
Endometriosis

Summary

- Endometriosis can cause the uterus, ovaries, fallopian tubes or bowel to stick to each other at points called 'adhesions'.
 - This can be extremely painful.
 - The exact cause is unknown, but research suggests that retrograde (backwards) menstruation and a family history of endometriosis might increase your risk.
 - Treatment with medication, surgery or both can help the symptoms of endometriosis.
 - Painful periods that impact on your day to day life are not normal, so speak with your GP if you have bad period pain.
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Endometriosis is a condition in which cells similar to those that line the uterus – the endometrium – grow in locations outside the uterus.

The endometrium normally responds to the sex hormones oestrogen and progesterone. In women with endometriosis, these endometrium-like cells growing outside the uterus also respond to these hormones.

During ovulation, the endometrium and the endometrium-like cells thicken. Unlike the endometrium, the misplaced endometrium-like cells cannot leave the body via menstruation. They bleed, cause inflammation and pain, and then heal. Over time, this process can create scar tissue.

Fibrous scar tissue can form on the lining inside the abdomen (the peritoneum), causing the uterus, ovaries, fallopian tubes and bowel to stick to each other. Endometriosis may cause very painful periods and may reduce fertility, but there are a number of treatment options.

Symptoms of endometriosis

The pain of endometriosis can be so bad that it stops you from going to work or school. Usually, it causes pain around the time of your period, but for some women, the pain is almost constant. If you need treatment, you may need emotional as well as physical support.

The symptoms of endometriosis include:

- painful periods
- pain with sex
- pelvic pain
- ovulation pain
- pain in the lower back and thighs
- bowel symptoms – pain using your bowel
- bladder symptoms – pain when passing urine
- reduced fertility
- nausea and lethargy
- premenstrual symptoms.

Many women think that painful periods are normal. If you have bad period pain, see your doctor.

Causes of endometriosis

The causes of endometriosis remain unknown, but research suggests a number of possible causes and risk

factors.

Endometriosis and retrograde menstruation

Retrograde menstruation is also known as 'backward menstruation'. This is when some of the menstrual fluid flows backwards into the fallopian tubes instead of leaving the body through the vagina.

Because the fallopian tubes are open-ended (they are not joined to the ovaries), menstrual fluid can drip into the pelvic cavity. It is suspected that, in women who experience endometriosis, the endometrial tissue contained in the menstrual fluid sticks to whatever structures it lands on (such as the ovaries) and the cells begin to grow.

Endometriosis and the immune system

Retrograde menstruation occurs in almost all women, but only 10 per cent of menstruating women develop endometriosis. One theory suggests that the immune systems of some women allow endometriosis to develop by failing to control or stop the growth of endometrial tissue outside the uterus.

Genetics and endometriosis

Research suggests that inheritance might play a role in the development of endometriosis. Women who have a first-degree relative (mother or sister) with endometriosis are more likely to have the condition.

Risk factors for endometriosis

Some of the suspected risk factors for endometriosis include:

- menstrual cycle factors – including early age of first period (menarche), heavy or painful periods, short menstrual cycles (less than 27 days) and long periods (more than one week)
- allergies – such as food, eczema and hay fever
- obesity
- family history of endometriosis
- exposure to toxins – some research suggests that persistent environmental pollutants, such as dioxins, might contribute to the development of endometriosis.

Reducing your risk of endometriosis

Factors that may help reduce your risk of endometriosis include:

- aerobic exercise for five hours per week – studies show a 50 per cent reduction in the risk of recurrence
- childbearing – for some women, this reduces the risk that endometriosis will recur
- hormones such as the contraceptive pill – prevent ovulation and may suppress endometriosis.

Diagnosis of endometriosis

Diagnosis usually begins with a detailed medical history to help your GP exclude other possible causes of your symptoms. Diagnosis of endometriosis can be difficult. The presence of typical symptoms of endometriosis and pain that does not improve with the usual medications for period pain can indicate the presence of the condition.

If necessary, further tests that can help diagnosis include:

- blood test – might be useful in later stages of endometriosis
- laparoscopy – a surgical procedure performed under general anaesthetic, where a slender medical instrument like a small telescope with a camera attached is used to examine your pelvic organs
- ultrasound – an ultrasound scan uses sound waves to create a video image of your pelvic organs. The scan is done by pressing an instrument against your abdomen (externally) or inserting a probe into your vagina
- colonoscopy – while you are sedated, a medical instrument with a camera attached is used to examine your bowel. This is done if it is thought the endometriosis could also be affecting your bowel.

Endometriosis does not usually show up during an internal pelvic examination. Your doctor may need to refer you to a gynaecologist.

Treatment for endometriosis

There is no known cure for endometriosis, but it can be treated with medication or with surgery. Most of the time, both medication and surgery are used. Some women also benefit from natural therapies.

Removal of scar tissue with surgery is the most effective treatment to lessen the chances of recurrence of endometriosis.

Observation with no medical intervention

In mild cases of endometriosis, it may be possible to simply monitor the condition with regular visits to your GP or gynaecologist. Non-steroidal anti-inflammatory medications such as ibuprofen and mefenamic acid can help to control any associated pain.

A mild condition can become moderate to severe. If symptoms progress, talk over the treatment options with your healthcare professional before making a decision.

Hormone treatment for endometriosis

The endometrium-like cells are sensitive to hormones and respond to cyclical fluctuations of oestrogen and progesterone during the menstrual cycle. This causes bleeding and pain which hormone therapy can sometimes effectively manage.

Options for hormone therapy include:

- **progestins** – these are a group of progesterone-like synthetic hormones that suppress the growth of misplaced endometrium. Side effects may include weight gain, tender breasts, acne, depression, mood swings, fatigue, nausea and vomiting
- **gonadotrophin-releasing hormone (GnRH) agonists** – these are brain hormones that control hormone release in other organs including the ovaries. They can be used to inhibit the growth of the endometrium-like cells. Side effects of GnRH agonists include menopausal symptoms such as hot flushes, dry vagina, night sweats, thinning of the bones, headaches, depression and loss of libido (sex drive). These side effects can be relieved with oestrogen
- **oral contraceptive pill** – this is frequently used to achieve long-term suppression of endometriosis. It may be used to slow the progression of the disease in women with mild endometriosis, or slow the recurrence of the disease following surgical or hormonal treatment.

Make sure you are well informed about the possible side effects of these options before you and your doctor decide on your treatment.

Surgery for endometriosis

Surgical methods used to treat endometriosis include:

- **Laparoscopic surgery** (keyhole surgery) is usually used to both diagnose and treat endometriosis. A slender tube called a laparoscope (which functions as a small telescope) is inserted into the abdominal cavity via a small incision, usually in the umbilicus, and endometrium-like cells, cysts and adhesions are cut out (excision) or burnt (diathermy).
- **Laparotomy** is major surgery. An abdominal cut is used to cut out or burn tissue or cysts. This is occasionally done when complex surgery is required that is unsuitable for laparoscopy.
- **Bowel surgery** may be necessary if endometriosis has developed within the bowel wall.
- **Hysterectomy** (removal of the uterus) may be an option if endometriosis is significantly impacting your quality of life and other treatments have not worked. Recurrence of endometriosis is over 50 per cent if the ovaries remain. If your ovaries are removed during a hysterectomy, you will need hormone replacement because menopause occurs.

Make sure you discuss these surgical options with your doctor before you make a decision, and that you are well informed about the potential benefits and risks.

Combined treatment for endometriosis

In some cases, a woman will benefit from undergoing hormone therapy as well as surgery. Hormone therapy may be offered before or after the surgery, depending on the circumstances.

Endometriosis and complementary and alternative medicine

Some women find natural therapies to be helpful in treating the symptoms of endometriosis. It is important that you always tell your doctor about the kinds of complementary therapies you are using (or considering) as they may affect other treatments that you might be using.

These therapies may help to treat the symptoms you experience:

- herbal medicine
- traditional Chinese medicine
- nutritional therapies
- massage
- yoga.

Where to get help

- Your GP
- Gynaecologist
- **Endometriosis Care Centre of Australia** Tel. (03) 9415 6855

This page has been produced in consultation with and approved by:

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