

Endometriosis: Diagnosis and Treatment

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“The average onset to diagnosis is about four to eleven years.”



Transcribed directly from MOGCAST Episode 18. Listen here:

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Hi all, it's Edwina Coughlin here from the Western Clinical School at Joan Kirner Hospital and I'm going to give you a quick tutorial which you can listen to on endometriosis. So I'm going to talk about some references to have a look at when you get a moment, which are really good to kind of give you some context and understand clinically endometriosis, but also why it's become a national kind of action plan around it, just because of the impact it has on women.

So, the references are 'A clinical diagnosis of endometriosis, a call to action', and that's by Agarwal et al in ACOG 2019. There's the RANZCOG Endometriosis Guidelines and there's the European Society of ESHRE Guidelines, that's ESHRE, and that's the guideline in 2005 and 2014 on 'Management of women with endometriosis.' And there's also, if you look up jeanhailes.org.au and look up endometriosis, you'll also find some great resources there.

Okay, so what is endometriosis? Well, it's defined as the presence of endometrial-like tissue outside the uterus, which produces a chronic inflammatory reaction. And the exact prevalence of endometriosis is unknown, but it's estimated to range from two to ten percent of women of reproductive age. It's thought that probably fifty percent of women who are infertile have some endometriosis. And some of the symptoms are, you need to have your menstrual cycle really to be having endometriosis, and it's a kind of chronic inflammatory systemic disease that commonly presents as pelvic pain.

So, we know that there's a delayed diagnosis of it because the symptoms are so nonspecific. The average onset to diagnosis is about four to eleven years and it's certainly worse for rural and regional women. There's persistent symptoms, we know that it can really wear down a patient-physician relationship. We know there's a development of central sensitization and chronic pain. We know there's adhesion formation and infertility. And we also know that laparoscopy is often indicated because there's a really poor correlation between symptoms and the extent of disease. And so even at laparoscopy, some women can have endometriosis clinically, so they can have quite significant endometriosis found and very minor symptoms. And other women can have really significant endometriosis, but very, very few clinical symptoms.

So, I think endometriosis is a little bit like preeclampsia. There's a full spectrum of how women present, and I'm sure if you see preeclampsia clinically, you'll see that some women are very, very unwell, and they're actually, their bloods are okay, their babies well grown, but they're very symptomatic. And other women come in and they don't know anything's wrong, but their blood pressure is really high and their baby's really growth restricted.

And so that's like endometriosis. Some women present with really bad period pain, they're not going to work when we go in, and they haven't got really significant disease. And other women only get it picked up when we're trying to investigate them for infertility.

So, if you want to think about endometriosis, you want to think about the presence of symptoms. So often if you think about symptoms, women can have painful periods, painful sex, they can have cyclical painful bowel motions, cyclical painful urination, they can also have in the history, infertility, or always had very painful periods when they were younger. Sometimes they're taking lots and lots of medications for painful period, and there is thought that it, you know, it can run in families. Sometimes I'll have a mother or a sister that's had quite significant endometriosis.

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When you examine them clinically, you can often have a pelvic floor spasm, so they often have a very upregulated pelvic floor, often a lot of pain to touch and a pain around the pelvic floor. And if you do a speculum examination, sometimes it's very painful for them, but sometimes you can notice nodulation at the top of the vagina, or the uterus can be retroverted clinically, and they can have what we call a frozen pelvis. If you saw that on physical examination, that would be really easy to diagnose, and that's often very progressive disease, but often early on it's really just painful periods and painful sex would be the two biggest clinical symptoms that we'd see in a patient's history.

So if we think about some of the management from something like the Jean Hailes Institute, often they would talk about a patient comes to see you, they've got a history of pelvic pain or painful periods, so you're going to take a good history and examination and a pain diary and see kind of how their pain is affecting their quality of life. And then the first line treatment is often to give them some NSAIDs and some Panadol, and you could give that to them at the time of their pain diary, when their pain is really significant, if it's certain parts of the cycle, sometimes it can be mid-cycle pain or it can be at time of menstruation.

And then the first line thing to do is often to try and suppress the menstrual cycle, so one of the simplest things we can do is to give them the combined contraceptive pill, and then clinically we can try and do an ultrasound scan to have a look and see have they got overt, really advanced endometriosis, so an obvious endometrioma or obvious adenomyosis in the lining of the womb, you know, ovaries stuck to the uterus, retroverted uterus, but most frequently the women, you know, like I said, the clinical symptoms don't always correlate with how bad the endometriosis is or also it's quite hard sometimes to pick up early endometriosis, which can be quite debilitating, and so that's the role of a laparoscopy.

So, if we're going to do a laparoscopy, we want to confirm endometriosis and then resect it out completely, or we don't find endometriosis we need to look at some of the other underlying reasons that could be causing a woman's pelvic pain. If we do confirm endometriosis, we resect it out, the next goal of the treatment is to really suppress the endometriosis, so menstrual suppression to stop that endometrium growing back, so that would either be putting a woman on a cyclical combined contraceptive pill, putting in a Mirena or an Implanon. Mirena's are really good because they actually suppress growth of the endometrium, so they're going to really stop the endometriosis or endometrium growing again, and things like Implanon or the combined contraceptive pill, Depo injections, actually suppress ovulation, so they're going to just level out and obviously when you ovulate you're going to have an endometrium that responds to that, so that's why we want to try and really suppress the menstrual cycle.

A lot of these women, just by removing the endometriosis, will improve their symptoms dramatically, but it's important that we continue to engage with these women so that they don't get chronic pelvic pain and continue also with things like ongoing pain management, trying to stop central upregulation. So we know that just like chronic back pain or chronic knee pain, if we don't treat the pain and don't treat the patient holistically and look at all the other ways that this pain is impacting on their life, then they do get worsening of pain and often a lot of central upregulation and they're then at risk of chronic pelvic pain, so you can often use short courses of things like Amitriptyline or Duloxetine Pregabalin.

Physiotherapy is incredibly useful to help with pelvic floor tension, so I often talk to patients about spraining

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their knee or hitting their back. Often the disc issue or the knee issue is one thing, but it's the muscular spasms around their knee or their lower back that causes them a lot of pain, and if you've got endometriosis in the pelvis and your periods have been really painful and sex is painful, then your pelvic floor is often very upregulated, so a good women's physio will help with down-regulating pelvic floor spasms, helping women to open their bowels and urinate effectively, allowing them to return to having pain-free sex and also just long-term helping with their pelvic floor.

And then we know that chronic pain is going to wear people down mentally and often has had huge impacts on relationships and work, and so there's the importance of involving a psychologist to help with chronic pain management. And we really want to avoid recurrent surgery, so we don't want surgery to be the only treatment for these women. So, while surgery is very important for either diagnosing and treating and resecting endometriosis or confirming there's not endometriosis, it's not the only goal of care. That's why it's so important to go and see a specialist that's going to engage with them and see them regularly and going to kind of help manage all the disciplines together.

So, if I'm going to run through some cases really quickly. First of all, we'd have a 17-year-old who presents with dysmenorrhea, heavy periods, bloating, fluctuating bowel symptoms, so diarrhea and constipation. She's never been sexually active because of pain. She doesn't go to school, and she tells you that her mother had endometriosis and issues with fertility, haven't done a pelvic exam because she's not sexually active yet. A transabdominal scan shows no pathology, normal pelvis. So, for her we're going to recommend self-care, heat packs, exercise, NSAIDs and then the first-line treatment for someone like her is going to be hormonal suppression with either the pill, Implanon or a Depo and that would be often done in the primary care setting. And then if her pain persists then you would consider referring her to a gynaecologist, adding in some more pain medication or also doing a consideration of a laparoscopy and inserting a Mirena to try and suppress her pain.

If we think about it, another case of a 27-year-old who's got deep dyspareunia and cyclical dyschezia, she goes to see a gynaecologist. On pelvic exam she's got a retroverted uterus, she's got nodularity which you can feel in the uterosacrals, she's got a tender pelvic floor, really upregulated and ultrasound scan shows a retroverted uterus, a mobile right ovary, very tender and then nodularity and thickening on her uterosacrals and looking for the presence of a sliding sign and that's looking for like the bowel not to be kind of attached to the back of the uterus.

Now again the first-line treatment is going to be heat packs, NSAIDs, regular exercise, talking to a woman's physio but we're going to try and see if we can improve her pain control with the pill or an Implanon or Depo. But if she doesn't, you know, based on those symptoms of deep dyspareunia and dyschezia, a laparoscopy will be warranted to try and excise and treat any endometriosis and then remember long-term it's going to be important if you did find endometriosis to suppress ongoing ovulation with progesterone either orally or Mirena and then continue with pain management, ongoing physiotherapy and then talk about the possible implications long-term for fertility with endometriosis.

Okay so take-home messages really for this quick audio tutorial is that endometriosis; very non-specific signs, delayed diagnosis, that the first-line treatment is really to try and suppress menstruation and see if that

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improves the woman's symptoms. If not, referring to a gynaecologist, thinking about a high-level scan and clinical examination.

Remember you don't always have clinical signs of endometriosis, but it can be there. Laparoscopy tends to be the gold standard but if you're going to do a laparoscopy you want to make sure that you excise the endometriosis and then you want to suppress any endometrium from growing back as long as possible. It's a multi-modal team that needs to manage these women so physiotherapists, pain specialists and also psychologists and there can be implications on a woman's future fertility and so it's important to talk to them about that.

In saying that, not all women who have endometriosis have issues with infertility but if I did see a young woman with endometriosis I'd make sure I told her that long-term if she's not pregnant when she wants to try, that she needs to make sure she tells the GP or her gynaecologist about endometriosis as it could be an underlying cause and she might need some more investigations.

I hope that was a useful tutorial. Good luck with the rest of your studies and I hope to run into lots of you at the Western Clinical School at Joan Kirner

Thanks, bye.