

ISSUE 6/JUN 25

ENDOLIFE

DR JÓN ÍVAR EINARSSON

Endometriosis Surgery: A
Surgical Perspective on
Proven Outcomes and
Recurrence

DR TAMARA SAVA

Endometriosis vs
adenomyosis: how can
we tell the difference?

DR SUSANNE JOHNSON

The use of
transvaginal
ultrasound in
endometriosis

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EndoLife digital magazine is an educational non-for-profit project of People with Endometriosis Association. This present edition of the magazine contains no paid publicity. The magazine will be published regularly.

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.

Every Little Helps: Educational Grant from iCare Better

Education is crucial in endometriosis because it bridges the gap between delayed diagnosis and timely, effective care. Many individuals live for years with debilitating symptoms, often dismissed as "normal" menstrual pain, simply due to a lack of awareness—both in the general public and among healthcare providers. By promoting education, we empower patients to recognise early warning signs, seek specialised care, and advocate for themselves.

In the UK, there is a well-known supermarket chain that has built its reputation around the simple yet powerful motto: "Every little helps." This phrase reminds us that even the smallest effort can make a meaningful difference. Indeed, when it comes to a complex and often misunderstood disease like endometriosis, every step forward in education counts — no matter how small.

We are proud to announce that we have received an educational grant from iCare Better, an organization dedicated to improving knowledge and awareness around health conditions such as endometriosis. This grant will enable us to develop and deliver vital educational resources aimed at patients, healthcare professionals, and the wider community.

iCare Better has been an ongoing supporter of our mission, having previously sponsored our recent conference, helping us bring together experts and advocates in the field. Their continued commitment through this grant underscores the importance of collaborative efforts in raising awareness and enhancing education.

Endometriosis affects millions worldwide, yet awareness remains limited, and misdiagnosis is common. By investing in education, we can empower individuals to recognize symptoms earlier, seek appropriate care, and ultimately improve outcomes. The support from iCare Better is an invaluable contribution to our work and to millions of people that suffer from endometriosis and/or adenomyosis.



Conference "Endometriosis, a multidisciplinary disease", organised by the Association of People with Endometriosis

On 15 March, our charity hosted a free conference in Bucharest dedicated to people living with endometriosis, their families, and anyone seeking to better understand this complex condition. The event brought together over 150 participants, including patients, relatives, medical students, and healthcare professionals, in an open and inclusive setting.

The conference shed light on the multidisciplinary nature of endometriosis, addressing key aspects such as early diagnosis, surgical options, nutrition, mental health, infertility, and the challenges associated with menopause. Through expert presentations and open discussions, the event aimed to empower patients with knowledge, reduce stigma, and encourage integrated approaches to care.

Our speakers were respected professionals from a range of disciplines, each bringing valuable insight into the complex challenges of endometriosis.

- **Prof. Dr Elvira Brătilă** – Endometriosis Specialist
- **Dr Voicu Simedrea** – Endometriosis Specialist
- **Dr Rubin Munteanu** – General Surgeon
- **Dr Andreea Veliscu** – Infertility Specialist
- **Dr Cătălin Coreleucă** – Gynaecologist Surgeon
- **Dr Mihail Bănac** – Gynaecologist Surgeon
- **Dr Tamara Sava** – Gynaecologist
- **Ms Oana Ștefăniță** – Psychologist
- **Ms Ioana Petcu** – Nutritionist
- **Ms Adela Bajan** – Psychologist

Moderator:

- **Andreea Berkhout** – Andreea Berkhout Academy





*Artesana

Artizanii laptelui

Thank You to Our Sponsors

We extend our sincere thanks to our sponsors, whose generous support made this event possible. Their commitment to raising awareness and improving the lives of people affected by endometriosis played a vital role in the success of our conference. Thanks to their contribution, we were able to offer free access to participants, bring together a multidisciplinary panel of experts, and create a space for education, empathy, and connection.

Together, we are helping to break the silence around endometriosis and move one step closer to better care and understanding.



Endometriosis Surgery: A Surgical Perspective on Proven Outcomes and Recurrence

Surgical management of endometriosis primarily involves either excision (cutting out lesions) or ablation (destroying lesions by heat/energy). The goal is to alleviate symptoms by eliminating visible endometriotic implants and restore normal anatomy. Excision has the advantage of providing tissue for histologic confirmation of endometriosis, which can reduce false-positive diagnoses. It is particularly important for deeply infiltrating disease, where lesions extend beneath the surface; simply burning the surface may leave active endometriosis behind. Ablation (using techniques like electrosurgery or laser) tends to be faster and can be technically easier with immediate hemostasis, but it risks incomplete destruction if lesions penetrate deeper tissue. There is also a potential for microscopic satellite endometriosis lesions around the macroscopic lesion¹ and therefore excision may be more effective.

Tailoring Treatment: How Surgeons Choose the Best Method

In practice, experienced surgeons often tailor their approach to the disease extent. Superficial peritoneal endometriosis (Stage I–II disease) can be effectively treated by either excision or ablation, with randomized trials suggesting little short-term difference in pain outcomes between these methods²⁻³. In contrast, deep infiltrating endometriosis (Stage III–IV or lesions invading organs like bowel or bladder) usually warrants excision to remove the entire nodule, as ablation may not reach all affected tissue.

Expert consensus and guidelines recommend excision over ablation for deep endometriotic lesions⁴



Jón Ívar Einarsson, MD, PhD, MPH

*Expert in Minimally Invasive Gynecologic Surgery
Former President of the AAGL*

Dr. Jón Ívar Einarsson, MD, PhD, MPH, is a leading expert in minimally invasive gynecologic surgery. A former Harvard professor and past President of the AAGL, he founded the MIGS Division at Brigham and Women's Hospital. In 2021, he established Iceland's highest-volume endometriosis center at the Reykjavík Center for Specialized Surgery. He has performed thousands of advanced laparoscopic procedures and published extensively on surgical outcomes. For more information visit www.gynsurgery.is.



joneinarssonmd

Surgeons may also combine techniques – for example, excising larger or deeper implants while ablating small superficial spots – to balance thorough treatment with surgical efficiency. Notably, overly aggressive “peritoneal stripping” (wide resection of normal peritoneum in early disease) is generally not recommended due to concerns about adhesion formation and potential complications. Overall, the surgical approach is individualized to maximize disease clearance while minimizing risk⁵.

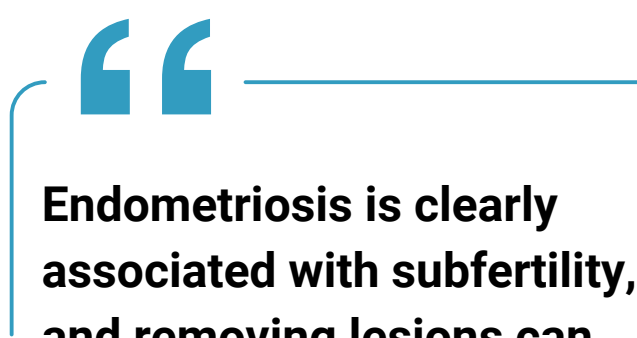
Excision vs. Ablation: What Research Says About Pain Relief

Early RCT data by Wright et al² focused on patients with minimal–mild endometriosis and chronic pelvic pain. At 6 months post-op, the majority of patients – regardless of whether they had lesions excised or ablated – reported significant symptom improvement. That trial found no short-term difference in pain outcomes between excision and ablation groups, suggesting that for superficial lesions, both methods provided comparable relief in the immediate months after surgery. Similarly, a double-blind RCT by Healey and colleagues reported no significant difference in pain reduction at 12 months when comparing excision versus ablation³. These findings reinforce that in the short term, both excisional and ablative surgery yield substantial and similar alleviation of endometriosis-associated pain.

The Long-Term Effectiveness of Surgical Endometriosis Treatment

However, differences between techniques may emerge over longer follow-up or in specific pain symptoms. In Healey et al.’s 5-year extended follow-up⁶, the excision group demonstrated better long-term relief of deep dyspareunia compared to the ablation group. The ablation group also had a higher reliance on medical therapy over time, suggesting possibly higher symptom recurrence. More recent evidence continues to explore these comparisons. A 2018 RCT by Riley et al⁷ likewise found no overall significant difference in pain scores at 12 months. Interestingly, patients who underwent ablation reported slightly better improvement in dyspareunia at 6 months, but this difference disappeared by 12 months.

Beyond pain scores, quality of life (QoL) and functional outcomes are important considerations. A recent large survey-based study⁸ took a patient-centered approach by analyzing patient experiences after undergoing both ablation and excision. Patients reported dramatically better symptom relief and QoL following excisional surgery compared to ablation. Specifically, excision improved all surveyed symptom domains, whereas ablation was associated with minimal improvement or even worsening in some. These findings underscore that many women perceive excision as more definitively relieving their endometriosis symptoms and improving their lives.



Endometriosis is clearly associated with subfertility, and removing lesions can improve chances of conception.

For women with endometriosis who desire fertility, surgical intervention can play an important role. The landmark randomized trials by Marcoux et al⁹ and the Italian Endometriosis Study Group provided the first high-level evidence¹⁰. The results showed a significant increase in subsequent pregnancy rates when endometriosis was surgically treated compared to leaving the implants in place. The takeaway is that treating visible endometriosis at the time of laparoscopy is beneficial for fertility. For moderate to severe endometriosis, surgical management is generally considered to improve fertility by restoring pelvic anatomy. Excision of ovarian endometriomas and deep lesions is generally favored. Preliminary data indicates that first-line surgery for deeply infiltrative endometriosis may be better than first line IVF treatment in these patients¹¹, but randomized trials are needed.

Despite optimal surgical management, endometriosis has a chronic relapsing tendency. Recurrence can manifest as return of pain symptoms, reappearance of lesions, or need for repeat surgery. Rates of recurrence reported in the literature vary, generally around 20–50% within five years. One long-term study by Shakiba et al. followed women after surgery for advanced endometriosis¹². Among women who had conservative excision, only 53% remained reoperation-free at 5 years. Those who had a hysterectomy had much lower rates of recurrence. This highlights that when the uterus or the ovaries are retained, endometriosis can persist or reoccur.

Even with expert excisional surgery, endometriosis can recur in a substantial number of cases.

A large 10-year series by Roman et al. provides contemporary data on long-term surgical outcomes¹³. Over 1,000 women underwent laparoscopic excision and were followed for a decade. The cumulative probability of requiring repeat surgery was about 28% at 10 years. Most repeat surgeries were for persistent pain or adenomyosis. The study showed that even with expert excisional surgery, endometriosis can recur in a substantial number of cases.

In summary, excision and ablation both improve pain and fertility outcomes in endometriosis. Excision may offer more durable relief, particularly for deep lesions. However, recurrence is common and should be anticipated. A combined approach with surgery and postoperative hormonal suppression can extend symptom-free intervals. Long-term follow-up and individualized care remain essential in managing this chronic condition.

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Targeted Supplementation in Endometriosis: A Functional Medicine Perspective

Juan Luis Gallardo M.D.

Functional Medicine, Hormonal Health and Clinical Nutrition Specialist

Endometriosis is a complex, estrogen-dependent inflammatory condition that goes far beyond pelvic pain. It involves immune dysregulation, oxidative stress, hormonal imbalance, and gut dysfunction. As a functional medicine practitioner, I approach endometriosis not as a local gynecologic issue, but as a systemic condition requiring a multifaceted strategy. Among the most promising tools in our clinical arsenal is targeted supplementation—when done correctly and supported by science.

Here, I share the key nutraceuticals with the strongest evidence and clinical relevance in endometriosis care.

Omega-3 Fatty Acids: The Inflammation Modulators

Chronic inflammation is at the core of endometriosis. Omega-3s, particularly EPA and DHA, have demonstrated significant anti-inflammatory effects by downregulating prostaglandins and cytokines involved in pelvic pain and lesion development. Studies have shown that higher omega-3 intake is associated with reduced risk and severity of endometriosis.

Clinical tip: A daily dose of 2,000–3,000 mg of combined EPA+DHA can help reduce pain and modulate inflammation.

Curcumin: The Natural COX-2 Inhibitor

Derived from turmeric, curcumin acts as a natural anti-inflammatory by targeting NF-κB and COX-2 pathways, which are overexpressed in endometriosis. In vitro and animal studies suggest curcumin may inhibit endometrial cell proliferation and angiogenesis, making it a promising adjunct in symptom control.

Clinical tip: Use a highly bioavailable form (liposomal or phytosomal) at 500–1,000 mg daily, taken with fat for optimal absorption.

N-Acetylcysteine (NAC): Detox, Antioxidant & Fertility Support

NAC is a precursor to glutathione, the body's master antioxidant. It supports detoxification, reduces oxidative stress, and improves immune modulation—all of which play a role in endometriosis. Studies have shown that NAC supplementation may reduce endometrioma size and pelvic pain, with a reduction in the need for surgery.

Clinical tip: Typical dosing ranges from 600–1,800 mg per day, though clinical judgment is required due to individual tolerance.

Magnesium: The Anti-Stress Mineral for Hormonal Balance

Women with endometriosis often experience dysmenorrhea, fatigue, and anxiety—symptoms associated with magnesium deficiency. Magnesium supports muscle relaxation, modulates pain perception, improves sleep, and enhances estrogen detoxification via COMT enzyme pathways.

Clinical tip: Magnesium bisglycinate or citrate (200–400 mg/day) are well absorbed and gentle on the gut.

Vitex agnus-castus (Chaste Tree Berry): Supporting the HPO Axis

While evidence is still evolving, Vitex agnus-castus has been traditionally used to support luteal phase defects and low progesterone levels, both recognized contributors to endometriosis-related symptoms. Its primary mechanism involves dopaminergic modulation, reducing prolactin levels and helping restore balance in the hypothalamic-pituitary-ovarian (HPO) axis—which regulates the menstrual cycle and ovulation.

Clinical tip: Best used in the luteal phase under practitioner guidance; dose commonly ranges from 20–40 mg of standardized extract.

Probiotics & Gut Support: The Estrobolome Connection

A balanced gut microbiome is essential for hormone detoxification, especially estrogen. Dysbiosis may lead to higher β -glucuronidase activity, which can increase estrogen reabsorption and worsen endometriosis. Specific probiotics (e.g., *Lactobacillus rhamnosus*, *L. reuteri*) have shown anti-inflammatory benefits and may help reduce pelvic pain.

Clinical tip: Consider rotating probiotic strains and combining with prebiotics and digestive support for synergistic effect.

DIM & Calcium-D-Glucarate: Estrogen Detoxifiers

Diindolylmethane (DIM), derived from cruciferous vegetables, supports phase 1 liver detoxification by promoting favorable estrogen metabolites (2-OH over 4-OH or 16-OH pathways). Calcium-D-glucarate aids phase 2 detoxification by inhibiting β -glucuronidase, reducing estrogen recirculation.

Clinical tip: DIM 100–200 mg/day and calcium-D-glucarate 200–500 mg/day are commonly used in protocols for estrogen excess or dominance.

Cautions & Considerations

Supplementation is not one-size-fits-all. While each compound has merit, bioindividuality must guide their use. Consider drug interactions, phase of the menstrual cycle, comorbidities (e.g., Hashimoto's, IBS), and personal goals (e.g., fertility, pain control, post-surgical support).

Also, avoid supplement overload. More is not always better, and synergy is often more effective than megadoses. Work with a qualified practitioner who can personalize your plan based on lab markers, symptoms, and root causes.

Final Thoughts

Endometriosis is a condition that requires patience, depth, and a systems-based approach. Supplementation is a powerful complement—not a replacement—for lifestyle changes, medical therapy, and, when necessary, surgery. When chosen wisely and tailored correctly, supplements can reduce inflammation, balance hormones, optimize detoxification, and empower women to reclaim their health.

In the era of functional and personalized medicine, we no longer treat endometriosis by simply silencing symptoms. We support the woman behind the diagnosis.

Complications of deep endometriosis

Dr. Georgios Grigoriadis, MD, MSc, MRCOG

Dr. Georgios Grigoriadis is an UK-trained gynaecologist specializing in minimally invasive surgery for benign gynaecological conditions, endometriosis, and infertility. He completed advanced surgical training in complex laparoscopic procedures at IFEMEndo in Bordeaux, gaining expertise in deep infiltrating endometriosis.



Deep endometriosis (DE) is considered to be the most severe form of endometriosis. It is estimated that around 1 in 5 patients with endometriosis have DE [1]. Although some patients suffering from DE may be asymptomatic, the majority of them present with severe symptoms, while DE itself may provoke a number of potentially serious complications [2]. But let us have a closer look at the complications that may arise from DE lesions.

Urological Complications:

The urinary bladder and/or the ureter(s) may be infiltrated by DE lesions. If symptomatic, patients may experience pain during urination, frequent urination, hematuria (blood in the urine), difficulty in emptying the bladder or incomplete bladder emptying (leading, potentially, to recurrent urinary tract infections). In case of DE of the ureter(s) (yes, unfortunately, both ureters can be affected by DE at the same time!), the disease may cause compression and, even, obstruction of the ureter(s). As this typically occurs over a period of time (not overnight!), it may not give any symptoms at all, leading to what we call "silent kidney loss". It is, therefore, evident why any specialist scanning in patients with confirmed (or suspected) DE should involve imaging of both the kidneys. Infiltration of the ureters by DE is considered a clear indication for expert surgical management, in a multi-disciplinary fashion (collaboration between different surgical specialties).

Gastrointestinal complications:

Deep endometriosis may affect parts of the colon or small bowel, typically causing severe symptoms, negatively affecting the patients' quality of life. Some DE lesions may invade really deep into the bowel wall, causing, in rare cases, acute or sub-acute obstruction. This rare complication is probably more common in infertile patients with bowel DE undergoing multiple IVF attempts [3,4], and it necessitates surgical intervention. Bleeding from the back passage may, also, be caused by bowel DE.

Ovarian Endometrioma complications (OMA):

Although OMA is considered another form ("phenotype" in medical jargon) of endometriosis, it often co-exists with DE [5]. Rupture of OMA, leading to spillage of chocolate material and/or internal bleeding has been reported, and is likely higher in cases of large OMAs [6,7], causing acute pain that requires urgent surgical intervention.

Diaphragmatic and Thoracic DE complications:

Although localisations of DE outside the pelvis are rare, DE can affect the diaphragm (the large muscle that separates the chest from the abdominal cavity), the lungs and the pleura (the thin tissue that covers the lungs and the interior of the chest wall), potentially causing recurrent episodes of catamenial pneumothorax or hemothorax (abnormal collection of air or blood around the lungs during menses) and hemoptysis (coughing up blood).

Pregnancy-related complications:

Various studies have suggested that pregnant patients with DE may be at higher risk of experiencing pregnancy loss, preterm birth, small babies or low-lying placenta [8]. Rare but potentially life-threatening complications include bowel perforation or internal bleeding due to decidualisation of DE lesions (a process in which the cells undergo significant changes in response to the hormone called progesterone) [9].

DE Surgery-related complications:

It is well established that excision of DE lesions (through minimal access surgery, be it laparoscopic or robotic), when performed by appropriately trained clinicians, leads to significant improvement of the symptoms caused by DE.

DE excision surgery is complex and technically challenging, often requiring multiple specialties working together. However, due to its complexity, complications may occur, including fistula (an abnormal connection between the bladder and the vagina or the bowel and the vagina), anastomotic leak (leak of faeces from the site of a bowel anastomosis), abscess formation (collection of pus in the pelvis) and, eventually, need for re-operation. However, those complications appear less likely to occur in the hands of expert surgeons [10]. Furthermore, it appears that, from a fertility perspective, even when these complications do occur, they may not have a detrimental effect on the reproductive outcome, as one might have anticipated [11].

Other complications:

A concern raised by many patients is that of malignancy within DE lesions. Albeit such cases have been reported, it is important to remind ourselves that they remain, as far as we know, exceedingly rare.

Another topic that warrants to be mentioned is that of adenomyosis. Adenomyosis (a condition whereby cells from the lining of the womb invade and grow within the muscle of the womb) often co-exists with DE lesions. Adenomyosis is linked to infertility, recurrent pregnancy losses and IVF failures.

Adenomyosis, particularly certain types of it such as diffuse adenomyosis, are notoriously difficult to treat surgically, when the patient wishes to retain the uterus. A uterus following excision of adenomyosis is at risk of rupture during future pregnancies.

Overall, it should be remembered that DE is the most severe form of endometriosis and it can, potentially, cause various, serious complications. However, these complications occur to a minority of patients with DE. Radical excision of DE lesions by appropriately trained surgeons drastically improves the quality of life of patients with DE and may prevent the above complications from occurring. The surgical complications need to be discussed in detail with the patient, however, they, thankfully, remain uncommon in the hands of appropriately trained excision surgeons.

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Is hysterectomy the only method of treating adenomyosis?

Adenomyosis is a common but often misunderstood condition affecting many women, especially those of reproductive age. Characterized by the presence of tissue similar to the lining of the uterus (endometrial tissue) growing into the muscular wall of the uterus, it can cause painful periods, heavy bleeding, and fertility issues. Until recently, the main treatment for adenomyosis was the surgical removal of the adenomyosis or the hysterectomy—surgical removal of the uterus. But for women wanting to keep their uterus or preserve fertility, surgery is not always a suitable option.

Understanding adenomyosis



Adenomyosis can be classified using various systems, such as based on its location within the uterus. In terms of its form, it is most commonly categorized as either 'focal' (restricted to a specific area) or 'diffuse' (widespread throughout the uterus). It's often found in women who also have endometriosis or fibroids. In the past, adenomyosis could only be diagnosed after a hysterectomy. But with today's imaging tools like ultrasound and MRI, it can be detected earlier—even in young women who still want children. **Fortunately, a wave of innovative non-surgical treatments is changing the way adenomyosis is managed.**



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Why Consider Non-Surgical Treatments?

Surgical treatment can be effective but carries risks, including damage to the uterus and recurrence of symptoms. Non-surgical approaches are now being developed and studied because they offer symptom relief with fewer risks, shorter recovery times, and the possibility of preserving the uterus and fertility.

Medical Treatments

Hormonal therapy is the first line of treatment. It doesn't cure adenomyosis but can reduce pain and bleeding.

- **Levonorgestrel-Releasing Intrauterine System (LNG-IUS):** A small device placed inside the uterus that slowly releases a hormone to thin the uterine lining. It reduces bleeding and pain significantly for many women and is considered the top choice for first-line treatment.
- **Other Hormonal Options:** These include birth control pills, progestins like dienogest, and medications that lower estrogen levels such as GnRH agonists or antagonists. These treatments aim to control symptoms, but symptoms often return if treatment stops.

While several medications are used off-label to manage the symptoms of adenomyosis, no specific drug has received regulatory approval for adenomyosis in any country. Although these treatments can be very effective, it is essential that your gynecologist provides a thorough and careful explanation of the options and potential outcomes.

Minimal invasive procedures

1. Uterine Artery Embolization (UAE)

In this outpatient procedure, tiny particles are injected into the blood vessels that supply the uterus. These particles block the blood flow to the adenomyotic tissue, causing it to shrink and symptoms to improve. However, the procedure may need to be repeated in the long term. It is a treatment of choice for large uteri or those with both adenomyosis and fibroids. However, it is not ideal for women who wish to conceive, due to its potential impact on fertility.

2. High-Intensity Focused Ultrasound (HIFU)

HIFU uses focused ultrasound waves to heat and destroy adenomyotic tissue without cutting into the skin. It's guided by imaging (MRI or ultrasound) to ensure precise targeting. It is mostly used for focal adenomyosis on the front of the uterus, but less effective for deeply located or large lesions. Although there is some evidence that women have become pregnant after treatment, further research is needed to draw safer conclusions.

3. Radiofrequency Ablation (RFA)

RFA involves inserting a probe into the uterus (via the cervix or during laparoscopy) and using heat to destroy the adenomyotic tissue. Our research group recently demonstrated that the treatment is highly effective for pain relief and reducing the bleeding. This is an established method of treating fibroids; however, it is off label for the treatment for adenomyosis and currently mostly used in research settings. Although there is some evidence of successful pregnancies after treatment, more research is needed.

4. Percutaneous Microwave Ablation (PMWA)

This technique uses a needle-like probe to send microwave energy into the uterus, heating and destroying the adenomyotic tissue. This method is less widely used, there are limited pregnancy data, and still considered experimental in many places.

Looking Ahead

While non-surgical options are showing great promise, more research is still needed—especially on long-term outcomes and fertility. However, what's clear is that women now have more choices than ever before to manage adenomyosis without undergoing major surgery.

If you're dealing with painful periods or heavy bleeding due to adenomyosis, talk to your gynecologist about the full range of treatment options. Relief might not require the operating room after all.

Robotic surgery for endometriosis:

what patients need to know



Mr Islam Gamaleldin

Consultant Gynaecologist, Endometriosis Specialist, Robotic Surgeon, Advanced Laparoscopic Surgeon

Endometriosis is a chronic, inflammatory, gynaecological disease marked by the presence of endometrial-like tissue outside the uterus, which in many patients is associated with debilitating painful symptoms. Patients with endometriosis are also at greater risk of infertility, emergence of fatigue, multisite pain, and other comorbidities. As the understanding of endometriosis has evolved, surgical interventions aiming to remove endometriosis lesions and restoring anatomy have become a cornerstone of treatment, particularly for women experiencing persistent pain despite medical treatment. Due to the anatomical structure of the major organs affected by endometriosis and the deeply infiltrative nature of the disease, endometriosis surgery is often highly complex and technically challenging.

Endometriosis affects approximately 190 million women and people assigned female at birth worldwide

In particular, deep infiltrating endometriosis can spread to multiple organs such as the intestines, bladder, ureters and diaphragm, making complete removal difficult. Among the surgical options available, robotic-assisted laparoscopic surgery (RALS) has gained popularity. This article will explore what patients need to know about RALS for endometriosis, highlighting its advantages and supporting evidence from recent literature.

Understanding Robotic Surgery

RALS is a minimally invasive surgical approach that was first developed in the late 20th century. It employs robotic systems to enhance the surgeon's capabilities. This technique allows for greater precision, flexibility, and control compared to traditional laparoscopic surgery. The robotic system consists of a console where the surgeon sits to manipulate instruments inside the patient's body while viewing a 3D high-definition image of the surgical site.

Advantages of Robotic Surgery for Endometriosis

Enhanced Precision and Control

One of the significant advantages of RALS is the enhanced precision it offers. The robotic instruments have a greater range of motion than the human wrist, allowing for more intricate movements.

This increased dexterity is particularly beneficial when navigating the complex anatomical structures associated with endometriosis, especially in challenging anatomical locations like diaphragmatic endometriosis or sites involving the sacral plexus or pelvic nerves.

Surgeons can more easily dissect adhesions, fully remove endometriosis lesions, and preserve healthy tissue, potentially leading to better surgical outcomes.

Minimally Invasive Approach

Robotic surgery is performed through small incisions, typically ranging from 1 to 2 centimetres. This minimally invasive nature leads to several benefits, including reduced postoperative pain, shorter recovery times, and minimal scarring. Patients often experience a quicker return to normal activities compared to traditional open surgery, where larger incisions are required.

Improved visualization

The robotic system offers high-definition, 3D visualization of the surgical field, which is invaluable during endometriosis surgery. The enhanced imaging helps surgeons identify and fully treat endometriosis lesions and surrounding tissues with greater accuracy. Improved visualization can reduce the risk of incomplete lesion removal and subsequent recurrence, potentially leading to better long-term outcomes for patients.

Reduced surgeon fatigue

Robotic surgery allows surgeons to operate from a seated position at a console, reducing the physical burden compared to traditional laparoscopic surgery.



This ergonomic advantage is significant in long and complex endometriosis surgeries, where sustained concentration and reduced fatigue can reduce the risk of errors, improve surgical performance and patient outcomes.

Evidence in the Literature

The advantages of robotic surgery for endometriosis are supported by a growing body of literature. A Cochrane review published in 2019, including 12 randomised controlled trials, and a meta-analysis of current evidence published in 2024, on effectiveness and safety of RALS vs. conventional laparoscopy have concluded that surgical complication rates are comparable between both groups. Moreover, several retrospective studies have concluded that RALS improves surgical performance without increasing surgical time, blood loss or intra- and postoperative complications, while reducing conversion rate to open surgery.

Despite these advantages, it is essential for patients to be aware of the potential disadvantages. One of the limitations of RALS is the lack of tactile feedback, which is important for differentiating fibrotic tissues in endometriosis. RALS may also be associated with higher costs due to the technology and expertise required, leading to not all surgical centres have access to robotic systems.

What patients should consider

Patients considering robotic surgery for endometriosis should consult with a healthcare provider who specialises in the condition. It's crucial to discuss the following:

01

Surgeon Experience

Ensure the surgeon has significant experience with robotic-assisted procedures for endometriosis.

02

Institutional Quality

Investigate the surgical centre's credentials and outcomes for robotic procedures.

03

Individual Health Factors

Discuss personal health factors and the specific nature and location of the endometriosis lesions, especially diaphragmatic and nerve endometriosis lesions, as these lesions are better treated using RALS.

04

Postoperative Care

Understand what to expect during recovery and the follow-up care needed, as well as potential lifestyle modifications to manage endometriosis.

05

Alternative Treatments

Consider all treatment options, including medical management, lifestyle changes, and other surgical approaches.

Conclusion

Robotic surgery represents an innovative approach to managing endometriosis, providing various advantages, including enhanced precision, minimally invasive techniques, and potentially improved patient outcomes. With growing evidence supporting its efficacy, patients can benefit from discussing this option with their healthcare providers. As with any medical treatment, informed decisions lead to the best outcomes, ensuring women with endometriosis receive tailored, effective care.



Urinary Tract Endometriosis

Yaniv M. Larish, M.D.

Consultant urologist, robotic specialist and endometriosis surgeon

Endometriosis is a condition where tissue similar to the lining of the uterus grows outside of it. While many people know that endometriosis can affect areas like the ovaries or fallopian tubes, it can also involve the urinary system—including the kidneys, ureters (the tubes connecting the kidneys to the bladder), and the bladder itself. This type of endometriosis is called urinary tract endometriosis (UTE), and it's rarer but can cause serious problems if not diagnosed and treated early.

How Can Urinary Tract Endometriosis Affect You?

In the Kidneys and Ureters (Upper Urinary Tract)

Endometriosis can press on or grow into the ureters, which can block the flow of urine from the kidneys to the bladder. This blockage can happen silently, without any obvious symptoms, but over time it can damage the kidneys and lead to permanent loss of kidney function. Some signs that might occur include:

- Flank pain or a dull ache in the back or side, often around your period.
- Blood in the urine (though this is less common).
- Swelling of the kidney (hydronephrosis), which may only be seen on imaging tests.

In the Bladder (Lower Urinary Tract)

Endometriosis can also affect the bladder, causing symptoms that might feel similar to bladder infections or interstitial cystitis. These include:

- Pain or burning when urinating, often worse during your period.
- Frequent or urgent need to urinate, without an infection.
- Blood in the urine, especially during menstruation.
- Pressure or discomfort in the lower belly or pelvis.
- Feeling like you can't fully empty your bladder.

If endometriosis in the bladder is left untreated, it can lead to scarring and stiffening of the bladder wall, making it harder for the bladder to hold urine and increasing the risk of further kidney problems.

What Causes These Symptoms?

Endometriosis doesn't just press on organs—it can also affect the nerves that control the bladder and bowels. The hypogastric nerve (which helps control bladder relaxation and rectal tone) and the sacral nerve roots (which control bladder contraction and bowel movements) can be surrounded by endometriosis, leading to nerve irritation or damage.

This can cause a mix of symptoms, such as:

- Difficulty emptying the bladder or bowels.
- Sudden urges to urinate or have a bowel movement.
- Constipation or even accidental leakage (incontinence).

These nerve effects can be unpredictable, and some people might experience both “overactive” and “underactive” bladder or bowel symptoms.

How Is Urinary Tract Endometriosis Diagnosed Prior to Surgery?

Doctors use a combination of imaging tests to figure out if endometriosis is affecting the urinary system:

- **Renal ultrasound:** A simple scan to look for kidney swelling (hydronephrosis).
- **MRI (Magnetic Resonance Imaging):** A detailed scan that can show endometriosis in the pelvis, including the bladder and areas around the ureters.
- **CT urogram:** A specialized scan that shows the urinary tract and can spot blockages.
- **Nuclear medicine renal scan:** This test checks how well each kidney is working and can detect loss of function from blocked urine flow.
- **Cystoscopy:** A test where a small camera is inserted into the bladder to look for endometriosis patches.

What Can Be Done to Treat It?

The most important step in treating urinary tract endometriosis is meticulous surgical removal of the endometriosis. This surgery aims to remove the tissue that is blocking or irritating the urinary system and to free any nerves trapped by scar tissue.

For people who continue to have overactive bladder symptoms (such as frequent urination or urgency) even after surgery, bladder Botox injections can help. Botox relaxes the bladder muscle and reduces these symptoms.

For those who experience both bladder and bowel problems, including urgency, incontinence, or constipation, sacral neuromodulation may be an option. This therapy involves placing a small device that sends gentle electrical pulses to the sacral nerves to help restore normal nerve signals to the bladder and bowel.

Both of these treatments—Botox and sacral neuromodulation—are additional therapies used after surgery when symptoms persist. They do not replace the need for surgery but can significantly improve quality of life.

Takeaway Message

Urinary tract endometriosis is rare but serious. It can quietly damage the kidneys and bladder and cause nerve-related problems with urination and bowel movements. Early diagnosis and comprehensive treatment are key to protecting your health. If you experience pelvic pain, urinary symptoms (especially around your period), or bladder and bowel issues, talk to your doctor about the possibility of endometriosis.

Modern imaging techniques—ultrasound, MRI, CT urogram, and renal scans—can help detect urinary tract involvement. With expert surgical treatment and, when needed, therapies like bladder Botox and sacral neuromodulation, many people can achieve lasting relief and preserve kidney and bladder

The Role of Robotic Surgery in the Treatment of Deep Endometriosis

What is deep endometriosis and how is it diagnosed?

Deep endometriosis is a condition in which endometrial cells – normally found only within the uterine cavity – develop outside the uterus. The presence of these cells outside the uterus can affect various pelvic structures, including the uterosacral ligaments, rectovaginal septum, intestines, bladder, and ureters.

The main symptom of the condition is menstrual pain (dysmenorrhoea). However, it may also be accompanied by other clinical signs such as chronic pelvic pain, dyspareunia (pain during sexual intercourse), digestive or urinary symptoms (depending on the organ involved), and often infertility.

Diagnosis is primarily made using imaging techniques: transvaginal ultrasound and MRI with an endometriosis protocol – both can accurately detect deep lesions and assess the extent of the disease. Diagnostic laparoscopy can confirm the diagnosis (both visually and histologically), but as it is an invasive method, current practice relies on non-invasive methods to establish a preoperative diagnosis.

For the diagnosis of endometriosis, a saliva test – a miRNA test – can be used, which confirms or rules out the presence of this condition.

This test does not provide information about the location of the disease or the extent of organ involvement. However, its use in individuals who do not have access to ultrasound, MRI, or specialised gynaecological consultation can guide the patient towards further investigations.

How can robotic surgery assist in surgical interventions for deep endometriosis?

Robotic surgery offers the surgeon a much better visualisation of endometriosis lesions and the affected structures, and allows for a much more precise excision of these lesions.



Dr. Răzvan Petrică

Consultant obstetrician-gynecologist

Specialist in robotic surgery, laparoscopy, and endometriosis treatment

Dr Răzvan Petrică is a consultant obstetrician-gynecologist and a renowned specialist in minimally invasive surgery, with extensive experience in advanced laparoscopy, operative hysteroscopy, and robotic surgery. He works at the Endo Institute in Timișoara, where he is directly involved in the diagnosis and complex treatment of endometriosis, holding accreditation in this pathology. He also has expertise in gynaecological and obstetric ultrasound.

The robotic platform provides a three-dimensional view magnified approximately 10 times and articulated instruments with 7 degrees of freedom. This allows the surgeon to dissect lesions more precisely in hard-to-reach areas and offers enhanced control.

Using the robot, the surgeon has three arms available, while the fourth is used for the optical camera. The three-dimensional view is clearly superior to that of laparoscopic or traditional surgery.

What are the advantages of robotic surgery compared to traditional surgery in cases of deep endometriosis?

Compared to traditional open surgery, the robotic approach (like laparoscopy) offers the benefits of a minimally invasive procedure:

- reduced postoperative pain,
- faster recovery,
- shorter hospital stay,
- decreased risk of complications related to the surgical wound.
-

Compared to conventional laparoscopy, robotic surgery provides technological advantages – 3D HD visualisation with depth perception, articulated instruments with 360° rotation, and tremor filtering – which enhance surgical precision. These features allow for the radical excision of deep endometriotic lesions with minimal trauma to surrounding tissues.

What types of complications can be avoided by using robotic surgery in the treatment of deep endometriosis?

Robotic surgery does not completely eliminate the risk of complications but can help avoid certain iatrogenic injuries thanks to the superior precision it offers.



For example, in a study on colorectal endometriosis, a significantly lower incidence of intraoperative complications was observed in the robotic group (2% vs. 14% laparoscopic, Ferrier et al., 2022), along with significantly more frequent resections with negative margins (91% vs. 76%). Improved instrument control allows for precise dissection of lesions on organs such as the intestines or ureters, reducing the risk of fistulas, ureteral injuries, or anastomotic dehiscence compared to an approach with reduced visibility. Thus, the use of the robot provides added safety in advanced cases of endometriosis by lowering the incidence of surgical complications.

What are the risks associated with robotic surgery in deep endometriosis?

It should be noted that better visualisation of anatomical structures, much greater precision in dissections, and significantly improved freedom of movement of instruments provide increased comfort for the surgeon as well as a reduction in complications for the patient.

Due to its minimally invasive nature, robotic surgery ensures less postoperative pain and a faster recovery compared to open surgery. Smaller incisions and minimal tissue trauma allow for early mobilisation of the patient and reduce the need for painkillers after the procedure.

Robotic surgery also helps reduce chronic pelvic pain by enabling the most complete excision possible of endometriotic lesions; for example, improvement in dysmenorrhoea and increased quality of life have been observed six months after robotic resection of endometriotic intestinal nodules. Therefore, patients recover faster and experience less pain compared to traditional surgery.

How does robotic surgery assist in removing endometrial tissue from hard-to-reach areas?

Robotic surgery is particularly useful for excising endometriotic tissue from anatomical areas that are difficult to access using conventional techniques. The articulated arms and enhanced vision allow the surgeon to work efficiently in narrow spaces, such as the pouch of Douglas, where laparoscopy has limited access. For instance, lesions located on the diaphragm or near the sacral plexus – very difficult to reach laparoscopically – can be safely resected with the help of the robot.

Robotic technology extends the scope of minimally invasive surgery, making it possible to completely remove endometriotic lesions even from the “hidden corners” of the pelvis and abdomen. Suturing during surgery is much easier for the surgeon to perform, and the quality is superior to that of laparoscopic surgery.

How effective is robotic surgery in improving fertility chances for women with deep endometriosis?

Although logically robotic surgery should help increase the chances of pregnancy through optimised excision of lesions, specific clinical evidence is lacking, and the treatment decision must be individualised. Because this condition mainly affects young women who wish to conceive, the surgeon must consider using techniques that preserve and even support fertility. For this reason, we strive to be as minimally invasive as possible when addressing ovarian lesions, practising cyst alcoholisation or superficial diathermocoagulation of the cyst wall with argon plasma whenever possible.

Thus, the patient’s ovarian reserve is affected as little as possible.

How long is the recovery after robotic surgery for deep endometriosis?

Depending on the severity of the endometriosis and the complexity of the procedure, the surgery can last from 2–3 hours up to 5–6 hours. Procedures requiring intestinal resections, sometimes double intestinal resections, ureteral resections with reimplantation into the bladder, diaphragmatic resections, or vaginal resections are time-consuming operations, but the most important thing remains the benefit the patient gains at the end of the surgery.

For patients operated on robotically, the postoperative hospital stay is approximately 2–3 days, and full recovery occurs within about 2–4 weeks – a duration similar to laparoscopy and much faster than after a traditional laparotomy.

Immediate postoperative pain is greatly reduced both due to the use of the robotic method and because of good collaboration with the anaesthetist. The need for painkillers during the procedure and throughout the hospital stay is much lower. Upon discharge, the patient will be advised to use standard painkillers, and the need for these will be much less than in the case of traditional surgery.

How can robotic surgery prevent damage to adjacent organs during surgery for deep endometriosis?

Robotic surgery offers a level of precision that helps protect adjacent organs (intestines, bladder, ureters) during the excision of deep endometriotic lesions. The detailed 3D visualisation allows clear identification of the boundaries between endometriotic tissue and healthy structures, enabling the surgeon to dissect precisely and avoid injuring neighbouring organs. The stability of the robotic arms and tremor elimination allow for delicate manoeuvres near sensitive structures, enhancing the safety of the procedure.

Euromaterna and Endomedicare Academy: A Partnership for Excellence in Endometriosis Treatment



Multidisciplinary team

Euromaterna and Endomedicare Academy

Euromaterna Hospital stands out for its commitment to excellence by entering into a partnership with **Endomedicare Academy**, under the guidance of Prof. Dr. Elvira Brătilă, a renowned specialist in endometriosis treatment in Romania. This collaboration aims to support the ongoing development of the Multidisciplinary Endometriosis Center in Constanta, which offers patients comprehensive care, from diagnosis to treatment and recovery.

Through this partnership, **Euromaterna** and **Endomedicare Academy** are joining forces to offer:

- Coordinated interdisciplinary consultations – combining gynecology and surgery;
- Fast access to advanced investigations – including transvaginal ultrasound, diagnostic, and operative laparoscopy;
- Minimally invasive surgical procedures, performed with state-of-the-art equipment that ensures fast recovery and minimal postoperative discomfort;
- Personalised care, focused on the patient's real needs.

A Modern and Coordinated Approach

Endometriosis is a condition that deeply affects patients' lives, not only through physical pain but also by impacting fertility and emotional well-being.

Modern Technology for Lasting Results

At Euromaterna, procedures are performed in state-of-the-art operating rooms designed for delicate gynecological surgery. Advanced equipment – including 4K laparoscopy systems and high-precision electrocautery tools – allows for minimally invasive, accurate interventions, with shorter hospital stays and a reduced risk of complications.

Euromaterna Hospital's continued investments in high-performance medical technology transform treatment into a safe, effective, and minimally traumatic experience, offering:

- Small incisions,
- Reduced postoperative pain,
- Quick recovery,
- Early discharge and fast return to daily activities.

Under the guidance of Prof. Dr. Elvira Brătilă, Euromaterna strengthens its commitment to women who need real, comprehensive, and timely care for endometriosis.



The use of transvaginal ultrasound in endometriosis

Dr Susanne Johnson FRCOG

Associate Specialist Gynaecologist

Southampton, UK

Author of @GynaecologyUltrasound YouTube channel



“It is an absolute tragedy that the delay in diagnosing endometriosis in women around the world is between 8-12 years. There are many reasons for this, but the most important one, in my opinion, is the way that the pelvic ultrasound is performed”.

An ultrasound of the pelvis (or ‘scan’) can be done by looking at the organs in the pelvis through the abdomen (by pressing on your tummy with a probe whilst you have a full bladder) or it can be done internally (transvaginal ultrasound, TV-US), where the probe is gently placed in the vagina after you have emptied your bladder. The views of the organs in the pelvis are so much better using TV-US, since the probe is much closer to the womb, the ovaries, the bowel and the bladder.

Most people performing such a scan were taught that ‘you cannot see endometriosis on ultrasound’. This is simply not true anymore. The latest research has taught us techniques on how to recognise Adenomyosis, Ovarian Endometriomas and Deep Endometriosis very accurately.

“The Sliding Sign helps us to determine whether frozen pelvis is present, and this should now be a routine part of any pelvic ultrasound.”

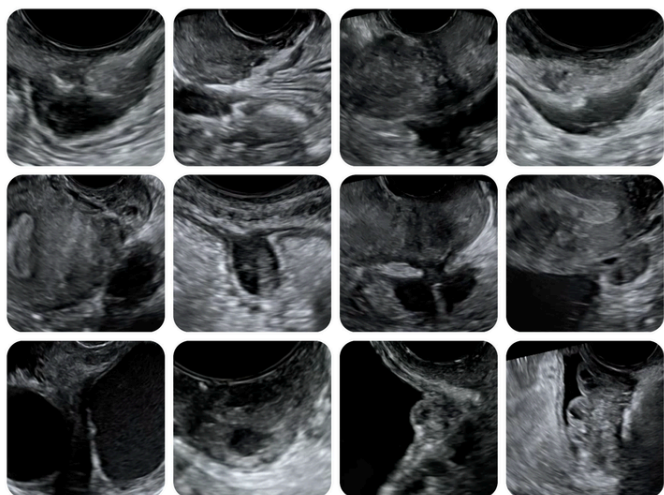
To see endometriosis, you have to do the scan internally (TV-US) AND you have to angle the probe backwards towards the patient’s backbone (sacrum). That way you can visualise the area between the womb (uterus) and the bowel much more clearly. The ovaries are often pulled low into the pelvis by endometriosis and can be assessed much more clearly too. Also overall pelvic mobility can be assessed, as in many cases the pelvic organs become adherent to each other, which can result in a ‘frozen pelvis’. The Sliding Sign helps us to determine whether this is present, and this should now be a routine part of any pelvic ultrasound.

After special training (angling the probe backwards and learning to recognise the appearance of Deep Endometriosis) the sonographers, radiologists and gynaecologists performing ‘endometriosis’ scans can then visualise Deep Endometriosis. There are training resources widely available including my free YouTube (REF 1) channel.

Deep Endometriosis often appears as small dark lumps or nodules which stand out in the contrasting white scar tissue (fibrosis). These nodules are most commonly found in the ligaments behind the womb (torus and uterosacral ligaments), in the muscular layer of the bowel wall and in or near the bladder wall.

Endometriosis can also occur in the ovaries, causing blood-filled cysts ('chocolate cysts'), which are often stuck down low in the pelvis to the surrounding tissues. With every period, more blood accumulates in the cyst and the cyst enlarges.

The womb (uterus) may be affected by a disease called Adenomyosis, which is a 'sister condition' of Endometriosis. This occurs when tissue similar to the lining of the womb (endometrium) is found in the muscle of the womb. This tissue reacts to hormones and may bleed during a period, which may cause the womb to become enlarged and cause symptoms including heavy painful periods. Adenomyosis can be accurately diagnosed on TV-US, but again more training is required for HealthCare Professionals (HCP).



Nodules of Deep Endometriosis in various locations (vagina, ligaments, bowel, ovary, bladder)

Endometriosis can also be present in other sites of the body ('extra-pelvic') such as bowel higher in the abdomen (eg small bowel, appendix), the belly button (umbilicus), Caesarean section scars, the diaphragm and the lungs. It can be very difficult to diagnose disease in these locations on a TV-US, and often an MRI scan (Magnetic Resonance Imaging) is required.

Some hospitals routinely use MRI rather than ultrasound to diagnose all Endometriosis. The two imaging modalities have similar accuracy, but MRI is very expensive and not all patients will be offered an MRI scan.

The latest NICE guidelines (REF 2) state that any patient with pelvic pain should now be offered a TV-US. But importantly: if the scan is said to be 'negative', and the patient continues to have symptoms, then the patient should still be referred to a gynaecologist. The HCP performing the scan may not have been trained to diagnose endometriosis and even severe endometriosis could have been missed.

Performing a scan to look for endometriosis may take longer to carry out than a more routine scan. The scan may take 30 – 40 minutes and due to pressure on appointments, many ultrasound departments are currently unable to allow this length of time for the scan. World-wide, Specialist Medical Societies (REF 3) are looking into how HCPs can access the extra training and have longer time slots, so that the accuracy of the scan can be improved.

In the meantime, if you have symptoms that could be due to endometriosis/adenomyosis, including heavy painful periods, painful sex, pain on opening your bowels during a period, pain on passing urine, pelvic pain throughout the month, and especially if these symptoms are interfering with your life, then please ask your GP to refer you for a pelvic ultrasound.

You can ask your HCP doing the scan if they are familiar with diagnosing endometriosis on ultrasound. If the answer is 'no', and if the pelvis is said to be 'normal', this may not actually be correct.

If the scan is 'normal' and you have symptoms, then you should still be referred to a gynaecologist, to exclude endometriosis and determine the cause of pain.

"In the future, I hope that many more patients with endometriosis will be diagnosed EARLY and the long diagnostic delay will be a thing of the past".

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Dr Tamara Sava

ENDOMETRIOSIS VS ADENOMYOSIS: HOW DO WE TELL THE DIFFERENCE?

On our journey toward the infinite horizon of knowledge, we must communicate. The patient learns to listen and to understand. Only through communication can we make medicine better and healthcare safer. I commend you for being here, and I thank you for the opportunity to speak to informed and empowered women. I find it truly inspiring that we can motivate one another and grow together.



Dr Tamara Sava is a consultant obstetrician-gynaecologist with over 20 years of experience in the field. She specialises in obstetric and gynaecological ultrasound, using advanced 3D and 4D probe technology, and has training in colposcopy and the ultrasound diagnosis of deep endometriosis.

Adenomyosis is also a form of endometriosis

What is Endometriosis?

In reality, it's quite simple: the endometrium is the thin layer that lines the inside of the uterine cavity. It is the tissue where a pregnancy implants when a woman becomes pregnant, and it is also the tissue that sheds during menstruation, causing bleeding. Endometriosis is a condition in which endometrial tissue is found outside the uterine cavity.

There are several types of endometriosis:

- **Internal endometriosis**, also known as adenomyosis, occurs when the endometrial tissue penetrates the muscular wall of the uterus and becomes embedded within it.

- **External Endometriosis** – This occurs when endometrial tissue (heterotopias) reaches the peritoneal cavity and implants in various locations.

Sometimes, the lesions are small and remain only on the surface of the peritoneum – this is called superficial endometriosis. Other times, the lesions infiltrate the peritoneum – this is known as deep endometriosis. In addition to the peritoneum, deep endometriosis can involve various organs such as the bowel, urinary bladder, ureters, and ligaments. Therefore, the difference between adenomyosis and endometriosis lies primarily in the location of the disease.

Another form of external endometriosis is the endometriotic cyst, or endometrioma, which forms when a cavity lined with endometrial tissue develops in the ovaries. During the menstrual cycle, this tissue proliferates just like the endometrium inside the uterine cavity.

At menstruation, the uterine endometrium is expelled through the vagina, but the endometrial tissue inside the cyst has nowhere to exit, so it accumulates, causing the cyst to gradually enlarge. Regardless of location, endometriotic lesions respond to ovarian hormones. Throughout the menstrual cycle, they proliferate, and during menstruation, they detach from the surrounding tissue and bleed, much like the uterine lining.

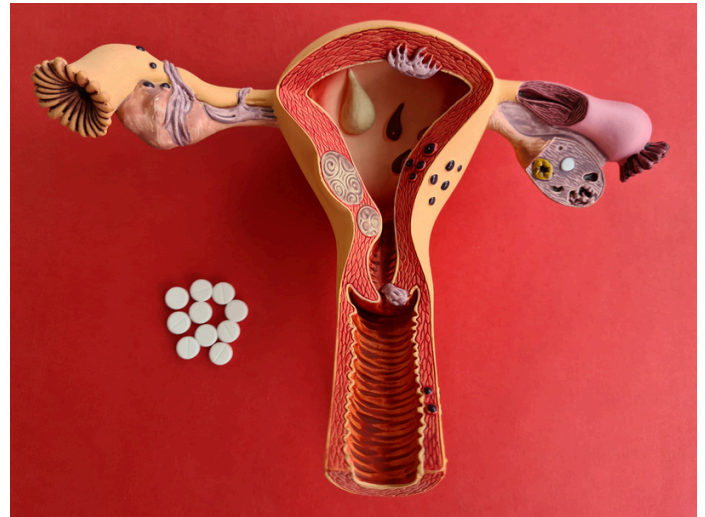
This results in mini-menstruations that accumulate either in various parts of the peritoneal cavity or within the muscle wall of the uterus in the case of adenomyosis.

When it comes to symptoms, both adenomyosis and endometriosis present with certain signs that are characteristic of endometriotic tissue involvement.

However, depending on the location of the lesions, the intensity of certain symptoms may vary. Likewise, the intensity of symptoms depends on the phase of the menstrual cycle. Symptoms are less intense in the first phase of the menstrual cycle and become more intense after ovulation.

Pain is the most frequent symptom of all forms of endometriosis, but the clinical picture can also include signs characteristic of a specific location of the disease. Often, the two conditions progress simultaneously.

If we were to talk about symptomatic adenomyosis, it often manifests through very painful and heavy menstruation, and sometimes brown discharge before and after menstruation.



This happens because those endometriotic trenches dug into the uterine muscle start to bleed slightly just before the onset of menstruation, and after menstruation, they close more slowly, causing spotting.

Menstruation is almost always painful, and the pain begins before the period starts. Often, women experience pain during sexual intercourse. Infertility may occur, but less frequently than in external endometriosis.

For external endometriosis, meaning endometriosis in the peritoneal cavity, the most common symptom is pain.

Why? Because, as mentioned earlier, these endometriotic implants in the peritoneal cavity also undergo mini-menstruations.

And because the blood from these mini-menstruations accumulates in the peritoneal cavity with no way to exit, inflammation occurs. The body tries to repair the local changes that result, and during this repair process, adhesions form. External endometriosis often manifests through chronic pelvic pain, a feeling of tension, bloating, pain during sexual intercourse, and severe menstrual pain. Bleeding in the peritoneal cavity causes inflammation and irritation of the peritoneum, which can lead to nausea, vomiting, and feelings of light-headedness.

In endometriosis affecting the urinary bladder, frequent urination, blood in the urine, and frequent cystitis after or around menstruation may occur. Rectal endometriosis is often accompanied by pain in the rectum during menstruation, pain when sitting, bloating, constipation, and frequent or painful bowel movements during menstruation.

Infertility affects approximately 50% of women with endometriosis. The same disease location can progress differently from one patient to another, and it must be acknowledged that a definitive distinction between adenomyosis and endometriosis cannot be made without imaging investigations. Non-invasive diagnostic methods include ultrasound, and if the doctor is uncertain, an MRI scan may also be recommended.



For many years, endometriosis was a neglected condition. But today we know that endometriosis can be very painful, sometimes debilitating, or catastrophic for reproduction. Moreover, understanding and compassion from both doctors and those close to the patient are often lacking.

“My doctor says I’m too anxious and emotional.”

“I feel like nobody even listens to me anymore.”

“My doctor thinks I’m making a fuss over nothing and sends me to a psychologist.”

“At 14, the doctor told me menstrual pain was normal.”

“He told me, ‘...I don’t see a future for us... you’re sick... I want a woman I can run with, ski with, and feel good with, but you can’t...’”

Unfortunately, endometriosis is one of the diseases most frequently missed in diagnosis, and it can take between 5 to 10 years from the onset of the first symptoms until the patient receives the correct diagnosis. In some women, the disease progresses without symptoms, while others deny or hide their symptoms.

“ The battle for an accurate and timely diagnosis is essential, and the light of victory will bring the patient out of darkness. ”

The UK's Uterus Transplant Program: A Solution to Infertility

Mr Benjamin P Jones

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More than 11 years ago, I joined the UK uterus transplant team as a PhD student; curious, hopeful, and slightly in awe of the ambition before us. I believed that this bold step could transform reproductive medicine, and hopefully many women's lives. I screened over 200 hopeful candidates and began evaluating those best suited for the procedure. Explaining the risks of major surgery and immunosuppression to these women was sobering. Sometimes, I wondered: why take such chances, when surrogacy or adoption were other paths to parenthood? But these women listened calmly, nodded with resolve, and never wavered. Their courage was humbling; nothing I said could dissuade them. During my research years, I became a Father myself. My wife and I welcomed two children, and I witnessed the magic of pregnancy and parenthood firsthand. I felt them kick, held them moments after birth, and experienced a love and bond that changed me forever. Only then did I fully grasp why our transplant patients were so determined.

After completing my PhD and becoming a consultant, I joined the Lister Fertility Clinic, one of the UK's busiest and reputable fertility clinics. Over the previous decade, I had the honour of getting to know Grace, our first uterus transplant patient.

Finally, 18 months after her transplant, Grace and her husband, Angus, sat once again in a clinic room with me, just as they had nearly ten years before, but this time to perform the embryo transfer. So much had changed, but their hope and trust remained as firm as ever.

What began with a simple embryo transfer ended in tears of joy and a miracle baby – a testament to hope, science, and unwavering determination.

Miracle' baby born after mum had first ever womb transplant in the UK



PHOTO SOURCE METRO

The embryo transfer itself was straightforward, almost anticlimactic. Nine days later, I awoke early, full of anticipation. Her message lit up my phone: a crying-face emoji. My heart sank. But when I opened it, I saw the emoji sat just beneath a photo of a pregnancy test that read 'Pregnant, 1-2 weeks'. The tears weren't of sadness; they were tears of joy! Two weeks later, I performed her first ultrasound scan and Grace and Angus watched in disbelief as they saw the baby they were told they would never have.

If that moment had an emoji, it would be three crying faces; we were all elated!

Seven months later, Grace held her miracle baby, Amy Isabel, in her arms.

As our work in uterus transplantation continues to evolve, our care of women with other reproductive complexities, such as endometriosis, does too. Endometriosis is more than just having painful periods. It's a chronic, frequently misunderstood condition that affects up to 10% of women of reproductive age, but up to 40% of those struggling with infertility. Endometriosis can infiltrate the ovaries, Fallopian tubes, bowel, and other pelvic structures, leading to a wide range of symptoms and, in many cases, difficulties conceiving.

The impact of endometriosis on fertility is multifaceted. It can distort pelvic anatomy, cause inflammation, create scarring that damages or blocks the Fallopian tubes, and it may even affect egg quality or implantation.

Despite these challenges, hope remains. While hormonal treatments can be effective for managing pain, they do not improve fertility and may of course ironically delay reproductive plans. For couples trying naturally to conceive, laparoscopic excision of endometriotic lesions restores anatomy and can improve conception rates. However, surgery must be approached with care, particularly when endometriomas are involved, as removing them may reduce ovarian reserve, which may negatively impact the number of eggs collected if in-vitro fertilisation (IVF) is later needed. In cases with endometriomas, especially if bilateral, fertility preservation, with egg or embryo freezing, can be undertaken. This helps safeguard options if ovarian reserve is impacted following surgery.

One of the main issues with endometriosis is the risk of damage or blocked Fallopian tubes. If the tubes are blocked, the embryo cannot make it to the uterus to implant. As such, undertaking an early assessment of the tubes, with an X-ray procedure called a Hysterosalpingogram, or ultrasound scan, called a HyCoSy is important. Interestingly, pregnancy rates may even increase in the 3-6 months after these procedures, likely from the mechanical effect of flushing contrast through the tubes, so there are multiple reasons to consider it.

Equally important is assessing the male partner's fertility. About 25% of infertility cases have a male factor, so a simple semen analysis early on can prevent lost time and guide appropriate action. If natural conception isn't successful, IVF can overcome many barriers posed by endometriosis. In cases of severe tubal damage, IVF is often the only viable route. When sperm quality is poor, intra-cytoplasmic sperm injection (ICSI) can usually overcome the issue. Importantly, IVF doesn't increase the recurrence of endometriosis, offering reassurance to those who need to go down this route.

The reproductive journey through endometriosis can sometimes be uncertain and emotionally exhausting. These women, just like those undergoing uterus transplantation, are brave and inspiring. The resilience I've seen in my transplant patients is mirrored in many of my patients battling endometriosis-related subfertility: that unwavering determination to be a Mum. Whether fertility is restored through surgery, IVF, transplantation, or simply by receiving the right advice or support at the right time; every path to parenthood matters.



Current approaches in the ovarian endometriosis treatment



Prof Dr Horatiu Roman

*consultant
gynecology surgeon*



Dr Irina Holt

*consultant
gynecology surgeon*



Dr Iuliana Iacoban

*consultant
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Endometriosis is a gynaecological condition characterised by the presence of endometrial tissue outside the uterine cavity. When this tissue is located on the ovaries, it can form endometriotic cysts or endometriomas, often associated with chronic pelvic pain and infertility. Accurate diagnosis is essential and involves a detailed medical history, clinical examination, transvaginal ultrasound, and MRI evaluation.

Treatment of this condition requires an individualised approach, considering symptoms, impact on fertility, patient age, anatomical severity, and previous treatment response. This article reviews current therapeutic options and emerging directions in the management of this pathology.

Introduction:

Endometriosis affects approximately 10% of women of reproductive age globally. Ovarian involvement is one of the most common forms, occurring in 17–44% of patients with endometriosis.

Endometriomas are blood-filled (“chocolate”) cysts resulting from the accumulation of menstrual blood in ectopic foci, particularly in the ovarian cortex, and are frequently associated with pelvic adhesions and ovulatory dysfunction.

Pathogenetic and Histological Mechanisms in Ovarian Endometriosis:

The pathophysiology of ovarian endometriosis includes multiple theories: menstrual reflux, coelomic metaplasia, lymphovascular dissemination, and immune dysfunction. Endometriomas likely form through coelomic metaplasia of ovulatory cysts.

Unlike other benign cysts, endometriomas originate on the ovarian surface, where the cyst invaginates into the ovary. This invagination site is usually (95%) adherent to neighbouring organs.

The wall of an endometrioma has two distinct layers:

- **Inner layer:** A thin layer of endometrial cells responsible for progression and recurrence through fluid accumulation within the cyst.

- **outer layer:** A thicker (~1 mm) fibrotic layer, strongly adherent to the underlying ovarian tissue.

The absence of a clear cleavage plane, even microscopically, means healthy ovarian tissue can be damaged when traction is applied to this fibrotic layer.

Therapeutic Strategies:

Medical Treatment – Conservative therapy is initially indicated in mild to moderate cases:

1. NSAIDs (Ibuprofen, Paracetamol, Celecoxib, etc.) combined with hormonal therapy for pain management.
2. Combined Hormonal Therapy (COCs, Ryeqo, vaginal ring): Combined oral contraceptives inhibit ovulation and induce an atrophic endometrium. Studies show significant pain reduction and prevention of post-surgical recurrence. Continuous use of monophasic preparations is preferred.
3. Progestins (oral tablets, implants, LNG-IUS): Dienogest (2 mg/day) is considered the therapeutic standard in many guidelines (ESGE, ESHRE), offering anti-inflammatory, antiproliferative, and antiangiogenic effects.
4. GnRH analogues and antagonists: Effective but associated with significant side effects, necessitating “add-back” therapy.

Surgical Treatment:

The type of surgical intervention must be individualised, based on:

- **Age and fertility desire:** The younger the patient, the more conservative the ovarian surgery should be, prioritising sclerotherapy or vaporisation.
- **Symptoms and previous treatment response.**
- **Size and bilaterality of endometriomas:** Large endometriomas (>7 cm) are best treated with sclerotherapy or a combination of sclerotherapy and vaporisation.
- **Ovarian reserve and hormonal status:** Good reserve allows for cystectomy; poor reserve suggests simple drainage.
- **Previous surgical history.**

Surgical Indications:

- Pain due to large cysts;
- Large cyst before IVF to facilitate oocyte retrieval;
- Suspicion of malignancy;
- Severe, treatment-resistant symptoms.

Surgical Techniques – Operating Principles:

Atraumatic techniques, minimal haemostasis, and preoperative AMH evaluation are recommended.

Cystectomy: Involves removal of the cyst wall (fibrous layer), which inevitably extracts part of the underlying ovarian tissue, reducing follicular reserve.

- Recommended for younger patients with good ovarian reserve.
- May impact ovarian reserve, especially in bilateral endometriomas.
- Lower recurrence risk compared to other methods; however, recurrence risk remains around 1% per ovulation, with approximately 25% recurrence at 2 years.



CO₂ Laser/Plasma Ablation or Vaporisation:

Destroys the inner endometrial layer in situ without removing the fibrotic layer. Energy sources used (laser/plasma) minimise thermal spread, protecting ovarian tissue.

- Preserves more functional ovarian tissue
- Indicated in patients with low ovarian reserve or severe endometriosis
- Higher recurrence risk than cystectomy

Sclerotherapy (Alcoholisation):

Instillation of 95° alcohol into the cyst for 10–15 minutes to destroy the inner endometrial lining without harming adjacent ovarian tissue.

Aspiration/Drainage:

Simple drainage for women with compromised ovarian reserve, usually prior to IVF to reduce surgical trauma to ovaries.

- Reserved for selected cases
- High recurrence rate; considered a temporary solution.

Impact on Fertility:

Treatment strategy depends on age, conception desire, and disease severity:

- Women <35 years: Conservative treatment followed by natural conception or IUI is feasible
- Women >35 years or with persistent infertility: IVF is recommended.
- Cryopreservation of oocytes/embryos should be considered before surgery in single women with good ovarian reserve, unilateral large cysts, or bilateral endometriomas.

Recurrence and Follow-up

The recurrence rate is high (20–50% within the first two years), making regular monitoring necessary.

Postoperative hormonal treatment (Dienogest or combined oral contraceptives) reduces the risk of recurrence.

Adopting a balanced lifestyle supports symptom control.

75% of women who undergo surgery for endometriomas using plasma energy vaporisation or cystectomy are pregnant within three years post-operation.

50% of pregnancies after surgical intervention are achieved naturally.

Future Perspectives

Research is focusing on molecular biomarkers, targeted anti-inflammatory therapies, SPRM modulators, gene therapy, and microbiome manipulation, with the aim of controlling the disease without compromising fertility or quality of life.

Conclusions

The management of ovarian endometriosis must be individualised and multidisciplinary.

Active patient involvement in therapeutic decisions is essential for achieving optimal long-term outcomes.

The treatment objective is twofold: preventing recurrence and preserving ovarian reserve.

At present, no surgical technique exists that fully satisfies and maximises both goals.

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Twenty-One Years to a Diagnosis: From Being Ignored to Supporting Others

Katy Phillips

Founder & Chief Kindness Officer
Endo Buddies CIO



It took Twenty-one years for me to get a diagnosis of Endometriosis. Let that sink in. Seriously, TWENTY-ONE YEARS!

Twenty-one years of my life where I wasn't really heard when I said I was in pain. Twenty-one years of being told, basically, it wasn't a big deal. Twenty-one years feeling completely on my own while this disease was doing irreparable damage to my insides. That's a long time to feel like you're being dismissed, not being taken seriously, not being believed, and honestly, it makes me really angry.

My personal hell began at age 11, with the arrival of my first period. It wasn't the gentle initiation into womanhood I'd perhaps naively imagined. Instead, it was a brutal onslaught. It was absolutely awful. My dad was brilliant, trying to help, but I just remember this overwhelming feeling of "What is happening to me?!" From that day forward, it was a constant battle to get anyone to listen. Fast forward to 32, and the only reason I finally got a referral to a gynae was because my uterus was being uncooperative on the baby-making front. **Go figure.**

My symptoms weren't subtle. We're talking really bad period pains where I would black out, plus about a week of pre-period pain that felt like a warm-up for the main event (in my late 20's and 30's) I ended up just having about one 'good' week per month of not feeling as bad. Then there was the sciatica – which, surprise surprise, wasn't "in my head" as one doctor told me, but actually endo having a little party around my sciatic nerve. I also had monthly nosebleeds, like clockwork, from age 11 to 39 (apparently just a coincidence, according to some...er...ok then?!).

Heavy, painful legs, random shoulder pain, and a digestive system that couldn't make up its mind – diagnosed as IBS, but it turned out my bowel was twisted and stuck thanks to the endo. Oh, and the thrillingly slow and stop-start action of my bladder. Chuck in some soul-crushing fatigue, the heartbreak of infertility, and even ovulation felt like a tiny internal rebellion. It's no wonder anxiety and a very large touch of the blues decided to join the fun.



“
*Seriously,
Endometriosis
is really is
the gift that
keeps on
giving*”

My first gynae appointment? She basically said she didn't think anything was wrong but would do a laparoscopy anyway, like she was doing me a favour. Months later, the appointment got moved to an Endo specialist. Even the pre-op nurse seemed to know the score, saying I'd likely be back. At the time, I didn't fully get what a long-term deal Endo can be. Then came the surgery. The gynae who didn't think anything was wrong? She told me they found loads of endo. Said if she'd done it herself, I'd have needed another surgery with the specialist anyway because of how much there was and the bowel situation. So yeah, not in my head. Finally, some answers.

I've had four surgeries in total, including a radical hysterectomy at 39 after trying literally everything to help (yes, I've done the diets, the yoga, the kale eating, the celery juice, the meditation, the turmeric.... you name it, I've tried it).

While a hysterectomy is not a cure, not having period and ovulation pains anymore has been a massive relief but now, 6 years later, some of my symptoms are creeping back. And guess what? Despite already having a diagnosis, I'm still fighting to be seen again.

And the stuff people have said to me over the years? Unbelievable. "It's in your head." "You're a woman, just get on with it." "You're probably just stressed." The worst was the "You need to get pregnant" advice by a gynaecologist after just telling him about my 4 failed rounds of IVF. Seriously? That level of dismissal and insensitivity just hits you hard. I was upset and anxious for a long time after that, and honestly, it still gets to me now.

By the end of 2018, I was done. Just completely fed up. I'd lost my sense of purpose. I didn't want to be here anymore. Luckily, I had some great friends who supported me after I finally opened up to them. After a while, I decided to use my difficult experience to help others.

That's how Endo Buddies and the Surgery Care Package Project started in 2019. Because what I realised was, after surgery, there was just...well, nothing. No info. No support. Zilch. Zero. Nada. So, I decided to change that. The care packages are a little hug in a box, they have practical stuff like sleep masks and peppermint tea (that trapped gas pain after a laparoscopy is no joke!), but also things for your mental well-being – a little fidget toy, positive cards, and even a mini anxiety toolkit.

In 2023, Endo Buddies became a registered charity

And a really popular item is the questions card for the medical team, because who remembers everything useful when you're still half-asleep from the anaesthetic? But, more importantly, for many patients the care packages are the first time they've felt supported and cared about on their endo journey. I'm brought to tears on a daily basis with the heart felt feedback we receive.

We've now sent out over 1000 of these little boxes of support, and the need is still huge. Because the truth is, even now, years after my diagnosis, people with Endo are still being dismissed and left feeling alone. It makes me determined to never stop fighting for change and offering support.



Katy with their care packages



We have also partnered with Shout to give a mental health support service, as I said my mental health hit rock bottom and I don't want anyone else to feel like they have no-where to turn. We conducted a mental health survey at the end of 2023 which showed 97.5% of people with endo said it has had a negative effect on their mental health and shockingly, 53.6% said they'd considered ending their lives because of it. Things need to change, and they need to change fast. In 2023, Endo Buddies became a registered charity, which I'm incredibly proud of. Turns out, my purpose is to be the kind of support I wish I'd had all those years ago.

Shout - Text ENDO to 85258 for free, confidential mental health support 24/7 (in partnership with Shout)

To sponsor a care package or enquire about supplying care packages to patients in the hospital where you work – email hello@endobuddies.com www.endobuddies.com

Managing Endometriosis Through Diet and Lifestyle

When I was first diagnosed with endometriosis, I was handed a pamphlet that mentioned the word chronic five times and cure exactly zero. The tone was heavy, the options narrow, and the prognosis felt... permanent. What that pamphlet didn't say—and what I've since learned through research, lived experience, and talking to hundreds of women—is that endometriosis doesn't always follow that (scary) line of progression. Contrary to what many of us are told, endometriosis lesions can regress, stabilize, or progress. Symptoms can also go into remission. There is hope.

Several human studies have found that lesion behavior varies widely. One review reported that while 29% of lesions progressed, 71% either stabilized or regressed. In another, 63% of women with deep infiltrating endometriosis saw no growth—or even a reduction—over two years. In a third, 93% of women with untreated rectovaginal lesions experienced no clinical change over up to nine years.

These studies weren't measuring why this happened—they simply observed lesion behavior. However, when we recognize that endometriosis is a disease driven by inflammatory processes, it becomes easier to understand how reducing inflammation may help alleviate the burden of endometriosis. And while diet and lifestyle aren't guaranteed to regress lesions (and this certainly isn't to say you won't also need a surgery on your healing journey), understanding that these tools may profoundly impact your symptoms, inflammation, immune response, and quality of life is an important topic to discuss.

Here are my top three consideration when learning about these integrative healing modalities:



Katie Edmonds

Katie Edmonds is a Certified Nutritional Therapist (NTC), Endometriosis Educator, and author of the best-selling book *Heal Endo: An Anti-Inflammatory Approach to Healing From Endometriosis*. She blends science with story to help women reclaim their bodies and trust their inner wisdom. Her work has supported thousands of people navigating chronic illness with compassion, curiosity, and courage. You can find her at healendo.com.

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Food as a Message, Not Just Fuel

When you live with a condition like endo, food becomes more than just energy. It's communication. It signals safety—or stress—to your immune and nervous systems. And because endometriosis is fundamentally inflammatory, our dietary choices influence how loud or quiet that inflammation becomes.

Anti-inflammatory foods—leafy greens, berries, cruciferous vegetables, omega-3-rich fish, iron-rich meats, turmeric, ginger—don't just “sound healthy.” They help modulate immune pathways and inflammatory mediators like prostaglandins and cytokines—it's a meaningful shift. Meanwhile, ultra-processed foods, excess sugar, and industrial seed oils (like canola and soybean oil) increase inflammatory load. These don't need to be “banned,” but awareness matters—especially when your symptoms are flaring. Another major player? Blood sugar. Many people overlook this, but chronic spikes can worsen fatigue, mood swings, and estrogen dominance—all of which affect endo. Stabilizing meals with protein, fiber, and fat can help regulate hormones and reduce flares.

Remember, this isn't about restriction. It's about supporting regulation.

Gut Health: The Hidden Key

What you eat matters—but the health of your microbiome is just as important (why I have a whole chapter on it in my book).

The gut and endometriosis are closely linked. A healthy microbiome regulates estrogen, produces immune-calming short-chain fatty acids, and influences systemic inflammation. A compromised gut can allow bacterial fragments (like LPS) to leak into circulation and aggravate the immune system, worsening symptoms and increasing inflammation. Then there's the estrobolome: the part of your gut microbiome that helps eliminate estrogen. If it's out of balance, your body may recycle excess estrogen, contributing to hormone-driven symptoms like pain, bloating, or heavy periods.

Supporting gut health is unique to each body but, for you, it might look like:

- Diagnosing and treating lingering infections or imbalances
- Eating more prebiotic fiber (e.g., garlic, leeks, asparagus)
- Incorporating fermented foods (if tolerated)
- Identifying and removing aggravating foods
- Chewing slowly and supporting stomach acid production

It's not about a perfect gut—it's about a functional one.

Nervous System Regulation = Symptom Relief

Here's something we don't talk about enough: the nervous system's role in chronic illness.

Pain doesn't just live in your pelvis. It lives in your brain, your fascia, your breath, your stress response. Over time, persistent pain and worry can rewire the nervous system to become hyper-reactive—even to things that aren't dangerous. This is called central sensitization, and it's common in endo.

That's why nervous system practices—like gentle movement, neural re-wiring, breathwork, nature time, singing, co-regulation, or simply slowing down—are not optional. They're therapeutic. They help signal safety to the brain, interrupt stress cascades, and reintroduce calm.

Not Perfection—Empowerment

Healing support through diet and lifestyle isn't about green smoothies, gut protocols, or clean eating checklists. It's certainly not about replacing a surgery when you need one. Rather, it's about getting curious, listening to your body, and changing the input to change the output.

Endometriosis is complex, but it is not hopeless. There are real tools—nutrition, gut support, nervous system regulation—that can reduce pain, calm inflammation, and improve quality of life. You deserve to know what's possible.

If you're ready to understand the root causes of endo and learn a step-by-step, sustainable approach to managing it, my book *Heal Endo* is the place to start. It's not a quick fix. It's a roadmap. And it's one I wish I'd had years ago.

More Than an Inconvenience: Heavy Menstrual Bleeding as a Clinical Red Flag

Why periods that disrupt your life deserve a closer look

“I just thought I was unlucky”

That’s what many women say about their heavy periods. For years, they adapt—carrying spare clothes, avoiding social plans, and planning work shifts around their menstrual cycle. It’s a common story: life revolves around the period, not the other way around. But heavy menstrual bleeding (HMB) isn’t just inconvenient. It’s a medical condition—and can be a red flag that deserves proper investigation.

What Is Heavy Menstrual Bleeding?

Heavy menstrual bleeding affects up to 1 in 4 women of reproductive age and is a leading cause of referral to gynaecological services¹. Yet, it is sometimes dismissed or poorly managed.

Clinically, HMB is defined as excessive menstrual blood loss that interferes with a woman’s quality of life—physically, emotionally, or socially.

Key signs include:

- Soaking through pads or tampons every two hours or more frequent change
- Needing to use two forms of protection (pads and tampons) simultaneously
- Bleeding that lasts longer than 8 days
- Passing large clots
- Waking up at night to change protection
- Flooding through clothes
- Experiencing fatigue, dizziness, or shortness of breath (suggesting anaemia)



Dr. Talat Uppal

Dr. Talat Uppal is an experienced Obstetrician and Gynaecologist, serving as the Director of Women’s Health Road, an innovative, multidisciplinary clinic in Sydney. Dr. Uppal is also the founder of the Bleed Better initiative, which established the International Heavy Menstrual Bleeding Day on May 11 to raise awareness of this condition, affecting 25% of women of reproductive age.



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Despite how common it is, many women do not realise their bleeding is abnormal, and healthcare providers may also not always ask the right questions to uncover the problem.

Heavy Bleeding and Endometriosis: A Hidden Link

Heavy bleeding is not the most recognised symptom of endometriosis, a condition where tissue similar to the uterine lining grows outside the uterus. However, many women with endometriosis experience HMB—especially when it coexists with adenomyosis, where endometrial tissue infiltrates the muscle wall of the uterus and HMB is a common symptom. In fact, studies estimate that approximately a third of women with endometriosis have adenomyosis ². HMB may be the only symptom a woman reports—or the one that's been overlooked in favour of more "textbook" signs like pelvic pain or painful periods. By recognising HMB as part of the endometriosis spectrum, we can reduce diagnostic delays and offer more holistic care.

Clinical Standards: What Patients Should Expect

The Heavy Menstrual Bleeding Clinical Care Standard, developed by the Australian Commission on Safety and Quality in Health Care, outlines best practices for assessment and management ³. According to the standard, a thorough assessment should include a medical history, pelvic examination where appropriate, pregnancy testing, and iron studies. Further investigations, such as a pelvic ultrasound (ideally between day 5–10 of the cycle), may be needed to assess the uterine lining and identify structural causes.

Pharmaceutical treatment, including the levonorgestrel-releasing intrauterine system (LNG-IUS), should be offered when appropriate. Shared decision making is essential—patients should be informed of all options and their preferences respected. Referral to a specialist is appropriate if there is concern about malignancy, significant pathology, or if symptoms persist after six months of treatment.

Two Stories, Two Outcomes

In a case example published by the Australian Commission on Safety and Quality in Healthcare, Lin, a 38-year-old with lifelong HMB, underwent multiple ultrasounds and eventually a hysterectomy—without ever being offered less invasive options. She lost work, faced significant costs, and felt unsupported. By contrast, her cousin Kathy saw a GP who followed the Care Standard: she was assessed properly, offered written information, and prescribed a pharmaceutical option while diagnostic tests were arranged. Kathy later opted for an LNG-IUS and reported dramatically improved quality of life—all without surgery.

Treatments: Medical, Radiological, and Surgical

There is no one-size-fits-all treatment, but options should be discussed transparently:

- Pharmaceutical treatments: Tranexamic acid, NSAIDs, hormonal contraceptives, or LNG-IUS
- Minimally Invasive surgical options: Endometrial ablation or hysteroscopic polyp/fibroid removal
- Radiological: Uterine Artery Embolisation
- Surgery: Hysterectomy may be appropriate if other treatments fail or by patient preference, but it should not be the default.

International Heavy Menstrual Bleeding Day was established on 11 May by Dr Talat Uppal and the Bleed Better initiative. The day focuses on raising awareness, challenging stigma, and encouraging open conversations about menstrual health. It also aims to empower women to seek timely medical advice and access appropriate care, including investigation for underlying conditions such as fibroids, endometriosis, or bleeding disorders. Menstrual health is an essential part of overall well-being and should not be overlooked.

A Call to Action: Ask, Advocate, Act

Heavy menstrual bleeding is not something you should just put up with. It is a clinical sign—sometimes of serious underlying conditions—and deserves a thorough, respectful evaluation. Whether you're a patient or a clinician, the time to act is now.

For patients:

- Track your symptoms.
- Don't downplay how bleeding affects your life.
- Ask your clinician about all available treatment options.

For clinicians:

- Use a structured history and assessment tool
- Offer evidence-based treatment in line with the Clinical Care Standard.
- Ensure patients are empowered with information and choice and practice shared decision making.

Let's change the narrative. Heavy menstrual bleeding isn't just a woman's burden—it's a health issue with real solutions. With greater awareness, structured care, and patient-centred communication, we can ensure no one is left to suffer in silence.

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The Voice Behind Kenya's Endometriosis Movement

Elsie Wandera

Founder of Endometriosis Foundation of Kenya



Can you tell us about your personal journey with endometriosis and when you first started noticing symptoms?

My journey with endometriosis began long before I had a name for it. At 16, I was experiencing debilitating pain, missing school, and told it was “just part of being a woman.” It wasn’t until I was 26 that I was officially diagnosed, after years of unexplained symptoms and countless visits to doctors. By then, the disease had already advanced. I’ve undergone four surgeries, lost my ovaries, and now live with the effects of surgical menopause. That pain—not just physical, but emotional and invisible—is what pushed me toward advocacy.

As a Black woman living with endometriosis, how have your experiences differed from others, and do you believe there are specific challenges within the Black community regarding the diagnosis and awareness of the condition?

Absolutely. There’s a deep-rooted cultural silence around menstrual pain in many Black communities. We’re often taught to endure, to not speak up. Medical bias compounds this—Black women’s pain is too often dismissed or minimized. I wasn’t believed for years. There’s a lack of representation in research, awareness campaigns, and clinical care models.

That invisibility delays diagnosis and care. I’ve made it my mission to change that—because we deserve to be seen, heard, and healed.

What inspired you to start the Endometriosis Foundation of Kenya (EFK), and how has the foundation helped to raise awareness about endometriosis in Kenya and beyond?

The Endometriosis Foundation of Kenya was born from my personal story—a story that, unfortunately, reflects the experience of so many others. After living for years with debilitating, unexplained pain, undergoing multiple surgeries, losing my ovaries, and entering surgical menopause, I realized that the greatest tragedy wasn’t just the disease—it was the silence surrounding it. I knew I couldn’t keep that pain to myself.

I wanted to turn it into purpose.

I founded the Foundation to create what I wish I had when I was younger: a safe, visible, and informed space for education, support, and advocacy.

Our goal has always been to normalize the conversation and denormalize the pain. For far too long, period pain has been brushed off, especially in African societies where silence is considered strength and suffering is internalized.



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**Elsie
Wandera**

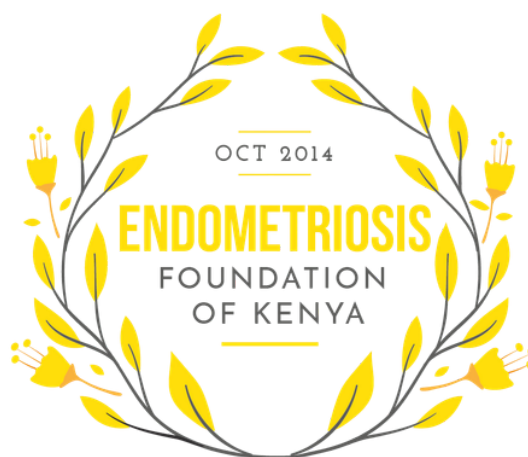
One of our biggest tools for public engagement has been the #SpreadTheYellow campaign. Yellow is the global color for endometriosis awareness, and through this campaign, we've been able to unify voices, raise visibility, and bring communities together both online and offline. We've mobilized individuals, schools, workplaces, and even healthcare providers to wear yellow, speak up, and create a ripple effect of awareness every March during Endometriosis Action Month—and beyond.

We've hosted learning sessions, webinars, and in-person conversations that demystify the disease. I've had the opportunity to appear in national and international media, speak at universities and conferences, and contribute to academic publications like the JEPP entry with MDT, where I highlighted the need for a multidisciplinary approach to managing endometriosis. I've also been featured in books and storytelling campaigns that document the lived realities of women with endo—because stories heal, but they also hold systems accountable.

We use every platform available to us—radio, TV, social media, print—to shift public understanding and equip people with knowledge. Whether it's educating adolescent girls about what's normal and what's not, training school counselors, or briefing journalists on how to cover the topic responsibly, we focus on changing culture, policy, and practice at the same time.

Our foundation is not just a response to a medical condition—it's a response to a systemic failure. We exist to say: You are not imagining it. You are not alone. And there is a community fighting for your right to live without pain. That's our why. That's my why.

We didn't come into this to assign blame. We came to fill the gap.



What was the initial reaction from the community and medical professionals when you started advocating for better understanding and treatment of endometriosis in Kenya?

At first, it was an uphill battle. The silence around endometriosis was deafening, even within the medical community. When I began reaching out to gynecologists and other health professionals to partner on awareness initiatives, many declined or distanced themselves from the cause. A common response was that endometriosis had “no known cause or cure,” and some even went as far as suggesting outdated and harmful advice like “just get pregnant.” It was clear that not only was there a gap in knowledge—but also a lack of willingness to sit in the discomfort of what they didn't know.

Many didn't want to be associated with the Foundation because acknowledging the problem publicly might have felt like admitting they had missed it in their own practice. And while they may never say it outright, there's been a resistance to collaboration that often stems from protecting their professional image. But we didn't come into this to assign blame. We came to fill the gap. That's why we've intentionally invested in learning—partnering with specialists, reviewing global research, and staying grounded in the lived experiences of patients.

Now, things are slowly changing. There's more interest—largely because more women are boldly sharing their stories. Social media, especially during Endometriosis Action Month, has become a powerful platform for both patients and professionals. We're seeing a new wave of doctors talking openly about the condition, and that visibility is incredibly important. Still, there's a delicate tension: some of these professionals are positioning themselves as experts, despite previously showing little interest or support. But we are not regulators in the healthcare space—our role has never been to police credibility. Instead, we stay focused on our mission: empowering the community to ask the right questions, to advocate for better care, and to know their rights as patients. While we've seen progress, we're careful not to confuse visibility with partnership.



Collaboration requires more than a post—it requires showing up consistently for patients. And that's what we will continue to do, with or without applause.

Endometriosis is often misunderstood and underdiagnosed, especially in marginalized communities. What are the key changes you hope to see in how endometriosis is recognized and treated in Kenya and other African countries?

We need earlier screening, mandatory inclusion in medical training, and policies that prioritize menstrual and reproductive health. One of the most urgent priorities is capacity building of our frontline healthcare workers—especially nurses, who are often the first point of contact for girls and women in pain. They need the tools to recognize the signs of endometriosis early and respond with empathy and clinical precision. We also need continuous medical education for doctors, investment in African-led research, (because data drives policy) and patient-centered care models that treat endometriosis as more than a gynecological issue—it's a systemic, biopsychosocial condition. The goal is early diagnosis, equitable treatment, and dignity in care.

How has your experience as an endometriosis patient shaped your approach to healthcare, both personally and in terms of advocacy for others?

It's made me fiercely compassionate and unapologetically bold. I understand the trauma that comes from not being believed. So I advocate for holistic, trauma-informed care. I push for multidisciplinary teams—because managing endometriosis isn't just about surgery, it's about mental health, nutrition, fertility support, and workplace accommodations. I've become a louder voice because so many suffer in silence.

In May 2025, I was honored to be appointed Co-Chair of the World Endometriosis Organisations—a significant milestone not just for me, but for Kenya and the entire African continent. This was during the 16th World Congress on Endometriosis in Sydney, Australia. It signals that our voices are finally being recognized at a global level.

What role do you believe cultural beliefs or societal norms play in the stigma surrounding endometriosis, and how can we work together to change this narrative?

Cultural norms have a huge impact. In many communities, periods are taboo. Pain is normalized. Infertility is shamed. This silence kills—not just dreams, but lives. To change the narrative, we need education at every level, collaboration between religious leaders, health providers, and media. We must tell our stories boldly and include men in the conversation—because endo is not just a women's issue, it's a human rights issue.



At World Endometriosis Congress in Australia, May 2025

Looking ahead, what are your goals for the Endometriosis Foundation of Kenya (EFK), and how can the global community contribute to your efforts in supporting endometriosis patients?

Our goals are to launch our Endo Resource Center, and rollout rural outreach programs, and advocate for policy inclusion at the Ministry of Health. With my role as Co-Chair of the World Endometriosis Organisations, I also aim to strengthen global partnerships and ensure Africa has a permanent seat at the table. The global community can support by funding research, amplifying patient voices, and collaborating across borders. We need solidarity, not charity—shared action, not sympathy.

What advice would you offer to those who are newly diagnosed with endometriosis, especially for women of color who may face additional barriers to care and support?

You are not alone. Your pain is real. And your story matters. Advocate for yourself, even when it's hard. Find a support system—whether it's a friend, a community like EFK, or an online group. Document your symptoms. Ask questions. Rest without guilt. And remember, you are not defined by this disease—you are still whole, still worthy, still powerful. We are rewriting the narrative, together.



Yoga in post-surgical recovery for endometriosis

Post-surgical recovery for women with endometriosis requires more than physical healing—it calls for emotional integration and nervous system regulation. Yoga, when approached mindfully and gently, offers a safe, therapeutic space to reconnect with the body, reduce inflammation, soothe the nervous system, and gradually restore movement. Far beyond just stretching or exercise, yoga is increasingly recognized in scientific literature as a supportive therapy for managing endometriosis symptoms and facilitating post-operative recovery.

Yoga is more than movement—it's a therapeutic tool supported by growing research. A 2017 randomized controlled trial published in the *Journal of Alternative and Complementary Medicine* found that a 12-week yoga program significantly reduced pain intensity and improved quality of life in women with endometriosis. Another 2019 study in *Frontiers in Psychology* demonstrated how slow, mindful movement and controlled breathing lower cortisol levels, decrease inflammation, and promote nervous system balance—essential components in post-operative healing.

These findings aren't surprising to those who have lived the experience. After surgery, the nervous system is often in a state of hypervigilance. The body has been under anesthesia, opened, manipulated, and placed in a sterile, unfamiliar environment. Patients emerge not just needing to move again—but needing to feel safe again in their own bodies.



Camelia Petrut

*Certified Yoga Teacher
Stage II Endometriosis*

When and how to begin?

Yoga should be resumed only after receiving medical clearance, typically a few weeks post-surgery, depending on the type and extent of the procedure. In the early recovery stages, it's crucial to focus on presence, breath, and gentle rest rather than physical exertion. The approach should always be trauma-informed, slow, and supportive—free from pressure or performance.

If physical movement feels too intense or triggers pain, that is not a cue to push through—it is a message to pause. In such moments, the most healing choice may be to set aside the physical practice altogether and turn inward to the breath. In the initial days and weeks post-surgery—especially after laparoscopy or hysterectomy—the breath itself can become the entire yoga practice. Many practitioners begin with *dirga pranayama*, the three-part breath. Lying down with one hand on the belly and the other on the chest, the inhale gently flows into the abdomen, then the ribs, then the chest; the exhale slowly reverses the path.

This practice, though subtle, supports profound healing. It helps reduce post-surgical anxiety, stimulates lymphatic drainage, and begins to reawaken the core—which may feel distant or fragile after surgery. Breath is the great awakener: it restores circulation, reduces pain perception, and calms the vagus nerve. Just five to ten minutes a day of deep belly breathing can make a difference—and it's typically safe to begin within days of surgery, with physician approval.

Another gentle and effective technique to regulate the nervous system and relieve pain is the 4-7-8 breath:

- Inhale through the nose for 4 counts
- Hold the breath for 7 counts
- Exhale through the mouth slowly for 8 counts
- Repeat for 4–6 rounds

This technique supports parasympathetic activation and can be practiced lying down or seated, even on days when physical movement is not accessible.



Gentle Yoga practices for healing

Below are three foundational practices to support post-surgical recovery in a safe and accessible way. These should always be approached with care and may be modified or omitted if any discomfort arises.

1. Restorative Butterfly (Supta Baddha Konasana)

Props: bolster or pillows, yoga blocks or folded blankets

- Lie on your back with a bolster supporting the spine
- Bring the soles of the feet together, allowing knees to fall open, supported by props
- Place one hand on the heart and one on the belly
- Remain for 5–10 minutes, breathing deeply and slowly

Effects: Gently opens the pelvic region, supports lymphatic flow, and fosters emotional release.

Precaution: If there's any tension in the inner thighs or lower belly, elevate the knees higher with cushions. Never force openness.

2. Supported Child's Pose (Balasana)

Props: bolster or pillows for support

- Kneel on the floor, big toes together, knees apart;
- Fold forward and rest the torso on a bolster or cushion;
- Forehead rests down, arms extended or beside the body;

Effects: Calms the nervous system and relieves lower back tension.

Precaution: Avoid any compression in the lower belly or pelvic area. Use additional height if needed.

3. Reclined diaphragmatic breathing

- Lie on the back with knees bent or legs supported
- Place one hand on the chest and one on the belly
- Inhale into the belly, allowing it to gently rise
- Exhale softly, feeling the belly fall

Effects: Supports nervous system regulation, promotes circulation, and reconnects the breath with the body.

Precaution: If deep breathing feels uncomfortable, simply observe the natural rhythm of the breath.

Start with 10–15 minutes per day, even if the practice consists solely of breathwork. Increase only as comfort allows. The priority is creating a sense of safety and connection—not achieving physical goals. Recovery is not a linear process, and yoga during this time should reflect that with patience and compassion.

Yoga in the post-operative period is not merely a practice of movement—it is a practice of reconnection. In the quiet moments after surgery, when the body feels unfamiliar and tender, yoga offers a safe path back home to oneself. Through breath, presence, and gentle awareness, it becomes possible to rebuild trust in the body, regulate the nervous system, and support deep, lasting healing. When approached with compassion and consistency, yoga transforms from a recovery aid into a source of empowerment, resilience, and inner renewal.

About pain and endometriosis



Endometriosis hurts, but it hurts in so many different ways. And that is why I want to start by talking about gentleness in the context of such an invasive condition. Beyond the solid scientific basis for dietary intervention in endometriosis—which remains essential—I want us to focus on compassion. Because we are talking about a disease that shows no mercy, that strikes from all directions, affecting multiple systems.

Sometimes it is silent, other times it is overwhelmingly loud. Even though endometriosis is a medical condition with clear scientific foundations, the suffering caused by this disease goes beyond the physical barrier and reaches the soul.

What exactly is ENDOMETRIOSIS?

Endometriosis is medically and scientifically defined as a chronic, inflammatory, estrogen-dependent condition, characterised by the presence of tissue similar to the endometrium outside the uterus.

The extent of the disease can vary greatly, from minimal peritoneal deposits to deep forms that can invade the intestine, urinary bladder, and ureter, and may spread to extrapelvic areas (1).

Because it affects our fertility. It hurts because it seems to stand stubbornly in the way of your happiness and fulfilment. It hurts because you feel unheard, unseen, so alone and helpless — even in the year 2025. Endometriosis comes with shame, disappointment, regret, anger, confusion, fear, and it seems to steal your identity, your relationship with yourself, with others, and with the idea of femininity and personal fulfilment.

Precisely because endometriosis is a disease of pain, I want us, those who guide patients towards healing, to hold compassion, patience, and empathy for their suffering in mind — beyond the scientific truth, but not without it. Gentleness is a therapeutic act in itself; it is part of healing.



**Drd. Diana Crișan,
Nutritionist-Dietitian**

Registered dietitian with over 12 years of experience, a PhD candidate in nutrition, and vice president of the Romanian Dietitians Association. She addresses a wide range of conditions through clinical nutrition, including endometriosis, providing nutritional support tailored to the needs of each patient.

Affecting approximately 10% of women of reproductive age, endometriosis presents with a wide range of symptoms, including pelvic pain, migraines, infertility, gastrointestinal discomfort, fatigue, mood disorders, and pain... a lot of pain.

Although it was once considered a localised gynaecological issue, endometriosis is now recognised as a whole-body condition, involving the reproductive/gynaecological system, the digestive system, the hormonal system, the nervous system, the immune system, the musculoskeletal system, and—importantly—it has a deeply negative impact on quality of life, affecting psychosocial health (2). Following this introduction, it's time to also look at things from a scientific perspective: what do we know today about the available options for managing endometriosis?

1. Current options for managing endometriosis

As previously mentioned, endometriosis is a chronic condition for which, at present, there is no curative treatment. However, symptoms can be significantly alleviated through an appropriate therapeutic approach.

Acute pain associated with endometriosis often responds initially to non-steroidal anti-inflammatory drugs (NSAIDs). Nevertheless, their effectiveness is frequently limited, and their side effects may restrict long-term use (3).

Hormonal therapy aims to reduce endogenous oestrogen production and includes: progestins, combined oral contraceptives, gonadotropin-releasing hormone (GnRH) agonists and antagonists, testosterone analogues, and aromatase inhibitors (4). Discontinuation of hormonal treatment is common and, in most cases, is due to adverse effects such as weight gain, nausea, headaches, vasomotor instability, reduced libido, or mood changes (3).

In severe cases, or when medication fails to produce results, surgical intervention is considered—most commonly minimally invasive laparoscopy for the excision or ablation of endometriotic lesions (3).

Lifestyle interventions

An increasing body of evidence supports the benefits of a holistic approach in managing endometriosis. Changes related to diet, physical activity, stress reduction, and sleep hygiene can have a significant impact on pain levels and quality of life (5).

2. The role of diet in inflammation and hormonal balance

The way we eat profoundly influences systemic inflammation and oestrogen metabolism—two key factors in the pathophysiology of endometriosis. Endometriosis is an oestrogen-dependent condition. Dietary patterns high in fibre and low in fat are associated with lower oestrogen levels. Increased fibre intake (from fruits, vegetables, legumes, whole grains) supports oestrogen elimination by reducing intestinal reabsorption, while reducing dietary fat intake may limit oestrogen production (3,6).

At the same time, a pro-inflammatory diet—rich in red and processed meat, saturated and trans fats, and added sugars—promotes the production of prostaglandins and inflammatory cytokines, which are involved in pain and the proliferation of endometriotic lesions (7,8).

Conversely, foods rich in anti-inflammatory compounds—Omega-3 fatty acids, antioxidants, and phytonutrients—help reduce inflammation. A diet that includes vegetables, fruits, nuts, seeds, oily fish, and olive oil can lower levels of IL-6, TNF- α , and oxidative stress (6,8).

2.1 Mediterranean Diet

The Mediterranean diet, renowned for its anti-inflammatory properties, is one of the most studied dietary patterns in the context of endometriosis. It emphasizes whole plant-based foods, fish, olive oil, and the avoidance of ultra-processed products.

Recent studies have shown that women who adopt this diet report reduced pain (including dysmenorrhea and dyspareunia), less fatigue, and an improved ability to carry out daily activities (6).

Some researchers consider the Mediterranean diet a cornerstone in the non-pharmacological management of chronic pelvic pain.

Although large-scale randomised studies are still needed, current evidence supports the recommendation of this diet as a complementary part of care for patients with endometriosis.

2.2 Elimination diets: when and for whom?

In the context of endometriosis, many patients experiment with dietary changes to manage symptoms such as pain, fatigue, or digestive discomfort. While there is no one-size-fits-all diet for all women with endometriosis, certain nutritional interventions—particularly elimination diets—are often explored in the hope of alleviating symptoms and, in some cases, reducing the risk of recurrence.

Over 85% of women with endometriosis experience digestive symptoms—bloating, flatulence, and altered bowel movements—often resembling those of irritable bowel syndrome. In such cases, one of the nutritional strategies that has been successfully investigated is the low-FODMAP diet.

This diet restricts fermentable carbohydrates that can worsen digestive discomfort. A 2025 randomised study (EndoFOD) showed that 60% of women with endometriosis and digestive symptoms experienced a significant improvement in abdominal pain and bloating after four weeks on a low-FODMAP diet, compared to 26% in the control group (9).

Important to note: the low-FODMAP diet should only be followed temporarily and under the supervision of a dietitian.

Gluten-free diet

Another nutritional intervention often mentioned by patients is gluten elimination. Although not all women with endometriosis have coeliac disease or a diagnosed non-coeliac gluten sensitivity, many subjectively report an improvement in digestive or pelvic symptoms after removing foods containing wheat, barley, and rye.

An observational study conducted in Italy included 207 women with endometriosis, 75% of whom reported a significant reduction in pain after 12 months on a gluten-free diet (10). Improvements in quality of life were also recorded, and in some cases, decreases in inflammatory markers (IFN- γ and IL-6) were observed. However, it is important to note that participants belonged to a subgroup already suspecting a link between gluten and their symptoms.

An international survey published in 2025 confirmed the widespread interest in this elimination strategy: over 45% of people with endometriosis had tried a gluten-free diet, and nearly half of them (45.4%) reported a reduction in pain (11). Still, the subjective perception of improvement does not equate to robust scientific evidence.



Important limitations regarding gluten restriction:

To date, there are no randomised controlled clinical trials investigating the effects of a gluten-free diet in women with endometriosis who do not have coeliac disease. Therefore, gluten elimination may benefit only a specific subgroup of patients – either due to an undiagnosed sensitivity or through the general improvement in dietary quality associated with reducing processed food consumption.

In clinical practice:

A trial period of exclusion (typically 6–12 weeks) may be considered, followed by the gradual reintroduction of gluten in the absence of symptom improvement. This approach helps avoid unnecessary dietary restrictions and supports maintaining a diverse, balanced diet.

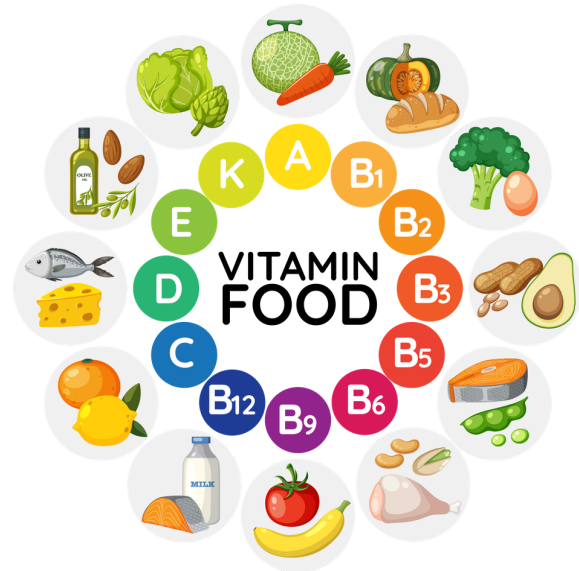
An essential observation: in the context of endometriosis, we often tend to focus on eliminations – on what should be removed from the diet. However, a truly essential step is to ask ourselves: am I eating regularly? Am I eating enough?

Nutrition in endometriosis must start from these fundamentals – consistency and adequacy. Only after establishing these can we meaningfully discuss what else can be adjusted and to what extent excluding gluten, dairy, or sugar is justified and supported by scientific evidence.

Properly nourishing the body matters more than a slice of bread. And let's not forget that sleep, physical activity, avoiding smoking, and reducing alcohol consumption and stress are also part of the treatment.

3. Supplements in Endometriosis

In recent years, more and more dietary supplements and nutraceuticals have been investigated for their supportive role in managing endometriosis symptoms. Although further clinical studies are needed to confirm their long-term efficacy and safety, there is already enough evidence to consider them useful complementary tools in an integrative approach to the disease.



- **N-acetylcysteine (NAC):** Known for its antioxidant properties, NAC has shown the ability to reduce the size of endometriomas, levels of inflammatory markers, and pain intensity. In addition, it may support fertility (12).
- **Omega-3 fatty acids:** In vitro and animal studies indicate that omega-3 fatty acids can reduce inflammation and lesion proliferation. In humans, the effects are more pronounced when combined with other nutrients such as quercetin, curcumin, vitamin B3, or methylated folic acid (13,14).
- **Vitamin D:** Although clinical trials have not shown a significant reduction in pain with vitamin D supplementation compared to placebo (15), many women with endometriosis have vitamin D deficiency, which justifies screening and correction of levels (16).
- **Antioxidants: vitamin E, C, curcumin, quercetin, resveratrol:** These compounds have anti-inflammatory and antioxidant effects, investigated in both preclinical and clinical studies. Some research has shown that the combined administration of curcumin and quercetin significantly reduces pain (14,17).
- **Magnesium:** Often used to support muscle relaxation, sleep quality, and nervous system regulation. In gynecology, magnesium is associated with improvement of dysmenorrhea, menstrual migraines, and premenstrual or perimenopausal symptoms (18). It may also help reduce prostaglandin levels, which are involved in both acute and chronic pain.

Instead of Conclusions:

The diagnosis of stage 4 endometriosis hit me like a storm – unexpected, without clear warning signs, but with overwhelming force. It brought with it a flood of emotions, initially negative – from pain, anger, and disappointment – and later, an unexpected reconnection with my own body and the gradual shaping of a professional calling.

This experience helped me understand, beyond theory, what it truly means to live with endometriosis. And it naturally led me to a sincere desire to contribute to this field – not just as a dietitian, but as a human being.

Endometriosis is a complex condition, but within this complexity lies our power to regain control. Perhaps not over the disease itself, but over our own lives. Gentleness, compassion, and science can coexist. And when they do, they create a safe space in which you can reconnect with yourself – with your body, your femininity, your identity.

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