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Special Issue Endometriosis: Answers

Answers to the queries included in the previous issue of EJOGRB, the Special Issue Endometriosis

1. What is the estimated prevalence of endometriosis in women of reproductive age?

B. 5–10%

Q1 Endometriosis is estimated to affect approximately 7–10% of women in the reproductive age group. (Parazzini et al. Epidemiology of Endometriosis. EJOGRB, 2016)

2. What is the most consistent sociodemographic factor that has been associated with the occurrence of endometriosis?

B. Family history

Various studies have examined the relationship between various sociodemographic characteristics and the occurrence of endometriosis. The data from these most of these studies are conflicting, however, the evidence for family history being a significant risk factor is consistent. An affected first degree relative increases the risk by an estimated 3–9 fold. (Parazzini et al. Epidemiology of Endometriosis. EJOGRB, 2016)

3. Physical activity has been shown to improve reproductive health. Some studies have suggested that it may indeed be associated with a reduction in the risk of endometriosis. What is the effect of physical activity on reproductive physiology in a woman with a strong family history of endometriosis?

E. Increase systemic levels of anti-inflammatory cytokines

Physical activity, may decrease estrogen levels, increase SHBG, reduce insulin resistance and hyperinsulinaemia and increase systemic anti-inflammatory cytokines. (Parazzini et al. Epidemiology of Endometriosis. EJOGRB, 2016)

4. In approximately what proportion of adolescents with chronic pelvic pain (CPP) resistant to treatment undergoing a diagnostic laparoscopy will endometriosis be found?

E. 65–75%

A systematic review by Jansesen et al. (2013) of 15 published studies showed that visually diagnose endometriosis was present in 75% of girls undergoing laparoscopy for CPP resistant to treatment, 70% in those with dysmenorrhea and 49% in those with CPP not necessarily resistant to treatment. Earlier studies also demonstrated that 69–73% of teenagers who did not respond to medical treatment for CPP had endometriosis. (Saridogan Adolescent endometriosis. EJOGRB, 2016)

5. A 16 year old is referred for a gynaecological opinion by her primary care physician because of chronic pelvic pain which has failed to respond to a variety of painkillers. She is scheduled for a diagnostic laparoscopy because of suspected endometriosis. If she is found to have endometriosis, what difference if any is there in the stage of the disease between adolescents and older women?

E. There are no differences in the stage of the disease between adolescents and others

The conclusion from the review by Saridogan (2016) shows that all stages of endometriosis, including deep endometriosis and ovarian endometriomas are found in teenagers (adolescents) and that the condition is not limited to the early form. (Saridogan Adolescent endometriosis. EJOGRB, 2016)

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6. A 27 year old is diagnosed with endometriosis and is placed on a GnRH agonist. At follow-up three months after the initiation of treatment, she reports a significant improvement in her dysmenorrhea and cyclic lower abdominal pain. She completes the course after 12 months and comes off the treatment. What would be the most likely recurrence rate of her symptoms at 12 months' follow-up?

D. 50%

Although GnRH agonist are effective and considered the gold standard medical treatment for endometriosis, limitations include a recurrence rate (about 50% of patients show a relapse of symptoms within 6 months after therapy discontinuation) and side effects associated with the transitory pharmacological menopause condition created: bone density loss, hot flushes, genitourinary atrophy, depression and decreases libido. (Tosti et al. Hormonal therapy for endometriosis: from molecular research to bedside. EJOGRB, 2016)

7. A 30 year old has been placed on the progestogen dienogest (2 mg) for symptomatic endometriosis. Her symptoms are almost completely alleviated by the end of the second month of treatment. She remains on this treatment for 12months and then discontinues it. What is the most likely course of her endometriosis related pelvic pain over the follow-up period?

B. Her symptoms will remain decreased for at least 6 months

Dienogest (DNG) has been shown to be as effective as GnRH agonist in the control of symptoms of endometriosis with fewer side effects and better tolerability. The European Multicentre Trial showed that long-term treatment with DNG had a favourable efficacy and safety profile, with progressive decrease in pain and bleeding irregularities during continued treatment; the decrease in pelvic pain persisted for at least 6 months after treatment interruption. (Tosti et al. Hormonal therapy for endometriosis: from molecular research to bedside. EJOGRB, 2016)

8. What is the estimated proportion of women with endometriosis that are placed on the levonorgestrel intrauterine system (LNG-IUS) that will continue to experience improvement in symptoms after 3 years?

D. 80–90%

The LNG-IUS has been shown to reduce the recurrence of moderate or severe dysmenorrhea after one year. Longer follow-up period of up to 3 years revealed a statistically significant reduction in dysmenrrhoea scores with up to 87.5% of patients who maintained the device reporting improvement in pain. (Lockhat F, Emembolu J and Konje JC, Human Reproduction 2005) (Tosti et al. Hormonal therapy for endometriosis: from molecular research to bedside. EJOGRB, 2016)

9. A 30 year old who suffers from chronic pelvic pain is diagnosed with deep infiltrating endometriosis of the rectovaginal pouch. She is counselled about treatment options (medical versus surgical). What is the difference if any in response to treatment by either excision or medical therapy?

D. The symptoms are not different by the end of one year with either treatment options

Although surgical excision was once considered the treatment option of choice for deep infiltrating endometriosis, convincing evidence is now emerging on the benefits of hormonal manipulation alone for the treatment of DIE. In fact a recent study comparing surgery and medical treatment in women with rectovaginal lesions documented a more rapid improvement in those receiving surgery but the difference between the two approaches lessens with time and at one year follow-up, pain symptoms were similar in the two groups. (Somigliana et al. Postoperative hormonal therapy after surgical excision of deep endometriosis. EJOGRB, 2016)

10. What is the estimated recurrence rate of endometriosis at 5 years following surgical excision?

D. 40–50%

Based on a systematic review, its has been estimated that the recurrence rate of endometriosis at 2 and 5 years is 20% and 40–50% respectively. (Somigliana et al. Postoperative hormonal therapy after surgical excision of deep endometriosis. EJOGRB, 2016)

11. A 32 year old was diagnosed with deep infiltrating endometriosis of the rectovaginal pouch. Surgery was offered and following this, she was placed on a combined estrogen-progestogen preparation for 3 months. What is the value of this post surgical treatment in this patient?

D. Has not been shown to be of benefit

The latest Cochrane meta-analysis on post treatment with various hormonal preparations for periods of 3–6 months have concluded that this does not offer any benefits. (Somigliana et al. Postoperative hormonal therapy after surgical excision of deep endometriosis. EJOGRB, 2016)

12. What is the advantage of offering post surgery hormonal treatment in women who are being managed with endometriosis?

A. A marked reduction in the recurrence risk of ovarian endometriomas

According to a recent meta-analysis, hormonal contraception resumption after normal surgery for ovarian endometrioma markedly prevents the recurrence rate of endometriomas with a pooled OD ratio of recurrence of 0.12 (95%CI 0.05–0.29) (need reference to the article here – the article on endometriomas). (Somigliana et al. Postoperative hormonal therapy after surgical excision of deep endometriosis. EJOGRB, 2017)

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