

Endometriosis

Health
professional **tool**

Assessment, investigations & management

Prevalence and presenting symptoms

Women with dysmenorrhoea often visit their GP multiple times before they are referred to a specialist. GPs are in a strong position to advocate for women with suspected endometriosis, helping to reduce the average seven-year delay in diagnosis.

Epidemiology & prevalence

Endometriosis is an oestrogen-dependent inflammatory condition, defined by endometrial cells found outside the uterine cavity. It is a progressive, recurrent and often debilitating condition.

- High prevalence - estimated to affect 5% to 10% of women, including adolescents
- More common than diabetes or breast cancer, yet has no known cause or cure
- Probability is 3 to 10 times higher if 1st-degree relative has the condition
- Diagnosed in 20-50% of women undergoing laparoscopy for assessment of chronic pelvic pain (CPP) or infertility.

Pathogenesis

The aetiology of endometriosis is unknown. Genetic factors contribute about 50%, with environmental, menstrual and dietary factors playing a less defined role.

Key message

Dysmenorrhoea that impairs quality of life (QoL) is not normal – if pain is persistent despite treatment with analgesia and/or hormonal management, refer to a gynaecologist.

Presenting symptoms may include:

Pain:

- severe dysmenorrhoea that gets progressively worse, impacting on quality of life (lost productivity, days off work/school)
- recurring or persistent pelvic pain with duration of >6 months
- worsening dysmenorrhoea while taking hormonal contraceptives
- ovulation pain
- deep dyspareunia
- pain during internal examination
- back or leg pain.

Bleeding:

- heavy, irregular, extended or post-coital bleeding with or without clots
- dark or old blood being passed before or at the end of period.

Bowel and bladder symptoms:

- cyclic bladder or bowel symptoms
- pain before or after opening bowels
- pain before, during or after urination
- bleeding from the bowel
- blood in the urine
- irritable bowel syndrome (IBS) type symptoms – constipation, diarrhoea or colic.

Other symptoms:

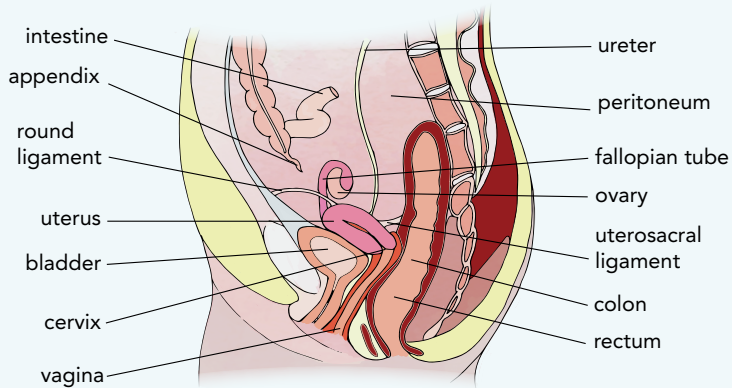
- chronic fatigue, weariness, bloating or pain not during period or ovulation
- infertility
- fainting during period or feeling faint
- nausea
- depression.

Note: A possible diagnosis of endometriosis should be considered in adolescents presenting with: persistent pelvic pain (cyclic and/or non-cyclic), severe dysmenorrhea, dysmenorrhea resistant to non-steroidal anti-inflammatory drugs (NSAIDs) and the oral contraceptive pill (OCP), and pain interfering with daily activity.

Possible sites of endometriosis

- Peritoneum, ovaries and fallopian tubes
- Uterosacral ligaments and Pouch of Douglas
- Bladder and bowel
- Recto-vaginal septum
- Abdominal surgery scars and, rarely, in other organs outside the pelvic cavity

Several potential sites of endometriosis are illustrated in the diagram below.



Early diagnosis is important

Normalisation of dysmenorrhoea by women and health professionals, diversity of symptoms and lack of clinical knowledge are barriers to diagnosis.

- Women face an average 7-8 year delay for surgical diagnosis and up to 13 years for deep infiltrative disease (DIE)
- Endometriosis is usually progressive, even in the asymptomatic patient
- Where DIE and endometriomas exist, more complex management is required.

Key message:

Delayed diagnosis can lead to infertility, debilitating pain and reduced QoL.

For more information on fertility, visit www.jh.today/fp

Assessment

Assessment should include:

- **history**
 - present and past menstruation
 - family history (1st and 2nd-degree relatives)
- **examination**
 - palpation of abdomen for areas of tenderness or guarding
 - vaginal exam (only in sexually active women) for tenderness, uterine size, nodules, ovarian cysts
- **imaging** (pelvic/abdominal ultrasound)
- **exclude other causes of lower abdominal pain**, eg, sexually transmissible infection (STI), ectopic pregnancy, pelvic inflammatory disease (PID), ovarian torsion, IBS.

Investigations

Ultrasonography is the first-line investigative tool

1. Abdominal/transvaginal ultrasound (TVUS)
 - may be negative
 - may detect endometriomas
 - if ultrasound is performed by gynaecologist trained in advanced ultrasound, it may detect DIE of the bowel, bladder or rectovaginal septum
2. MRI (specialist use).

Key message

The combination of laparoscopy and histological verification is considered the gold standard for the diagnosis of endometriosis.

Referral

When to refer patient for confirmation of diagnosis and/or treatment of endometriosis to specialist gynaecologist:

- severe dysmenorrhoea (any woman presenting with dysmenorrhoea, regardless of age, should be investigated)
- period pain that is not managed by either NSAIDs or OCP
- presents with a range of non-specific symptoms including dysmenorrhoea.

After referral to gynaecologist, arrange 3-month follow-up, with longer appointment time to review.

Post-diagnosis management

- Liaise with treating gynaecologist and other health professionals
- Ongoing management depends on treatment response, persisting symptoms, and expected health outcomes
- 30% of women with endometriosis will experience infertility
 - refer to fertility specialist after 6 months of trying to conceive or >35 years of age

See 'Multidisciplinary management plan' section.

Managing pain

Endometriosis-associated pain may be:

- recurrent endometriosis
- recurrent pelvic pain and/or
- related to chronic pain syndrome

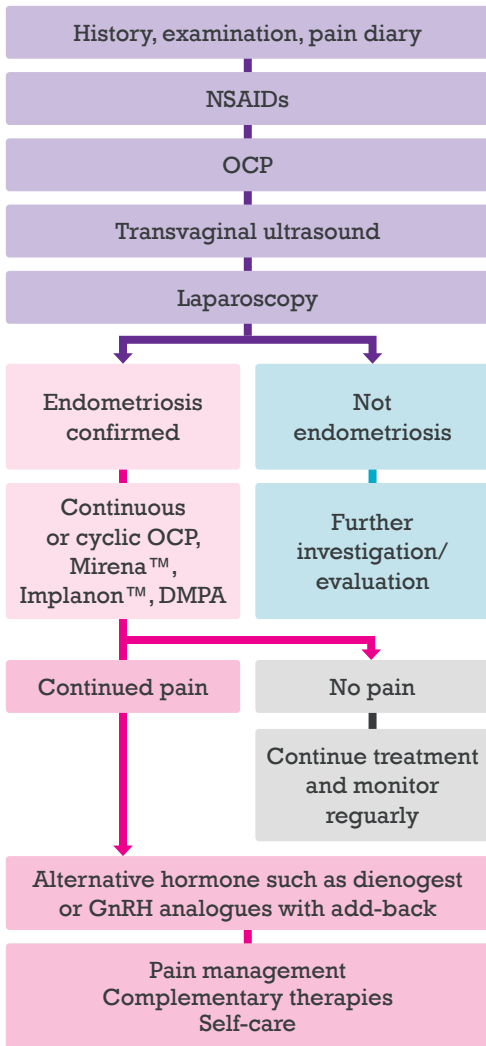
Multidisciplinary pain management:

- analgesics including NSAIDs
- endometriosis pain suppression:
 - OCP (continuous or conventional), NuvaRing™, Implanon™ +/- Mirena™, together or individually

- pain management medications such as amitriptyline, duloxetine, pregabalin
- physiotherapy for targeted treatments
- gynaecologist may prescribe:
 - GnRH agonists (lead to low oestrogen, add back HRT/MHT, maximum use 6 months)
 - progestogens and anti-progestogens.
- Patients with persistent pelvic pain should be taken seriously to assist early diagnosis and symptom control.
- Suggesting the pain is psychosomatic/psychological can disempower the patient and lead to reduced QoL.
- Refer to a pain clinic, pain specialist and/or psychologist at the earliest opportunity.
- Avoid recurrent surgery for women who are refractory to any surgical treatment.

Key message

Patients with persistent or severe pelvic pain are at increased risk of depression and anxiety; routine screening is recommended.



Multidisciplinary management plan

Create a management plan with a multidisciplinary team to help address symptoms. Include the patient in the decision-making process, informing her of all side-effects and benefits of treatment.

Encourage a healthy lifestyle and a strong support network to address both the physical and mental aspects of endometriosis to improve QoL.

Physical activity

Regular physical activity may reduce pain and improve wellbeing.

Pelvic floor physiotherapy

- Treatment of pelvic floor muscle dysfunction, persistent pelvic pain and dyspareunia
- Rehabilitation of associated muscles of the pelvic and abdominal region

Complementary medicine

Women may seek and feel benefits from complementary therapies in the management of endometriosis-associated pain. According to the European Society of Human Reproduction and Embryology (ESHRE) endometriosis guidelines, evidence for the following is not well established:

- acupuncture
- transcutaneous electrical nerve stimulation (TENS)

- magnesium, vitamin B1 and B6 (B6 – concern over safety of high doses)
- fish oils (omega-3 fatty acids).

Mental health

Endometriosis can negatively impact QoL and have a detrimental effect on physical, emotional and mental wellbeing. Early diagnosis and treatment may reduce this effect. Discuss the management plan with the patient. Consider referral to a counsellor or psychologist.

Key message

Assess mental and emotional health.

Ask your patient the questions below. If any responses are positive, further exploration is required.

During the last month, have you:

- often been bothered by feeling down, depressed or hopeless?
- often been bothered by having little interest or pleasure in doing things?
- been bothered by feeling excessively worried or concerned?

Seek out other health professionals with endometriosis experience, including:

- specialist women's health general practitioner
- gynaecologist with skills in advanced laparoscopy and pain management
- psychologist/pain specialist
- fertility specialist
- community health nurse
- pelvic floor physiotherapist
- dietitian
- accredited exercise physiologist
- sex therapist
- naturopath.

Putting it into practice

Case study 1

Teenager with primary/secondary dysmenorrhoea. Possible causes include endometriosis, bowel and/or bladder or pelvic floor dysfunction:

- self-care early – heat, analgesics, exercise, pacing
- NSAIDs then review at 3 months (book long appointment)
- if no improvement:
 - hormonal suppression of menstrual cycle with agents such as continuous OCP, Implanon, NuvaRing, Mirena. Review in 3 months
- if pain persists:
 - refer to gynaecologist (preferably with advanced laparoscopic skills) for assessment and laparoscopy
- tests (if heavy menstrual bleeding present): FBE, iron studies, thyroid function tests, Von Willebrands platelet function studies

- ultrasound, high-quality transvaginal ultrasound if sexually active, or transabdominal if not.

Case study 2

Patient returns after laparoscopy:

- monitor patient response to treatment
- continue prescribed management
- refer back to gynaecologist if pain recurs.

Case study 3

Patient returns after 14 months trying to conceive, without success. Is depressed and struggling with recurrent pelvic pain:

- refer to fertility specialist with skills in endometriosis
- review with operating gynaecologist
- assess mental health and refer if required.



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