced during the procedure (0-10), the quality of visualization of the uterine cavity (0-3) and the complications were recorded. The examination was considered successful when the pain score was <4, visualization score was >1 and no complication occurred.

Results

Less pain, better visualization and higher success rates were observed with mini-hysteroscopy (P <0.0001, P <0.0001 and P <0.0001, respectively), in patients with vaginal deliveries (P <0.0001, P <0.0001 and P <0.0001, respectively) and in procedures performed by experienced surgeons (P=0.02, P=NS and P=NS, respectively). The effects of patient parity and surgeon experience were no longer important when mini-hysteroscopy was used.

Conclusions

Our data demonstrate the advantages of mini-hysteroscopy and the importance of patient parity and surgeon experience, suggesting that mini-hysteroscopy should always be used, especially for inexperienced surgeons and when difficult access to the uterine cavity is anticipated. They indicate that mini-hysteroscopy can be offered as a first line office diagnostic procedure.

Mayer-Rokitansky-Küster-Hauser syndrome.

[JBR-BTR](#). 2004 May-Jun;87(3):140-1.

[Janssens F](#), [Verswijvel G](#), [Mestdagh G](#).

Source

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Endometrial ossification and infertility: the diagnostic value of different imaging techniques.

[Abdom Imaging](#). 2003 Nov-Dec;28(6):893-6.

[Ombelet W](#), [Lauwers M](#), [Verswijvel G](#), [Grieten M](#), [Hinoul P](#), [Mestdagh G](#).

Source

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Abstract

We present a case of longstanding secondary subfertility caused by endometrial ossification. Of all diagnostic techniques performed, magnetic resonance imaging and hysterosalpingography did not detect the abnormality. Transvaginal ultrasound and computed tomography clearly showed the endometrial pathology. After successful operative hysteroscopy with removal of the osseous tissue, the patient became pregnant spontaneously within 2 months.