Specific Symptoms Point to Endometriosis Dx

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — The constellation of symptoms characterizing endometriosis may be more specific than currently thought, Karen D. Ballard, Ph.D., said at the annual meeting of the AAGL.

There is often a long delay in the diagnosis of endometriosis, in large part because the symptoms—primarily pelvic pain and dysmenorrhea—are nonspecific and can overlap with other conditions. But now, a case-control study from a primary care database in the United Kingdom suggests that women with a combination of gynecologic, urologic, and bowel symptoms are likely to have the condition.

"Specific, unremitting symptoms should raise a high suspicion of endometriosis," said Dr. Ballard of the University of Surrey, Guildford, England.

Data were collected from the General Practice Research Database, the largest computerized database in the world containing longitudinal medical records from primary care. It currently comprises more than 3 million active patients from about 450 primary care practices, the setting in which all nonemergency patients in the United Kingdom are first seen.

During 1992-2002, 5,540 cases of endometriosis were identified from a total of 1,276,100 women aged 15-55 years. The average age at diagnosis was 35 years. The incidence of diagnosed endometriosis was 0.97 per 1,000 women-years, and the prevalence—calculated from the incidence rate and the average disease duration—was 1.5%. This proportion is lower than what has been reported in the literature, probably because it comes from general medical practice rather than a gynecology-based setting, Dr. Ballard noted.

There were 21,239 matched controls. The women with endometriosis were significantly thinner, with 49.3% having a body mass index less than 25 kg/m^2, compared with 42.1% of the controls. They were also 20% less likely than were the controls to have had a previous pregnancy.

As expected, the women with endometriosis had high rates of pelvic pain (15.6%) and dysmenorrhea (24.6%). But somewhat surprising was how low those rates were in the controls—1.5% and 3.4%, respectively—suggesting that "these symptoms are actually more specific than previously acknowledged," Dr. Ballard said.

Other menstrual/pain symptoms reported significantly more often by the endometriosis patients than the controls were dyspareunia (9% vs. 1%, respectively), abdominal pain (45% vs. 13%), menorrhagia (23% vs. 6%), and menstrual problems (27% vs. 13%).

Gastrointestinal symptoms were also more common in the endometriosis group than in the control group, including constipation (9.2% vs. 4.4%) and rectal bleeding (2.0% vs. 1.1%), as were the urologic symptoms cystitis (8.8% vs. 5.3%) and dysuria (6.1% vs. 2.7%). Postcoital bleeding was reported by 2.9% vs. 0.7% and backache by 16.4% vs. 11.0%. All of these differences were statistically significant.

Women with endometriosis were also significantly more likely than were controls to have been diagnosed with subfertility (9.6% vs. 1.8%). But less expected was an association with the diagnosis of irritable bowel syndrome: 10.6% vs. 3.3%. Other diagnoses reported significantly more often among the women with endometriosis were urinary tract infection (18.5% vs. 9.8%), pelvic inflammatory disease (10.3% vs. 1.8%), and ovarian cysts (6.8% vs. 0.6%).

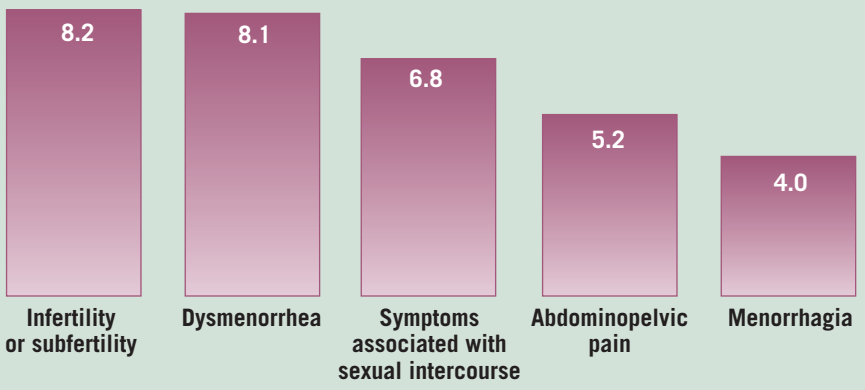
Stepwise regression analysis showed that the five "key symptoms" most strongly associated with endometriosis were infertility or subfertility (adjusted odds ratio 8.2), dysmenorrhea (8.1), symptoms associated with sexual intercourse (6.8), abdominopelvic pain (5.2), and menorrhagia (4.0).

In all, 84% of those with endometriosis had at least one of those symptoms, compared with 23% of those without, Dr. Ballard said.

The data also suggest there is opportunity for intervention: Nearly all (98%) of the women who were ultimately diagnosed with endometriosis had made at least one visit to a physician in the year before the diagnosis, compared with 81% of the controls.

In fact, 62% had visited the physician at least six times in that year, compared with 27% of those not diagnosed with endometriosis, she reported. ■

Adjusted Odds Ratios for Five "Key Symptoms" of Endometriosis



Note: Based on a study of 5,540 women with endometriosis, compared with 21,239 controls.
Source: Dr. Ballard

ELSEVIER GLOBAL MEDICAL NEWS

Rhubarb Extract May Soothe Menopausal Hot Flashes

BY FRAN LOWRY
Orlando Bureau

An extract derived from the roots of the rhubarb plant has been shown in a randomized, placebo-controlled trial to provide relief of vasomotor symptoms in peri- and postmenopausal women, Dr. David S. Riley said at the annual meeting of the North American Menopause Society.

The trial, which was conducted at University Hospital, Frankfurt, Germany, showed that women who consumed one tablet containing 4 mg of the extract *Rheum rhaponticum*, or ERr 731, every day for 12 weeks had a significant reduction in the number and severity of hot flashes, compared with women who took placebo.

After 12 weeks of treatment, 82% of the women taking the extract ERr 731 had a decrease of at least 10 points in their MRS scores.

Although ERr 731 has been available in Germany for several years, it is still relatively unknown on this side of the Atlantic, Dr. Riley of the University of New Mexico, Albuquerque, explained in a telephone interview. As a consultant to the German researchers, he thought it would be interesting to present their data to clinicians in the United States.

"This is a substance that has been on the market in Germany since 1993, and the research was done in order to reregister it as an herbal medication," said Dr. Riley, also editor-in-chief of Explore, The Journal of Science and Healing.

Hormone therapy, the standard for relieving vasomotor symptoms of menopause, can have unwanted side effects; other therapies, which do not have troublesome side effects, are of questionable efficacy, he said.

In this study, 112 perimenopausal women were randomized to 4 mg per day of ERr 731 or to placebo for 12 weeks. At the beginning of the trial, all of the women had a menopause rating scale (MRS) score of at least 18, which meant that their menopausal symptoms were moderate to severe.

Factors rated in the MRS score included hot flashes and sweating, heart complaints, sleep disturbances, depressive mood, irritability, anxiety, physical and mental exhaustion, sexual problems, urinary tract complaints, vaginal dryness, and joint and muscle complaints.

The women rated their symptoms on a scale from 0 (no symptoms) to 4 (very severe symptoms). The maximum attainable MRS score was 44 points, Dr. Riley explained.

After 12 weeks of treatment, there was a significant reduction in MRS score in the women taking the extract; 46 of the 56 (82%) women randomized to ERr 731 had a decrease of at least 10 points in their MRS score, compared with 2 (4%) of the women randomized to placebo.

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An extract derived from the roots of *Rheum rhaponticum*, shown here, has been on the market in Europe since 1993.

ERr 731 was associated with a significant reduction in hot flashes, compared with placebo, from 11 per day at baseline, to 4 per day at 12 weeks, Dr. Riley said.

The compound was safe and was associated with no breast tenderness or increase in endometrial thickness as assessed on ultrasound and biopsies, no changes in liver enzymes, no changes in blood pressure, no changes in weight, no increase in estradiol or progesterone, and no enhanced bone turnover, he added.

"Women are looking for safe and natural alternatives to hormones to relieve their menopausal symptoms, especially hot flashes, which appear to be the most annoying. This compound is exciting and shows promise, and hopefully we can generate some interest on this side of the Atlantic," he said. ■

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