Histology Necessary for Endometriosis Diagnosis

BY DOUG BRUNK
San Diego Bureau

SAN DIEGO — When it comes to diagnosing endometriosis, visual inspection is not enough, Dr. Georgine Lamvu said at the annual meeting of the International Pelvic Pain Society.

"We need to be more careful to use excisional biopsies during laparoscopies and careful about the thorough evaluation of the pelvic structures, to record these so we can keep track of the infiltration, size, and distribution of the lesions," said Dr. Lamvu of the department of obstetrics and gynecology at the Florida Hospital, Orlando.

She went on to note that not all endometriosis causes chronic pelvic pain. In one study of 15 patients with presumed endometriosis who went on to have conscious laparoscopic pain mapping, endometriotic lesions reproduced pain in 7 patients, all of whom had histologic confirmation of the diagnosis. Endometriotic lesions did not reproduce pain in eight cases.

"Seven of nine cases with histologically confirmed endometriosis mapped their pain to endometriotic lesions but none of the six cases in which the visual diagnosis of endometriosis was not histologically confirmed mapped their pain to 'endometriotic' lesions," she said. "So although it's very important to confirm histology, we should not always assume that because you have pathology you'll have pain."

Level A evidence suggests that endometriosis is associated with chronic pelvic pain in 50%-70% of patients. "This still does not answer the question: Is endometriosis the source of their pain?" Dr. Lamvu said. "Eighty percent of women with chronic pelvic pain also end up being diagnosed with endometriosis at some point. That does not mean that the endometriosis is the source of pain."

Other potential causes of pelvic pain to rule out include urinary sources such as interstitial cystitis, gastrointestinal sources such as irritable bowel syndrome, and musculoskeletal trigger points.

"It's important to explain to patients with chronic pelvic pain that they may have symptomatic endometriosis or that they may have been misdiagnosed with endometriosis," she said. "It's also important to explain to them that endometriosis can be inadequately treated and can exacerbate pain from other sources."

The pathophysiology of endometriosis remains unclear but one concept developed in 1949 called the composite theory has gained the attention of researchers in recent years. This theory suggests that a variety of immunologic and genetic factors may mediate endometriosis, including direct extension into myometrium and adjacent organs, exfoliation of viable endometrial cells through tubes, and implantation of these cells into the peritoneum and adjacent organs.

'Endometriosis can be inadequately treated and can exacerbate pain from other sources.'

DR. LAMVU

"There [are] a lot of convincing data that retrograde menstruation and implantation of endometrial fragments are the primary mode of developing endometriosis in the peritoneal cavity, but it's definitely not the only process," Dr. Lamvu said. "Research is now focusing on mechanisms that are involved in the attachment and the clearance of viable endometrium from the pelvic cavity. So the focus has come to alterations in the immune system."

Current treatment for endometriosis associated with pelvic pain includes observation with palliative treatment with NSAIDs, hormonal suppression with continuous oral contraceptives, and gonadotropin-releasing hormone agonists (GnRH), excision, ablation, or cystectomy, and definitive extirpating surgery such as hysterectomy or bilateral salpingo-oophorectomy.

"A lot of us are now doing a combination of medical and surgical therapies," Dr. Lamvu said.

Which surgical technique is best for managing endometriosis remains unclear. "There have been no comparison trials," she said. "Some experts suspect that excision may be more effective for pain management in deep lesions, but for the general population of gynecologists superficial ablation with some type of medical therapy afterwards will be less risky."

She added that pain improvement in the postoperative period "may be best for patients who have extensive disease. There may be some correlation between the extent of disease and response to treatment."

Pain usually recurs within a year in 40% of patients who undergo surgical therapy and within 1-2 years in 30%-40% of patients who receive medical therapy. "This is a frustration for all of us," said Dr. Lamvu, who is also assistant director of the Florida Hospital Family Practice Residency program. "There is no telling whether these numbers will [improve] now that we are incorporating so many different therapies for the management of pain."

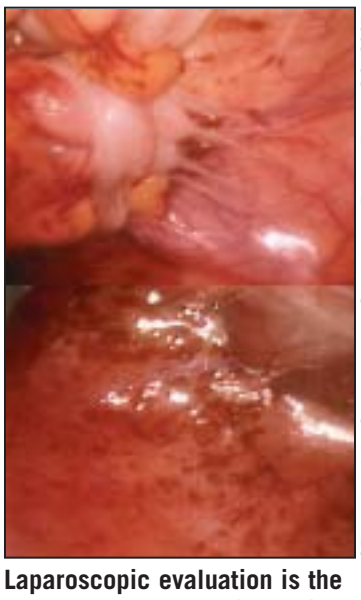
Future therapies include selective progesterone receptor modulators such as asoprisnil, which induce amenorrhea without side effects of hypoestrogenism and control uterine prostaglandins. Doses of 5, 10, or 25 mg per day may be effective in reducing pelvic pain. ■

Response to Hormonal Therapy Doesn't Point to Endometriosis

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — Response to hormonal therapy does not accurately predict whether a patient has endometriosis, Dr. Todd R. Jenkins reported at the annual meeting of the AAGL.

Laparoscopy has long been the standard for diagnosing endometriosis. But a 1999 paper by Dr. Frank W. Ling questioned the necessity for doing laparoscopy in women with chronic pelvic pain (Obstet. Gynecol. 1999;93:51-8).



©ELSEVIER, KATZ: COMPREHENSIVE GYNECOLOGY, 5TH ED. FIGURE 8-9, 2007

Laparoscopic evaluation is the gold standard for a diagnosis.

Findings in that study, sponsored in part by depot leuprolide manufacturer TAP Holdings Inc., suggested that a diagnostic algorithm plus a reduction in symptoms with a 3-month trial of depot leuprolide could noninvasively identify women for whom endometriosis was the cause of pain.

"Our clinical impression has been that many women who failed to respond to hormonal treatment [had] endometriosis. Many women have been told they did not have endometriosis since they did not respond to [the] treatment," said Dr. Jenkins, director of the division of women's reproductive health care in the department of obstetrics and gynecology at the University of Alabama, Birmingham.

In a retrospective study by Dr. Jenkins and his then-associates at the Chattanooga (Tenn.) Women's Laser Center, chart reviews identified 486 patients at the private endometriosis referral center who had undergone laparoscopy for chronic pelvic pain and who had received at least 3 months of preoperative hormonal therapy.

Of those, 105 met the study criteria, which included complete information on response to treatment and less than 3 months between completion of hormonal therapy and the laparoscopy.

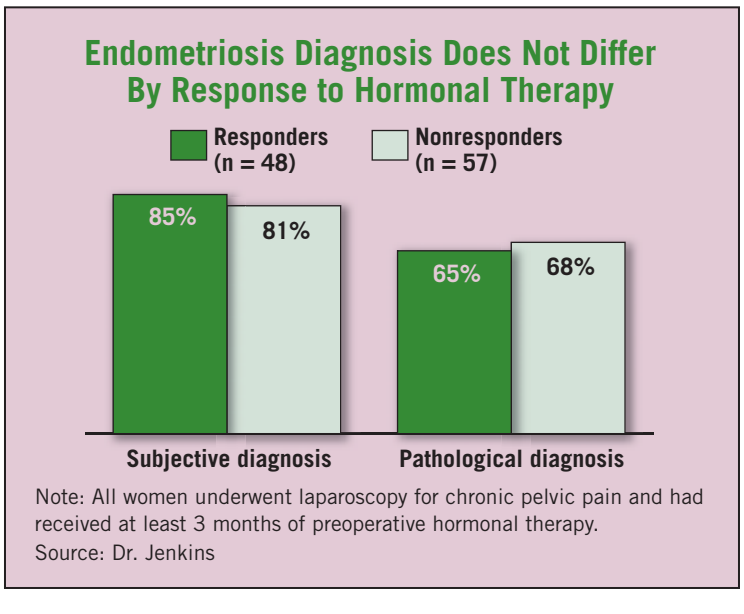
The hormonal treatments were oral contraceptive pills in 80% of the patients and gonadotropin-releasing hormone (GnRH) agonists in 20%. Response to the hormones, defined as either partial or complete symptom relief, was achieved in 46% (48), whereas 54% (57) had no relief of symptoms. Endometriosis was identified subjectively during laparoscopy in 84% (88) of the women, and a pathological diagnosis was made in 67% (70). These findings confirm those of Dr. Ling and others that endometriosis is present in about 80%-85% of women with well-defined chronic pelvic pain.

There was no significant difference in the rate of endometriosis between all hormonal therapy responders and nonresponders, either by subjective impression or pathological diagnosis. Subjective diagnoses of endometriosis were made for 85% of responders and 81% of nonresponders, and pathological diagnoses in 65% and 68%, respectively. Endometriosis rates also did not differ between the 35 responders and 48 nonresponders to oral contraceptives specifically.

Differences were significant for those who took GnRH agonists: Subjective diagnoses of endometriosis were made in 100% (9/9) of responders, compared with just 50% (4/8) of nonresponders, and pathological diagnoses in 89% (8/9) of responders vs. 25% (2/8) of nonresponders. However, the number of cases was too small to be conclusive.

Response to hormonal therapy also did not predict the diagnosis of endometriosis at any specific location except for the anterior bladder wall peritoneum (70% of responders vs. 30% of nonresponders), but only 10 patients had endometriosis at that site. The same was found for pathologically confirmed diagnoses: Only endometriosis of the anterior peritoneum was statistically more likely in responders than nonresponders (85% vs. 15%), and again, the data were limited because the numbers were small.

Dr. Jenkins said the findings should not be interpreted to mean that a trial of GnRH agonists isn't a good idea. "No ... diagnosis of endometriosis [should be] based on the response to hormonal therapy without a laparoscopic evaluation. A laparoscopic diagnosis is still the gold standard." ■



ELSEVIER GLOBAL MEDICAL NEWS