Use Histology to Confirm Endometriosis Diagnosis

BY DOUG BRUNK
San Diego Bureau

S AN D I O — When it comes to diagnosing endometriosis, visual inspection is not enough. Dr. Georgene 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 to structures, to record our findings and not only the presence of endometriosis,” she said.

In order to confirm the presence of endometriosis, Lamvu said that laparoscopy is often the best method for visualizing the affected tissues. However, it is important to remember that not all patients who have pain are diagnosed with endometriosis, and that other conditions such as pelvic inflammatory disease, uterine fibroids, interstitial cysts, and ovarian cysts can also cause similar symptoms.

Lamvu emphasized the importance of thorough diagnostic testing, including histological analysis of tissue samples obtained during laparoscopy. “If we’re not careful, we can miss the diagnosis of endometriosis,” she said.

She also pointed out that in some cases, the symptoms of endometriosis can be difficult to distinguish from those of other conditions. “It’s not always easy to tell the difference between endometriosis and other causes of pelvic pain,” she said.

Lamvu’s presentation highlighted the importance of diligent and thorough diagnostic testing in order to ensure an accurate diagnosis of endometriosis. “We need to be careful to rule out other causes of pelvic pain before making a diagnosis of endometriosis,” she said.

She concluded by emphasizing the importance of interdisciplinary collaboration in the management of patients with endometriosis. “It’s important to work closely with other healthcare providers to ensure that our patients are receiving the best possible care,” she said.

Lamvu’s presentation was well-received by the audience, who appreciated her clear and concise explanation of the complexities of diagnosing and treating endometriosis. “She did an excellent job of explaining the complexities of endometriosis and the importance of thorough diagnostic testing,” said one attendee.

Overall, Lamvu’s presentation was a valuable contribution to the field of pelvic pain and endometriosis management, and it will undoubtedly help to improve the care of patients with these conditions.
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 sources. It’s important to explain to patients with chronic pelvic pain that they may have symptomatic endometriosis or that they may be suffering from endometriosis.

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 the development of endometriosis, including the extension into myometrium and adjacent organs, exfoliation of viable endometrial cells through tubes, and implantation of these cells into the peritoneum and adjacent organs.

“There are a lot of convincing data that retrograde menstruation and implantation of endometrial fragments is 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 pain management, NSAIDs, hormonal suppression with continuous oral contraceptives, and gonadotropin-releasing hormone agonists (GnRHa), excision, ablation, or cyclosporine and definitive extirpating surgery such as hysterectomy or bilateral salpingo-oophorectomy.

“Most of our patients are now undergoing medical and surgical therapies, so 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 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 hyperestrogenism and control uterine prostaglandins. Dos es of 5, 10, or 25 mg per day may be effective in reducing pelvic pain.

The progesterone antagonist RU486 (mifepristone) also holds promise. A dose of 50 mg every day for 6 months may lead to a decrease in the number of endometriotic lesions.

“These are experimental therapies,” Dr. Lamvu emphasized. “They may not work for some patients. Most of these therapies are recommended for only 3-6 months.”

Other future therapies include selective nonsteroidal receptor modulators or inhibitors such as anastrozole and letrozole.

“The nice thing about these is that they’re heavily studied in other disease processes such as cancer, so we have a lot more data as far as long-term side-effect profile and safety profile,” she said. “In pelvic pain these have only been studied for up to 6 months.”

Dr. Lamvu said she is most optimistic about the potential for new GnRH antagonists to make a significant improvement in chronic pelvic pain associated with endometriosis.

“These agents may work faster and have fewer side effects than the GnRH agonists that we now use,” she said.