

Endometriosis: menstrual cycle and staff



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Endometriosis is an often painful disorder in which tissue that normally lines the inside of your uterus, the endometrium, grows outside your uterus.

Endometriosis most commonly involves your ovaries, bowel or the tissue lining your pelvis. Rarely, endometrial tissue may spread beyond your pelvic region (Staff, 2010). They can also be found in the vagina, cervix, and bladder, although less commonly than other locations in the pelvis. Rarely, endometriosis implants can occur outside the pelvis, on the liver, in old surgery scars, and even in or around the lung or brain.

Endometrial implants, while they can cause problems, are benign (Stoppler, 2011). In endometriosis, displaced endometrial tissue continues to act as it normally would: It thickens, breaks down and bleeds with each menstrual cycle. And because this displaced tissue has no way to exit your body, it becomes trapped. Surrounding tissue can become irritated, eventually developing scar tissue and adhesions, which is the abnormal tissue that binds organs together (Staff, 2010). Endometriosis affects women in their reproductive years.

The exact prevalence of endometriosis is not known, since many women may have the condition and have no symptoms. Endometriosis is estimated to affect over one million women (estimates range from 3% to 18% of women) in the United States (Stoppler, 2011). Estimates suggest that 20% to 50% of women being treated for infertility have endometriosis, and up to 80% of women with chronic pelvic pain may be affected. While most cases of endometriosis are diagnosed in women aged around 25 and 35 years, endometriosis has been reported in girls as young as 11 years of age. Endometriosis is rare in postmenopausal women.

Endometriosis is more commonly found in white women as compared with African American and Asian women. Studies further suggest that endometriosis is most common in taller, thin women with a low body mass index (BMI). Delaying pregnancy until an older age is also believed to increase the risk of developing endometriosis (Stoppler, 2011). The cause of endometriosis is unknown. One theory is that the endometrial tissue is deposited in unusual locations by the backing up of menstrual flow into the Fallopian tubes and the pelvic and abdominal cavity during menstruation, termed retrograde menstruation (Stoppler, 2011).

In retrograde menstruation, menstrual blood containing endometrial cells flows back through the fallopian tubes and into the pelvic cavity instead of out of the body. These displaced endometrial cells stick to the pelvic walls and surfaces of pelvic organs, where they grow and continue to thicken and bleed over the course of the menstrual cycle (Staff, 2010). Retrograde menstruation alone may not cause endometriosis, though. Instead, the condition may develop when one or more small areas of the abdominal lining turns into endometrial tissue.

This is possible because the cells lining the abdominal and pelvic cavities are descended from embryonic cells with the potential to specialize and take on the structure and function of endometrial cells. What activates that potential remains unknown (Staff, 2010). The primary symptom of endometriosis is pelvic pain, often associated with your menstrual period. Although many women experience cramping during their menstrual period, women with endometriosis typically describe menstrual pain that's far worse than usual.

They also tend to report that the pain has increased over time (Staff, 2010). Common signs and symptoms of endometriosis may include painful periods (dysmenorrhea), pain with intercourse, pain with bowel movements or urination, excessive bleeding during periods and/or between periods, and infertility. Some other symptoms that may be experienced are fatigue, diarrhea, constipation, bloating or nausea, especially during menstrual periods (Staff, 2010). The reasons for a decrease in fertility are not completely understood, but might be due to both anatomic and hormonal factors.

The presence of endometriosis may involve masses of tissue or scarring (adhesions) within the pelvis that may distort normal anatomical structures, such as Fallopian tubes, which transport the eggs from the ovaries.

Alternatively, endometriosis may affect fertility through the production of hormones and other substances that have a negative effect on ovulation, fertilization of the egg, and/or implantation of the embryo (Stoppler, 2011).

The severity of your pain isn't necessarily a reliable indicator of the extent of the condition.

Some women with mild endometriosis have extensive pain, while others with advanced endometriosis may have little pain or even no pain at all (Staff, 2010). Endometriosis is sometimes mistaken for other conditions that can cause pelvic pain, such as pelvic inflammatory disease (PID) or ovarian cysts. It may be confused with irritable bowel syndrome (IBS), a condition that causes bouts of diarrhea, constipation and abdominal cramping. IBS can accompany endometriosis, which can complicate the diagnosis (Staff, 2010). Treatment for endometriosis is usually with medications or surgery.

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The approach you and your doctor choose will depend on the severity of your signs and symptoms and whether you hope to become pregnant (Staff, 2010). Doctors may recommend that you take an over-the-counter pain reliever, such as ibuprofen to help ease painful menstrual cramps. However, if you find that taking the maximum dose doesn't provide full relief, you may need to try another treatment approach to manage your signs and symptoms (Staff, 2010). These pain-relieving medications have no effect on the endometrial implants.

However, they do decrease prostaglandin production, and prostaglandins are well-known to have a role in production of pain sensation. Because the diagnosis of endometriosis is only definite after a woman undergoes surgery, there will of course be many women who are suspected of having endometriosis based on the nature of their pelvic pain symptoms. In such a situation, NSAIDs are commonly used, such as naproxen or ibuprofen, are commonly used. If they work to control pain, no other procedures or medical treatments are needed (Stoppler, 2011). If they do not relieve the pain, additional evaluation and treatment generally occur.

Since endometriosis occurs during the reproductive years, many of the available medical treatments for endometriosis rely on interruption of the normal cyclical hormone production by the ovaries. These medications include GnRH analogs, oral contraceptive pills, and progestins (Stoppler, 2011). Supplemental hormones are sometimes effective in reducing or eliminating the pain of endometriosis. That's because the rise and fall of hormones during a woman's menstrual cycle causes endometrial implants to thicken, break down and bleed (Staff, 2010).

Gonadotropin-releasing hormone analogs (GnRH analogs) have been effectively used to relieve pain and reduce the size of endometriosis implants. These drugs suppress estrogen production by the ovaries by inhibiting the secretion of regulatory hormones from the pituitary gland. As a result, menstrual periods stop, mimicking menopause (Stoppler, 2011). Oral contraceptive pills (estrogen and progesterone in combination) are also sometimes used to treat endometriosis. The most common combination used is in the form of the oral contraceptive pill (OCP).

Sometimes women who have severe menstrual pain are asked to take the OCP continuously, meaning skipping the placebo (sugar pill) portion of the cycle. Continuous use in this manner will free a woman of having any menstrual periods at all. Occasionally, weight gain, breast tenderness, nausea, and irregular bleeding are mild side effects. Oral contraceptive pills are usually well-tolerated in women with endometriosis (Stoppler, 2011). If you have endometriosis and are trying to become pregnant, surgery to remove endometrial implants may increase your chances of success.

If you have severe pain from endometriosis, you may also benefit from surgery (Staff, 2010). Conservative surgery removes endometrial growths, scar tissue and adhesions without removing your reproductive organs. Your doctor may do this procedure laparoscopically or through traditional abdominal surgery in more extensive cases. In laparoscopic surgery, a slender viewing instrument (laparoscope) is inserted through a small incision near your navel. Guided by the laparoscope, your doctor inserts other instruments through another small incision to remove endometrial implants.

Such instruments might include a laser, small surgical instruments or a cautery, an instrument that destroys tissue with heat (Staff, 2010). Assisted reproductive technologies to help you become pregnant are sometimes preferable to conservative surgery, and doctors often suggest these approach if conservative surgery is ineffective (Staff, 2010). In severe cases of endometriosis, surgery to remove the uterus and cervix (total hysterectomy) as well as both ovaries may be the best treatment.

Hysterectomy alone is not effective; the estrogen your ovaries produce can stimulate any remaining endometriosis and cause pain to persist. Surgery is typically considered a last resort, especially for women still in their reproductive years. You can't get pregnant after a hysterectomy (Staff, 2010). REFERENCES Staff, M. C. (2010, September 11). Endometriosis. Retrieved July 24, 2011, from Mayo Clinic: <http://www.mayoclinic.com/health/endometriosis/DS00289> Stoppler, M. C. (2011). Endometriosis. Retrieved July 24, 2011, from MedicineNet. com: <http://www.medicinenet.com/endometriosis/article.htm>