

HOSPITAL PHYSICIAN®

OBSTETRICS AND GYNECOLOGY BOARD REVIEW MANUAL

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The *Hospital Physician Obstetrics and Gynecology Board Review Manual* is a peer-reviewed study guide for residents and practicing physicians preparing for board examinations in obstetrics and gynecology. Each manual reviews a topic essential to the current practice of obstetrics and gynecology.

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Nonsurgical Management of Endometriosis

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Table of Contents

Introduction	2
Approach to Diagnosis of Endometriosis.....	2
Management of Endometriosis.....	7
Conclusion	11
References	11

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Nonsurgical Management of Endometriosis

Gerald J. Harkins, MD

INTRODUCTION

Endometriosis is the presence and growth of functioning endometrial tissue in places outside the uterus, most commonly the ovaries, the pouch of Douglas, and the pelvic peritoneum. Clinically, endometriosis can cause pelvic pain (which may be chronic), dyspareunia, dysmenorrhea, and infertility.

The prevalence of endometriosis is 38% in infertile women¹ and 70% in women with chronic pelvic pain.² There may be a familial association with endometriosis. Patients with an affected first-degree relative have an almost seven-fold increase in the risk of developing endometriosis.³

Although the factors leading to endometriosis are unclear, leading theories include lymphatogenous spread, coelomic transformation or metaplasia, and the Sampson hypothesis,⁴ which posits that retrograde menstruation causes hematogenous spread (**Figure 1**). Survival of endometrial glands in the pelvic cavity is poorly understood, but it appears that the ectopic endometrial cells may be able to resist apoptosis.⁵ Endometriosis may be linked to autoimmune changes as well. There is also increasing evidence of alterations in cell-mediated and humoral immunity in patients who develop endometriosis. Some patients with endometriosis may demonstrate decreased T-cell and natural killer cell cytotoxicity. This alteration may lead to decreased capacity of the immune system to remove the ectopic endometrial cells.⁶

This manual reviews the most common presentations of women with endometriosis, with a focus on physical examination, diagnostic testing, and evaluations available for the practitioner as well as the medical treatment options for endometriosis and its resultant pelvic pain. The treatment of infertility related to endometriosis and surgical interventions for endometriosis and pelvic pain are beyond the scope of this review.

APPROACH TO DIAGNOSIS OF ENDOMETRIOSIS

CASE PRESENTATION

History

A 21-year-old Caucasian woman, gravida 0, is referred to a gynecologist by a family medicine physician after complaining of many months of increasingly painful menses and pain in the week prior to the onset of her menses. She is a new patient and completed the International Pelvic Pain Society's (IPPS) Pelvic Pain Assessment Form as part of her intake evaluation.

The patient is a generally healthy young woman with no significant prior medical or surgical history. She reports no prior hospitalizations and she had a normal growth and development history. The patient began menstruating when she was 12 years old and reports a long history of painful periods. By age 16 years, she consistently missed school on the first day of her menstrual period. At her mother's suggestion, she was evaluated by her family physician for pelvic pain and excessively painful menses. She remembers this being her first gynecologic examination. At the time, she was not sexually active. Tests were completed to rule out sexually transmitted diseases and bladder infection. She was subsequently informed that nothing was wrong and that the pain was comparable to what is normally associated with menstruation. She has continued to experience pelvic pain with menstruation since that time, but she has not sought another evaluation for painful menses.

At this time, she is seeking further evaluation due to the worsening symptoms of severe pain and cramping in the first days of her period. She denies any spotting or bleeding between her menstrual cycles. Although she denies dyspareunia, she avoids sexual activity the week prior to her menses due to feeling "bloated and crampy." The patient is a single nonsmoker who is