ENDOMETRIOSIS/ ADENOMYOSIS

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INTRODUCTION

- Endometriosis one of the most common conditions requiring treatment
- Growth of endometrial like tissue outside the uterus
  - Bowel
  - Bladder
  - Pelvis
  - Remote- lungs/ diaphragm
- Disease of reproductive years

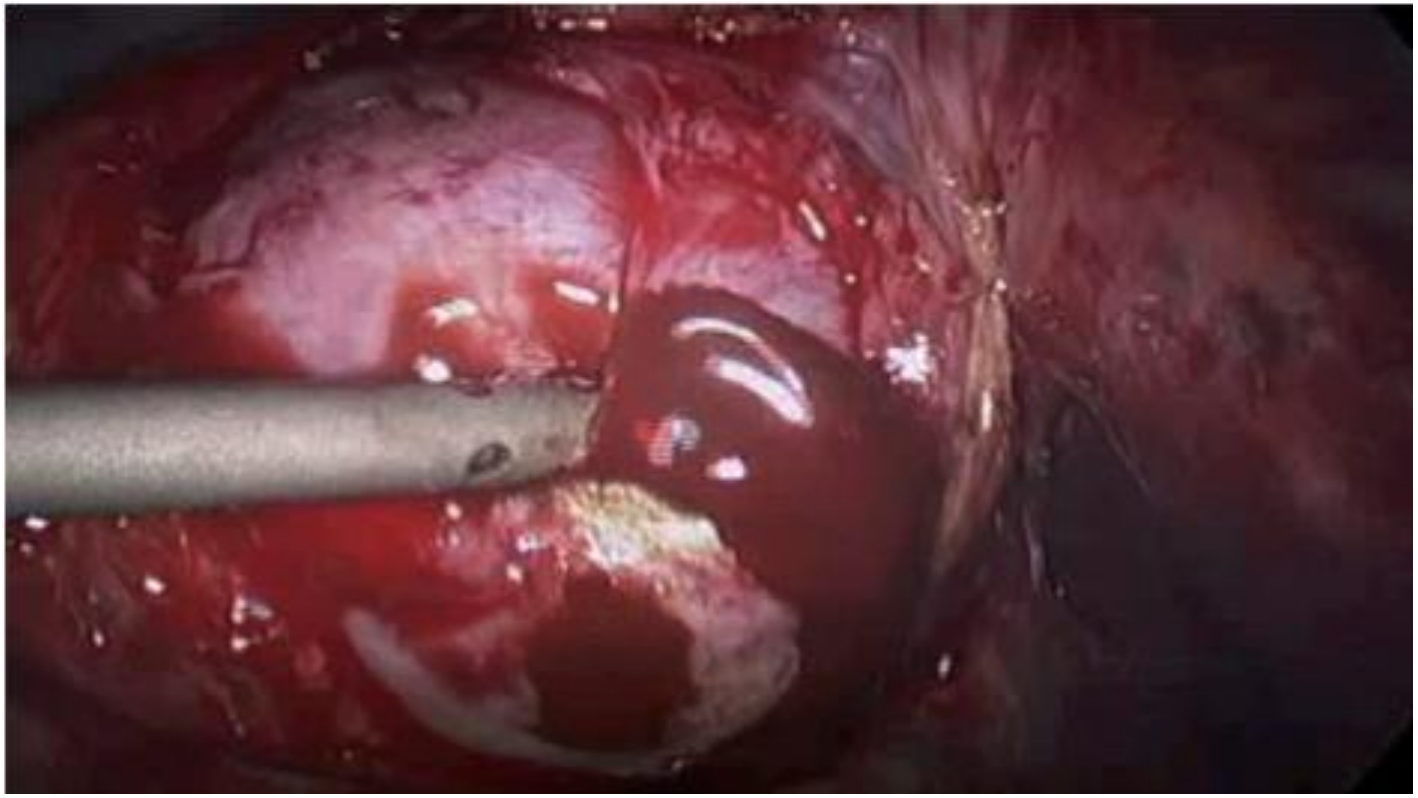
INTRODUCTION

- Lesions can be superficial, ovarian or deeply infiltrating
- Associated with Menstruation
- Hormone Mediated

- Exact cause unknown
  - Retrograde menstruation
  - Metaplasia of embryonic deposits

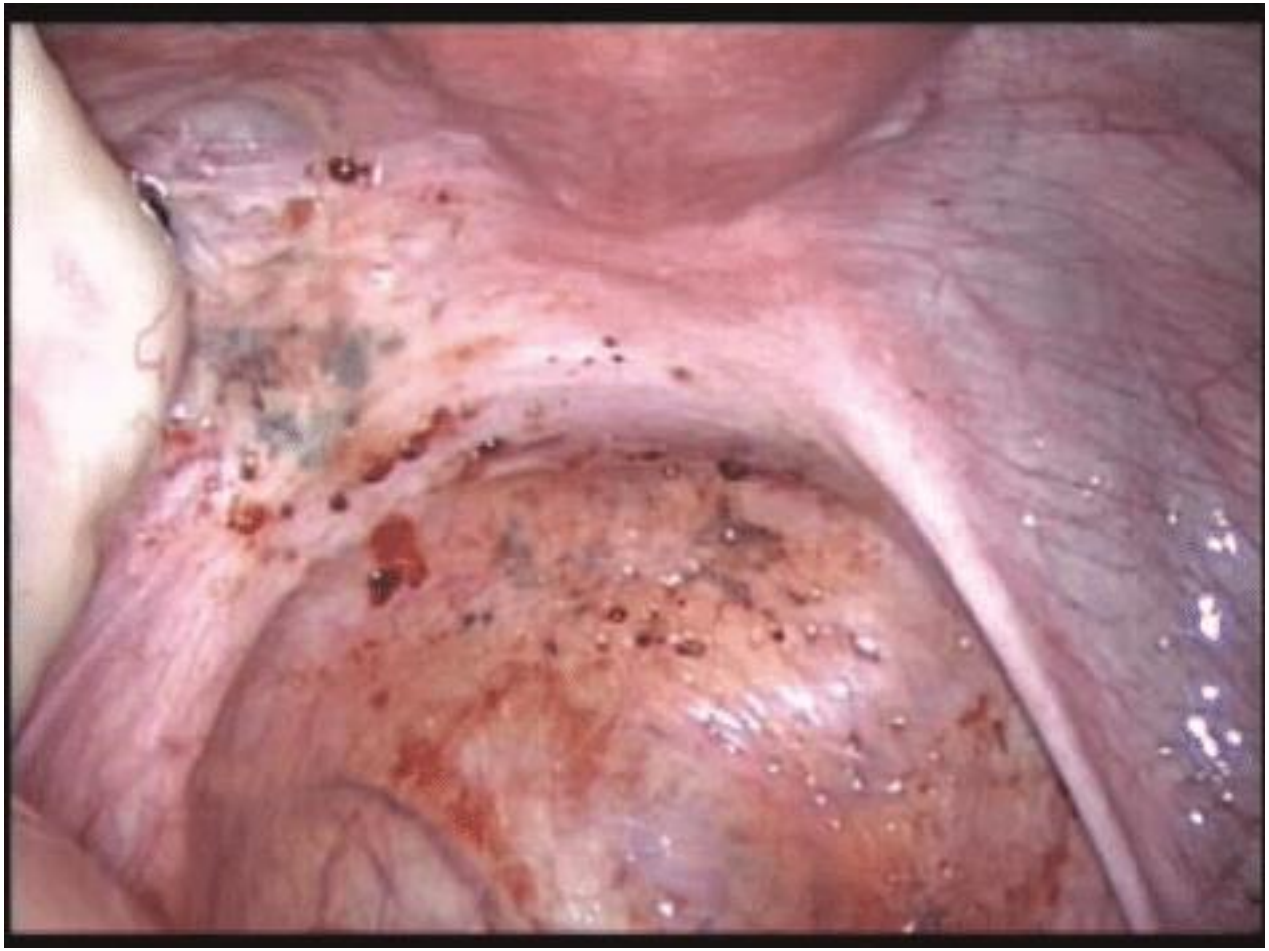
OVARIAN

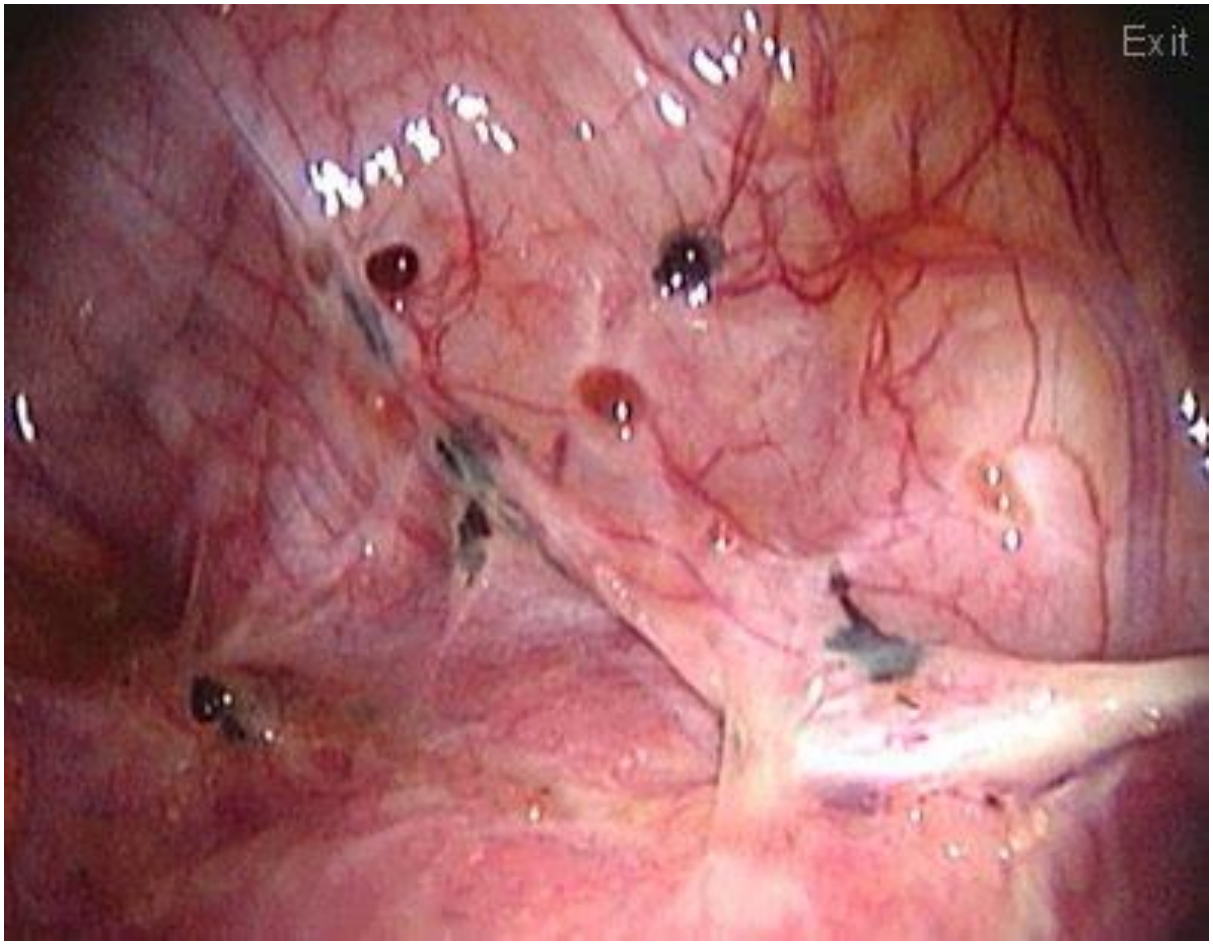
- Endometrioma
- Ectopic endometrial tissue bleeds and forms haematoma
- 30% of cases bilateral
- Fibrous walls
- ‘chocolate’ material
- Can lead to hyperplasia or atypia in cyst lining



DEEPLY INFILTRATING

- Solid nodules >5 mm deep to the peritoneum
- Generally found in rectovaginal septum
- Can infiltrate into other cavities
  - Pouch of douglas
  - Uterosacral ligaments
  - Ovarian fossae
  - Cervix/ vagina
  - Surgical incision sites




Exit

SYMPTOMS

- Pelvic pain
- Dysmenorrhoea
- Dyspareunia
- Subfertility
- Poor quality of life due to pain
- Chronic condition
  - Tiredness
  - Sick days
  - Physical and sexual impact
  - Psychological burden
  - Subfertility

INCIDENCE

- Difficult to determine
- Some women are asymptomatic
  - 1-7 percent of women undergoing tubal ligation had asymptomatic endometriosis
- When surgery was indicated 57% of women had endometriosis
- 50% of women with infertility
- 40% of adolescents with genital tract abnormalities
- 70% Adolescents with pelvic pain

RISK FACTORS

- Nulliparity
- Early menarche
- Late menopause
- Shorter menstrual cycles
- Heavy bleeding

Protective:

- Multiple births
- Extended lactation
- Late menarche
- Race- lower in Afro-carribean
- Ocp

PATHOGENESIS

- Inflammatory changes in pelvis
- Neurologic dysfunction
- Scarring and adhesion formation
  - Subfertility if involving tubes
  - Interferes with sperm motility and fertilisation

PRESENTATION

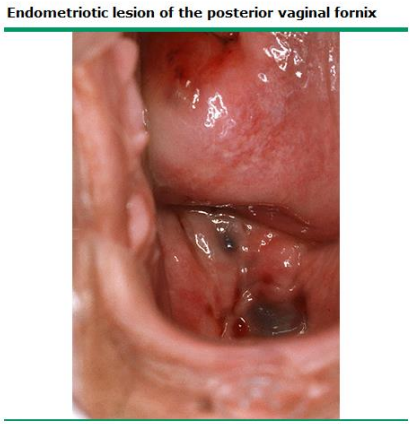
- Pain- 80%
  - Chronic, dull throbbing, sharp or burning
  - dyspareunia
- Dysmenorrhoea
  - 1-2 days before onset of menses
  - Continues till several days afterwards
- Infertility - 25%
- Ovarian mass -20%
- Incidental finding
- Cyclical scar pain
- Back pain

PRESENTATION

- Bowel
  - Diarrhoea
  - Constipation
  - Dyschezia
  - Bowel cramping
  - Rectal bleeding
- Bladder
  - Haematuria
  - Frequency, urgency
  - Colicky flank pain
  - cyclical

EXAMINATION

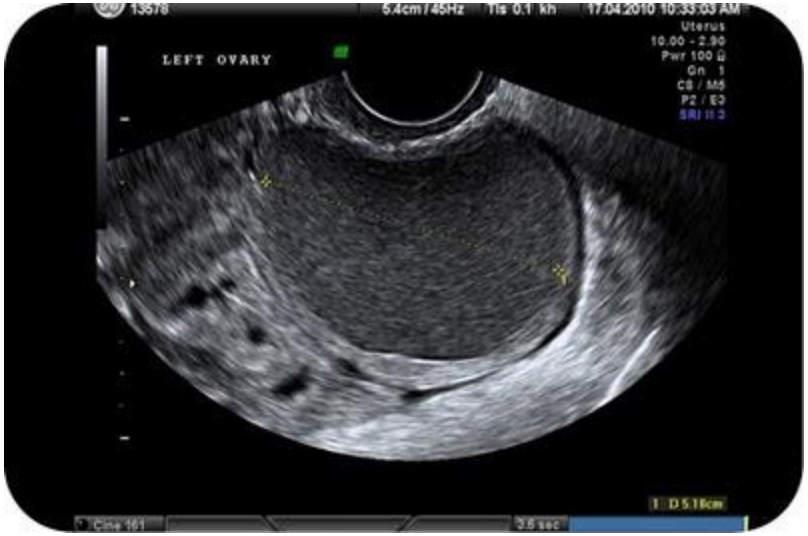
- Variable
- Pain on deep palpation
- Nodules in vagina and fornices
- Lateral placement of cervix
- Visible nodules on speculum



INVESTIGATION

- Imaging
  - Ultrasound scan
  - MRI
  - CT not helpful

- Laboratory
  - Ca 124



MANAGEMENT

- Presumptive diagnosis
  - If history and imaging strong indicators, then could attempt non-surgical diagnosis
  - Examination and imaging non invasive and avoids surgery
- Therapy
  - Combined hormonal contraceptive
  - Progesterone therapy
    - Provera 10 mg bd for 3 months

SURGERY

- Laparoscopy
  - Allows extensive diagnosis
  - Able to treat endometriomas
  - Need to strip capsule to prevent recurrence
  - Allows biopsy for histopathological confirmation
  - Can diathermy active lesions
  - Tubal patency can be carried out at same time

STAGING

- American Society for Reproductive Medicine
  - Stage 1- Mnimal disease
  - Stage 2 – Superficial implants less than 5 cm in aggregate and scattered
  - Stage 3 – Moderate, multiple implants both superficial and deeply invasive with adhesions
  - Stage 4 – Severe, deep implants and large endometriomas

PREGNANCY

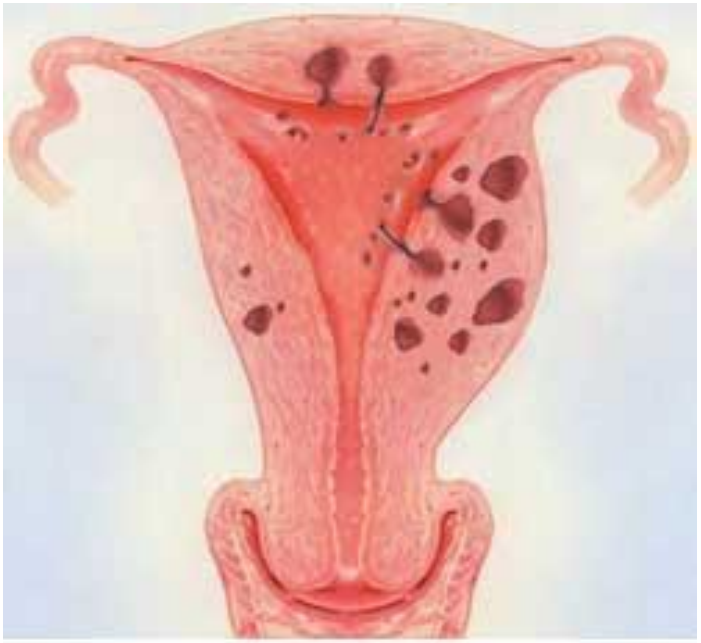
- Lesions and symptoms disappear or improve
- Decidualisation of lesions and altered hormonal environment
- Complications have been reported in pregnancy- very rare
  - Intestinal perforation
  - Haemoperitoneum
  - uroperitoneum,
  - Acute appendicitis
  - Traction of adhesions

LINK TO CANCER

- Endometriosis associated with some epithelial ovarian cancers
  - Overall risk low
  - X3 risk of clear cell EOC
  - X2 risk of endometrioid and low grade serous
  - Risk greater if ovarian endometrioma
  - No increase risk with peritoneal disease

- Use of OCP reduces risk of ovarian cancer.

ADENOMYOSIS



Adenomyosis. Note thickened wall of uterus which can be mistaken for fibroids.

TREATMENT

- Medical
  - NSAIDs
  - Hormonal
    - COC - continually
    - Progestagens – Side effects
    - Mirena coil
    - Aromatase inhibitors
  - GNRH analogues – max 6 months unless with add back
    - Prostap
    - Zoladex
    - Care in younger women with immature bone density

SURGERY

- First line if fertility the main focus
- Laparoscopy or laparotomy
- Ablation or excision
- If endometrioma present then cystectomy rather than drainage
- If family complete and especially if suscpicion of Adenomyosis then hysterectomy is needed

SUPPORT

- Psychological
- Main complaint is late diagnosis
- Refer for fertility treatment sooner
- Information www.endometriosis.org
- Chronic pain advice
- Lifestyle modifications
  - Exercise
  - Avoid too many peroids
  - Reassure re long term use of CHC