CLINICAL MANIFESTATION OF ENDOMETRIOSIS

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Patient Presentation

- Pelvic pain: 80%
- Dysmenorrhea
- Dyspareunia
- Infertility 25%
- Ovarian mass 20%

Incidentally:
- During surgery
- Imaging
- Alone or combination

Increased number of symptoms associated with increased likelihood of endometriosis (5-7 symptoms 20% versus 2%)
Less Common Symptoms

- Bowel dysfunction
- Bladder dysfunction
- AUB 20%
- Low back pain
- Chronic fatigue
- Asymptomatic
Dysmenorrhea

- Dull or crampy pelvic pain
- Typically begins 1 to 2 days before menses
- Persistent throughout menses
- Can continue for several days
Dysmenorrhea

- Dysmenorrhea is not directly to the amount of visible disease
- In many women with endometriosis dysmenorrhea worsens over time
- Endometriosis should be considered etiology in patients who present with dysmenorrhea that does not respond to OCP or NSAIDs
- Endometrioma are not associated with dysmenorrheal severity
- Dysmenorrhea is less frequent with only endometriomas versus other lesions
Dysmenorrhea

- In adult women dysmenorrhea especially suggestive of endometriosis
- IF begins after years of pain free meses
- In adolescents:
  - The pain may be present after menarche without an interval of pain-free menses
  - Absenteeism from school
- Incidence and duration ocp use for sever primary dysmenorrhea higher in women who later develop DIE than the women without DIE
Pelvic Pain

- Typically chronic:
  - Dull
  - Throbbing
  - Sharp
  - And/or burning

- Pelvic pain or pressure are the most common symptoms with an adnexal mass
Mechanisms causing pain

- Local peritoneal inflammation
- Deep infiltration with tissue damage
- Adhesion formation
- Fibrotic thickening
- Collection of shed menstrual blood in endometriotic implants resulting in:
  - Painful traction with the physiologic movement of tissue
Pelvic Pain

- Distribution of pain variable most often bilateral
- Local symptoms arise from rectal, ureteral and bladder involvement
- Lower back pain

- All endometriosis lesion types are associated with pelvic pain, including minimal and mild endometriosis

- Endometriomas can be considered a marker for greater severity of deep lesions

- Deep lesions are consistently associated with pelvic pain, GI symptoms and painful defecation
- The role of adhesions in pain and endometriosis poorly understood
Pelvic Pain

- Did not correlation between degree of pelvic pain and severity of endometriosis

- Some studies reported positive correlation between endometriosis stage and dysmenorrhea or chronic pelvic pain

- A strong association was between uterosacral and posterior cul-de-sac lesions and dyspareunia

- Dyspareunia typically reported on deep penetration, but there is no correlation between dyspareunia and the extent of endometriosis

- The character of pelvic pain is related to anatomic location of DIE

- Sever pelvic pain and dyspareunia may be associated with DIE

- Increasing evidence suggests a close relationship between the density of innervation of endometriotic lesions and pain symptoms
Symptoms of The Types Endometriosis

- Peritoneal – DIE often is dyspareunia
- Bladder endometriosis typically present with:
  - Dysuria or lower urinary tract symptoms such as urgency and frequency
  - Bladder endometriosis present with nonspecific urinary symptoms:
    - Frequency
    - Urgency
    - Pain at micturition
    - Symptoms worsened with menses
  - Ureteral endometriosis can be asymptomatic
    - Or with colicky pain
    - hematuria
Ureteral endometriosis

- Ureteral endometriosis can be asymptomatic or:

  - with colicky pain
  - Gross hematuria
  - Ureteral stenosis
  - Ureteral obstruction

- Hydronephrosis in asymptomatic patients may result in silent loss of renal function
Symptoms of The Types Endometriosis

- Association with significant GI symptoms:
  - Pain
  - Nausea
  - Vomiting
  - Early satiety
  - Bloating and distension
  - Altered bowel habits
  - Motility change due to:
    - Ampulla of vater-duodenal spasm
    - A seizure equivalent of the enteric nervous system
    - With bacterial overgrowth
Symptoms of The Types Endometriosis

- Bowel endometriosis
- Diarrhea
- Constipation
- Dyschezia
- Bowel cramping
- DIE implants of posterior cul-de-sac and rectovaginal septum:
  - Dyspareunia
  - Painful defecation
  - Rectal bleeding is rare
Symptoms of The Types Endometriosis

- **Abdominal wall endometriosis:**
  - Painful abdominal wall mass
  - Pain may be cyclic with menses or continues

- **Thoracic endometriosis:**
  - Chest pain
  - Pneumothorax or hemothorax
  - Hemoptysis
  - Scapular or neck pain
  - Symptoms often catamenial
Endocrinologic abnormalities

- Anovulation
- Abnormal follicular development
- Impaired follicle growth
- Reduced circulating E2 levels during preovulatory phase
- Disturbed LH surge patterns
- Premenstrual spotting
- Luteinized unruptured follicle syndrome
- Galactorrhea
- Hyperprolactinemia

No convincing data exist to conclude incidence of these abnormalities increased with endometriosis
CLINICAL EXAMINATION

- Reliability of the clinical examination in detecting pelvic endometriosis is improved during menstruation
- Values for transvaginal ultrasound (TVUS) were similar for most locations but were superior to vaginal examination in cases of ovarian, uterosacral ligament and rectosigmoid endometriosis

- Strong recommendations (ESHRE 2021)
  - Clinical examination, including vaginal examination where appropriate, should be considered to identify deep nodules or endometriomas in patients with suspected endometriosis, although the diagnostic accuracy is low
  - In women with suspected endometriosis, further diagnostic steps, including imaging, should be considered even if the clinical examination is normal

- Justification
  - Overall, the evidence suggests that clinical examination of symptomatic women does not reliably predict the presence of endometriosis in the abdomen and pelvis
Clinical examination

- Finding are variable and depend upon the location and size of the implants
- No abnormality is detected in many patients
- Inspection of vulva, vagina, and cervix
- Rarely endometriosis lesion on the cervix or vaginal mucosa
- Black–blue-colored lesions in the lateral and posterior aspect of cervix
- Episiotomy scar
- A narrow pinpoint cervical ostium is a risk factor
Clinical examination

- Tenderness on vaginal examinations,
- Nodules in the posterior fornix
- Nodularity of uterosacral
- Adnexal masses
- Immobility or lateral placement of the cervix or uterus by uterosacral scar
- Painful swelling of the rectovaginal septum
- And unilateral or bilateral ovarian cystic enlargement
- In more advance disease uterus fixed retroversion, reduced mobility of ovaries and tubes *(frozen pelvis)*

- Inspection and palpation of abdominal wall with abdominal endometriosis

Deep endometriosis is deeper than 5mm under the peritoneum
Rectovaginal digital examination may allow the detection of infiltration or mass involving the rectosigmoid colon or adnexal masses.

Vaginal and/or rectovaginal examination might be inappropriate in certain situations and in adolescents. Furthermore, it can be very painful in some women.

Vaginal examination should ideally be omitted and other medical technologies should be used as a first step towards diagnosis.

Clinicians should not use measurement of biomarkers in endometrial tissue, blood, menstrual or uterine fluids to diagnose endometriosis.
References

ESHRE GUIDELINE ENDOMETRIOSIS 2021
THANK YOU