Common Pathologies of the Female Reproductive Tract

Endometriosis

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Pelvic pain and infertility in any woman of child bearing age must point the mind toward this disease entity. Endometriosis is a very common, albeit not frequently diagnosed pathology of the female reproductive tract. As mentioned above the hallmarks of this disease are pelvic (low abdominal and waist) pains and infertility. The spectrum of these symptoms varies widely from mild pelvic pains (even just mere discomfort) and normal fertility, to severe, debilitating pelvic pains and infertility that defies all forms of management. As a result of this confusion in its diagnosis and management may ensue.

Endometriosis is the appearance of endometrial tissue (the tissue lining the inner part of the uterus, the part that is shed monthly, and the part that the embryo and fetus develops in) outside the layer in which it is meant to be. Normally endometrial tissue may not be found outside the layer known as the endometrial layer. Even during menses, when there is possibility of retrograde blood flow, the immune system of the body, in its bid to maintain the structural integrity of the body, would not tolerate the appearance of endometrial tissues in the lining of the free abdominal cavity. Though endometriosis is a disease of unclear causes, it is assumed that the immune system of the patient with endometriosis is, at least, partially compromised to allow the appearance of these tissues elsewhere.

The cause(s) of endometriosis is unknown. It is known as a disease of theories. There are 4 main theories to explain it, but these are beyond the purview of this article. It is worthy though to mention here that there is often co-existence between endometriosis and uterine fibroids. In patients with the two conditions co-existing, there is mix up in the clinical picture they present with. This must be borne in mind so that proper management is instituted.

Endometriosis affects up to 15% of women worldwide, but this percentage is much higher amongst women with infertility. Ectopic endometrial tissue (endometriosis) may be found in the muscular layer of the womb (adenomyosis), in the fallopian tubes, on or in the ovaries, on the cervix (neck of the womb), on the vaginal walls, on the peritoneum (the lining of the free abdominal cavity) or even in very distant places like the trachea, lungs, ears etc. These localizations would determine the specific clinical picture the patient would present with. It is thus not uncommon to have a lady present with pelvic pains, infertility and nose bleed during menses, which may indicate ectopic endometrial tissue in the nasal cavity. These ectopic endometrial sites bleed easily on contact and react, like endometrial tissue, to hormonal changes of the host (including shedding during menses).

The pelvic pain of endometriosis typically precedes the onset of menstrual flow and typically stops with the onset of the flow, in mild cases, whereas they continue until well beyond the flow in more severe cases. The pain is usually described as deep seated and more throbbing in nature than sharp. The pain is usually refractory to mild analgesics and often would require hospital admission. It is worthy to point out that the degree or extent of endometriosis does not usually correlate with the intensity of pelvic pains, or indeed with the presence or not of infertility. Some women with extensive disease seen by chance at surgery for an unrelated reason have been known to be fertile and pain free, whereas some women with clinically mild disease have been known to have debilitating symptoms.

Diagnosis of endometriosis for now is typically surgical- either at open laparotomy (abdominal surgery) or by laparoscopy. The physician has to be 'endometriosis minded' in many cases to make the diagnosis or it would elude him/her. Having made the diagnosis the treatment is usually medical. Surgery may only be used as an adjunct to medical management. The aim of medical management is to create a pseudo-pregnancy or a pseudo-menopause. The idea behind this is that both conditions, pregnancy and menopause, have been found to inhibit progression of the disease. As a matter of fact, the disease regresses with them. There are many commercially available preparations and formulations for achieving any of the above. Your physician would decide which is best suited to your condition and your desires. Pseudo-menopause is the preferred option for many physicians nowadays and the treatment and its antecedent discomforts usually continue for about 6 months.

Work is ongoing to obtain a less invasive lab technique for diagnosis of endometriosis whereby the patient's blood is tested for some markers of the disease. This work is still largely experimental, but the results are encouraging.
Think you should comment on the risk of death of this disease.
Perhaps also comment on the chances of cure and/or reoccurrence.
Does it require permanent management? Unlike the fibroids where surgery can take it away & its most likely final, what s the case with this?