Endometriosis – investigation, diagnosis and management

Dr Roopendra Banerji
Clinical Director, O&G
GV Health

Endometriosis – Statistics & Awareness

- Frequency of Endometriosis:
  - 1 in 7 Australians assigned female at birth are diagnosed with endometriosis by the age 44 – 49 years.
  - 8.8% of Australians assigned female at birth are estimated to have been diagnosed with Endometriosis by the age 26-31 years.

Endometriosis – New Developments

- Significant publicity and investment in endometriosis recently.
- Specialist Women's Health clinics being set up and specialist imaging services.
- Despite this – the investigation, diagnosis and management of endometriosis has not significantly changed.
- *A significant number of people with endometriosis can be successfully managed in General Practice without ever needing referral to a specialist service.*

Endometriosis – Difference between Endometriosis and Adenomyosis

Endometriosis

- Chronic, inflammatory, gynaecologic disease marked by the presence of endometrial-like tissue outside of the uterus.
- Cause is not fully understood.
- There is no cure.

Adenomyosis

- Tissue that normally lines the inside of the uterus grows into the muscle wall of the uterus.
- It is affected by oestrogen and can occur with or without endometriosis.
- Can by difficult to identify.

Endometriosis – Common signs and symptoms

- Symptoms can vary – from very little or no pain whilst others may have significant pain or reoccurring symptoms affecting quality of life

Commonest Symptoms (associated with 25 to 70% or cases):

- Severe painful periods
- Pain with sex (pain during or after intercourse)
- Infertility
- Pelvic pain
- Heavy menstrual bleeding

Less Common symptoms (associated 10 to 25% of the cases):

- Bowel symptoms
- Severe tiredness
- Back pain
- Sleep difficulty
- Headache
- Urinary symptoms

Endometriosis – Investigation

- Abdominal and pelvic examination
- CST
- STI screen
- Transvaginal pelvic ultrasound is the first line investigation.
- A pelvic MRI can of offered if ultrasound is not available or if deep endometriosis is suspected (Should the GP organize this before referral if the patient can afford it?)
- If transvaginal ultrasound is not possible or appropriate, due to age, sexual history and MRI is not available, then transabdominal ultrasound could be suggested.

Endometriosis – Diagnosis

- Goals of TV U/S:
  - Identify endometrioma
  - Identify endometriosis in the pelvic including including rectosignmoid, pouch of Douglas, bladder and ureters
    Assess for other conditions that could be causing symptoms, and
  - Guide for further diagnosis and treatment

- A pelvic MRI can of offered if ultrasound is not available or if deep endometriosis is suspected.

Endometriosis – Diagnosis

- CT scan should not be used as a primary modality to investigate endometriosis.

- Surgery is not required as a first-line option to diagnose endometriosis.

- Role of imaging at specialist clinics and specialist women's health services – Most patients can be managed by the GP with referral to local radiology services for Ultrasound and local specialist services if second line management is needed. Patient rarely will need referral to tertiary services for diagnosis or management.

- Laparoscopy may be used for definitive diagnosis when the Ultrasound and MRI are normal and patient continues to have symptoms.

Endometriosis – Treatments – 1st Line (General Practice Setting)

- Hormonal treatments are first line:
  - COCP
  - Progestrogens : injection, implant, IUD

- Consider additional interventions including:
  - Analgesics – NSAID's, paracetamol
  - Physiotherapy – course of pelvic physiotherapy may be associated with improvements in pain
  - Psychology – can be associated with small improvements in pelvic pain and quality of life.

- If no improvement after 3 months trial an alternative first line treatment.

- There is little evidence on the benefit of Complementary and Alternative Medicines including medicinal cannabis.

Endometriosis – When to refer

- Initial management of first line treatments is not effective, not tolerated or contraindicated.
- Ultrasound or imaging are suggestive of endometrioma or deep endometriosis.
- Severe, persistent or recurrent symptoms of endometriosis.
- Ongoing concerns about fertility delay.
- Wanting to conceive and difficulty with conception.

Endometriosis – Treatment Details – 2nd Line (Specialist setting)

- 2nd line treatments
    - GnRH agonist or GNRH antagonist

- Role of laparoscopy and surgery if failure of 1st and 2nd line treatments

Type of surgery – laparoscopy vs laparotomy

- Ablation vs excision

- Indications for recurrent surgeries

- When should people be referred locally versus referred to tertiary

- Complex surgeries which include bowel and bladder and other organs

Endometriosis – Management after surgery

- People with endometriosis not trying to conceive should be offered hormonal suppression (minimum 6-12 months) after excision or ablation surgery to reduce disease or pain recurrence (Strong recommendation, Moderate evidence)

Endometriosis – Special Situations – Wanting to Conceive

- Consider referral to a fertility specialist

- May offer excision or ablation with superficial or peritoneal disease at the time of laparoscopy as it may improve the change of a viable intrauterine pregnancy (Conditional Recommendation, Evidence Low)

- Testing for tubal patency

- People with deep endometrosis, there is no evidence that laparoscopy surgery as a treatment option improves fertility outcomes. (Conditional Recommendation) (Conditional Recommendation, Evidence Low)

Adenomyosis – Treatments

- Consider hormonal treatment with:
  - Oral dienogest (Visanne)
  - Oral contraceptives
  - LNG – IUD (Mirena)
  - Etonogestrel implant (Implanon)

- Trial for 3 months, if fails trial an alternative first line treatment.

- If treatment failure continues refer to specialist service.

- There is current no evidence to inform surgical management for adenomyosis.

References

Endometriosis Clinical Practice Guideline - RANZCOG

QUESTIONS?