

EP13.25. Vaginal vs uterosacral deep endometriosis without vaginal involvement: a case-control study

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Objective

To compare **pain symptoms, lesion characteristics and clinical management** between women with **vaginal deep endometriosis** (VDE) and those with **uterosacral ligament deep endometriosis** (USLDE) without vaginal involvement (noVDE).

Methods

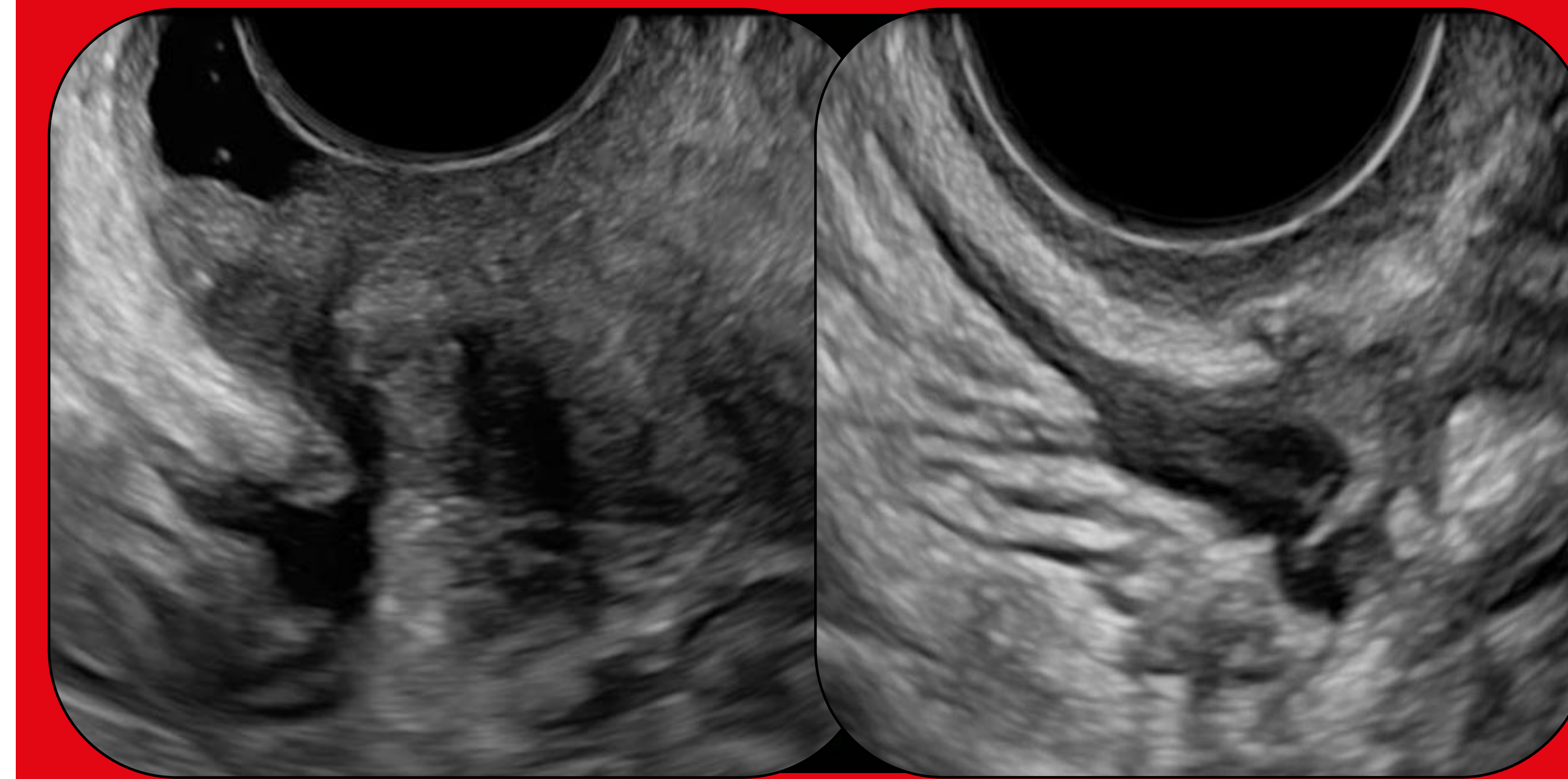
A retrospective case–control study was conducted at a tertiary university hospital. Cases included women with ultrasound-diagnosed deep endometriosis (DE) involving the vaginal wall, whereas controls were consecutive women with ultrasound-diagnosed DE affecting the USL without vaginal extension. All diagnoses were established by transvaginal ultrasound following the IDEA consensus. Demographics, prior surgeries, hormonal treatment, NRS pain scores, lesion size and location, adenomyosis, endometriomas, rectal involvement, and surgical indication were collected and compared between groups.

Results

Age, nulliparity and hormonal treatment rates were similar between groups, while **prior DE surgery was more common in VDE** (26.2% vs 12.5%; $p = 0.017$). **Deep dyspareunia NRS scores were higher in VDE** (4.4 ± 3.9 vs 2.9 ± 3.7 ; $p = 0.022$), without significant differences for dysmenorrhea, non-cyclical pelvic pain, ovulatory pain, dyschezia, or dysuria.

USL lesions were found up to **76% of women with VDE**, with **larger diameter** than noVDE (21.9 ± 11.3 mm vs 15.0 ± 8.3 mm; $p = 0.009$), and **rectal muscularis propria involvement** was more frequent (64.3% vs 29.5%; $p < 0.001$).

Adenomyosis prevalence was **higher** in VDE (44.4% vs 27.6%; $p = 0.017$), while ovarian endometriomas did not differ significantly (39.3% vs 32.1%; $p = 0.345$). **Surgery** due to hormonal treatment failure was more common in VDE (25.9% vs 11.3%; $p = 0.009$).



*Vaginal deep
Endometriosis (VDE)*

*Uterosacral ligament
deep endometriosis
(noVDE)*

Conclusion

Vaginal DE represents a more **severe, multifocal posterior** disease phenotype than USL DE alone, with **greater dyspareunia, larger lesions, more frequent rectal involvement, higher adenomyosis rates and greater surgical need**. Given its accessibility on exam, vaginal involvement should be routinely assessed in women presenting with deep dyspareunia and suspected posterior DE.