Endometriosis

Endometriosis is the presence of endometrium (the lining of the uterus that women menstruate every cycle) in locations outside of the uterus. Changes in these cells can be associated with bleeding and pain. The exact reason for the development of endometriosis is unknown.

Inheritance

A tendency to inherit endometriosis has been identified; 8-10% of women with endometriosis have first degree relatives (mother or sister) with the disease. Women in affected families develop endometriosis at an earlier age and are more likely to have advanced disease.

Physical Findings

On examination, your physician can sometimes feel changes in the pelvic structures that may suggest you have endometriosis. These changes include the presence of cysts on the ovaries, scarring around the uterus, and painful nodules (bumps) around the support ligaments to the uterus.

Diagnosis

Laparoscopy surgery is the only definitive way to make a diagnosis of endometriosis. The smallest areas of growth appear as blue-black raised lesions covering the surfaces of the internal organs. Larger lesions can form cysts in the ovaries called endometriomas. There is no blood test available to detect endometriosis.

Therapy

For infertile women with endometriosis, the infertility evaluation should be completed and all potential factors contributing to infertility should be addressed. Endometriosis can be treated with either medications or surgery. A variety of different drugs have been used to treat endometriosis. The role of medications in the treatment of infertility is limited and the following medications have been shown to be effective in control of pain due to endometriosis.

Oral contraceptive pills (birth control pills)

Treatment with estrogen and progesterone combination hormone therapy (oral contraceptives) has been used in order to create a stable hormonal environment that does not stimulate endometriosis. By establishing such a hormonal state, endometriosis has been found to stop growing and symptoms can resolved partially or completely. In general, oral contraceptive pills are the first-line therapy. Therapy with medication alone is most beneficial in mild to moderate disease. Pain is usually relieved and in over 75% of patients, an improvement of disease has been observed.

Other oral medications include Provera, Depo-Provera and Danazol. Such medications are options but not used often because of the side effects. Indications for these medications are individualized for your personal medical situation and should be discussed in detail with your SRM physician.

Leuprolide Acetate

Leuprolide Acetate (Lupron® injection or Lupron Depot®) is a hormone-like medication taken as a daily or monthly injection. The drug works by blocking the release of specific hormones from the pituitary gland. This down regulation forces the ovaries into a dormant state. Ovulation does not occur and endometriosis lesions tend to regress.

Therapy usually lasts between 3 and 6 months. Treatment is typically combined with a low-dose hormone regimen to prevent hot flashes and reserve bone mass.

This therapy will keep you from becoming pregnant while on the medication. However, you should not rely on this as a method of contraception, and you should use a barrier method of contraception during this treatment such as a diaphragm or condoms.

Potential Benefits

The goal in treatment of endometriosis is to improve the symptoms, such as severe menstrual cramps, pain with sexual intercourse, pelvic pressure and pelvic pain, and /or bowel and bladder problems. Since endometriosis depends on estrogen, the medications may dissolve the spots of endometriosis and /or shrink any ovarian cysts related to this condition (endometriomas). After therapy, endometriosis may grow again, so follow-up examinations are necessary.

Surgery

Surgical removal of areas of endometriosis involves laparoscopy, a procedure done on an outpatient basis. Medical and surgical treatments are sometimes combined in order to try and prevent the disease from coming back.
Endometriosis can be difficult to deal with because of its recurrence. In general, the more severe, the greater chance that it will come back.

Potential Risks and/or Side-Effects

- Temporary discontinuation of menstrual periods
- Temporary mild worsening of the disease early in treatment
- Bone loss, which is usually reversible, has been shown to occur after a 6 month course of therapy
- Headaches, hot flashes, vaginal dryness, mood swings, and local skin reaction or bruising around injection site

Conclusion

Management of endometriosis is individualized to each patient. Your physician will review the specific recommendations in your situation whether it is the treatment of pain or infertility due to endometriosis.