

ENDOLIFE

DIGITAL MAGAZINE

**DR. CARLOS HENRIQUE
TRIPPIA**

The Power of Imaging in
Diagnosing Endometriosis
Before Surgery

DR ALEXANDRA CRISTOFOR

Endometriosis and
adenomyosis in the
perimenopausal and
postmenopausal period

**DR. CUAUHEMOC
CANO AGUILAR**

Endometriosis
infiltrating uterosacral
ligaments.

A portrait of Dr. Gaby Moawad, a man with short dark hair and a light beard, smiling. He is wearing a blue checkered blazer over a white shirt and a dark tie. He is sitting at a table with his arms crossed, wearing a watch on his left wrist.

Dr Gaby Moawad

The Human Behind the Surgeon

**Endometriosis is not
an harmless disease!**



**Seek specialist
care if you suffer
from
endometriosis**

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This current edition contains articles written by doctors, endometriosis advocates and healthcare practitioners.

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EndoLife magazine has taken all the necessary measures to ensure that all information provided herein are correct at the time of publication, however these do not substitute medical advice. The information provided herein is solely for educational purpose and not for diagnosing and/or treatment. EndoLife recommends seeing an endometriosis specialist if you suffer from endometriosis.

Table of Contents

- 5** **A Grant Rooted in Care: Thank You to iCareBetter**
Editorial
- 6** **Dr. Carlos Henrique Trippia**
The Power of Imaging in Diagnosing Endometriosis Before Surgery
- 8** **Mr Benedetto Mondelli**
Reproductive outcomes after surgical excision of endometriosis
- 11** **Nicole Notar**
Medical Gaslighting and Endometriosis: Breaking the Silence
- 13** **Dr Alexandra Cristofor**
Endometriosis and adenomyosis in the perimenopausal and postmenopausal period
- 16** **Dr. med. Rasmus Schmaedecker**
Advancements in endometriosis diagnostics - a clinician's perspective
- 18** **Dr Gaby Moawad**
The Human Behind the Surgeon
- 24** **Dr. Cuauhtemoc Cano Aguilar**
Endometriosis infiltrating uterosacral ligaments
- 27** **Dr Alexandra Andreea Poienar**
Menopause and Endometriosis - How Do We Find the Balance?
- 29** **Dr. Claudia Grigorov**
Estrogens and Endometriosis: What Is the Connection Between Hormones and This Painful Condition?
- 31** **Dr. Ruxandra Plesea**
What leads endometriosis patients to seek nutritional support?



A Grant Rooted in Care: Thank You to iCareBetter



In June, we were honored to share the news that our organization received a generous grant from iCareBetter, a platform that has become a trusted name in the endometriosis community. iCareBetter is known worldwide for its work in vetting endometriosis specialists and ensuring that patients can access high-quality, evidence-based care. Over the years, their involvement has extended beyond clinical vetting; they have consistently invested in supporting patient voices, advocacy, and education.

What makes this grant particularly meaningful is that it came unprompted. We did not seek it out; instead, it was an initiative from iCareBetter, a gesture that reflects their ongoing commitment to strengthening the community and to sustaining independent organizations like ours. It is a recognition that advocacy, awareness, and support services are essential alongside clinical care.

We are deeply grateful for this support. Grants like this allow us to continue developing resources, amplifying patient voices, and fostering dialogue between patients, clinicians, and researchers. They enable us to build bridges and provide spaces where those affected by endometriosis can feel seen, heard, and supported.

At a time when endometriosis continues to be underfunded and under-recognized globally, the involvement of organizations like iCareBetter reminds us that progress happens when communities, clinicians, and platforms work together. Their example is one of leadership, integrity, and care, values that resonate strongly with our mission.

To the team at iCareBetter, we extend our heartfelt thanks. Your trust and support are both an encouragement and a responsibility, one we carry forward with dedication and purpose.



Seeing the Invisible: The Power of Imaging in Diagnosing Endometriosis Before Surgery



Dr. Carlos Henrique Trippia

Radiologist specializing in endometriosis

Endoglobal group

Instagram: Endomapping

Dr. Carlos Trippia is a radiologist with specialized expertise in pelvic imaging and endometriosis. He's passionate about advancing diagnostic strategies and improving outcomes for women with complex pelvic disease.

Endometriosis is a complex and often misunderstood disease affecting an estimated 1 in 10 women of reproductive age. It occurs when tissue similar to the lining of the uterus grows outside the uterus, often causing pain, inflammation, and infertility.

While its impact can be devastating, the diagnosis of endometriosis is frequently delayed—on average by 7 to 10 years in first world countries—largely due to its elusive nature and the reliance on surgery for definitive confirmation.

As a radiologist who specializes in endometriosis, I've witnessed the transformative role that advanced imaging techniques—specifically magnetic resonance imaging (MRI) and transvaginal ultrasound (TVUS)—can play in the diagnostic journey. These tools don't just show us what's happening inside the body; they give us a roadmap to better, more effective treatment.

Why Is Diagnosing Endometriosis So Challenging?

One of the biggest challenges in diagnosing endometriosis is that symptoms can vary widely and overlap with other conditions like irritable bowel syndrome or pelvic inflammatory disease. Some women experience severe menstrual pain, fatigue, pain during intercourse, or bowel and urinary symptoms—while others may have no symptoms at all.

In the past, the standard method for diagnosing endometriosis was laparoscopic surgery, which involves making small incisions to insert a camera and visually inspect for lesions. While effective in some cases, surgery is invasive, carries inherent risks, and may still miss deeply infiltrating or hidden disease. This is where advanced imaging plays a crucial role.

What Is Endometriosis Mapping?

Endometriosis mapping is a specialized imaging process performed before surgery to locate and assess the extent of disease. It's like creating a GPS for the surgeon—a way to visualize where endometriosis is likely hiding, how deep it has invaded, and which organs are affected.

By identifying the precise location and depth of lesions before entering the operating room, endometriosis mapping significantly improves surgical outcomes. It allows surgeons to anticipate complexities, involve multidisciplinary specialists when needed, and tailor the surgical approach to each patient's anatomy and disease severity.

For patients, this means fewer surprises during surgery, a reduced risk of incomplete excision, and a higher likelihood of symptom relief. In essence, mapping transforms what was once a blind procedure into a targeted, informed intervention—empowering both doctors and patients in the fight against endometriosis.

Why Mapping Before Surgery Matters

Surgery for endometriosis is not a one-size-fits-all procedure. In fact, the complexity of the surgery can vary greatly depending on where the lesions are located and how deeply they invade surrounding tissues. Preoperative imaging helps in several critical ways:

- **Precision:** Surgeons can plan the exact approach needed—sometimes involving multidisciplinary teams like colorectal or urologic specialists.
- **Safety:** Knowing where nerves, vessels, or bowel are involved reduces the risk of complications.
- **Effectiveness:** Comprehensive removal of lesions minimizes the chances of needing repeat surgeries.
- **Empowerment:** Patients go into surgery better informed, with more realistic expectations about outcomes and recovery.
- **Avoiding Unnecessary Surgeries:** In some cases, imaging may reveal that surgical intervention is not necessary or that a different medical approach might be more effective.

Limitations and the Importance of Expertise

It's important to recognize that not all imaging centers are equipped to perform endometriosis mapping. Both MRI and ultrasound require specialized protocols and radiologists with specific training in endometriosis imaging. Without this expertise, lesions can be missed, misinterpreted, or underestimated.

Patients seeking imaging for suspected endometriosis should ask if the center follows an established endometriosis protocol and whether the radiologist has experience with deep infiltrating disease.

A Paradigm Shift in Care

We are entering a new era where imaging is no longer just a support tool, but an essential first step in the diagnosis and treatment of endometriosis. Just as we wouldn't perform heart surgery without first doing an echocardiogram or angiogram, we shouldn't approach complex pelvic surgery without first "seeing" what's inside.

By integrating advanced imaging into routine care for patients with pelvic pain or suspected endometriosis, we can offer earlier diagnoses, better-targeted treatments, and ultimately, improved quality of life. For too long, endometriosis has been invisible—both in medicine and in society. Through the lens of radiology, we are finally learning to see what's been hidden and, more importantly, to act on it.





Reproductive outcomes after surgical excision of endometriosis

Mr Benedetto Mondelli

Consultant Endometriosis Specialist

Endometriosis affects up to half of women experiencing infertility¹. While medical therapies can alleviate symptoms and reduce recurrence after surgery, excisional surgery plays a critical role in restoring pelvic anatomy, removing endometriotic lesions, and improving quality of life. However, the exact mechanisms by which endometriosis impairs fertility remain unclear, and the frequent coexistence of other factors such as adenomyosis adds further complexity to management.

Reproductive outcomes in mild endometriosis
Evidence suggests that surgical excision of minimal to mild endometriosis can enhance spontaneous conception rates. For instance, a Cochrane review (2020)² demonstrated that laparoscopic removal of endometriotic lesions improved pregnancy rates compared to diagnostic laparoscopy alone (OR 1.64; 95% CI 1.05–2.57).

Bafort et al.³ reported similar findings, with an odds ratio of 1.89 (95% CI 1.25–2.86) for viable intrauterine pregnancies following surgical treatment versus diagnostic laparoscopy alone. Based on such data, the European Society for Human Reproduction and Embryology (ESHRE, 2022⁴) guideline recommend operative laparoscopy as a treatment option to increase pregnancy rates in cases of mild endometriosis-associated infertility.

Adenomyosis, which commonly coexists with DE, may further impair endometrial receptivity and uterine function, making it challenging to determine the primary infertility cause^{5,6}. When surgery is undertaken, the approach should prioritise symptom relief, preservation of reproductive anatomy, and optimisation of conception chances.

A meta-analysis by Casals et al.⁷ indicated that performing surgery prior to ART resulted in a 1.84-fold increase in pregnancy rates per patient and cycle. Similarly, Ferrier et al.⁸ found improved pregnancy outcomes in patients undergoing surgery before ART in their retrospective comparative analysis. Bafort et al.⁹ reported pooled pregnancy rates nearing 60% within a year postoperatively, while Ferrero et al.¹⁰ documented cumulative rates between 50% and 60% even without ART.

Excisional surgery plays a critical role in restoring pelvic anatomy, removing endometriotic lesions, and improving quality of life.

Conversely, other studies suggest that while endometriomas or their surgical removal may reduce oocyte yield, ART outcomes such as embryo development and aneuploidy rates remain similar to those seen in other infertility diagnoses, indicating that pre-ART surgery does not uniformly improve outcomes.¹¹

Ultimately, patient-centred, multidisciplinary, individualised approaches based on symptoms, ovarian reserve, and surgical risks remain essential. Impact of ovarian endometrioma excision on fertility

The management of ovarian endometriomas is particularly contentious. Endometriomas are observed in up to 40% of women with endometriosis and can adversely affect ovarian function¹². Endometriomas impair ovarian function by depleting the ovarian reserve, interfering with follicle development, and modifying the ovarian microenvironment via mechanisms such as oxidative stress, inflammation, and fibrosis.

Surgical options include cystectomy, ablation, or ethanol sclerotherapy, with similar pregnancy rates across techniques. However, all approaches are associated with postoperative reductions in anti-Müllerian hormone (AMH) levels, reflecting diminished ovarian reserve, especially in bilateral cases. Factors such as cyst size, baseline AMH, and patient age also influence this decline. Despite the drop in AMH, laparoscopic cystectomy generally does not reduce ART success rates. Ethanol sclerotherapy has emerged as an alternative with promising results for ovarian reserve preservation and comparable live birth rates^{13,14,15}.

“Personalised management strategies tailored to individual symptoms, reproductive goals, and surgical risks remain central to effective treatment planning.”



In summary, personalised management strategies tailored to individual symptoms, reproductive goals, and surgical risks remain central to effective treatment planning. Especially in women seeking IVF, where the cystectomy may not improve ART outcomes.

Conclusion

Overall, treatment decisions should balance the potential reproductive benefits of surgery against its risks, especially regarding ovarian reserve preservation. In infertile patients, careful evaluation of age, symptoms, ovarian reserve markers, surgical risks, and reproductive goals is essential. Collaborative decision-making with the patient is vital to weigh the potential benefits for natural conception or ART outcomes against the inherent surgical risks.

Multidisciplinary input is essential to tailor management strategies, whether pursuing natural conception or ART, ensuring that surgical intervention aligns with the patient's individual circumstances and fertility plans.

Furthermore, future research and RCTs should continue to refine patient selection criteria, optimise surgical techniques to minimise ovarian damage, and determine long-term reproductive and obstetric outcomes to guide evidence-based practice.

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Medical Gaslighting and Endometriosis: Breaking the Silence

Nicole Notar
Endometriosis patient

The journey to an endometriosis diagnosis is often paved with dismissal, doubt, and disbelief. Medical gaslighting—when healthcare providers dismiss, minimize, or deny a patient's symptoms—is particularly prevalent in endometriosis cases, with patients waiting an average of 10 years for a proper diagnosis. This systematic dismissal of pain and symptoms doesn't just delay treatment; it fundamentally impacts patients' physical and mental well-being.

Understanding Medical Gaslighting

Medical gaslighting occurs when healthcare providers:

- Dismiss symptoms as "all in your head"
- Minimize severe pain as "normal period pain"
- Attribute symptoms to stress or anxiety without proper investigation
- Prescribe painkillers without seeking the root cause
- Suggest that patients are exaggerating their symptoms
- Dismiss the impact of symptoms on daily life
- Fail to order appropriate diagnostic tests
- Tell patients to "just deal with it" as it's "part of being a woman"

My story exemplifies this pattern. At 16, I received diagnoses of IBS and ovarian cysts, while my underlying endometriosis remained undiagnosed for a decade.

The response to my debilitating menstrual pain—being prescribed Naproxen and Percocet at age 18—shows how serious medical conditions are often bandaged with painkillers rather than properly investigated.

The Impact of Medical Gaslighting

The consequences of medical gaslighting extend far beyond delayed diagnosis:

Physical Impact:

- Progression of untreated disease
- Increased pain and symptom severity
- Development of additional health complications
- Reliance on painkillers and their side effects
- Deteriorating overall health

Mental and Emotional Impact:

- Decreased self-trust and confidence
- Anxiety about medical appointments
- Depression and isolation
- Strain on relationships with family and friends
- Professional challenges and career impact
- Financial burden from seeking multiple opinions

I've experienced these impacts firsthand—from missing work due to escalating pain to the emotional trauma of having my symptoms dismissed. The progression from missing half a day of work to being unable to work from bed demonstrates how untreated endometriosis can severely impact quality of life.

Recognizing the Signs

Patients can recognize medical gaslighting through several red flags:

1. Dismissive Language:

- "It's just anxiety"
- "All women go through this"
- "You're being dramatic"
- "It can't be that bad"

2. Inadequate Investigation:

- Refusing to order tests
- Dismissing symptoms without examination
- Jumping to psychological causes without ruling out physical ones
- Prescribing pain medication without diagnostic work

3. Patronizing Behavior:

- Interrupting or talking over you
- Dismissing your research or knowledge
- Making assumptions without listening to your full history
- Refusing to consider your suggested diagnoses or concerns

Breaking Free from Medical Gaslighting

My experience with an endometriosis excision specialist illustrates what proper medical care looks like: a doctor who listens, validates, and takes action. When my excision specialist asked about my pain level and I said "100. It is awful, awful, awful," they didn't dismiss my experience—they acknowledged it and offered real solutions. They believed me when I described my pain, understanding that it needed to be acknowledged and healed, not ignored and normalized as part of womanhood.

Here are the Top 3 Things You Can Do to Advocate for Yourself:

1. Document Everything:

- Keep a detailed symptom diary
- Record how symptoms impact daily life
- Track treatments tried and their effects
- Save medical records and test results

2. Build a Support Network:

- Connect with advocacy groups
- Find supportive medical professionals
- Share experiences with others who understand
- Bring an advocate to appointments

3. Trust Your Body:

- Remember that you know your body best
- Don't accept dismissal of severe symptoms
- Seek second (or third) opinions when needed
- Continue advocating for proper care

The path to proper endometriosis diagnosis and treatment shouldn't require a decade of suffering and dismissal. My story highlights both the challenges within the medical system and the transformative power of finding healthcare providers who listen and validate. By recognizing medical gaslighting and its impact, we can work toward a future where endometriosis patients receive prompt, compassionate, and effective care.





Endometriosis and adenomyosis in the perimenopausal and postmenopausal period

Dr Alexandra Cristofor

consultant obstetrician-gynecologist

Endometriosis and adenomyosis are oestrogen-dependent conditions, most commonly diagnosed in women of reproductive age. Traditionally, the onset of menopause has been associated with regression of symptoms and endometriotic lesions. However, recent data indicate that a significant proportion of women continue to experience manifestations even after menopause, whether natural, medically induced, or surgically induced. Moreover, the use of hormone replacement therapy (HRT) in this category of patients introduces additional diagnostic and management challenges.

The prevalence of postmenopausal endometriosis is estimated at 2–5% according to narrative and retrospective studies. A cohort study reported a prevalence of approximately 4% among postmenopausal women. Although the incidence is lower compared with reproductive age, the documented cases highlight the complexity of the underlying pathophysiological mechanisms.

The transition to menopause represents a distinct clinical phase for women with endometriosis and adenomyosis.

Hormonal fluctuations during this period—characterised by progressive decline in progesterone and variable persistence of oestrogen—can exacerbate pain symptoms and trigger abnormal uterine bleeding. These manifestations are often mistaken for physiological perimenopausal changes, leading to diagnostic delays or even underdiagnosis.

In adenomyosis, heavy menstrual bleeding and dysmenorrhoea may persist or worsen during this stage, frequently being misattributed to perimenopausal cycle disorders. Therapeutic decisions are particularly challenging: while spontaneous improvement may be expected after definitive menopause, persistent severe symptoms often require medical or surgical intervention, with careful consideration of age-related risks and comorbidities.

Thus, perimenopause should be regarded as a critical window for the evaluation and monitoring of women with endometriosis and adenomyosis, aiming to prevent symptom aggravation as well as disease reactivation due to hormonal therapies initiated during this stage.

Despite the sharp fall in systemic oestrogen levels after menopause, endometriosis can persist or even progress through:

- local oestrogen production within lesions via aromatase and other steroidogenic enzymes,
- extra-ovarian sources of oestrogen (e.g. adipose tissue, skin),
- the use of menopausal hormone therapy, particularly oestrogen-only regimens, which may reactivate residual foci.

Therefore, postmenopausal endometriosis should not be regarded as a rare or irrelevant entity, but rather as a clinically significant condition with potential complications. Both GnRH analogues and bilateral oophorectomy can induce artificial menopause, lowering oestrogen rapidly. This approach often improves pelvic pain and cyclical symptoms but also induces sudden, severe climacteric symptoms such as hot flushes, insomnia, mood disturbances, vaginal atrophy, dyspareunia, and loss of libido—making the balance between disease control and quality of life difficult to achieve.

Data regarding postmenopausal adenomyosis are even more limited.

While regression is generally expected, documented cases of persistent symptoms and incidental histopathological discovery exist. Adenomyosis may contribute to chronic pelvic pain in postmenopausal women, often alongside other comorbidities. Most cases are diagnosed incidentally, but when symptoms persist (abnormal bleeding, chronic pelvic pain), total hysterectomy remains the treatment of choice, considered definitive and curative. In selected patients with major surgical contraindications, conservative management with symptomatic therapy or hormonal agents may be considered, though evidence of efficacy after menopause is scarce.

Women with premature or surgically induced menopause face additional risks such as osteoporosis and cardiovascular disease, making HRT essential in most cases. Principles include:

- Continuous combined HRT (oestrogen + progestogen) is preferred, even post-hysterectomy, to reduce the risk of reactivation or malignant transformation.
- Oestrogen-only HRT may be considered only after several years, in hysterectomised women with no residual disease, and requires individualised decision-making.
- Regimens including tibolone or combinations with testosterone may benefit women with loss of libido.
- Local vaginal oestrogen or DHEA preparations can improve urogenital symptoms without significant risk of reactivation.



The oestrogen threshold theory proposes that a minimum serum oestrogen level is sufficient to preserve bone density and alleviate vasomotor symptoms, yet insufficient to stimulate residual endometriotic foci. Although the exact threshold is not well defined, estradiol levels comparable to natural postmenopause (<20 pg/mL) are generally associated with minimal recurrence risk. In clinical practice, continuous combined HRT at the lowest effective oestrogen dose is preferred to maintain this balance.

Rare but documented cases of malignant transformation of postmenopausal endometriosis or adenomyosis have been reported, particularly in endometriomas and cystic adenomyotic lesions.

Associations with epithelial ovarian cancer, and less frequently with other gynaecological malignancies, have been described. Therefore, in postmenopausal women with a history of endometriosis presenting with a pelvic mass, oncological protocols should be followed. Surgical management remains the first-line approach for symptomatic postmenopausal women, primarily for diagnostic confirmation and exclusion of malignancy.

Medical options are limited but may include:

- analgesics and anti-inflammatories for symptom control,
- aromatase inhibitors (AIs) as the main non-surgical option, shown in case series to reduce pain and lesion size.

Diagnosis of postmenopausal endometriosis is often delayed, as symptoms may be nonspecific and mistaken for other pathologies (recurrent cystitis, irritable bowel syndrome, musculoskeletal pain). In women with pelvic masses, differentiation from malignancy remains the principal challenge. Although primarily considered conditions of reproductive age, endometriosis and adenomyosis may persist or recur after menopause, even in the absence of hormone therapy. Major clinical challenges include differential diagnosis, the (albeit small) risk of malignant transformation, and the delicate balance between disease control and maintaining quality of life with HRT.

In conclusion:

- Postmenopausal endometriosis should not be overlooked.
- Management should be individualised, considering metabolic, skeletal, and oncological risks.
- Patient communication and education are essential, as both natural and induced menopause in women with endometriosis present complex challenges that require a multidisciplinary approach.



Advancements in endometriosis diagnostics - a clinician's perspective

Dr. med. Rasmus Schmaedecker

Consultant Endometriosis Centre
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In the last ten years, diagnosis of endometriosis has changed radically. When I started my career more than fifteen years ago, diagnostic laparoscopy was the gold standard in the diagnosis of endometriosis. Nowadays, the term „diagnostic laparoscopy“ amongst endometriosis specialists is not even unheard of, but a term that will instantly disqualify yourself. Today, nobody would dare to perform an invasive procedure to merely diagnose the disease and not treat it at the same time. Back then, many patients in the referral centers that had been operated on multiple times still had a lot of disease - mostly deep endometriosis - that so far had been overlooked.

So what has changed? First of all, endometriosis and especially deep endometriosis has been getting more attention. Myself working in large endometriosis centers for more than ten years, my perception is probably blurred, but I am sensing an increased interest of the public and medical and paramedical personell in the field. Looking at congresses and workshops, the endometriosis sessions ten years ago were rather small, while in the last couple of years (especially since Emmanuel Macron announcing his action plan in 2022) the events have been getting bigger and more crowded. This just describing the change in public awareness of the disease.

Moving away from the diagnostic laparoscopy is something that, in my perception, has been driven by three main points:

Number one: the nature of endometriosis as a chronic disease often needing long term hormonal treatment for reliable symptomatic control. This has sparked the idea in us clinicians: if I have to treat the patient with hormones postoperatively to prevent relapse, or if the dysmenorrhea is mainly caused by adenomyosis (which in many cases is not adequately surgically treatable while preserving the uterus) why do I not try it instead of surgery and see how the patient is responding? Turns out, very many patients did not require surgery in the first place to achieve very good symptomatic results.

Fig 1: Transvaginal ultrasound of a large deep infiltrating nodule of the rectum



Number two: transvaginal ultrasound has been getting better and better in detecting adenomyosis, ovarian and deep endometriosis as well as adhesions and - with limitations- peritoneal endometriosis so nowadays, in expert hands, you can get a very reliable and good idea of the extent of the disease without invasive procedures. The same applies to the role of MRI in diagnosis of endometriosis, in the end, the expertise of the diagnostician interpreting the images is the most important factor.

Number three: ultimately, the sheer number of patients that would have to receive a diagnostic laparoscopy probably was a factor, too. Many health systems are far from being capable of performing this incredible amount of procedures every year. Think about it, around ten percent of the female population of reproductive age.

So this, in my opinion, were the most important factors driving that change of paradigm that has characterized endometriosis care in the last ten years, with the development of expert transvaginal ultrasound undoubtedly playing the most important role in our day to day clinical life. The other big factor is something I would like to call a clinically pragmatic attitude: Once you rule out other common (i. e. fibroids) or rare (congenital malformations) reasons for the dysmenorrhea, even with a vaginal ultrasound that is not showing any abnormalities, endometriosis is a likely diagnosis. And, in the end, it is in most cases not a diagnosis we should be treating, but the symptoms the patient is having. This, for me, is the factor why I see no clinical application of the saliva test for diagnosis of endometriosis in my practice - other than the strong wish of the patient „to know if I have it or not“.

So how do we tell the patients with „normal dysmenorrhoea“ (70-90% in young women) from the ones needing treatment? There is many factors (such as pain being more than VAS 5 regularly, analgetics only helping a bit, regularly missing school, work or social life and autonomic dysregulation with nausea, vomiting etc.) In the end, a patient seeing you because of her symptoms will be a good indicator that she probably needs treatment.

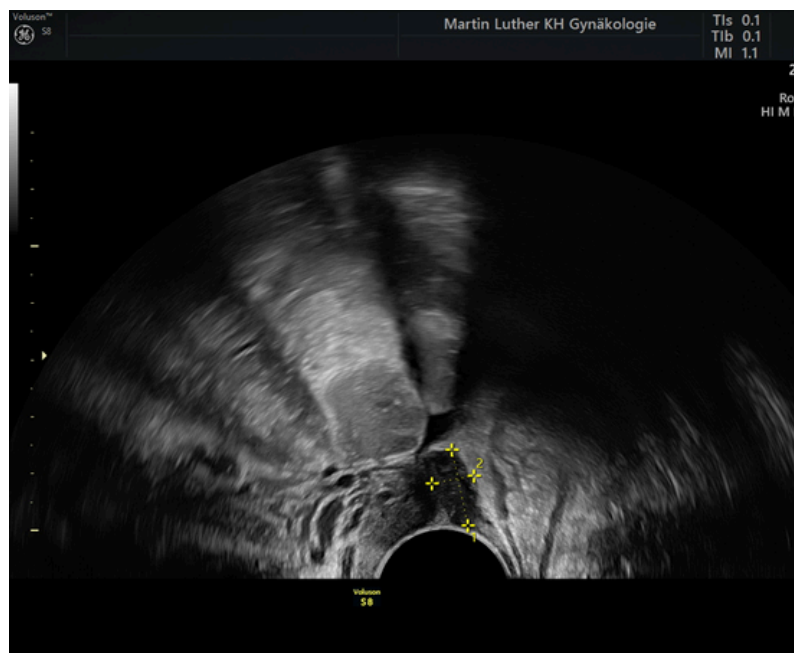


Fig 2: Transvaginal ultrasound of a nodule in the rectovaginal septum not infiltrating the rectum

So the three symptomatic pillars of endometriosis - pain, infertility and organ destruction - should be addressed, and ovarian endometriosis should be ruled out as well as deep endometriosis affecting the ureter by doing a kidney ultrasound.

In my opinion, this clinically pragmatic attitude might in the end be even more important than any advancements in diagnostics. Turns out we do not need a histological diagnosis to treat every patient. We just need a good clinical workup to rule out anything that might become a problem in the future and to get an exact picture of the disease. This is where the advancements in vaginal ultrasound nowadays can provide us clinicians with the safety to pragmatically treat the symptoms of the patient.



Dr. Gaby Moawad: The Human Behind the Surgeon

Patient-centered care is most essential , it's no longer just about technical mastery; it's about empowering patients with knowledge and advocating for their needs.

My journey toward medicine, and specifically gynecology, was deeply shaped by my personal experiences and the circumstances of my upbringing.

Growing up during a time of war in Lebanon, I witnessed firsthand how many people felt helpless and overlooked, which instilled in me a profound desire to make a difference in other people's lives. I realized that I wanted to help and provide support to those who feel vulnerable and sidelined.

After being shot and rehabilitated, I learnt a powerful lesson about how compassion, listening, and trust in healthcare are of crucial importance. During that difficult time, I experienced the pain of being dismissed and misunderstood by doctors when I desperately needed their attention. It made me see how vital it is for patients to feel heard and validated, especially when they are vulnerable and in pain.

Gynecology, in particular, appealed to me because it combines intricate surgical skills with the opportunity to improve the quality of life for younger patients - something incredibly motivating for a lot of doctors. The complexity of female reproductive health and the meaningful relationships with patients drew me to this specialty early in my career.

At what point did you realize endometriosis would become the central focus of your career?

What drew me in was the recognition that this disease demands a multifaceted approach - one that combines cutting-edge research, compassionate patient care, and innovative surgical techniques.

The difficult journey of each patient navigating a condition that is often misunderstood or underestimated has inspired me to delve deeper, to pioneer better diagnostic tools, and to refine surgical strategies that can truly improve the quality of life for the patients. It's like having a puzzle that you want to fix, and each aspect of the puzzle is important to improving the patients' care. Endometriosis, with its elusive diagnosis, nuanced surgical management, and the critical importance of meticulous postoperative care, exemplifies the challenges that we face every day, and this fuels an amazing passion in this field.



My recognition in robotic excision surgery for endometriosis isn't just a title, but a reflection of a journey rooted in purpose and driven by a relentless commitment to excellence and hope.



You've become a recognized name in robotic excision surgery for endometriosis. Was that a conscious direction, or did it evolve over time?

For me, the journey has always begun with a vision. Whenever you have a vision, you start aspiring to make a meaningful difference in the lives of your patients. Initially, this vision was just a spark, fueled by a desire to provide better care, to push the boundaries of what's possible, and to truly understand the complexities of endometriosis.

Throughout my path, the choices I made became stepping stones towards that vision. One pivotal decision was embracing robotic da Vinci platforms - not as an end in itself, but as a powerful tool that could sharpen my surgical ability, enhance precision, and ultimately improve outcomes for my patients. Robotics offered me a new lens through which I could execute even the most intricate excisional surgeries with confidence and finesse. It became an opportunity to serve patients with the optimal excisional treatment they deserve. It also became a platform to uplift fellow surgeons - sharing knowledge, elevating skills, and fostering a community committed to excellence.

Operating publicly, especially in front of a large audience, is an energizing challenge. It pushes me to continually refine my skills, to be transparent about my process, and to inspire others by demonstrating that excellence is attainable through dedication and teamwork. Every live surgery shared becomes an opportunity to learn, to teach, and to elevate the standards of our field.

Ultimately, it's more about thinking that there's a patient there, irrelevant of the audience, and you have to provide the highest standards of surgical care for them. So the patient is at the center of the focus, and all the rest comes from the experience and the expertise you gather through the years.

Whenever you do things in a standardized way, every day will become a challenge but whenever you utilize the same approaches, the same technique, it will flow more fluid than if you don't know what you're doing, or if you don't know where to start.



“

For me, the true inspiration lies in knowing that my contributions can empower surgeons to perform with greater confidence, precision, and compassion. Whether in a bustling city hospital or a smaller regional facility, the impact of education becomes a catalyst: transforming the way surgeons approach complex diseases like endometriosis and shaping a future where every patient receives the care they deserve. It's a reminder that change begins with a single skill, a single lesson, and that these moments of teaching can ripple out profoundly, impacting lives long after the surgeries are done.

Is there a country or setting where teaching had an especially powerful impact on you or the local surgeons?

While I have been privileged to teach and learn across various settings, it's important to recognize that the most profound impact often doesn't come from a single country or a specific place, but rather from the diverse hospitals and institutions I've had the honor to collaborate with. Each hospital, each team, represents a unique microcosm of challenges and opportunities - a place where shared knowledge can directly transform patient outcomes and lives.

What makes this particularly powerful is the ripple effect - when I teach at one hospital, the skills I impart can elevate entire teams, improve surgical standards, and ultimately benefit countless patients.

How do you manage the balance between teaching, operating, research, and patient care?

Balancing teaching, operating, research, and patient care is a dynamic dance - an ongoing effort to harmonize each element in a way that fuels my passion and ultimately benefits those I serve. You have to identify your priorities. You need to be very responsible with your time because you have to use it wisely so you can take care of yourself at the same time.

Teaching invigorates my curiosity and keeps me humble, reminding me that I am always a student as well as a mentor. Operating provides the hands-on experience and skill mastery necessary to deliver exceptional care, grounding me in the realities and complexities of each patient's journey. Research fuels my desire to innovate, pushing the boundaries of what we know and can achieve, so that progress becomes part of our shared future.

It's a trifecta between personality, surgical skills, and academic knowledge. Patient care combines personality as well. You have to listen to be empathetic. So whenever you have one missing, if you're a very good surgeon and a very good publisher, but you don't know how to talk to your patients, nobody's going to come to you.

If you know how to talk to your patients, and you're a very good surgeon, but you don't know the latest research in science, you might be doing something harmful to the patient. If you're a very good surgeon and you take very good care of patients, if you don't publish academically, that puts you in a weaker position in the community.

What part of your work feels most essential to you right now, and has that changed over time?

Currently, I believe patient-centered care - listening, understanding, and addressing individual needs - is most essential. Over time, I've shifted from solely technical excellence to ensuring that care aligns with each patient's unique circumstances and goals. Because when we're younger we want to build our technical excellence, and that's why many times focus on the volume. When you grow and mature, and you have good surgical skills, patients should always be at the center of your care.

At the core, I believe that providing exceptional surgical treatment - especially for complex conditions like endometriosis - remains the foundation of everything I do. But over time, this sense of purpose has evolved; it's no longer just about the technical mastery of surgery. It's about empowering patients with knowledge, advocating for their needs, and inspiring a new generation of surgeons to push boundaries and embrace excellence.



Our educational models sometimes fall short in preparing clinicians to recognize the disease early and to execute comprehensive surgical treatments that can truly alter its course.



What do you see as the biggest gap in how endometriosis is currently treated or taught?

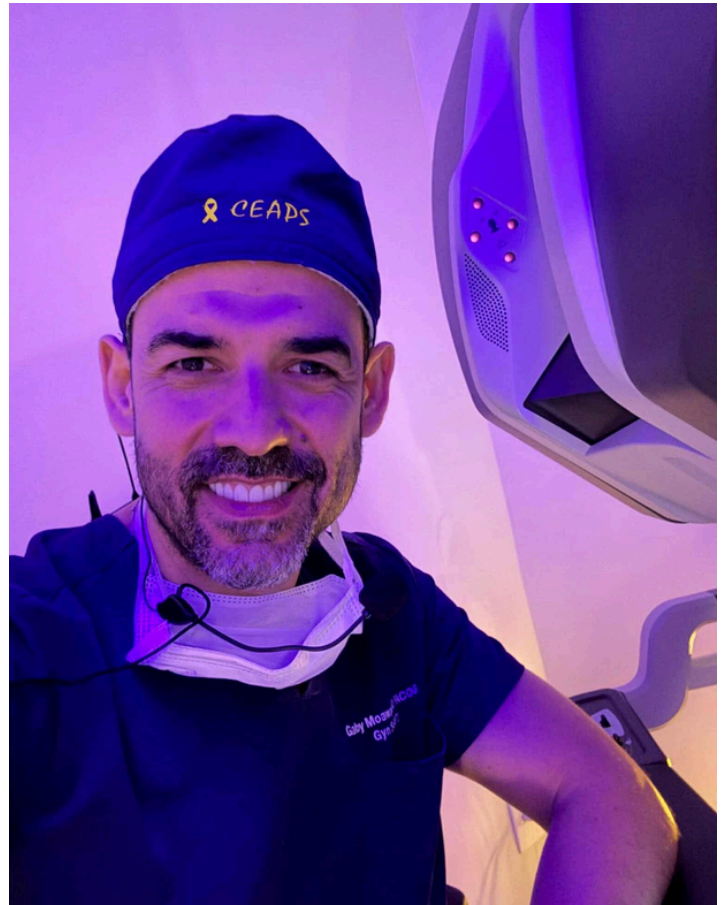
The biggest gap in how endometriosis is currently treated and taught is the persistent challenge of approaching it as a complex, multifaceted disease rather than a single symptom or isolated condition. Too often, treatment focuses narrowly on symptom management rather than addressing the root causes with complete, evidence-based excisional procedures.

We need to elevate training standards, foster a deeper appreciation for the disease's complexity, and promote surgical mastery that emphasizes complete excision and lasting relief. Only through advancing our knowledge and refining our approach can we truly close this gap and provide patients with the comprehensive care they deserve - transforming lives one surgery, one education, and one breakthrough at a time.

What are the most complex or high-risk types of endometriosis cases you regularly operate on, and what makes them challenging?

The most complex and high-risk cases I regularly encounter involve deep infiltrating endometriosis that extends into vital structures - such as the bowel, bladder, or ureter - and cases where multiple organs are affected simultaneously. These cases are particularly challenging because they demand a meticulous balance: the need for complete excision to alleviate symptoms and prevent recurrence, while preserving organ function and minimizing the risk of complications. The disease's infiltrative nature often blurs the boundaries between healthy tissue and affected areas, requiring a surgeon's precision, detailed understanding of the pelvic anatomy, and the ability to adapt quickly. Each surgery becomes a complex puzzle, where success hinges on both technical mastery and careful judgment - things that can only be cultivated through experience, ongoing learning, and a deep commitment to patient safety.

These cases remind me that our work isn't just about removing disease - it's about restoring hope and quality of life in the most delicate and high-stakes circumstances.



You're one of the few surgeons who operate on diaphragmatic and thoracic endometriosis. How do you approach multi-compartment disease?

As a specialist in diaphragmatic and thoracic endometriosis, I see multi-compartment disease not merely as a clinical challenge, but as a call to demonstrate unwavering dedication and precision. My approach begins with a comprehensive and meticulous assessment and mapping - understanding that each patient's disease is unique and requires a tailored strategy grounded in the latest evidence and surgical innovation.

I believe that successful management transcends technical skill; it demands a deep empathy for the patient's experience and a commitment to restoring their quality of life. By adopting a multi-disciplinary mindset, I aim to address each involved compartment - pelvic, diaphragmatic, thoracic - as interconnected parts of a whole, ensuring no aspect is overlooked. My aim is always to achieve complete excision while minimizing patient risk, often in staged procedures if necessary.

What is CEAPS, and how does your approach differ from more conventional treatment protocols?

When we do surgery, what we provide very differently is the standardized approach. That means we provide standardized steps to surgery, so we can ensure that we're going to get a better functional outcome. We combine excellent surgery with proper comprehensive care preoperatively and postoperatively. It's about treating the patient as a whole, with a combination of holistic approaches - sometimes cognitive therapy, pain management, and post-surgery gut recovery.

We think of the patient with endometriosis as a continuum. Intervention is a continuum, it's not a single point in the timeline because surgery alone is not magical. Understanding the causes of pain and how we can help improve the quality of life is not always surgical. So we empower patients with knowledge, we guide them, we develop a strategy that covers all aspects of the disease rather than treating a symptom or pain only.

Are there any recent cases that, for you, captured what robotic surgery makes possible that traditional laparoscopy might not?

A recent challenging case involved a robotic excision of deeply infiltrating endometriosis affecting the pelvic nerves. This scenario exemplifies that the profound capabilities of robotic surgery (precision, flexibility, and enhanced visualization) are essential when navigating such delicate and complex anatomy.

The goal was to remove the endometriotic tissue completely while safeguarding critical nerve structures that influence bladder, bowel, and sexual function. The robotic system's articulating instruments and 3D visualization allowed us to perform meticulous dissection in confined spaces, minimizing trauma to surrounding tissues. This case underscores how robotic surgery transcends traditional laparoscopy ergonomics and precision limitations, transforming what was once a high-risk, technically demanding procedure into a safer, more controlled intervention.

If you could change just one thing about how the medical system globally approaches endometriosis, what would it be?

If I could change one aspect of the global medical system's approach to endometriosis, it would be prioritizing early diagnosis and comprehensive care. Too often, women endure years of uncertainty, dismissive attitudes, and fragmented treatment before receiving a proper diagnosis. I believe that by fostering awareness, education, and a patient-centered approach from the outset, we can transform lives.

The goal should be to treat endometriosis not just as a condition to manage, but as a complex, multifaceted systemic disease that deserves respect, understanding, and timely intervention. We have to shift the perception that this is a gynecological disease only. When we shift the focus to early recognition and appropriate surgical care coupled with holistic care, we empower individuals to reclaim their health, reduce unnecessary suffering, and we pave the way for a future where no one has to wait years for the support they urgently need.

What message would you give to family members or partners of people living with endometriosis? How can they best support their loved ones?

To family members and partners of those living with endometriosis, my message is one of compassion and active listening. Understand that their pain is real, often invisible, and deeply impactful. Your support can be a pillar of strength - by simply being present, patient, and open to learning about what they are going through.

Empower them by encouraging their choices, advocating for their needs, and respecting their experience. In doing so, you help foster a sense of hope and resilience amidst the challenges. Supporting someone with endometriosis isn't just about managing symptoms - it's about standing with them as they navigate their journey toward healing, reminding them they are not alone in this fight. Your understanding and unwavering support can make all the difference in their resilience and quality of life.



Endometriosis infiltrating uterosacral ligaments

Dr. Cuauhtemoc Cano Aguilar

Gynecologist and endometriosis specialist

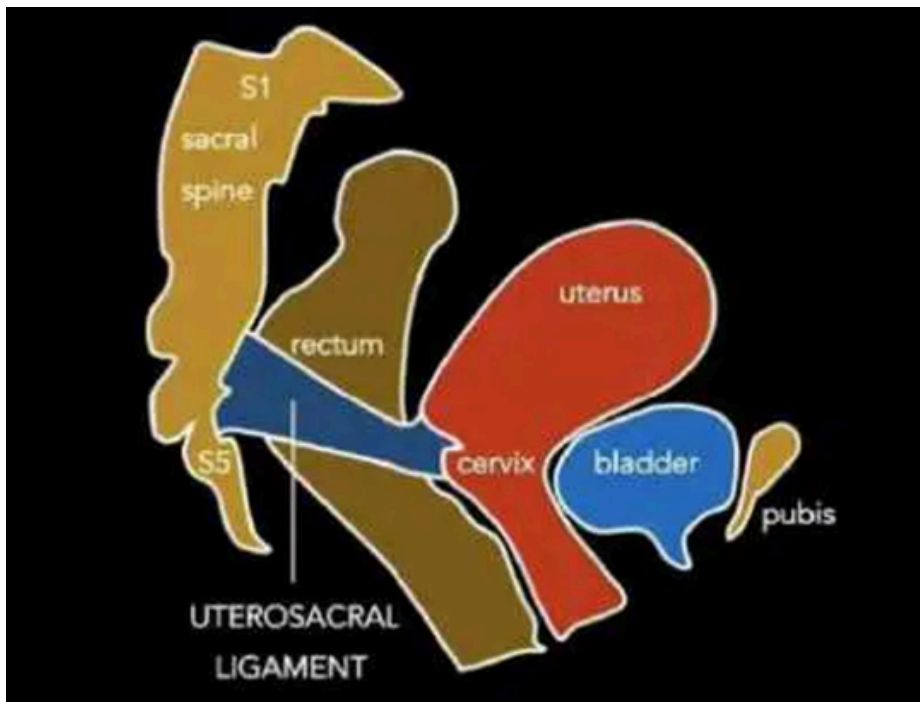
Uterosacral ligaments are one of the common targets of pelvic endometriosis, which is usually clinically rather than surgically diagnosed.

The paired uterosacral ligaments (USL), sometimes called the sacrouterine or rectouterine ligaments, are important supporting structures of the uterus and the apical vagina. They extend posteriorly from the uterine cervix, define lateral boundaries of the rectouterine and rectovaginal spaces, and attach to the sacral spine indirectly, via the presacral fascia.

USLs are composed of collagen, smooth muscle, autonomic nerves, blood vessels and lymphatic channels. Deep infiltrating endometriosis (DIE) was defined as an endometriotic lesion that infiltrates the peritoneum and penetrates into the retroperitoneal space or the wall of the pelvic organs to a depth of at least 5 mm ([Koninckx and Martin, 1992](#)). It occurs in 15–30% of patients with endometriosis ([Yantiss et al., 2001](#)). The most common involved location was uterosacral ligament 69.2 % ([Chapron et al., 2003](#); [Bazot et al., 2007](#)), followed by vagina (14.5%), bladder (6.4%), and intestine (9.9%). The involvement of USL may cause many clinical symptoms, such as chronic pelvic pain and deep dyspareunia ([Hummelshoj et al., 2014](#)).

When endometriosis invades these ligaments, it's akin to vines growing over those foundation pillars, slowly but steadily causing strain and damage. This can lead to significant pain, particularly deep within the pelvis and lower back. The misplaced endometrial tissue causes inflammation and scarring, disrupting the normal function of the ligaments and leading to pain that can be persistent and debilitating.

There is a delay between the onset of the first symptoms and the clinical diagnosis of endometriosis and usually the interval was approximately 7–10 years ([Matsuzaki et al., 2006](#); [Hudelist et al., 2012](#)) because of the low sensitivity of TVS (transvaginal ultrasound) for USL (uterosacral ligaments) endometriosis ([Bazot et al., 2004](#); [Vimercati et al., 2012](#); [Holland et al., 2013](#)). The latest meta-analysis ([Guerriero et al., 2015](#)) for detection of USL endometriosis demonstrated that the overall pooled sensitivity of transvaginal sonography (TVS) was only 53% (95% confidence interval (CI), 35–70%).



Pathophysiology:

Endometriotic implants:

- ↑ Production of inflammatory and pain mediators
- Anatomical changes (e.g., pelvic adhesions) → infertility
- Nerve dysfunction.

Similar to other forms of endometriosis, deep endometriosis lesions can cause several symptoms related to their location, such as dysmenorrhea (painful menstruation), dyspareunia (pain during intercourse), dysuria (pain while urinating), dyschezia (constipation), chronic pelvic pain, and infertility.

The pain is often more intense and can radiate to areas not typically associated with endometriosis, such as the lower back and legs, due to the proximity of the ligaments to the spine and sciatic nerve.

This condition is like having a constant, heavy pressure deep within your pelvis, coupled with sharp, shooting pains that flare up unpredictably. These symptoms are more likely to be felt during activities that involve bending, lifting, or any movement that affects the lower abdomen and pelvic area, as these actions can exacerbate the irritation and inflammation of the affected tissues.

This impacts physical and mental health, as well as the social well-being of the patient, due to a significant deterioration in the quality of life. Uterosacral ligament endometriosis sciatica happens when endometrial tissue on the uterosacral ligaments impinges on the sciatic nerve. The sciatic nerve runs from the lower back down each leg, and when it is irritated or compressed, it can cause significant pain and discomfort. This specific form of sciatica is caused by the inflammatory response and scarring associated with endometriosis on the uterosacral ligaments.

Also a nodule within the USL may grow and exert extrinsic force on the ipsilateral ureter, leading to stricture and proximal hydroureter or hydronephrosis.

Diagnosis:

Transvaginal ultrasound serves as a non-invasive diagnostic tool for endometriosis, including the DE (deep endometriosis) of the USLs (uterosacral ligaments). If a patient is diagnosed with DE; the examination of USLs is crucial as they have been reported to be the most common site of DE. During the ultrasound examination, clinicians will look for irregular contour and hypoechoic (dark) areas, which are the irregular masses/nodules.



Clinicians will also ask patients about the site-specific tenderness which is whether they're experiencing pain in their USLs during the scan. MRI is also an excellent imaging modality for the evaluation of patients with deep pelvic endometriosis, showing high accuracy in the diagnosis and prediction of disease extent

MRI is also an excellent imaging modality for the evaluation of patients with deep pelvic endometriosis, showing high accuracy in the diagnosis and prediction of disease extent. The sensitivity of MRI for the diagnosis of deep endometriosis of the torus uterinus was 83%.

Treatment:

The best treatment approach is often individualized, taking into account the patient's medical history, symptom severity, and personal preferences.

Multidisciplinary Approach is a cornerstone: This may involve collaboration between endometriosis gynecologists expert, pain specialists, dietitians and potentially mental health professionals, especially for patients with chronic pelvic pain.

Medical treatment:

Medical treatments for endometriosis have focused on the hormonal alteration of the menstrual cycle in an attempt to produce a pseudo-pregnancy, pseudo-menopause or chronic anovulation. Each of these situations is believed to cause a suboptimal milieu for the growth and maintenance of endometrium and, by extension, of implants of endometriosis (examples of medical drugs for endometriosis: danazol, progestational drugs, oral contraceptive pills, GnRH agonist and pain relievers like NSAIDs).

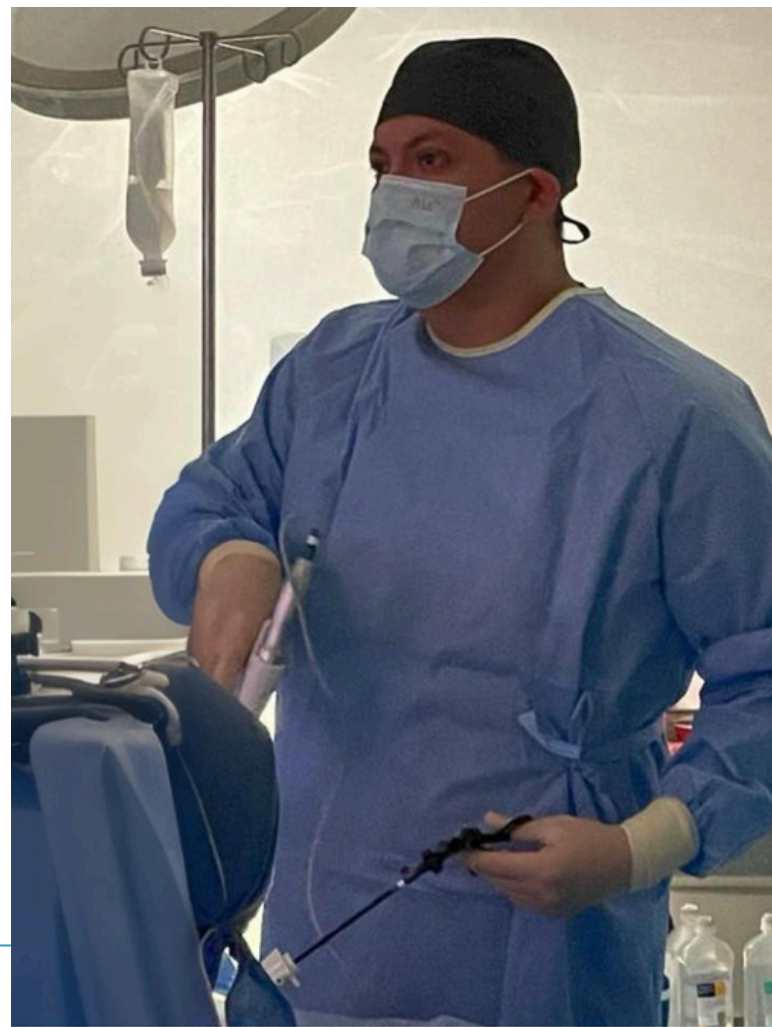
Physiotherapy: Engaging in physiotherapy exercises can strengthen the muscles supporting the lower back and pelvis, helping to alleviate pressure on the sciatic nerve. Gentle stretches and low-impact exercises such as yoga may also be beneficial.

Surgical treatment:

Provided by a highly skilled laparoscopic surgeon. Operative laparoscopy (uterosacral ligament resection and endometriosis excision) is efficient for the treatment of painful symptoms related to deep endometriosis infiltrating uterosacral ligaments.

Risk of malignant transformation:

Van Gorp et al. (2004), stated in a review article that the incidence of malignant transformation of endometriosis was calculated at 2.5%. They also reported that atypical endometriosis can occur in a spatial and chronological association with ovarian cancer. In addition, they cited that common alterations have been detected in endometriosis and ovarian cancer at the molecular level, suggesting that some tumours, especially endometrioid and clear-cell carcinomas, can arise from endometriosis.





Menopause and Endometriosis – How Do We Find the Balance?

Dr Alexandra Andreea Poienar
consultant obstetrician-gynecologist

Menopause represents a transition in a woman's life. It is characterised by gradual changes in ovarian function until a new, well-defined hormonal status is established. Women with endometriosis often view menopause as a potential endpoint of their disease and look forward to this period with hope. Unfortunately, menopause can also be accompanied by aggressive changes in general health, including a spectrum of autonomic dysfunctions that may interfere with daily activities.

Until recently, menopausal hormone therapy (MHT) was approached with caution, particularly in patients diagnosed with endometriosis. In recent years, the medical community has intensified its focus on the effects of menopause on the female body, sparking a revolution in the way this stage is managed. Increasing emphasis is placed on ensuring the well-being of women, encouraging them to take their symptoms seriously and discuss them openly with their gynaecologist or endocrinologist.

Although significant progress has been made in the management of menopause in women without endometriosis, there is still no clear consensus regarding those with endometriosis.

Given the oestrogen-responsive nature of endometriosis, there are understandable reservations about prescribing MHT in this patient group. Even during menopause, women with endometriosis remain patients who require a personalised therapeutic approach, based on careful medical counselling.

The evaluation of menopausal symptoms, as well as of changes in endometriosis manifestations during this period, is a key element in determining the optimal treatment plan.

Some patients experience medically induced menopause, making the transition relatively smooth. In such cases, the focus is on monitoring potential menopausal complications, such as osteoporosis or cardiovascular disease, and managing them with targeted treatments, without necessarily resorting to oestrogen preparations.

In contrast, in patients entering menopause with intense and disruptive symptoms, a careful discussion about the risks and benefits of MHT becomes essential.

Concerns about MHT in endometriosis include the risk of disease persistence, recurrence, or malignant transformation of residual lesions. Because of the hormonal reactivity of endometrial tissue, any woman with endometriosis remains at risk of progression under oestrogen therapy. For this reason, it is recommended that patients who require MHT receive oestrogen in association with progesterone, administered continuously rather than cyclically.

The goal of this treatment is not to mimic a normal hormonal cycle, but rather to maintain amenorrhoea, i.e. the absence of menstrual bleeding. In this context, oestrogen alleviates menopausal symptoms, while progesterone exerts an inhibitory effect on endometrial tissue. Even in women who have undergone hysterectomy, when endometriosis is present, combined oestrogen–progestogen therapy is still recommended.

In patients who have undergone surgery for endometriosis and no longer show active lesions, the risk of recurrence persists. It is important to remember that a body predisposed to endometriosis often retains this tendency.

Consequently, combined oestrogen–progestogen therapy remains the preferred option. When combined therapy is not feasible, tibolone—a synthetic steroid with weak oestrogenic, progestogenic, and androgenic properties—can be considered. Tibolone is regarded as one of the most valuable alternatives for MHT in women with endometriosis.

With regard to the risk of malignant transformation of endometriotic lesions, global estimates suggest an incidence of 2–3%. It should be noted that these figures do not include women undergoing MHT. While it is estimated that this risk may increase in such cases, there are no official data to confirm this hypothesis.

A considerable number of patients prefer phytotherapy for symptom management, perceiving it as a safer option. However, in women with endometriosis, these therapies can trigger reactions similar to those induced by classical hormone therapy. For this reason, caution is advised.

Conclusion

Although there is no clear consensus regarding MHT in women with endometriosis, it must be considered a valid therapeutic option. Denying patients access to active symptom management would be inappropriate; instead, they should be encouraged to approach this stage of life without fear.

Patients on MHT require close and active monitoring, particularly in the context of endometriosis. A state of well-being can be achieved when women are correctly informed, thoroughly counselled, and carefully followed-up according to their individual needs. Every woman's case is unique, and identifying the best solution requires a personalised and collaborative approach between patient and physician.





Estrogens and Endometriosis: What Is the Connection Between Hormones and This Painful Condition?

Dr. Claudia Grigorov
consultant endocrinologist

Endometriosis is a common gynecological condition, yet it is often misunderstood or diagnosed late. Many women live for years with severe menstrual pain, irregular bleeding, or fertility issues without receiving a clear explanation. Increasing research indicates that a key factor in this condition is a significant hormonal imbalance: excess estrogen. But what exactly does this “hyperestrogenism” mean? How does it influence the onset and progression of endometriosis? And most importantly, what can be done to manage it?

Endometriotic lesions outside the uterus can produce their own estrogen through an enzyme called aromatase.

Estrogens are female hormones that stimulate the growth of endometrial tissue. Normally, their levels rise during the first part of the menstrual cycle. Problems arise when there is too much estrogen in the body—or when tissues react too strongly to these hormones. Endometriotic lesions outside the uterus can produce their own estrogen through an enzyme called aromatase.

Moreover, these lesions often fail to deactivate estrogen, meaning its levels remain persistently high—even when blood hormone tests appear normal. It is as if these cells have their own independent hormonal maintenance system. They become small “estrogen factories” fueling the disease from within.

Symptoms That May Raise Concern

If you experience any of the following, it is important to consult a gynecologist or endocrinologist:

- Severe menstrual pain that does not respond to standard painkillers
- Irregular bleeding between periods
- Pain during sexual intercourse
- Chronic pelvic pain
- Difficulty conceiving

These can all indicate a hormonal imbalance that supports potential endometriosis.

Hormonal Imbalance: It's Not Just About Estrogen

Besides estrogen, progesterone plays a critical role by balancing and tempering estrogen's effects. In endometriosis, a condition called progesterone resistance often develops—meaning cells no longer respond normally to this hormone. Without this balance, estrogen remains “unchecked,” worsening the disease.

A vicious cycle emerges: estrogens stimulate endometriotic lesions, and the inflammation from these lesions promotes the production of even more estrogen.

How Can We Intervene? Hormonal and Other Solutions

Treatment must be tailored to each patient. Depending on severity, fertility goals, and response to therapy, a doctor may recommend:

- Hormonal treatments that reduce estrogen levels or block its effects (e.g., contraceptives, GnRH agonists/antagonists, progestins)
- Aromatase inhibitors, which reduce local estrogen production (used in more severe or recurrent cases)
- Surgical interventions, when large cysts or severe adhesions are present
- Supportive metabolic and anti-inflammatory therapy to help manage pain and inflammation

Long-term hormonal balance is essential. This includes maintaining healthy body weight, good sleep, stress management, and a natural diet while avoiding exposure to xenoestrogens—environmental substances with estrogenic effects, such as certain plastics or cosmetics.

Conclusion: Listen to Your Body and Seek Help
Endometriosis is not just “painful periods.” It is a real, hormonally influenced disease that can impact quality of life and fertility. If you suspect you may be affected, seek professional advice. With the right treatment and a personalized approach, symptoms can be managed, and hormonal balance restored.





What leads endometriosis patients to seek nutritional support?

Dr. Ruxandra Plesea

specialist in diabetes and nutrition

Do patients come directly to a nutrition consultation after receiving this diagnosis? The answer is no.

Although nutrition is an important part of managing this chronic condition and should be considered from the beginning, that's not usually the case. Patients often come to a nutritionist before receiving the diagnosis, due to intense, painful, and uncomfortable bloating, sometimes accompanied by weight gain. Assuming the issue is food-related, they seek help, and through further investigations, they discover they are dealing with endometriosis.

Once the diagnosis is confirmed, both specialties—nutrition and gynecology—must be involved. Endometriosis cannot be treated through nutrition alone; it also requires appropriate gynecological treatment. However, proper nutrition can significantly improve the progression of endometriosis and its symptoms. Endometriosis is a chronic, inflammatory condition in which endometrial tissue grows outside the uterus (in the intestines, chest, etc.), causing pain, intense abdominal bloating, cramps, and discomfort during sexual intercourse.

What aspects of endometriosis can be improved through nutritional strategies:

1. Inflammation Reducing inflammation leads to a decrease in pain and characteristic symptoms.
2. Modulating and lowering circulating estrogen levels Improving the balance between estrogen and progesterone is essential. It is desirable to reduce estrogen levels, eliminate the excess (via bowel movements), and support progesterone levels, as progesterone counteracts excess estrogen. Estrogen metabolism is closely linked to liver function, gut microbiota, intestinal transit, and insulin resistance. If these systems are not balanced, estrogen dominance increases, which in turn raises inflammation and unpleasant symptoms.

To support healthy estrogen metabolism, one must:

- Provide nutrients that support liver function
- Follow a diet that nourishes beneficial gut flora and does not disrupt the intestinal microbiome
- Adopt a diet that reduces insulin resistance

Each of these goals will be discussed in turn.

Anti-inflammatory diet

This involves two main components:

- Including nutrients with anti-inflammatory roles
- Reducing foods that promote inflammation

Anti-inflammatory foods and nutrients include:

- Omega-3 fatty acids from low-mercury fatty fish (such as sardines), walnuts, flaxseeds, and chia seeds
- Monounsaturated fats from avocado and cold-pressed olive oil
- Foods rich in polyphenols and antioxidants, especially plant-based ones: berries, spices, cold-pressed olive oil, fresh fruits and vegetables

Pro-inflammatory foods include:

- Foods high in sugar and simple carbohydrates
- Excessive additives
- Trans fats and industrial oils
- Highly processed foods lacking micronutrients and dietary fiber
- Red meat, sugar, and high-fat foods
- Alcohol and caffeine, which tend to negatively affect endometriosis
- For some patients, gluten and dairy may also be problematic—eliminating them can lead to improvement, though not for everyone

The Mediterranean Diet: A strong anti-inflammatory model

This diet includes all the beneficial food types mentioned above. It promotes low meat consumption and almost no red meat. It features cold-pressed olive oil rich in polyphenols and vitamin E, aromatic herbs, vegetables, fruits, legumes, and whole grains consumed frequently, even daily. The absence of cholesterol-rich foods like red meat and full-fat dairy may reduce estradiol synthesis from cholesterol at endometriosis lesion sites. Sweets in the Mediterranean diet are typically made with Greek yogurt, honey, and nuts, or consist of dried fruits. Cakes and pastries are consumed rarely, usually on special occasions, similar to red meat. The diet is rich in vitamins C and E, and even vitamin D, which have been shown to reduce pain and lower levels of inflammatory prostaglandins, cytokines, and chemokines.

The number of observational studies on nutritional interventions in endometriosis has increased significantly, especially those focused on anti-inflammatory diets. However, research is still ongoing and far from complete.

At this moment, studies support the following:

Regarding fats and dietary fiber: The quantity and quality of dietary fats modulate certain factors in endometriosis. Animal fat leads to an increase in circulating estrogen levels. Trans fats increase the risk of developing endometriosis, while the total amount of fat consumed does not carry this risk. It is not yet clear whether animal fats versus vegetable fats increase the risk more. There are also protective fats, such as omega-3 fatty acids. It has been shown that reducing fat intake while increasing dietary fiber intake may lower circulating estrogen by 10 to 25 percent, which leads to symptom improvement.

Regarding processed and unprocessed red meat: Prospective studies have demonstrated a correlation between endometriosis and the consumption of both processed and unprocessed red meat. One study (The Nurses' Health Study II) showed that women who consumed more than two servings of red meat per day had a 56% higher risk of developing this condition compared to women who consumed only one serving per week. Red meat was associated with higher levels of estrogen (estradiol, estrone) and increased concentrations of inflammatory steroids.

Regarding dairy products: Dairy products rich in estradiol and palmitic acid are associated with an increased risk of endometriosis.

Regarding polyphenols and vitamin D: They have anti-inflammatory activity.

Regarding vitamins C and E: They have anti-inflammatory activity and reduce symptoms.

Regarding seaweed: It has effects that modulate estrogenic activity.

Regarding vegan diets: There is evidence that these diets have anti-inflammatory effects, contain less fat, more polyphenols and antioxidant compounds, and lead to a decrease in plasma concentrations of SHBG (sex hormone binding globulin), a protein that binds less estrogen. These diets are supported, but it is very important how they are constructed to avoid nutritional deficiencies and other drawbacks

Supporting estrogen metabolism at the intestinal level: To properly eliminate excess estrogen, constipation must be addressed. This depends on the presence of dietary fiber (35 grams/day), hydration, minerals, prebiotic foods (which feed beneficial bacteria), and dietary variety, which leads to microbial diversity and a healthy gut flora. Only a varied intestinal flora is a healthy one. Having a daily bowel movement is already a very important first step. At this level, the enzyme called glucuronidase will metabolize and eliminate estrogen through the stool. Otherwise, if bowel movements are infrequent, estrogen will be reabsorbed in the intestine and return to circulation, contributing to estrogen dominance. Fiber-rich foods include vegetables, legumes, whole grains, fruits, seeds, and nuts. It is important to remember that constipation is influenced not only by diet but also by hydration, rest, nervous system health, other medical conditions, or medications.

Note: Fiber intake should be increased gradually, allowing time for adaptation, because a sudden shift from a low-fiber diet to a high-fiber one can worsen bloating and abdominal discomfort.

Diet that supports progesterone production: Certain nutrients are necessary for the synthesis of this hormone. Zinc helps regulate the menstrual cycle, supports ovulation (which generates progesterone), and is found in chicken, shellfish, pumpkin seeds, and eggs.

Diet that reduces insulin resistance: Reducing insulin resistance also means reducing inflammation and improving hormonal balance. To lower insulin resistance, both meal timing and content are important, especially the glycemic index. Ideally, a protein-rich breakfast should be consumed within the first hour after waking, with lunch and dinner no later than 7 PM. To achieve meals with a low glycemic index, proteins, fiber, healthy fats in moderate amounts, and slow-absorbing carbohydrates should be combined. If meals are too rich in carbohydrates and lack protein, are too high in calories, contain too much fat and sugar, and too little fiber, the opposite effect occurs.

For example, a serving of fish with salad and a baked purple potato induces a completely different insulin and hormonal response compared to a pork hamburger with white bread, fries, and no vegetables. Low glycemic index meals are preferred because they prevent sudden spikes in blood sugar, which ultimately lead to increased glucose levels and insulin resistance. Note: not only carbohydrates raise blood sugar, but also proteins and fats in excess. Even if these increases do not happen rapidly, they are still present five hours after such meals.

Foods that reduce pain, bloating, and cramps: A LOW FODMAP diet and magnesium-rich foods. In conclusion, it is important to emphasize that there is no single ideal diet that applies to all women and produces the same reproducible effects. However, generally speaking, if the focus is on consuming anti-inflammatory foods, avoiding processed foods and excess fats, and achieving normal intestinal transit, improvements will certainly occur. The remaining elements—such as the frequency of meat, alcohol, dairy, caffeine, gluten, and sweets consumption—must be carefully evaluated and monitored to personalize the diet as effectively as possible.



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