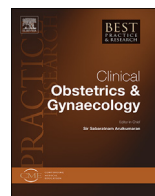




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12

### A focus on the distinctions and current evidence of endometriosis in adolescents

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#### A B S T R A C T

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Endometriosis (EM) occurring in adolescents presents distinct clinical and histologic characteristics compared to the disease in women. Because the symptoms of EM are nonspecific, often overlapping with those experienced in a range of gynecological and gastrointestinal conditions, the process of reaching a diagnosis of EM is often delayed. The diagnosis of EM is suspected depending on the history and the symptoms and signs, is corroborated by physical examination and imaging techniques, and is finally proved by histological examination of specimens collected during laparoscopy. Currently, there is insufficient evidence to make strong recommendations for management in adolescents who may have EM. This short report reviews some peculiarities of EM in adolescents and provides an update of recent knowledge of the diagnosis and treatment of EM. We hope that the present

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contribution may help to bring more attention to the clinical diagnosis of EM and consequently aid in decreasing diagnostic delay.

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## Background

Endometriosis (EM) is one of the most common gynecological diseases, and it is characterized by the presence of endometrial glands and stroma outside the uterus, such as in the ovaries, fallopian tubes, or bladder [1]. Menstrual bleeding at these sites causes inflammation and promotes tissue scarring and adhesion, leading to chronic pelvic pain (CPP) and impaired fertility [2,3]. EM is a complex and highly variable disease that still challenges modern science in etiology, presentation, symptoms, diagnosis, and management.

EM is classified depending on the number, size, and superficial and/or deep location of endometrial implants, plaques, endometriomas, and/or adhesions [2]. Importantly, morbidity does not necessarily correlate with severity; women with minimal disease at laparoscopy may be highly symptomatic, and vice versa [1,2].

Susceptibility to EM is thought to depend on the complex interaction between factors. The literature over the last 5 years has advanced our critical knowledge related to hormones, hormone receptors, immune dysregulation, hormonal treatments, and the transformation of EM to ovarian cancer [3–5].

Contrary to traditional beliefs, EM occurs in adolescents and younger women. Indeed, it has been reported that most women with EM first experienced symptoms in their teens [2,3]. Sadly, despite several medical reports, delay in diagnosis still occurs in many women who present with the classic symptoms of considerable dysmenorrhea or CPP.

As there are currently no accurate noninvasive diagnostic tests specific for EM, it is imperative to become knowledgeable about its etiology, clinical presentation, diagnosis, and current treatment to avoid a potentially long and tortuous road to appropriate diagnosis and treatment.

Thus, this short report aims to review some peculiarities of EM in adolescents and to report the current evidence for its diagnosis and treatment. The present contribution aims at bringing more attention to the clinical diagnosis of EM and decreasing the diagnostic delay.

## Incidence and prevalence of endometriosis

EM is most commonly a disease seen in women in the second half of their reproductive life between 30 and 45 years of age and tends to regress at menopause or earlier [6].

The incidence and prevalence of EM cannot be accurately determined because of the uncertainties in making a definite diagnosis without laparoscopy. It is thought to affect up to 5–10% of women of reproductive age, although in those presenting with pelvic pain and/or infertility, its frequency may reach 50% [7].

The Endometriosis Association's 1998 registry of 4000 adult women with EM reported that 2/3 of those responding to the survey experienced their first pelvic symptoms before 20 years of age, 21% before 15 years, and 17% between 15 and 19 years [8].

Compared to adults, there are limited data on the frequency and symptoms of EM in adolescents. Approximately 5% of young women, aged 15–19 years, report severe dysmenorrhea not alleviated by combined oral contraceptives (COCs) and pain medication, a condition suggestive of EM [9,10].

Based on 15 selected studies, the overall prevalence of visually confirmed EM was 62% (543/880; range 25–100%) in all adolescent girls undergoing laparoscopic investigation, 75% (237/314) in girls with CPP resistant to treatment, 70% (102/146) in girls with dysmenorrhea, and 49% (204/420) in girls with CPP that is not necessarily resistant to treatment [11].

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