ENDOMETRIOSIS

"He who knows endometriosis knows gynecology."
Sir William Osler

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Definition

Growth of endometrial tissue outside the uterine cavity, associated with infertility, abnormal uterine bleeding, and pain.

Introduction

Endometriosis is one of the most commonly encountered diseases in the reproductive-age female. Endometriosis occurs when endometrial tissue grows somewhere outside the body of the uterus---usually elsewhere in the reproductive tract (i.e. on the ovaries). A growth of endometrial tissue outside the uterus, it is thought to occur in about 15% of women.

Despite its prevalence, however, endometriosis remains one of the most enigmatic disorders encountered by the gynecologist. The uterus (womb) contains a lining, which is referred to as the endometrium. This special lining grows in the uterus each month for the purpose of nourishing a fertilized egg. The endometrium also provides nourishment for the developing fetus. The endometrium growth occurs in response to a complex cycle of hormones produced by the pituitary gland and the ovaries. If the endometrium is not used (egg is not fertilized), then it will be shed through the process of menstruation. Women who do not get pregnant until later in life are more likely to have the disease. The average age of women found to have endometriosis is 37. Pregnancy seems to prevent or correct this problem in most of the cases.

Epidemiology and Prevalence

The typical age at which endometriosis is diagnosed appears to be in the range of 25 to 29 years. Endometriosis is extremely rare in premenarche. Its occurrence rate in adolescents is unknown, but it appears not to be rare in the teenage years. In two studies of women under age 20 with chronic pelvic pain or dysmenorrhea unresponsive to medical therapy, endometriosis was found at surgery in 47% to 65% of cases. Endometriosis is commonly believed to be rare in menopausal women. However, 2% to 4% of all women requiring laparoscopy for endometriosis are postmenopausal. Although most of these patients are receiving hormonal replacement therapy, this is not true in all reports.

Symptoms

Endometriosis is associated with a variety of symptoms. However, there is no truly consistent pattern to these symptoms, and many affected patients are entirely asymptomatic.

Today, the symptoms most likely to bring the patients with endometriosis to the physician's office are:

1. Pain during or following sexual intercourse.
2. Pelvic pain. This particular expression of the disease may take on many forms. Dysmenorrhea is reported in 25% to 67% of women with endometriosis. Good evidence of the disease is secondary dysmenorrhea. In patients with a history of primary dysmenorrhea, increasing severity may be a clue that endometriosis is present.
3. Infertility
4. Dyspareunia is also common, generally reported in approximately 25%. The greatest incidence of dyspareunia is seen in association with uterosacral ligament involvement.
5. Other types of pain are also reported: noncyclic lower abdominal pain in 25% to 39% and backaches in 25% to 31%.
6. Dysfunctional uterine bleeding is often linked with endometriosis.
7. A diverse array of symptoms may result from implantation of endometrium on the pelvic viscera. Thus, endometriosis may result in bowel-related symptoms, such as tenesmus or dyschezia, or urinary tract symptoms, such as dysuria, frequency, or urgency.
8. Finally, endometriosis at remote sites may produce unusual site-specific complaints: examples include pleuritic pain due to pulmonary involvement and seizures secondary to brain lesions.

Physical Findings

A physical finding associated with endometriosis is variable and dependent on the severity and location of disease as well as the character of the population under study. Common findings include:

1. Nodularity or tenderness of the cul-de-sac (a blind pouch),
2. Parametrial thickening, and
3. Adnexal masses (tissue or structures in the body that are next to or near another structure. The ovaries and the uterine tubes are adnexa of the uterus, for example.).
4. A retrodisplaced uterus, often fixed, has been frequently noted.
5. Cutaneous lesions may even be present, with likely sites being vagina, perineum, umbilicus, and within surgical scars.
6. Rarely, significant ascites may be observed.

As disease manifestations often become more pronounced and areas of ectopic endometrial implantation tenderer during the menses, it is often useful to examine the patient during the perimenstrual period.

Diagnostic Methods

Three classes of techniques have been used to diagnose and observe women with endometriosis: **serum immunology, imaging, and laparoscopic examination** of the peritoneal cavity.

However, Laparoscopy remains the optimal diagnostic method for endometriosis. But the value of this modality is directly dependent on the ability of the surgeon to recognize the lesion when visualized. This is due to the great variety in appearance characteristic of endometrial lesions.

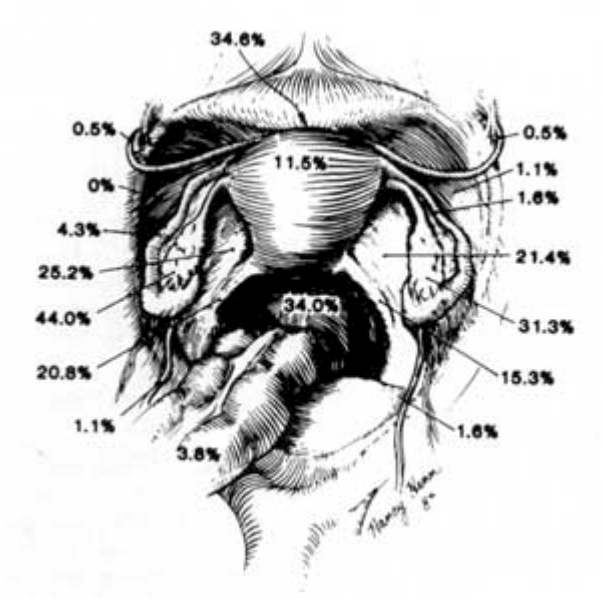

Fig: Anatomic distribution of endometriotic implants in 182 infertility patients found to have endometriosis at laparoscopy. The rates shown indicate the percentage of all with implants in a given locale. (From Jenkins S, Olive DL, Haney AF. Endometriosis: Pathogenetic implications of the anatomic distribution.)

Treatment

Treatment of the endometriosis depends on the following factors:

Extent of Disease: It is widely believed that endometriosis is a relentlessly progressive disease. However, longitudinal data in untreated women tend to dispute this concept. In 17 such patients observed for 6 months, 29% showed a decrease in the extent of the endometriosis (based on the revised AFS score), 24% demonstrated no change, and 47% showed a worsening of disease.

Because determination of extent of disease is by nature subjective, it can be subject to ascertainment bias on the part of the investigator. This is evidenced by one treatment trial demonstrating a decrease in adhesions as assessed by the surgeon at laparoscopy following medical therapy. This effect was not present when photographic documentation was used in a similar trial. Thus, ascertainment

bias can play a significant role in subjective study results and must be accounted for.

Pelvic Pain: Pain is a truly subjective phenomenon that is dependent on a complex interaction of patho-physiologic and psychologic factors. It is difficult to quantify, and even more difficult to evaluate, results of treatment because the types of pain are heterogenous and an effective classification of endometriosis-related pain has yet to be established.

Two other factors are critical to evaluating pain related treatment trials. First, relief of pain symptoms may be time-dependent. Although pain relief may be substantial at the conclusion of therapeutic intervention, once treatment is discontinued, a recurrence rate is inevitable. Evaluation of this recurrence is essential to proper evaluation of the therapeutic agent.

Second, there is generally a substantial placebo effect in the treatment of pain. Most types of pain symptoms respond to placebo, at least temporarily, at a rate of roughly 30%. However, placebo treatment of endometriosis-associated pain has shown a partial response of up to 55% of those affected. Proper evaluation of treatment of this symptom must take such a response into consideration.

Infertility: Although infertility has been associated with endometriosis, except in extreme cases of extensive pelvic adhesions with tubal obstruction, the infertility is not absolute. In the majority of such women, there is a relative decrease in fertility reflected in a lower (but finite) rate of conception than that seen in the general population.

Homoeopathic Treatment

Pain during intercourse: Sepia, Lyssin, Arg Nit, Ferrum Phos, Cal Phos, Berbersi Vulg, Kreosote, Hepar Sulph, Kali Carb, Kali Bich

Pain follows intercourse: Kola, Nat Mur, Platina, Staphisgaria, Sulphur, Rhus Tox, Sabina

Dysmenorrhea: Belladonna, Cactus G, Chammomilla, Cimicifuga, Erigeron, Mag Phos, Kali Carb, Vibernum O, Xanthoxyllum, Psorinum, Ustilago

Infertility: Borax, Sepia, Natrum Mur, Graphites, Pulsatilla, Medo.

Obstruction of Fallopian Tubes: Eupion

Pelvic adhesions: Thuja, Cal Carb, Sepia, Nitric acid.

Ovarian Cyst: Apis Mel, Iodum, Palladium, Lachesis, Sulphur,Belladona

Uterine Tumors: Cal Carb, Cal Flour,Terebinthina, Fraxinus am, Aur Mur Nat, Crot Hor, Phos, Silicea, Secale cor.

Dysfunctional Uterine Bleeding: Bell, China, Cal Carb, Ferum Met, Crocus, Ipecac, Hamamelis, Millifolium, Phos, Platina, Puls, Sabina, Secale cor, Psorinum, Sepia

Displacement of Uterus: Sepia, Lillium tig, Bell, Nat Mur, Puls, Cal Carb, Phos, Seneco, Thuja.

WARNING!

Under no circumstances the medicines provided in this article should be taken on your own. This information is for educational purpose only!