Endometriosis

Disclaimer

This pathway is about suspected endometriosis and endometriosis that has been histologically diagnosed at laparoscopy.

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Red Flags

- Severe, uncontrolled pelvic pain
- Known endometriosis with hydronephrosis or bowel obstruction

Background

About endometriosis

Endometriosis is defined as the presence of endometrial tissue outside the endometrial cavity.

- Asymptomatic in one third of women.
- Common – occurs in:
  - 5 to 10% of women of reproductive age.
  - up to 50% of women with infertility or chronic pelvic pain.
- Diagnosis:
  - Usually diagnosed at age 25 to 30 years, but common from adolescence.
  - Often 8- to 10-year delay in diagnosis.
- Prognosis – progressive, recurrent, and often debilitating condition.

Assessment

Practice Point

Presumptive diagnosis of endometriosis is based on the clinical picture. Diagnosis can only be confirmed by laparoscopy and biopsy.

1. Take a history. Ask about:
   - risk factors.

   Risk factors
   - First-degree female relative affected
   - Early menarche
   - Short menstrual cycles (< 27 days)
   - Nulliparity or subfertility
   - Low BMI
   - Structural abnormality of reproductive tract

   - patient history and symptoms.

   Patient history and symptoms
   Ask about:
   - age of menarche.
➢ current cycle – regularity, length of cycle, days of bleeding, quantity of blood loss, pain before and during menstruation.
➢ deep dyspareunia (painful sexual intercourse) or dyschezia (pain on defaecation).
➢ details of previous surgical and medical management including course and outcome of treatment.
➢ functional impact of symptoms on daily activities including impact on work, study, school, or carer role.
➢ previous pregnancies.
➢ contraception history.
➢ planned fertility.
➢ relevant medical and surgical history.
➢ social and emotional impact.
➢ urinary symptoms around time of menses – dysuria, urinary frequency, haematuria.
➢ gastrointestinal symptoms around time of menses – altered bowel habit, rectal bleeding, faecal urgency, bloating.

Consider menstrual diary (printable version or app).

• family history of endometriosis, dysmenorrhoea, uterine structural abnormalities, and gynaecological cancers.

2. Look for **common clinical presentations**.

### Common clinical presentations

*Note that young patients with symptoms that started within 6 to 12 months of menarche are unlikely to have endometriosis.*

- Dysmenorrhoea (occurs in 60 to 80% of patients) – often starts several days before menses
- Heavy menstrual bleeding (10 to 20%)
- Deep dyspareunia (40 to 50%)
- Dyschezia (pain on defecation), tenesmus, bloating (10 to 40%)
- Chronic pelvic pain (40 to 50%)
- Subfertility (30 to 50%)
- Dysuria, haematuria (5%)
- Lower back or leg pain

3. Consider **differential diagnosis**.

### Differential diagnosis

- Other gynaecological – primary dysmenorrhoea, adenomyosis, pelvic inflammatory disease (PID), ovarian cysts, Mittelschmerz
- Gastrointestinal – inflammatory bowel disease (IBD), diverticulitis, constipation, irritable bowel syndrome (IBS), appendicitis
- Urinary – interstitial cystitis, urinary tract infection (UTI), kidney stones
- Musculoskeletal – pelvic muscular pain
- General – neuropathic pain, adhesions, pelvic congestion syndrome
4. Perform **abdominal and pelvic examination:**

**Abdominal and pelvic examination**

*Abdominal palpation usually demonstrates non-specific tenderness without guarding or rebound.*

**Perform:**

- **bimanual pelvic examination** – assess:
  - size and mobility of uterus, any cervical or adnexal tenderness, pelvic masses.
  - lateral pelvic walls, for levator ani spasm and tenderness.
  - utero-sacral ligaments (posterior to cervix), for tenderness and nodular endometriosis.
  - urethra and bladder (examine anterior vaginal wall), for tenderness.
- **speculum examination** looking for vaginal endometriosis (rare).

- Avoid pelvic exam in patients who have not had vaginal intercourse.
- Discuss examination required and obtain verbal consent.
- Consider chaperone for pelvic examination.

5. Arrange investigations:

- Pregnancy test if indicated.
- **Cervical screening** if due.
- Sexual health check for STI screening.
- Transvaginal ultrasound to assist with **diagnosis**.

**Diagnosis of endometriosis**

*Presumptive diagnosis of endometriosis is based on the clinical picture. Diagnosis can only be confirmed by laparoscopy and biopsy.*

*General transvaginal ultrasound can reliably detect cystic endometriomas only. Referral to a specialist gynaecology ultrasound service is recommended for detection of deep infiltrating endometriosis. A specialist scan is preferred prior to referral for gynaecology assessment.*

- A transabdominal pelvic ultrasound can be performed for women who have not become sexually active or have declined a transvaginal pelvic ultrasound.
- For detection of deep infiltrating endometriosis, referral to a specialist gynaecology ultrasound service is recommended.

- If presenting complaint involves other organ systems (e.g., bladder, bowel), consider further investigations (e.g., MRI) to exclude other diagnoses and detect deep infiltrating disease. Discuss with gynaecology registrar prior to organising these tests.
Management

1. Refer to emergency department or for immediate gynaecology assessment if:
   - severe uncontrolled pelvic pain.
   - known endometriosis with hydronephrosis or bowel obstruction.

2. Refer for urgent or routine gynaecology assessment if:
   - significant deep dyspareunia.
   - dyschezia (pain on defecation).
   - suspected endometrioma.

3. If suspected mild endometriosis, consider:
   - **non-pharmacological management.**

**Non-pharmacological management**

*There is limited evidence to support recommendations. Patients may seek non-pharmacological treatment and may experience improved symptoms.*

- Advise about pain relief:
  - Local heat
  - Transcutaneous electrical nerve stimulation (TENS)
  - Acupuncture
- Discuss lifestyle changes:
  - Optimise BMI.
  - Increase exercise and fitness levels.
- Offer patient support:
  - Provide education and link the patient with support groups – see Endometriosis Australia.
  - Monitor mood and address psychosocial factors.

- medical management using analgesia and/or hormonal therapies. Consider a trial of each treatment option for ≥ 3 months.

**Analgesia**

- Nonsteroidal anti-inflammatory drugs (NSAIDs) – ideally start 48 hours before expected menstruation or with onset of pain. Consider:
  - *Ibuprofen* – 200 to 400 mg three to four times a day.\(^1\)
  - *Mefenamic acid (Ponstan)* – 500 mg three times a day. Only to be used in patients aged > 14 years.
  - *Naproxen* – two 275 mg tablets initially then 275 mg every six to eight hours. Maximum 5 tablets a day. Suitable for patients aged > 12 years.
- Paracetamol – consider adding if NSAIDs contraindicated, insufficient for analgesia, or not tolerated.
- Neuromodulating medication (e.g., tricyclic antidepressants, SNRIs, anticonvulsants) – consider if the patient has central sensitisation. See Pelvic Pain (Chronic) pathway.
Hormonal therapies

Trial each treatment option for ≥ 3 months:

➢ **Progestogen-only long-acting reversible contraceptives (LARCs)**

  ➢ Levonorgestrel-releasing IUD (Mirena):
    - Effective at managing adenomyosis and probably at preventing recurrence of endometriosis (prophylaxis).
    - Has not been shown to effectively treat existing endometriosis.
    - If Mirena alone is not adequate, consider adding combined hormonal contraceptives (CHCs) for ovulation suppression.

  ➢ Implanon – only effective if amenorrhoea can be achieved.

  ➢ Depot medroxyprogesterone acetate (DMPA) – only effective if amenorrhoea is achieved, may reduce bone density if used long-term, so not recommended.

➢ **Continuous oral higher-dose progestogen**

  ➢ Does not provide contraceptive benefit, so barrier contraception may be required if risk of pregnancy.

  ➢ Monitor for side-effects e.g., mood changes, fluid retention, loss of libido, acne, weight gain.

  ➢ Monitor lipid profile and bone density if used long-term.

  ➢ Recommended regimes (these are not contraceptive regimes):
    - Medroxyprogesterone 10 mg orally, twice a day for up to 6 months.
    - Norethisterone 5 mg orally, twice a day for up to 6 months.
    - Dienogest (Visanne) 2 mg orally, once a day (not PBS-listed). See also [Dienogest for Endometriosis](#).

➢ **Combined hormonal contraceptives (CHCs)**

  ➢ Choice dictated by patient preference and clinical considerations. See Combined Hormonal Contraceptives (CHCs).

  ➢ May be more effective if active hormone tablets administered continuously.

  ➢ If breakthrough bleeding occurs when continuously taking active tablets for > 3 weeks, suggest a hormone-free break for 4 to 7 days before restarting active tablets. During the break, the patient will have a withdrawal bleed.
4. Consider requesting:
   • psychological therapy and counselling.
   • women’s health physiotherapy for help with pelvic floor relaxation exercises.

5. If symptoms fail to respond to adequate medical management, request urgent or routine gynaecology assessment for diagnostic laparoscopy and consideration of surgical management.

6. If appropriate, discuss pregnancy planning. Presence of endometriosis is a risk factor for infertility – advise patient to consider trying for a pregnancy sooner (fertility also decreases with age).

7. If reproductive issues related to known endometriosis, request urgent or routine gynaecology assessment.

8. If the patient has difficulty managing persistent pain, despite maximal medical and gynaecological interventions:
   • aim for multidisciplinary management and create a GP Management Plan and Team Care Arrangement and/or a GP Mental Health Treatment Plan.
   • follow the Persistent Pelvic Pain pathway.

Referral

- Refer to emergency department or for immediate gynaecology assessment if:
  • severe uncontrolled pelvic pain.
  • known endometriosis with hydronephrosis or bowel obstruction.
- Refer for urgent or routine gynaecology assessment if:
  • significant deep dyspareunia.
  • dyschezia (pain on defecation).
  • suspected endometrioma.
  • known endometriosis with associated reproductive issues.
  • suspected endometriosis that has not responded to adequate medical management.
- Consider requesting:
  • psychological therapy and counselling.
  • women’s health physiotherapy for help with pelvic floor relaxation exercises.

Information

For health professionals

Further information
- Jean Hailes for Women’s Health – Endometriosis Tool
- National Institute for Health and Care Excellence (NICE) – Endometriosis: Diagnosis and Management

For patients
- Jean Hailes for Women’s Health – Endometriosis
- Pelvic Pain Foundation – Information for Women
- The Royal Women’s Hospital – About Endometriosis
References


Select bibliography


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