ENDOMETRIOSIS
TREATMENT STRATEGIES

THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA
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The right solution for you will depend on your age, how your symptoms affect your quality of life, your desire to have children and the extent of endometrial growth.

If you have endometriosis, there are treatment options that can improve your quality of life: reducing your pain, shrinking or slowing the endometrial growth, preserving or restoring your fertility, and preventing or delaying recurrence of the disease.

What is endometriosis?

Endometriosis is a common and potentially debilitating condition associated with chronic pelvic pain and sometimes infertility. It is caused by the growth of tissue, similar to the kind that lines the uterus every month, elsewhere in your abdomen. This tissue responds to your menstrual cycle each month; when the tissue breaks down, it can lead to inflammation, causing pain and scarring.

The first step: evaluation

The first step in treating endometriosis is usually a thorough medical evaluation, starting with collecting your **medical history**, including your symptoms and your gynaecologic health history. Your health-care professional will also perform a **physical examination**, which will include a pelvic exam and possibly a rectal-vaginal exam. You may also need **imaging tests** such as an ultrasound, which can detect ovarian cysts and other pelvic disorders that might be causing your symptoms.

These examinations will allow your health-care professional to rule out non-gynaecological sources for your symptoms and determine important characteristics of your endometriosis, so that he or she can recommend appropriate treatment. For some women, **further diagnostic tests** (such as a laparoscopy) might be necessary.

The next step: 1st line medical therapy

Combined hormonal contraception (such as the "pill", the "patch" or the "ring") is one of the most widely used treatments for endometriosis, and is usually the first therapy a woman will be asked to try. It reduces the pain caused by endometriosis by suppressing menstruation and inhibiting the growth of endometriosis.

Combined hormonal contraception can be prescribed without the usual seven-day break each month – this is referred to as 'continuous' use, rather than 'cyclic' use. This method prevents you from menstruating, and may be a useful option for women who experience their worst endometriosis symptoms during their period.

After you have been on combined hormonal contraception for at least three months, you may want to follow up with your health-care professional to discuss how you are adjusting to the treatment and whether your symptoms are improving.

If you are still experiencing pain: 2nd line medical therapy

Progestin therapy

Progestin therapy (such as "the shot" or a progestin-releasing intrauterine system) is widely used for birth control and has also been studied for the relief of endometriosis pain. It can be administered in a pill form, as an injection or as a small device inserted into your uterus. Progestin therapy helps to lessen the effects of the estrogen that stimulates endometriotic growth in your body.

One drawback of injection-based progestin therapy is that there can be a delay between when therapy is stopped and when ovulation resumes. For this reason, this is not an effective option if you are planning to conceive in the near future.

Ovarian suppression

If combined hormonal contraception or progestin therapy doesn't work for you, your health-care professional may recommend a *GnRH agonist* (gonadotropin-releasing hormone agonist). This hormone, given by injection or nasal spray, will cause you to stop menstruating.

The side effects of this type of medication tend to be similar to symptoms you might experience in menopause and can be relieved with add-back therapy, which is routinely given when a GnRH agonist is prescribed. Add-back therapy involves taking a low dose of estrogen and progestin to help deal with the menopause-like side effects, while maintaining the pain relief.

Can surgery help? Laparoscopy

Laparoscopy is the most common type of conservative surgery used to diagnose and treat endometriosis. Laparoscopy can be used to remove endometriotic growth or scarring and interrupt the nerve pathways that transmit pain. However, as with any invasive procedure, there are risks involved; for this reason, laparoscopy is not generally considered unless other pain management methods have been unsuccessful.

If you are an adolescent

If your health-care professional has diagnosed you with endometriosis after taking your medical history and doing physical examinations and imaging tests, you will likely be prescribed cyclic combined hormonal contraception. If this doesn't work after a three-month trial, you may need to try continuous combined hormonal contraception or progestin options. If these therapies are also unsuccessful, you may need to have a laparoscopy to confirm the diagnosis of endometriosis, and be prescribed ovarian suppression drugs, such as a GnRH agonist (depending on your age, you may also be prescribed add-back therapy).

What if I'm trying to conceive, or will be soon?

In this case, combined hormonal contraceptives may not be an appropriate therapy for your pain. In addition to taking your medical history and performing physical examinations and imaging tests, your health-care professional may also do extra testing to evaluate your fertility.

If you've been having trouble conceiving, you may be referred for a laparoscopy, as the removal of endometriotic growth or scarring may help you to conceive. You may also be referred for assisted reproductive therapy; in vitro fertilization can also improve your chances of pregnancy.

Endometriosis and infertility

If you have endometriosis, it may be more difficult to become pregnant because scar tissue can block your Fallopian tubes, making it challenging for egg and sperm to meet. Endometriosis can also lead to an increased risk of ectopic pregnancy. But, the good news is that many women with endometriosis are able to conceive — it may just take longer. If you have endometriosis, are under 35, and have not conceived after having regular, unprotected sex for a year, you may be experiencing infertility problems associated with endometriosis.

What if I have deeply infiltrating endometriosis?

If you have endometriosis which has been unresponsive to first- and second-line medical therapies, you may need to undergo laparoscopic surgery for complete removal of endometrial growths.

What if I'm perimenopausal?

If other first- and second-line medical therapies have failed to relieve your pain, you may be a candidate for laparoscopy or **definitive surgery**, which involves the removal of the ovaries (causing menopause), and may also include removal of the uterus and Fallopian tubes. As well, all visible endometriotic growth is usually removed during this type of surgery.

Alternative treatments

Many women with endometriosis report that nutritional and complementary therapies such as acupuncture, traditional Chinese medicine, herbal treatments and homeopathy improve pain symptoms. There is no evidence from randomized control trials to support these treatments for endometriosis, but you shouldn't necessarily rule them out if you think they are beneficial to your overall pain management and your quality of life. Speak with your health-care professional if you are considering incorporating alternative treatments into your lifestyle.

Pain relief

The therapies used to treat endometriosis may take at least one menstrual cycle to become effective. For this reason, your health-care professional may recommend pain relief medication for use until the long-term treatment begins to work. Over-the-counter anti-inflammatory medication is often effective in treating the pain caused by endometriosis. These medications are inexpensive and non-addictive.

Tip: If you are taking an NSAID such as Advil, Motrin, Aleve or Naproxen and aren't getting much pain relief, you may want to try again. Unlike other pain medications, NSAIDs do not block existing pain. Instead, they block the production of prostaglandins, which produce the pain. You must take the medication before the prostaglandins are produced — start taking the medication before you expect the pain to start — and you must keep on taking it every six hours around the clock to ensure it works effectively.