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Endometriosis – a growing problem?

INVITERT KOMMENTAR

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Despite more women being diagnosed with endometriosis than before, many continue to experience symptoms for a long time before receiving treatment.

Endometriosis is a condition in which endometrium-like tissue grows outside the uterus, in the pelvis, on the peritoneum, or as cysts on the ovaries. The tissue can also appear around the intestines and urinary tract and, less commonly, in the upper abdominal cavity or lungs. When such changes occur within the uterine wall (myometrium), the condition is called adenomyosis. Endometriosis is estimated to affect 6–10 % of all women (1), while adenomyosis is less common.

Endometriosis causes pain and menstrual disturbances and is a common cause of infertility. Despite this, the condition has received little attention, as noted by Moen et al. in their article 'Look out for endometriosis', published in the Journal of the Norwegian Medical Association in 2021 (2). Patients with endometriosis often experience symptoms for a prolonged period – on average 5–6 years – before being evaluated and diagnosed. Awareness of endometriosis has increased in recent years, and several media reports have helped raise women's awareness of the condition.

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Doctors in primary care often have the first contact with women with endometriosis, but establishing the diagnosis in general practice can be challenging. Clinical presentation and the location of pain can vary. Endometriosis should always be considered in cases of pelvic pain, menstrual disturbances and infertility, as well as in young women with intractable menstrual pain. The gold standard for diagnosing endometriosis is laparoscopy (3). Transvaginal ultrasound and MRI are also diagnostic options, but they are less accurate and do not provide a histological diagnosis. Endometriosis can be diagnosed clinically, and treatment can be initiated in primary care.

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The Norwegian Society for Gynaecology and Obstetrics recommends empirical treatment of dysmenorrhea with an extended-cycle oral contraceptive or progestin (3). If symptoms persist after six months, close follow-up is recommended, with a low threshold for referral to laparoscopy. General practitioners (GPs) are therefore advised to initiate hormone therapy based on medical history, clinical findings and clinical suspicion. Referral to the specialist health service is not required initially. Taking an extended-cycle oral contraception or progestin, with the aim of stopping menstrual bleeding, may be sufficient treatment for some women with endometriosis. Surgery is the main treatment option for women with severe bleeding disorders and pronounced pelvic pain, and these patients should always be referred to a specialist.

If endometriosis is left untreated, symptoms can worsen. Early diagnosis can help reduce symptoms. It is therefore important to initiate treatment and for the woman to continue with hormone therapy until menopause, provided there are no other contraindications.

In a study published in this edition of the Journal of the Norwegian Medical Association, Magnus et al. present new knowledge on diagnosed cases of endometriosis, adenomyosis and related health problems (4). This is the first population-based study of these conditions in Norway. Dysmenorrhoea, dyspareunia and menorrhagia are common symptom diagnoses in primary care. The study demonstrates a high prevalence of such symptoms among women who have received an endometriosis or adenomyosis diagnosis in the specialist health service. Women without such a diagnosis can also experience these symptoms, but much less frequently, highlighting the importance of considering symptoms as well as clinical findings. The study reports an increased prevalence of endometriosis and adenomyosis from 2008 to 2021, which the authors attribute to improved diagnostics, but a genuine increase in cases cannot be ruled out.

GPs in Norway have called for national guidelines for the treatment of endometriosis. However, recommendations and proposals have been issued by the Norwegian Society for Gynaecology and Obstetrics, which are clear and suitable for use in general practice.

The Women's Health Committee has noted that more research and the introduction of tools for GPs would help improve health care for women (5). It is therefore encouraging that the Research Council of Norway has recently awarded NOK 12 million to a research project on endometriosis and adenomyosis, which will investigate, among other things, risk factors and health consequences (6).

Further research could help clarify whether there is a genuine increase in endometriosis cases, the factors contributing to any such rise, how early diagnosis and treatment can be improved, and the most effective way of preserving fertility. Clinical trials of GnRH agonists and aromatase inhibitors are among the promising projects (7).

In the meantime, follow the earlier advice: look out for endometriosis!

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