Endometriosis of the retrocervical septum is proposed to replace the anatomically incorrect term endometriosis of the rectovaginal septum

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ABSTRACT: We propose that the term retrocervical septum be added to the medical lexicon to designate the anatomic location of endometriosis of the septum that separates the vagina and posterior vaginal fornix from the rectovaginal pouch of Douglas. Use of the terms retrocervical septum and endometriosis of the retrocervical septum would correct the century-long misuse of the anatomically incorrect term, endometriosis of the rectovaginal septum.

Key words: endometriosis / endometriosis of retrocervical septum / endometriosis of rectovaginal septum / retrocervical septum / rectovaginal septum

Introduction

We propose that the term retrocervical septum be added to the medical lexicon to designate the anatomic location of endometriosis of the septum that separates the vagina and posterior vaginal fornix from the rectovaginal pouch of Douglas. Use of the terms retrocervical septum and endometriosis of the retrocervical septum would correct the century-long misuse of the anatomically incorrect term, endometriosis of the rectovaginal septum.

Time to correct a century-long error

The rectovaginal septum separates the lower vagina from the rectum (Milley and Nichols, 1969). Endometriosis rarely infiltrates the rectovaginal septum. Yet paradoxically, for 100 years, endometriosis of the septum that separates the vagina and the posterior vaginal fornix from the rectovaginal pouch of Douglas has been designated endometriosis of the rectovaginal septum. We traced this century-long error to an article by Lockyer entitled: Adenomyoma of the rectovaginal septum (Lockyer, 1913). Cullen adopted the term adenomyoma of the rectovaginal septum from Lockyer (Cullen, 1913).

Adenomyoma of the retrocervical septum

In 1919 and 1920, Cullen published illustrations that proved unequivocally the lesion he called adenomyoma of the rectovaginal septum was actually an adenomyoma of the retrocervical septum (Cullen, 1919; Cullen, 1920; Figs 1 and 2).

The retrocervical septum separates the vagina and posterior vaginal fornix from the rectovaginal pouch of Douglas

The depth of the rectovaginal pouch of Douglas has been measured in three studies. Observations from all three studies support the illustrations of Cullen (Figs 1 and 2). In the first study, the rectovaginal pouch ‘extended to at least the level of the middle third of the vagina in 93% of the patients’ (Kuhn and Hollyock, 1982). In the second study the mean depth of the pouch of Douglas in nulliparous and parous females without genital prolapse extended to half the total length of the vagina.
Interestingly, Baessler and Schuessler found the depth of the rectovaginal pouch varied from very deep (extending caudally to a depth of 89% of the total length of the vagina) to very shallow (extending caudally only to a depth of 11% of the total length of the vagina). In the third study, the depth of the rectovaginal pouch in women with a normal pelvis measured $5.5 \pm 0.8$ cm (Vercellini et al., 2000). Influenced by these three studies, in 2001, we restricted the meaning of retrocervical to describe endometriosis of the septum that separates the vagina and the posterior vaginal fornix from the rectovaginal pouch of Douglas (Martin and Batt, 2001). This is the same structure that we now propose to name the retrocervical septum.

**Deep infiltrating endometriosis of the retrocervical septum**

In surgery Vercellini et al. found endometriotic plaques and nodules in the posterior vaginal fornix cranial to the rectovaginal septum (Vercellini et al., 2000). In agreement with Vercellini et al., Chapron et al. demonstrated that deep infiltrating endometriosis (DIE) originates in the upper posterior vaginal wall behind the cervix; it does not originate from the rectovaginal septum. They made a retrospective study of eight patients with histologically proven DIE lesions. Preoperative magnetic resonance imaging studies were compared with intraoperative findings. Chapron et al. found the DIE nodules were in identical locations in every case, lying below the torus uterinum, level with the posterior vaginal fornix and the upper third of the posterior vaginal wall. Without exception, the DIE nodules were located above the upper edge of the rectovaginal septum, with the latter appearing fine and regular with no image of any nodule (Chapron et al., 2002). In 2004, Chapron et al. emphasized that deeply infiltrating endometriotic lesions originate from the retrocervical area of the posterior vaginal wall (Chapron et al., 2004).

**Conclusion**

The term endometriosis of the retrocervical septum is meant to designate endometriosis of the septum that separates the vagina and posterior vaginal fornix from the rectovaginal pouch of Douglas. So defined, endometriosis of the retrocervical septum describes the anatomic location of the adenomyomas illustrated in the publications of Cullen (Cullen, 1919; Cullen, 1920) and the anatomic location of DIE described by Vercellini et al. and Chapron et al. (Vercellini et al., 2000; Chapron et al., 2002). Importantly, as Chapron et al. emphasized, precise anatomic details are not only essential for understanding the pathogenesis of DIE, but knowledge of the precise location also provides the basis for selecting the optimal operative procedure for complete excision of the DIE lesions (Chapron et al., 2004). In that scientific context, we propose that the term retrocervical septum be added to the medical lexicon to designate the anatomic location of endometriosis of the septum that separates the vagina and posterior vaginal fornix from the rectovaginal pouch of Douglas.

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All three authors contributed equally to this opinion article.

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Conflict of interest

The authors have no conflicts of interest to declare in relation to this manuscript.

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Cullen TS. The distribution of adenomyomata containing uterine mucosa. Am J Obstet Dis Women Child 1919;180:130–138. Fig. 1, page 136 reprinted with permission from Elsevier.

Cullen TS. The distribution of adenomyomas containing uterine mucosa. Arch Surg 1920;1:215–283. Fig. 2, page 269 reprinted with permission from The American Medical Association.


