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WOMENS HEALTH

Endometriosis

Overview

Endometrium is the tissue that normally lines the uterine cavity (inside space of the uterus). After the onset of puberty, women experience menstruation as a result of the cyclical shedding of the endometrium, which is released as blood through the vagina.

Endometriosis is a condition where endometrium-like tissue attaches, grows and spreads in locations outside the uterine cavity. In response to the menstrual cycle, endometrium-like tissue responds in the same way as the lining of the uterus does. This means that at the time of menstruation, these endometrium-like tissues also break down and bleed into the surrounding areas. This process can cause irritation, inflammation and scarring.

Most commonly, endometriosis occurs in the pelvis, the ovaries, the ligaments holding the uterus in place and the area between the uterus and the bowel known as the pouch of Douglas. It may also occur on the bladder, the bowel, the appendix, the abdominal wall, but rarely outside the abdominal and pelvic cavity.

It is estimated that endometriosis affects the health, well-being and personal relationships of nearly 15% of women of reproductive age. Endometriosis can cause period and pelvic pain, abnormal bleeding, digestive problems, mood changes and extreme fatigue. It can also make it more difficult to get pregnant and may lead to infertility.

Research to date suggests that there is still an average delay of 7-9 years from when a woman first experiences symptoms suggestive of endometriosis to the time she has a correct diagnosis and receives appropriate treatment. The good news is endometriosis can be diagnosed and treated early and women with this condition can frequently expect to lead a healthy and fulfilling life.

Causes

Unfortunately the causes of endometriosis are not fully understood, although there are known contributors, including:

- Retrograde menstruation. This refers to the flow of menstrual blood backing up and spilling out of the fallopian tubes into the pelvic areas. The endometrial cells may attach to the surface of the pelvic lining and pelvic organs and develop into endometriosis.
- Family history. A woman whose mother or sister/s has endometriosis is more than five times more likely to develop the condition herself.
- Immune system deficiencies.
- Menstrual outflow obstructions due to congenital abnomalies or post-surgery
- Possible exposure to certain chemicals such as dioxins but this is still being investigated.
- Other hormonal factors.

Symptoms

The type and severity of symptoms are variable and may fluctuate or increase in severity over time.

Endometriosis involving the pouch of Douglas (area between uterus and bowel) and the uterosacral ligaments seems to cause more pain than other areas.

Common symptoms of endometriosis include:

Pain. Period pain is by far the most common complaint. However, endometriosis pain can include chronic pelvic pain, abdominal or lower back pain, pain while urinating, passing wind or opening the bowels, pain during or after sexual intercourse (also known as dyspareunia), and pain from ovulation, sometimes felt in the thighs.

Bleeding. This can include heavy periods, abnormal bleeding at any time during the menstrual cycle, and irregular bleeding (also known as spotting), often just before a period is due.

Cyclical premenstrual or menstrual bowel or bladder symptoms including constipation, diarrhoea, bloating, crampy pain on opening bowels or passing urine, urinary frequency and. rarely blood in bowel motions or urine.

Difficulty getting pregnant and infertility.

Chronic fatigue.

Psychological effects including diminished motivation, lack of self-esteem, loss of self-confidence, depressive moods.

Diagnosis

There is no simple, externally applied test to diagnose endometriosis. Your family doctor may suspect endometriosis based on your history and will usually refer you to a specialist (gynaecologist).

By taking a full history looking for symptoms, performing physical examination (in sexually active women) and organising imaging tests such as ultrasound, your doctor determines the chance of you having endometriosis.

While ultrasound may detect cysts associated with endometriosis (called endometrioma) in 10% of all cases, surface endometriosis lesions cannot be seen.

This means a negative ultrasound does not exclude endometriosis.

Currently, laparoscopy (a key-hole operation involving a small incision at the belly button through which a small telescope is inserted into the abdomen) performed under a general anaesthetic is the only way the gynaecologist can tell for certain if you have endometriosis.

The laparoscopy will provide you and your doctor with accurate information about the location, extent and depth of the endometrial implants, ovarian cysts, as well as scarring or damage to reproductive and pelvic organs.

To help select appropriate treatment, the doctor may classify the endometriosis into mild, moderate or severe, and sometimes may take a tissue sample for testing.

Treatment

Generally, treatments for endometriosis are broken up into the following types – wait and see (watchful waiting), medication and surgical.

Wait and see

As we do not fully know the natural history of endometriosis, this may be an appropriate option if you have minimal endometriosis with no significant symptoms and have not tried to get pregnant.

Medication

- Pain killers: Medication is used to control pain and also to prevent the advancement of the disease. Effective pain medications include non-steroidal anti-inflammatory drugs (NSAIDs), and paracetamol-based drugs. These are available over the counter, but if they are not effective, stronger painkillers may be prescribed.
- The Pill: One of the most commonly used medications for controlling the advancement of endometriosis is the contraceptive pill. This can be taken continuously so there are no periods. This helps prevents the excess endometrial tissue from breaking down and causing pain and further inflammation. This treatment will not cure existing damage or scarring.
- Other hormone products: Including progesterone, danazol (testosterone derivative) or menopause-inducing medications to reduce oestrogen production can also help relieve symptoms.

All medications can have side effects and should be discussed with your doctor before and during treatment.

Surgical

If medication does not improve the symptoms and the condition continues to deteriorate, surgery may be the next option.

A pelvic laparoscopy can be performed for surgical removal (excision) of endometrial tissues.This can either be done at the time of the diagnosis or later on.

It is important to remember that endometriosis can reoccur after medications or surgery, so repeated treatments may be intermittently required during the menstruating years.

Surgical removal of endometriosis in infertile women has been found to improve chances of getting pregnant. Those who do not wish to have surgery or have not become pregnant after surgery may benefit from IVF treatments. You should discuss with your doctor which treatment is suitable for you.

In severe, recurrent cases of endometriosis where the woman has completed childbearing or has decided that she does not want any future pregnancies, a hysterectomy may be advised to address endometriosis symptoms. This involves removing the uterus.

In addition, as the source of oestrogen hormones that stimulate the growth of endometriosis comes from the ovaries, you will want to discuss with your doctor to decide the

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benefits and risks of keeping or removing the ovaries should you undergo a hysterectomy.

Support and resources online

Here are some useful resources for endometriosis.

The Centre for Advanced Reproductive Endosurgery
www.sydneycare.com.au/endometriosis

Endometriosis.org
endometriosis.org/endometriosis

The Jean Hailes Foundation for Women's Health
www.endometriosis.org.au

The Endometriosis Care Centre of Australia
www.ecca.com.au

The Endometriosis Association (QLD) Inc
www.qendo.org.au

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