ENDOMETRIOSIS JUNE, 1985

In many women of reproductive age some of the endometrial tissue ordinarily expelled from the body through menstruation travels outside the uterus and sticks there. In susceptible women, this tissue implants itself on the ovaries, the tubes, the outer wall of the uterus, the pelvic lining, the cervix or the vagina. This condition is known as endometriosis.

Endo is a Greek word meaning within, and metri refers to the Greek Metra, or uterus. Osis is a suffix that means an abnormal or diseased condition. Put them all together and you have "an abnormal condition within the uterus."

In fact, the problem lies outside the uterus. Emigrating endometrial tissue implants itself on other organs. The grafted patches of endometrial tissue, although most commonly localized in or near the reproductive system, have been found in the rectum, on the intestine, on the appendix and as far away as the elbow.

Acting as though they were still in the uterus, these refugee endometrial cells respond every month to the same hormones produced during the menstrual cycle. So although they are exiled from their uterine home, they thicken, enlarge and bleed as if they were still inside the uterus.

Problems:

Any or all of these occur in varying degrees not necessarily related to the severity of the condition.

Pain
Heavy Menstrual flow
Abnormal bleeding
Blood clots during menstruation
Lower Back pain
Painful defecation and rectal bleeding
Infertility
Painful deep vaginal penetration
Urinary infrequency
Bloating and tenderness

Causal theories:

1. Menstrual Backup (Retrograde Menstruation)

Endometrial tissue from the uterus backs up and out the tubes and into a woman's abdominal cavity. Julia Older in Endometriosis gives evidence that this happens in many women. What is not known is why the tissue tends to "collect on pelvic organs" in some women.

2. Blood and Lymph Glands

This theory proposes that blood and lymph systems circulate throughout the body and may prove to be carriers of endometrial tissue to sites outside the pelvic cavity.

3. Endometriosis on Surgical Scars

During surgery related to the uterus/pelvic area (like episiotomies, laparatomy, cesarian sections and amniocentesis) endometrial tissue may be inadvertently moved along surgical scars where sutures penetrate and to other areas outside the uterus.

4. Immunologic Theory

Endometriosis may cause an auto-immune response (sensitization to a substance produced by one's own body.) Endometriosis is thought to create an "antigen" from endometrial proteins. These are recognized by a woman's body as "foreign." There are then no antibodies to fight these off.

5. Genetic Connections

Susceptibility to the condition may correlate with whether one's mother or sister have it.

6. Hormone Imbalances

See next page.

ENDOMETRIOSIS

Medical Treatments:

1. Anti-inflammatory drugs such as Motrin, Ponstel, Anaprox to suppress prostaglandin F_2.

2. Menopause or pregnancy

Endometriosis ends with menopause and may end after pregnancy though some women find it returns.

3. Hormones

Hormones create pseudopregnancy which limits bleeding. Options are birth control pills (combination estrogen and progesterone) and Depo-Provera which is a progesterone compound given by injection. Danazol is a synthetic androgen (hormone secreted in the male testes.) It stops ovulation by blocking the pituitary stimulation of the ovaries and released LH and FSH. This prevents the egg from bursting out of it follicular sac. Therefore no progesterone can be produced. Thus, there is no shedding of endometrial tissue.

4. Surgery

There are several options:

Removal of scar tissue and adhesions (where tissue binds two or more organs together)

Cutting nerves in the sacral area of the spine to reduce pain (presacral Neurectomy.)

Cutting the nerves that relay messages from the uterus to the brain (uterosacral neurectomy)

Hysterectomy.

Laser Therapy.

FOR THE PROS AND CONS OF THESE MEDICAL TREATMENTS PLEASE CONSULT ENDOMETRIOSIS BY JULIA OLDER AND WOMANCARE BY MADARAS AND PATTERSON

For further information please see:

"Endometriosis" in Let's Live. January, 1983

Winning the Fight Against Breast Cancer: The Nutritional Approach by Carlton Fredericks, Ph.d

ENDOMETRIOSIS AND HYSTERECTOMY

Endometriosis can recur or continue after hysterectomy IF:

1) All ovarian tissue is not removed. About 85% of women with endometriosis severe enough to undergo hysterectomy are estimated to get it back if all ovarian tissue is not removed.

2) If the ovaries are removed, an estimated 5% will again experience endometriosis if they take estrogen to prevent menopause. The Endometriosis Association of Milwaukee, Wisconsin, U.S.A. has been recommending that women consider not taking estrogen for some months after hysterectomy and removal of the ovaries to allow time for endometrial growths still in the body to regress from hormone starvation. (It is sometimes impossible for remove all as they can be microscopic or in locations the surgeon cannot see or cut on.) Menopausal symptoms may be experienced. Their current recommendation is that those women with ovaries removed wait 3 to 6 months (though some have waited longer) and then take a low dosage of estrogen daily. A low dosage of estrogen is .3 milligrams or .625 milligrams a day. The Endometriosis Association worries about women with early removal of the ovaries perhaps being at high risk for osteoporosis(thinning and brittle bones) and other health problems that appear to be related to lack of estrogen.