Specialists In Reproductive Medicine & Surgery, P.A.

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Endometriosis Awareness Week/Month
Common Questions and Answers

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What is endometriosis?

When cells from the inner lining of the uterus are found outside of the uterine cavity, it is called endometriosis.

How does endometriosis occur?

When women menstruate, not only does blood and tissue flow down through the cervix and out the vagina but some of the menstruation also flows back through the Fallopian tubes in a retrograde fashion into the pelvic cavity. Some of these uterine lining cells implant and grow on various pelvic structures resulting in endometriosis. Normally, the immune system sweeps out these islands of endometriosis each month but, for reasons that are uncertain, some lesions will survive and grow. Each month, when a woman menstruates, these same islands of tissue swell and bleed. Over time and repeated menstrual cycles, these islands of tissue invade into nearby structures causing symptoms and damage to the pelvic organs.

How common is endometriosis?

In fertile women, a very small amount of endometriosis may be present at any time in about 1/3rd of the patients. It is found in 70% of reproductive age women with significant symptoms and even in 50% of symptomatic women 18 years and younger. Inpatients with “unexplained infertility”, about 50-70% will have endometriosis.

What kind of symptoms may I have if I have endometriosis?

Endometriosis may cause pelvic pain, painful periods, painful intercourse and infertility. Intestinal symptoms, back pain and urinary symptoms may also occur from endometriosis making it more difficult to differentiate endometriosis from other diseases. As a hint, most symptoms tend to be cyclic with worsening in the week or two just leading up to menstrual bleeding.

How is endometriosis diagnosed?

Classically, endometriosis is diagnosed at the time of surgery. In the past, endometriosis was often diagnosed and treated by inpatient open laparotomy incisions. Nowadays, it is far more common to diagnosis and treat endometriosis though an outpatient laparoscopy procedure.

Advanced endometriosis may be suspected by a transvaginal pelvic ultrasound although endometriosis truly remains a surgical diagnosis.

Where is endometriosis usually found?

As retrograde flowing menstrual fluid settles in the pelvis, the cells of the lining of the uterus tend to attach to non-moving structures. Finding endometriosis on the inner peritoneal surfaces and nearby ligaments is common.

Endometriosis is an estrogen-dependent disease, so the cells also flourish when they attach to the ovaries, often causing the greatest physical damage. Endometriosis is infrequently found on moving structures such as the Fallopian tubes and intestines.

Endometriosis has been found in numerous other locations in the body as these cells somehow find an unusual position and take up residence.

How does endometriosis cause infertility?

These inappropriately placed islands of tissues seem to release or result in the production of substances that are toxic to eggs, sperm and embryos. Numerous theories exist as to exactly how this occurs but none have been conclusively proven.

In the more advanced stages, endometriosis can cause significant physical damage to the pelvis. Severe pelvic adhesions may prevent the egg from being released from the ovary. The anatomical damage may also interfere with the pick up of the egg by the Fallopian itself.

How do you diagnose and treat endometriosis?

Endometriosis is diagnosed by surgery. Gone are the days when the surgeon simply looked inside and diagnosed the disease without treating it at the same time. Commonly, outpatient laparoscopy is used to both diagnose and treat the disease. Fortunately, about 80-90% of patients will have an improvement of their symptoms following surgical care.

The treatment of endometriosis is surgical. If the lesions are very superficial, simple cautery will generally destroy the smaller lesions. Many lesions of endometriosis, however, burrow deep into the tissues requiring excision of the entire segment. If lesions that are deeply invading undergo simple cauterization of the surface cells, the lesions and symptoms tend to return rapidly. Surface cautery for deep lesions is just like cutting off the top of a weed, which results in the weed sprouting once again a very short time later.

Collections of endometriosis within the ovaries are called endometiomas or chocholate cysts. These cysts need to be removed and not just drained. There is a higher degree of skill needed by the surgeon to treat the more advanced stages of endometriosis.

Sometimes, in severe cases, removal of the ovaries becomes necessary and cures most patients.

Will medication treat endometriosis?

If you do not want to conceive, it is probably best to stop your menstrual cycles. The most common way of doing this is taking hormonal contraceptive medication in a continuous fashion to prevent menses. Pain medications may be necessary although should be taken within prescribed dosages.

Temporary menopause can be induced with the administration of Lupron™. Unfortunately, the lesions simply don't disappear although they do grow smaller. The lesions are generally return to their pre-treatment size within three months of the Lupron ™ wearing off. Because of the significant menopausal symptoms during treatment and the potential for bone loss, one should use Lupron™ sparingly.

A newer group of medications called aromatase inhibitors may be useful in some of the more challenging patients. These medications prevent the conversion of the hormone testosterone to estrogen, which occurs naturally in the body. The endometriosis lesions are often dependent on estrogen, so symptoms may improve with this treatment because the estrogen levels drop. Testosterone levels increase slightly protecting bone and libido but not enough to cause extra facial hair growth. This experimental treatment is usually reserved for women who have had their pelvic organs removed, seem to have a recurrence of disease and conservative medical treatment has failed.

Is it important to stage my endometriosis?

Staging the disease is very important in determining the prognosis and treatment plans. There are four stages of endometriosis, stage I (minimal), stage II (mild), stage III (moderate) and stage IV (severe). Any woman less than 25 years old diagnosed with endometriosis, especially in the more advanced stages, may be at risk for additional surgeries or more aggressive treatments.

Are the symptoms I am having related to the stage of endometriosis?

The stage of the disease is not related to your symptoms. A patient with severe symptoms may have stage I disease and patients with stage IV disease may not have any symptoms at all. Staging, however, becomes very important in deciding infertility treatment plans.

According to more recent studies, symptoms may be more associated with the depth of invasion of the endometriosis than the stage of the disease. The deeper the invasion, the worse the symptoms.

How do you treat my infertility caused by endometriosis?

Careful surgery in the lower stages of disease has clearly been shown to modestly improve natural pregnancy rates, at least during the first eight months following surgery.

If natural means fail following surgery, stages I-III may be treated with ovulatory medications combined with intra-uterine inseminations (IUI). Stage IV patients are best treated with in vitro fertilization (IVF). Unfortunately, the disease may return faster than pregnancy occurs so one does not want to waste time in advanced stages. IVF often results in excellent pregnancy success rates, no matter what the stage of disease.

When should I see my doctor?

You should see your physician when your symptoms are affecting your life. If the painful periods keep you home from work or school, if the painful intercourse results in being with your partner less frequently or if the pelvic pain is causing you to take pain medications frequently, you should see your Obstetrician/Gynecologist.

Why would I see a Reproductive Endocrinologist for my endometriosis?

If you have symptoms such as painful intercourse, painful periods or pelvic pain and are also experiencing infertility (inability to conceive after 12 months of trying), you may benefit from seeing a Board Certified Reproductive Endocrinologist. This is especially true if you are also above the age of 35.

Regardless of your age, if you are found to have stage III and IV disease and still want to keep your pelvic organs, a Reproductive Endocrinologist may be able to give you a more complete set of options.

If you have completed childbearing, debilitating symptoms and significant or recurrent disease, your Obstetrician Gynecologist may want to offer a hysterectomy with removal of your ovaries. Most Reproductive Endocrinologists do not perform this type of surgery. This surgery, under most circumstances, can result in a cure of the disease.

Will pregnancy cure my disease?

If you have stage I or II endometriosis, pregnancy combined with breast feeding will often delay the recurrence or may, in some cases, result in a total cure of the disease. A delay of recurrence is commonly found even in the more advanced stages of the disease but cure is less frequently found.

Is there anything new on the horizon with endometriosis?

There is some promise of the following in the treatment of endometriosis:

- The anti-progesterone RU486 (mefipristone) is under study.
- Progestin-impregnated IUD's (Mirana™) may be useful.
- Screening laboratory tests are being tested to diagnose the disease rather than surgery.
- Genetic studies are underway to determine if specific gene mutations that leave some women susceptible to endometriosis.

Additional Links:

Endometriosis Association: http://www.endometriosisassn.org/endo.html

Women's Health (US Government): http://www.womenshealth.gov/faq/endometriosis.cfm
American College of Obstetrics & Gynecology: http://www.acog.org/
Endometriosis Research Center: http://www.endocenter.org/

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Updated 3/7/2010
C:\docs\review\Endometriosis Awareness Week-Month, Common Questions and Answers.doc
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