Clinical Assessment and Management of Endometriosis and Dysmenorrhea

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Introduction

Endometriosis is a chronic inflammatory condition in which endometrial-like tissue is found outside the uterus. It can cause pelvic pain, painful menstruation, pain during or after sexual activity, bowel or bladder symptoms, fatigue, and infertility, although symptoms vary widely and some people have little pain. Dysmenorrhea means painful menstruation and may be primary, without an identifiable pelvic disease, or secondary to conditions such as endometriosis, adenomyosis, fibroids, or pelvic infection. A patient with progressively worsening menstrual pain, infertility, and tenderness or nodularity in the posterior pelvis may have endometriosis, but no single symptom or examination finding is automatically confirmatory. The original assumption that surgical visualization is always required has also changed. ACOG's 2026 diagnostic guidance supports a presumptive clinical diagnosis based on history, symptoms, examination, and imaging when appropriate, allowing treatment to begin without forcing every patient to undergo surgery. Assessment should be systematic, patient-centered, and attentive to fertility goals, pain severity, medical risk, and the possibility of other diagnoses. (American College of Obstetricians and Gynecologists, "ACOG Publishes New Endometriosis Clinical")

Clinical Assessment and Differential Diagnosis

Evaluation begins with a detailed history. Clinicians should ask when pain began, whether it is cyclical, how it affects school, work, sleep, exercise, relationships, and sexual activity, and whether there are bowel or urinary symptoms around menstruation. Bleeding pattern, contraception, pregnancy history, infertility duration, family history, prior surgery, medication use, and previous treatment response are relevant. Pain should not be dismissed simply because menstruation is expected to cause some discomfort. Severe pain that limits normal activity, progressively worsens, or fails to improve with initial therapy requires further assessment. Adolescents may have different presentations and should be interviewed with sensitivity and privacy.

Physical examination may identify pelvic tenderness, reduced organ mobility, masses, or nodularity, but a normal examination does not exclude endometriosis. The differential diagnosis includes primary dysmenorrhea, adenomyosis, uterine fibroids, ovarian cysts, pelvic inflammatory disease, gastrointestinal disorders, urinary conditions, pelvic-floor dysfunction, and musculoskeletal pain. Pregnancy-related causes must be considered when relevant. Laboratory tests do not provide a

reliable stand-alone diagnosis. Transvaginal ultrasound is commonly used to assess ovarian endometriomas and other pelvic pathology, while specialized ultrasound or MRI may help evaluate deep disease. Imaging can be normal in superficial endometriosis, so results must be interpreted with symptoms and clinical judgment. (American College of Obstetricians and Gynecologists, “Diagnosis Endometriosis Clinical Practice Guideline”)

Diagnosis and the Role of Surgery

Historically, laparoscopy with biopsy was treated as the definitive route to diagnosis. Surgery remains important when symptoms are severe, imaging suggests disease requiring intervention, medical treatment fails, fertility planning requires anatomical information, or the diagnosis remains uncertain. It can allow direct visualization and treatment of lesions during the same procedure. However, surgery has costs and risks, including anesthesia, bleeding, infection, organ injury, adhesions, and recurrence of symptoms. Requiring surgery before offering any treatment can delay care for years.

Current guidance supports clinical diagnosis and empiric treatment when the history is strongly suggestive and other urgent causes have been considered. Shared decision-making is essential. Some patients prefer to begin medical therapy, while others prioritize diagnostic certainty, fertility evaluation, or surgical treatment. Clinicians should explain that symptom severity does not always correspond to the visible extent of disease and that surgery is not a guaranteed cure. Endometriosis is a chronic condition that may require long-term management even after lesions are removed.

Management of Pain and Fertility Concerns

Follow-up is essential because response to treatment provides information and because side effects can change the balance of benefits and risks. A patient may need several trials before finding an acceptable option. Clinicians should agree on what improvement means—fewer days of disabling pain, better sleep, reduced bleeding, improved participation, or progress toward pregnancy—and should set a reasonable review period. If symptoms worsen, new red flags appear, or treatment fails, the diagnosis and plan should be reconsidered. Urgent evaluation may be needed for sudden severe pain, hemodynamic instability, pregnancy-related concerns, infection signs, or other acute conditions.

Pain management should also address the social consequences of delayed diagnosis. People with endometriosis often report missing school or work and being told that severe menstrual pain is normal. Repeated dismissal can reduce trust in clinicians and contribute to anxiety or depression. Documentation for educational or workplace accommodation may help patients remain engaged while treatment is adjusted. Partners and family members can be included with the patient’s permission so that pain and fatigue are understood as health issues rather than lack of effort. These supports do not replace medical care; they reduce the secondary harm caused by chronic symptoms. (National Institute for Health and Care Excellence)

Initial pain treatment may include nonsteroidal anti-inflammatory drugs when safe, hormonal suppression, or both. Hormonal options can include combined hormonal contraceptives, progestin-only therapy, and other agents chosen according to symptoms, contraindications, side effects, cost, and reproductive goals. Gonadotropin-releasing hormone therapies may be considered in selected patients, often with measures to reduce hypoestrogenic side effects. Treatment should be individualized; a patient who wants pregnancy now requires a different plan from someone seeking menstrual suppression. Opioids are generally not a preferred long-term strategy for chronic endometriosis pain because of limited benefit and substantial risk.

Surgical management may involve excision or ablation of lesions, treatment of endometriomas, and restoration of anatomy. The choice of surgeon and expertise matters, particularly for deep disease involving bowel, bladder, ureters, or complex fertility concerns. Hysterectomy is not an automatic cure and is not appropriate for everyone; endometriosis exists outside the uterus, and decisions about removing the uterus or ovaries have major consequences. Multidisciplinary care may include pelvic-floor physical therapy, pain specialists, gastroenterology, urology, mental-health support, and fertility specialists. Chronic pain can affect mood and relationships, but psychological care should support coping rather than imply that symptoms are imaginary.

Infertility evaluation should consider age, ovarian reserve, duration of trying to conceive, partner factors, tubal status, and the location and extent of disease. Options may include expectant management, surgery, ovulation treatment, intrauterine insemination, or in vitro fertilization. The best choice depends on the individual rather than a general rule that surgery or IVF is always first. Endometriomas require careful discussion because surgery may reduce ovarian reserve even when it improves access or symptoms. Patients need realistic information about benefits, risks, and time.

Health equity deserves explicit attention. Diagnostic delays may be longer when clinicians rely on stereotypes about race, age, gender identity, pain tolerance, or fertility preferences. Transgender and nonbinary people with uteruses may also experience endometriosis and may avoid care when services are not inclusive. Patient-centered language should reflect anatomy and individual identity without erasing the fact that endometriosis disproportionately affects women and girls. Access to specialists, imaging, surgery, and fertility treatment varies greatly by insurance and location. Improving care therefore requires both better clinical knowledge and systems that make timely evaluation affordable. (World Health Organization)

Research continues because endometriosis remains incompletely understood. There is no simple blood test that reliably diagnoses all disease, symptom severity does not map neatly onto lesion burden, and recurrence is common. Patients should be protected from claims that a single diet, supplement, or procedure guarantees cure. Lifestyle changes may support general health or help individual symptoms, but they should not be used to blame patients or delay evidence-based care. Clear communication about uncertainty is part of good medicine.

Communication about fertility must be careful because endometriosis does not mean that pregnancy

is impossible. Some patients conceive without assistance, while others experience substantial difficulty. Clinicians should avoid both false reassurance and unnecessary alarm. Early referral may be reasonable when age, infertility duration, ovarian reserve, tubal disease, or partner factors make delay costly. Fertility preservation may be discussed in selected cases, but it is not a guarantee and can be expensive. Decisions should reflect the patient's values rather than assumptions that every patient prioritizes pregnancy.

Because dysmenorrhea is common, the challenge is recognizing when it exceeds the range of expected menstrual discomfort. Pain that repeatedly prevents normal activity, begins after years of less painful cycles, is associated with intercourse, bowel movements, urination, infertility, or persistent noncyclical pain deserves evaluation. Education in schools and primary care can reduce normalization of disabling symptoms. Earlier recognition does not require diagnosing every menstrual pain as endometriosis; it requires taking symptoms seriously and using a structured differential diagnosis.

Conclusion

Endometriosis should be considered when dysmenorrhea is severe, progressive, associated with infertility, or accompanied by pelvic, bowel, bladder, or sexual pain. Nodularity or tenderness may support the diagnosis, but it is not independently confirmatory, and a normal examination or ultrasound does not rule the condition out. Modern care allows a presumptive clinical diagnosis and empiric treatment in appropriate patients rather than requiring immediate surgery. Management may include anti-inflammatory medication, hormonal therapy, surgery, fertility treatment, pelvic-floor care, and multidisciplinary pain support. The central principles are early recognition, exclusion of urgent alternatives, shared decision-making, and respect for the patient's symptoms and reproductive goals. Because treatment choices carry medical and fertility implications, this information is educational and should not replace assessment by a qualified gynecologic clinician.

References

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