

# GYNAECOLOGY & OBSTETRICS UPDATE

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## Management of Endometriosis

Endometriosis is the presence of endometrium at sites outside the endometrial cavity. It is a common cause of pelvic pain.

### Presentation

- \* The disease is difficult to diagnose because patients may present with a variety of symptoms and there is considerable overlap with other conditions such as irritable bowel syndrome, pelvic inflammatory disease and renal tract diseases.
- \* Endometriosis may present with any or a combination of the following: Dysmenorrhoea (the commonest) - Pelvic pain - Uterine bleeding (heavy or irregular)- Dyspareunia - Infertility - Pelvic mass - Lower abdominal pain or back pain - Pain/ bleeding on defecation - Loin pain - Pain/bleeding on micturition - Pain on exercise. There is no evidence that endometriosis is associated with recurrent pregnancy loss or that medical or surgical treatment of endometriosis reduces the spontaneous abortion rate
- \* Prevalence of endometriosis in asymptomatic cases is 2-22%, in dysmenorrhoea is 40-60%, in pelvic pain is 15% and in infertility is 20-30%. The severity of symptoms and the probability of diagnosis increase with age. Incidence of endometriosis peaks at about age 40.
- \* It has been found that 32% of patients with endometriosis saw one other specialist before being referred to a gynaecologist, and 25% consulted two other specialists before seeing a gynaecologist.

Painful symptoms in women of childbearing age may be caused by endometriosis, particularly when the symptoms have a cyclical element. **Doctors, therefore, should be alert to this possibility even when the patient presents with apparently non-gynaecological symptoms.**

### Management of suspected cases of Endometriosis in Primary Care

Referral is indicated in presence of

- \* Pelvic mass: clinically or on transvaginal scan
- \* Infertility
- \* Moderate to severe symptoms
- \* Failure of first line management of mild to moderate symptoms

First line management of pain in primary care should include:

- \* **Non-steroidal anti-inflammatory drugs** (such as diclofenac, mefenamic acid, rofecoxib) may be effective in reducing the pain associated with endometriosis. For dysmenorrhoea; rofecoxib [Vioxx Acute 50 mg daily] or Mefenamic acid [Ponstan 500 mg tds] for up to a week every month are effective in controlling the pain.
- \* If a woman is not trying to conceive there may be a role for a therapeutic trial of a **combined oral contraceptive** (tricycling) or a **progestogen** (such as medroxyprogesterone acetate [Provera or Depo-Provera], norethisterone but **not** dydrogesterone, ) for 6 months.
- \* **Danazol is better avoided:** side effects/ possible increased ovarian cancer risk

### Diagnosis

- \* Laparoscopy is still regarded as the '**gold standard**' diagnostic test for endometriosis and its severity. Endometriotic implants have a varied appearance including blue-black lesions (classic appearance of active endometriosis), white plaques, clear vesicles, and newly formed blood vessels
- \* The symptoms may seem disproportionate to the extent of the disease observed within that patient's pelvis e.g. severe symptoms may be associated with a minimal pelvic disease)

### Prognosis

In untreated women observed over 12 months, endometrial deposits resolved spontaneously in a 25%, deteriorated in 50%, and were unchanged in the remainder. Treatment is usually effective to control endometriosis. However it may recur in the future.

### Principles of Management of diagnosed Endometriosis

- \* The aim is to control the associated illness rather the disease itself. Therefore symptomatic treatment should be used first and if it fails then the control of the disease may be needed. This leads to a **temporary** remission of its activity (The only **permanent** cure of endometriosis is the menopause; either natural or artificial by removing both ovaries)
- \* GnRH (gonadotrophin releasing hormone) agonist therapy given for 3 months is an effective treatment for relieving endometriosis-associated pain. Combining GnRH agonist with continuous combined HRT (add-back therapy) reduces the side effects (e.g. menopausal symptoms) and protect the bones without reducing its effectiveness. It makes the use of GnRH analogues safer especially if the treatment is required for more than 3 months.
- \* Laparoscopic ablation of minimal-moderate endometriosis appears to relieve pain and may improve fertility rates.
- \* GnRH agonist should be given for 6 months after surgery for endometriosis-associated pain
- \* There is no role for hormonal therapy in the treatment of endometriosis associated infertility (even after surgery).
- \* Cystectomy for endometriotic ovarian cyst is better than drainage in improving pain and fertility rates.

References: RCOG: The investigation and management of endometriosis, 2001, *BMJ* 2001;323:93-95, Endometriosis in 'Clinical Evidence', 2002