

DIAGNOSING ENDOMETRIOSIS

Red flags

- Recurring pelvic pain or chronic pelvic pain with onset of 6 months+
- Infertility
- Worsening/recurring dysmenorrhoea while taking OCP
- Ovulation pain
- Deep dyspareunia
- Cyclic bladder or bowel symptoms



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Timely laparoscopic diagnosis and treatment of endometriosis is key to limiting complications.

INTRODUCTION

SEVERE dysmenorrhoea is not normal. It has a detrimental effect on a patient's quality of life and warrants early investigation.

Patients who present with recurring or worsening dysmenorrhoea may be among the estimated 8-15% of the female population who have endometriosis.

This condition is the most common cause of chronic pelvic pain (CPP) in females in Australia and is defined by the presence of endometrial stroma and glands outside the uterine cavity.

The average time between first presenting with symptoms to diagnosis for adults is an alarming 7-9 years for this heterogeneous condition. In adolescent females, the diagnosis time may be a long as

8-10 years. This delay may be due to society's normalisation of this type of pain, a reluctance to complain on the part of the patient, or a lack of awareness in the primary care community.

While some women who have endometriosis may be asymptomatic, many will present with worsening dysmenorrhoea, cyclic CPP, cyclic bladder or bowel symptoms and deep dyspareunia.

Cyclic pain and subfertility are the key markers for this condition.

Early intervention is advocated with endometriosis, due to its progressive nature.

Adopting a "wait and see" attitude can have a devastating effect on a patient's quality of life and fertility prospects. Ovarian reserve and function can be compromised if the condition is allowed to progress.

IVF is recommended in older patients keen to start a family but counselling may be advised if ovarian damage has occurred, as this adversely affects IVF success rates. Menopause halts endometriosis, but if the patient takes HRT, symptoms often reappear.

PATHOPHYSIOLOGY

While the aetiology is unknown, the main causative factor of endometriosis is considered to be retrograde menstruation via the fallopian tubes. This allows

endometrial cells to migrate to the pelvic region causing widespread inflammation. The endometrial cells adhere to structures such as the pelvic peritoneum, recto-vaginal septum, bladder, bowel and ovaries. Lesions or plaques form, which may increase in size and form nodules.

SIGNS AND SYMPTOMS

- Recurring pelvic pain or chronic pelvic pain with onset of six months+
- Worsening dysmenorrhoea while taking hormonal contraceptives
- Infertility
- Presenting with period pain
- Heavy, irregular or extended bleeding
- Ovulation pain
- Deep dyspareunia
- Cyclic bladder or bowel symptoms.

DIAGNOSIS & TREATMENT

A full history needs to be taken to rule out other causes of CPP, such as pelvic inflammatory disease or irritable bowel disease, alongside screening for STIs and urinalysis.

The gold standard for diagnosis of endometriosis is laparoscopy by an experienced endoscopic gynaecologist. Transvaginal ultrasound is useful, especially in diagnosing

endometriomas, bowel involvement and deep infiltrating endometriosis (DIE), but standard ultrasound may return a negative result, due to the small size of the plaque-like lesions found in less advanced cases.

The main benefit of a diagnostic laparoscopy is that a visual diagnosis of endometriosis can be confirmed and treatment carried out immediately.

The aim of surgery is to remove as many spots of endometriosis and adhesions in the pelvis as possible, careful removal of cysts and nodules and repairing any damage found.

If DIE involving extensive invasive lesions into the bowel, bladder or other structures is discovered, further surgery with a multidisciplinary team will be recommended.

Recovery times after laparoscopy are short in comparison to open procedures, on average 5-6 days in most cases, but for more extensive procedures expect around 7-10 days.

Fertility is greatly enhanced after surgery, with pregnancy usually achievable.

A recent UK study has discovered, however, that women diagnosed with endometriosis appear to have a greater risk of ectopic pregnancy and miscarriage.

Radical surgical interventions

such as hysterectomy and bilateral salpingo-oophorectomy are less common and only considered in patients with very severe disease progression.

MEDICATION

Surgeries followed by medication such as GnRH analogues before an IVF cycle are of benefit. Ovarian hyper stimulation may cause an increase in symptoms though, as endometriosis is reactive to oestrogen levels.

Hormone therapy to stop ovulation and bleeding may reduce the severity of symptoms and halt the progression of endometriosis but the condition may return after an initial period of relief.

Commonly used medications include Implanon, Mirena IUD, GnRH analogues such as Zoladex (>6 months), Provera, progestins, danazol, and pain relief NSAIDs.

PRACTICE POINTS

- Endometriosis affects an estimated 176 million women worldwide.
- Delayed diagnosis is closely tied to poorer patient outcomes. ■

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