key points

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Endometriosis is defined as the presence of endometrial-like tissue outside the uterus. Deposits are commonly distributed on the ovaries, uterosacral ligaments, pouch of Douglas, rectum and sigmoid colon, bladder and ureter. Endometriosis is common affecting 10% of the female adult population and up to 50% of women with infertility.

Risk factors include early menarche, late menopause, delayed childbearing, vaginal outflow obstruction and a first-degree relative affected. Women commonly present to their GP with pelvic pain, painful intercourse or subfertility. Classically the pain starts several days before the period which is extremely painful. After the period, symptoms tend to improve until mid-cycle when the pattern repeats again. Women with endometriosis also complain of fatigue.

Abdominal palpation, bimanual and speculum examination are important to identify signs of endometriosis, but also to exclude alternative diagnoses such as fibroid uterus, infection or pregnancy. However, a normal examination does not exclude a diagnosis of endometriosis. Serum CA125 can be raised in endometriosis, but is not specific or sensitive for the condition and is therefore not recommended as a screening test. A normal pelvic ultrasound scan does not exclude a diagnosis of endometriosis. The gold standard investigation for endometriosis is laparoscopy and biopsy with histological confirmation.

There is good evidence that NSAIDs improve pain in primary dysmenorrhoea. The combined oral contraceptive pill reduces endometriosis-associated dysmenorrhoea, dyspareunia and non-menstrual pain. A number of studies have demonstrated a significant reduction in pain with a levonorgestrel-IUS. Referral should be considered if pain is not controlled with simple analgesia or the diagnosis is suspected in a woman who is actively trying to conceive. Early referral should be considered in women with abnormal examination findings, or an abnormal ultrasound result. An ovarian endometrioma is predictive of more extensive endometriosis.

Management in secondary care will typically involve diagnostic laparoscopy with primary treatment of visible endometriosis with diathermy or excision and ovarian cystectomy for ovarian endometrioma. Hysterectomy will not necessarily cure endometriosis pain. Surgical oophorectomy combined with hysterectomy may provide a permanent solution. Endometriosis can recur after medical and surgical treatment with symptoms typically returning one to five years after treatment. There is no evidence that endometriosis causes cancer or increases the overall incidence of cancer.