

Endometriosis explained



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THE 10th World Congress on Endometriosis took place in Melbourne in March, with more than 1000 delegates attending from all over the world.

CLINICAL PRESENTATION

Endometriosis is thought to occur in 10% of women but the prevalence may be lower.

A study using data from the UK General Practice Research Database showed the specific symptoms of dysmenorrhoea, menorrhagia and abdominal and pelvic pain were significantly associated with endometriosis.

In the year prior to diagnosis, about 10 per cent of the women had multiple visits to their doctors to seek help and were twice as likely to take time off work because of the symptoms.

There is a greater risk of being misdiagnosed with irritable bowel syndrome or pelvic inflammatory disease, or of

these conditions co-existing.

A study to establish the typical menstrual experience of teenagers using the Menstrual Disorders of Teenagers questionnaire was undertaken, including 1051 women aged 16-18 years in the ACT.

About 70% felt their periods were normal, but 25% had significant menstrual disturbance including severe pain, school absence, concern about their personal menstrual experience and visits to the GP.

DIAGNOSIS

The mean time from onset of symptoms to diagnosis of endometriosis is seven to 12 years and even longer if the endometriosis has infiltrated into deep tissues such as the uterosacral ligaments, bowel, bladder, ureter or rectovaginal septum.

The diagnosis of endometriosis by investigations other than laparoscopy is not available. Ultrasound – transvaginal and rectal – may have a limited place in diagnosis of endometriomas and deep infiltrative disease.

At the congress, many studies were presented that were investigating markers that could possibly be developed as a less invasive test for endometriosis.

Inflammatory markers including macrophages, cytokines, growth factors and prostaglandins are being studied.

Sensory C nerve fibres have been shown to occur in the

endometrium of women with endometriosis confirmed on laparoscopy but not in the endometrium of women without endometriosis. This may become a way of diagnosing endometriosis or targeting which women to laparoscope.

MANAGEMENT

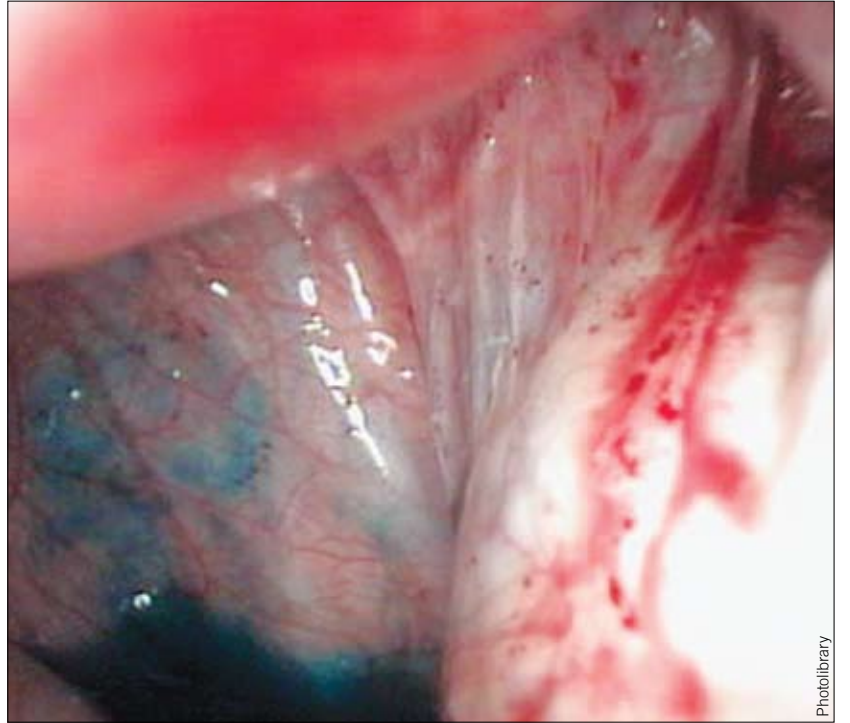
There is debate about the use of empirical treatment to suppress ovulation as first-line management rather than operative laparoscopy with excision.

Suppressing ovulation reduces endometrial tissue growth and may be considered first-line in young teenage women.

Various therapies have been prescribed for ovarian suppression, including the combined oral contraceptive pill continuously, long-acting progestins such as Implanon, and the Mirena IUD.

When symptoms persist despite suppression of ovulation, operative laparoscopy with excision would be appropriate as a second-line treatment.

Operative laparoscopy with excision and/or diathermy of



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endometriotic plaques is the most widely used treatment.

CONCLUSION

Endometriosis is a heterogenous disorder. Symptoms may range from minimal to none, through to severe and crippling.

The degree of disease varies and is classified according to its clinical staging at laparoscopy.

Especially in women in their teenage years, endometriosis may appear differently. The endometriotic plaques visible at laparoscopy may appear as clear areas rather than the classical dark brown or red implants.

There is concern about young women undergoing multiple surgical, mainly laparoscopic, procedures with excision of tissue and its consequence on long-term fertility.

■ *The Jean Hailes Foundation for Women's Health is a national, non-profit health organisation focusing on clinical care, innovative research and practical education opportunities for health professionals and women.*

Recommendations for GPs

1. Dysmenorrhoea, menorrhagia and abdominopelvic pain in a woman of any age who regularly has to take time off school or work, leading to visits to her doctor, should be investigated for endometriosis.
2. The time taken to diagnose endometriosis is too long in most cases. The condition should be part of the differential diagnosis of any woman, regardless of age, presenting with the complex of menstrual symptoms, including menstrual pain, which impede normal function.
3. Laparoscopy remains the gold standard for diagnosis of endometriosis.
4. Management remains controversial. In young teenage women, an initial trial of ovarian suppression may be appropriate.
5. Endometriosis is chronic and long-term follow-up is necessary. Post-operative ovarian suppression may be necessary.
6. When symptoms persist, refer to either a specialist endometriosis clinic or a gynaecologist with advanced skills in laparoscopic surgery or a special interest in endometriosis management.