

STANDARD OPERATING PROCEDURE

Endometriosis

Special Region (1)

Union of Myanmar

Version: (1)

Effective Date: 24 May 2026

Review Date: 24 May 2027

Approved by: Internal Medicine Unit

Endometriosis

Endometriosis is defined as the presence of endometrial-like tissue outside the uterus, which induces a chronic, inflammatory reaction. - The exact prevalence of endometriosis is unknown, but estimates range from 2% to 10% within the general female population and up to 50% in infertile women. Clinical presentations Suspect endometriosis in women (including young women aged 17 and under) presenting with 1

- 1 or more of the following symptoms or signs:
- chronic pelvic pain
- period-related pain (dysmenorrhoea) affecting daily activities and quality of life
- deep pain during or after sexual intercourse
- period-related or cyclical gastrointestinal symptoms, in particular, painful bowel

movements

- period-related or cyclical urinary symptoms, in particular, blood in the urine or pain

passing urine

- infertility in association with 1 or more of the above.

Physical examination

- Offer an abdominal and pelvic examination to women with suspected endometriosis to

identify

- abdominal masses
- pelvic tenderness
- adnexal masses (enlarged ovaries)
- reduced organ mobility (fixed retroverted uterus) and enlargement
- tender nodularity in the posterior vaginal fornix
- visible vaginal endometriotic lesions.
- If a pelvic examination is not appropriate, offer an abdominal examination to exclude

abdominal masses. Investigations

- The diagnosis of endometriosis is first suspected based on the history, the symptoms and

signs, then corroborated by physical examination and imaging techniques and finally is proven by histological examination of specimens collected during laparoscopy. Transvaginal ultrasound

- is the primary imaging technique
- may detect the presence of an endometrioma, typically appearing as a unilocular, thick walled, homogenous cyst with low level echogenicity ('ground glass' appearance). - to investigate suspected endometriosis even if the pelvic and/or abdominal examination is normal. - to identify endometriomas and deep endometriosis involving the bowel, bladder

• r ureter. - If a transvaginal scan is not appropriate, consider a transabdominal ultrasound scan of the pelvis.

- Do not exclude the possibility of endometriosis if the abdominal or pelvic examination and ultrasound scan are normal. MRI

• Consider pelvic MRI to assess the extent of deep endometriosis involving the bowel, bladder or ureter Serum CA 125

- Do not use serum CA 125 to diagnose endometriosis.
- Moderate elevation can be observed.

Laparoscopy

• Visual inspection of the pelvis at laparoscopy is the gold standard investigation, unless disease is visible in the posterior vaginal fornix or elsewhere.

- During a diagnostic laparoscopy, consider taking a biopsy of suspected endometriosis:
- to confirm the diagnosis of endometriosis (be aware that a negative histological

result does not exclude endometriosis)

- to exclude malignancy if an endometrioma is treated but not excised.
- During a laparoscopy to diagnose endometriosis, consider laparoscopic treatment of the

following, if present:

- peritoneal endometriosis not involving the bowel, bladder or ureter
- uncomplicated ovarian endometriomas.

Management Medical treatment of endometriosis-associated pain Analgesics

- paracetamol or a non-steroidal anti-inflammatory drug (NSAID) alone or in

combination is first line management Hormonal treatment

- Suppression of ovarian function for 6 months reduces endometriosis-associated pain.

- Symptom recurrence is common following medical treatment of endometriosis.
- Hormonal treatments are
 - combined oral contraceptive pill
 - progestogen
 - anti-progestogen (Gestrinone)
 - danazol
 - levonogestrel-releasing intrauterine system
 - GnRH analogue + Add-back hormonal therapy
 - Aromatase inhibitors in combination with oral contraceptive pills, progestagens, or

GnRH analogues (letrazole, anastrozole) reduce endometriosis-associated pain in case of rectovaginal endometriosis refractory to other medical or surgical treatment. Surgical treatment

- Surgical treatments involve elimination of endometriotic lesions, division of adhesions and interruption of nerve pathways.

- Perform surgery for endometriosis laparoscopically unless there are contraindications.
- Laparoscopic excision is surgical treatment of choice in endometriomas.
- As an adjunct to surgery for deep endometriosis involving the bowel, bladder or ureter,

consider 3 months of gonadotrophin-releasing hormone agonists before surgery.

- Postoperative hormonal therapy should be considered to prolong the benefits of surgery and manage symptoms.

- If fertility is no longer an issue, hysterectomy with bilateral oophorectomy

(laparoscopically unless there are contraindications) may provide a cure, but disease excision may be incomplete.

- If fertility is a priority, excision or ablation of endometriosis plus adhesiolysis /

laparoscopic ovarian cystectomy or drainage and ablation improves the chance of spontaneous pregnancy.

- Do not offer hormonal treatment alone or in combination with surgery to women or people with endometriosis who are trying to conceive.

References

1. Obstetrics and Gynaecology Myanmar management Guidelines, 2024
2. Amso, NN. and Griffiths, A. (2011). Pelvic inflammatory disease. In: Shaw, RW., Luesley, D.M and Monga, A. (eds). Gynaecology, 4th edition, Edinburgh, Churchill Livingstone Elsevier, 942 - 954.
3. Royal College of Obstetricians and Gynaecologists (2012). The management of chronic pelvic pain, Green Top Guidelines No 41, RCOG, London.
4. Stones, W. (2011). Chronic pelvic pain. In; Shaw, RW., Luesley, D.M and Monga, A. (eds). Gynaecology, 4th edition, Edinburgh, Churchill Livingstone, Elsevier, 929 - 941.
5. West, CP. (2016). Disorders of menstruation. In; Lusely, DM. and Kilby, MD (eds). Obstetrics & Gynaecology: An evidence based text for MRCOG, 3rd edition, New York, CRC Press, 589 - 590.
6. Becker CM, Bokor A, Heikinheimo O, Horne A, Jansen F, Keisel L, King K, Kvaskoff M, Nap A, Petersen K (2022). ESHRE guideline: endometriosis. Hum Reprod. 2022, (2).
7. National Institute of Clinical Excellence (2017). Endometriosis Diagnosis and Management. NICE guideline 73, RCOG press.
8. Royal college of Obstetricians and Gynaecologist (2006). The investigation and management of endometriosis. Green Top Guideline No.24, RCOG, London.
9. Shaw RW. (2011). Endometriosis. In; Shaw, RW., Luesly, D.M and Monga, A. (eds). Gynaecology, 4th edition, Edinburgh, Churchill Livingstone Elsevier, 488 - 506.