Treat Endometriosis Pain as a Chronic Condition

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Contributing Writer

SANTA FE, N.M. — No treatment option for endometriosis is likely to provide permanent relief from pelvic pain, and patients should be warned accordingly before undergoing surgery for the condition, Stephen M. Cohen, M.D., advised.

"When we are going to do surgery on a patient who has this disease, we have to tell her, 'This is a chronic disease. I am there to make you feel better but not to cure you,' " he suggested at a conference on gynecologic surgery sponsored by Omnia Education.

"If they expect a cure, you will be the 14th doctor on the hit parade that the patient has gone to and been dissatisfied with," warned Dr. Cohen, chief of the division of gynecology and director of women's minimal access surgery at Albany (N.Y.) Medical College.

Pain will recur in about a third of patients within 2 years of surgery. Pain and stage are unrelated, however, and the causes of endometriosis are unclear. "Stage I hurts as much as stage IV," he said, reporting that the least pain is associated with black lesions, the worst with red lesions.

When a patient complains of pelvic pain, Dr. Cohen said that empiric therapy—"treating without looking"—is an option. A thorough work-up is essential, however, to rule out all other possible causes, including fibromyalgia and depression.

"In point of fact, you will be right in diagnosing endometriosis 75% of the time without putting the laparoscope in," he said. "If you include infertility and pain, you will be right 85% of the time."

The preferred medical treatment of endometriosis is leuprolide, but surgery can help some patients, according to Dr. Cohen. Conservative treatment with excision, ablation, or both can be undertaken when patients undergo diagnostic laparoscopy. The choice would depend on the surgeon's preference and experience.

Dr. Cohen cited mixed data on the effectiveness of adhesion excision. In his experience, he said, it helps patients who can point to the exact spot where the pain originates. "The ones that have diffuse adhesions don't seem to get better very often for any extended period of time," he said. "Many patients that have adhesions never have pain."

Before undertaking endometriosis surgery, tell the patient, 'This is a chronic disease. I am there to make you feel better but not to cure you.'

Presacral neurectomy is another option that might be helpful, Dr. Cohen said, but only for patients with pure midline pain or dysmenorrhea. Because as many as 9 out of 10 patients are likely to become constipated after this surgery, he recommended using it selectively.

He argued against laparoscopic uterosacral nerve ablation (LUNA), citing two studies that reported it had no effect on pelvic pain (Fertil. Steril. 1997;68:1070-4; Fertil. Steril. 1997;68:393-401). In one randomized controlled study of LUNA, significant differences favored the patients who had laser vaporization of endometriosis without LUNA.

Whatever surgery is done, Dr. Cohen said it should be conservative and should be followed immediately by treatment with a GnRH agonist. "If you do treat these patients with some form of [postoperative] medical therapy—progesterone, Danazol, Lupron—you won't reduce the recurrence of pain, but you will lengthen the time before recurrence takes place," he said, citing a study showing dramatic differences over 2 years, compared with patients who had excision or ablation without postoperative medical therapy (Obstet. Gynecol. 2003;102:397-408). ■

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