



Endometriosis- What a Pain !

By Jane Mears

Pelvic pain and difficulty getting pregnant may mean that you have endometriosis. But don't worry; it can be treated – by painkillers, hormones, or surgery. Here's an overview.

Endometriosis is when the cells, which normally line the womb, are growing outside of the womb. Endometriosis is not a cancer and is rarely life threatening but does affect women's quality of life.

Endometriosis can occur in different sites around the pelvis and can also cause cysts on the ovaries; these are called endometriomas or 'chocolate' cysts. The different sites of endometriosis can be related to the problems it causes.

How common is it?

We know endometriosis is common but there is much debate as to how common it is. It is found more frequently in women with fertility problems and those with pelvic pain but can also be found in women without any symptoms.

We know that it is more common in women who have not had children, professional women, women in their 30's and also if they have a sister with endometriosis. However this does not mean that women who do not fulfil these criteria don't get the disease.

What symptoms would I experience?

The most common symptoms that women with endometriosis suffer with are pain and problems conceiving.

Pain related to endometriosis can be related to the menstrual cycle or be more constant in nature. Endometriosis can also cause pain with intercourse; most commonly the pain is felt in the pelvis with penetration rather than pain on the surface outside.

Women with endometriosis can experience infertility or problems conceiving. It's easy to see how severe endometriosis can cause problems getting pregnant as the tubes and ovaries can become scarred and stuck preventing the pick up and transport of the egg. Endometriomas or cysts on the ovaries can also affect release of the egg.

What's more difficult to explain is why women with mild or minimal endometriosis should be affected. There is still debate about how important a small amount of endometriosis is to a woman's fertility.

How can it be diagnosed?

The doctor can do an internal examination and get a clue that you might have the condition but the only sure way to diagnose endometriosis is by performing an operation called a laparoscopy. A general anaesthetic is required but most women can go home on the same day. During the procedure the gynaecologist uses a small camera to look into the abdomen through an incision in the umbilicus. Usually one other incision is required to allow an instrument to be inserted which can manipulate organs to ensure all areas have been inspected.

An ultrasound of the pelvis may also be performed. This is often done by inserting a probe just inside the vagina (called transvaginal ultrasound). This is a good method to look for cysts or endometriomas but cannot diagnose endometriosis deposits elsewhere.

What treatments are available?

Treatments for endometriosis can be divided into medical or surgical. The treatment options will depend upon your age, fertility plans, symptoms and

previous treatments. Hormonal treatments, which stop menstruation and therefore activity in the deposits, are not useful for women with fertility problems as they work by stopping the natural menstrual cycle and will prevent a pregnancy occurring.

REMEMBER!

Not all pelvic pain is caused by endometriosis. Alternative diagnoses include pelvic inflammatory disease, irritable bowel disease.

Medical treatments may involve taking simple painkillers such as Non-Steroidal Anti-Inflammatories (NSAIDs like Ibuprofen) or using hormone treatment to suppress the growth of the endometriosis. A combination of medical and surgical treatments may be considered.

Hormonal treatments include the combined oral contraceptive pill, progesterone, danazol and gonadotrophin releasing hormone analogues (GnRH analogues). All of these treatments have been shown to be equally effective in the treatment of endometriosis. The main difference between them is the side-effects that they can cause. Recurrence of symptoms is common after stopping medical treatment.

Combined oral contraceptive pill (COCP)

- Taken continuously or in 3-monthly cycles can be beneficial
- Side effects: nausea, vomiting, breakthrough bleeding, water retention, breast tenderness, acne
- *Note:* you need to check that there is no contraindication, such as heart disease, to you taking the COCP

Progestogens

- Can be given orally, by injection (for 12 weeks) or using the intra-uterine system (Mirena®)
- Side effects: bloating, breast tenderness, mood changes, breakthrough bleeding
- *Note:* Normal ovulation can be delayed following the depot injection and this should be considered if you are planning a family in the near future.

Danazol

- Is less commonly used now due to its side-effects.
- Side effects: acne, weight gain, libido changes, hair growth and rarely deepening of the voice, which is irreversible.

GnRH analogues

- These are given as monthly or 3-monthly injections. They aim to induce a temporary 'menopause'.
- Side effects: hot flushes, night sweats, vaginal dryness, reduced libido, breast reduction, reduced bone density
- *Note:* These drugs are normally only used for 3-6 month courses due to the concern over reducing bone density. Giving add-back hormone replacement can reduce the side effects.

Surgical treatment

Surgery can either be conservative to preserve fertility or radical if fertility is not an issue.

Conservative surgery

This is usually performed through a laparoscope (key-hole) and aims to remove or destroy the endometriosis deposits. This type of surgery aims to reduce pain due to endometriosis and may have some benefits for women trying to conceive.

Laparoscopic surgery offers a quicker recovery to normal functioning than open surgery. Laparoscopic surgery can also be used to remove endometriomas from the ovary.

IVF may need to be considered for women who have failed to conceive.

Radical surgery

If fertility is not a concern then a hysterectomy with or without removal of the ovaries may be considered. The decision to remove the ovaries would depend on your age, amount of disease present and would be discussed with your surgeon. If the ovaries are removed prior to the menopause then hormone replacement therapy should be considered.

Who can I ask for help?

Your general practitioner is the first person you should contact. They can discuss your symptoms with you and perform an examination; they may also arrange an ultrasound scan of the pelvis. Starting simple treatments such as painkillers or the “pill” may be appropriate.

If your GP feels that you require more investigation or more advanced treatment you will be referred to a gynaecologist.

Are there any alternative treatments?

There are no recognised alternative therapies to treat endometriosis; however maintaining a healthy and active lifestyle is beneficial.

HELPFUL LINKS:

The National Endometriosis Society

www.endo.org.uk

Endometriosis SHE trust

www.shetrust.org.uk

**The Royal College of Obstetricians
and Gynaecologists**

www.rcog.org.uk

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Wellbeing of Women

Registered Charity No: 239281

www.wellbeingofwomen.org.uk

