CONDITION

Endometriosis

Endometriosis is a long-term condition in which tissue similar to the uterine lining grows elsewhere in the body.

WHAT IT IS
Uterine-lining-like tissue growing outside the uterus

BODY SYSTEM
Reproductive system, sometimes bowel and bladder

MAIN SYMPTOMS
Pelvic pain, painful periods, painful sex, fertility problems

WHAT CAUSES IT
Unknown, involving hormonal, immune, and inherited factors

HOW IT IS DIAGNOSED
Clinical assessment, imaging, sometimes laparoscopy and biopsy

MAIN TREATMENT
Pain relief, hormonal treatment, and surgery

CAN IT BE CURED?
No - treatment can control symptoms

IS IT AN EMERGENCY?
Sometimes - sudden severe pain, fainting, or heavy bleeding

LONG-TERM OUTLOOK
Often manageable, but symptoms may persist or return

Overview

Endometriosis is a long-term condition in which tissue similar to the lining inside the uterus grows elsewhere. These areas, called lesions, are most often found in the pelvis, including on the ovaries, fallopian tubes, bowel, bladder, and pelvic lining.

Lesions can respond to hormones during the menstrual cycle, causing inflammation, bleeding, scar tissue, and adhesions. Adhesions are bands of scar tissue that can make organs stick together.

Endometriosis can cause ongoing pain, painful periods, fatigue, and difficulty becoming pregnant. Symptoms may affect school, work, exercise, sex, sleep, and emotional wellbeing. The amount of visible endometriosis does not always match the severity of pain: small lesions can be very painful, while extensive disease may cause few symptoms.

It most often affects people who menstruate, including some transgender men and non-binary people. Symptoms can begin during adolescence and may continue after periods stop, although they often improve after menopause.

Symptoms

Symptoms vary, and some people have none. Common symptoms include:

These symptoms can also occur with conditions such as irritable bowel syndrome, pelvic inflammatory disease, adenomyosis, ovarian cysts, and bladder disorders. Period pain alone does not confirm endometriosis.

Less commonly, endometriosis occurs outside the pelvis. Disease near the diaphragm or chest can cause pain or breathing symptoms that follow the menstrual cycle.

- Pelvic pain, especially before or during a period
- Period pain that limits normal activities or responds poorly to usual pain relief
- Pain during or after vaginal sex
- Pain when passing stool or urine, especially during a period
- Heavy or irregular bleeding
- Bloating, constipation, diarrhoea, or nausea linked to the menstrual cycle
- Ongoing lower back, abdominal, or pelvic pain
- Fatigue
- Difficulty becoming pregnant

Causes and risk factors

The exact cause is unknown and probably involves several processes. Suggested explanations include menstrual tissue moving backwards through the fallopian tubes, cells changing into endometriosis-like tissue, and cells spreading through blood or lymph vessels. Hormones, inflammation, and immune-system activity also appear to contribute.

Endometriosis can run in families. Having a close biological relative with it increases the chance of developing the condition, but does not mean you will definitely have it.

It is also associated with periods beginning at a younger age, shorter cycles, longer or heavier periods, and conditions that block menstrual flow. These associations cannot reliably predict

who will develop endometriosis.

Endometriosis is not caused by sex, contraception, stress, lifestyle choices, or anything you did.

Diagnosis

There is no single blood test that can confirm or exclude endometriosis. Diagnosis begins with your symptoms and medical history. Recording pain, bleeding, bowel or bladder symptoms, and their timing within your menstrual cycle may reveal a pattern.

A healthcare professional may offer an abdominal and pelvic examination. This can sometimes identify tenderness, reduced organ movement, or an ovarian cyst, but a normal examination does not exclude endometriosis.

Ultrasound can identify ovarian endometriomas-cysts caused by endometriosis-and some signs of deeper disease. A transvaginal ultrasound uses a narrow probe placed in the vagina. If it is unsuitable or you do not want it, an abdominal scan may be considered. MRI may provide more detail when deep endometriosis is suspected or surgery is planned.

Normal ultrasound or MRI results do not rule out endometriosis because small or superficial lesions may not appear.

Laparoscopy is keyhole surgery under general anaesthesia. A surgeon examines the abdomen through a small cut, usually near the navel, and may remove tissue for examination. Laparoscopy with biopsy can confirm endometriosis, but treatment can sometimes begin without surgery.

Diagnosis may take time because symptoms overlap with other conditions. Review is important if treatment does not help, symptoms change, or they continue to interfere with daily life.

Treatment and management

Treatment aims to reduce pain, improve daily function, and support fertility goals. Choices depend on your symptoms, pregnancy plans, previous treatment, and the location and extent of known disease.

Pain-relieving medicines may help. Anti-inflammatory medicines are often tried, but they are not suitable for everyone and can cause stomach, kidney, or other problems. Ask a pharmacist or healthcare professional about safe use.

Hormonal treatments reduce or stop ovulation and periods. Options include combined hormonal contraception, progestogen treatments, and medicines that temporarily lower oestrogen. Some cause menopause-like effects, including hot flushes and reduced bone density, and may be paired with low-dose replacement hormones. Hormonal treatment can control symptoms but does not permanently remove lesions. It is not used while actively trying to become pregnant.

Surgery may be considered when symptoms are severe, medicines have not helped, fertility is affected, or an endometrioma or deep endometriosis is present. During laparoscopy, a surgeon may remove or destroy lesions, release scar tissue, and treat ovarian cysts.

Symptoms can return after surgery. Ovarian operations may also reduce the number of remaining eggs, so discuss fertility goals before ovarian surgery.

Hysterectomy, or removal of the uterus, may be considered when other treatments have failed and future pregnancy is not wanted. It does not guarantee a cure because lesions may remain outside the uterus. Removing both ovaries causes surgical menopause and requires careful discussion.

If pregnancy is difficult, options may include fertility-focused surgery or assisted reproduction such as in vitro fertilisation. The best approach depends on age, ovarian function, fallopian tube health, semen factors, and the pattern of disease.

Pelvic physiotherapy, pain-management services, psychological support, heat, activity pacing, and sleep support may improve function and quality of life, although they do not remove lesions.

Complications

Endometriosis can cause ongoing pelvic pain and sensitisation, in which pain pathways become more responsive. Pain may therefore continue even when visible disease is limited or has been treated.

Other possible complications include:

Many people become pregnant without fertility treatment. For others, inflammation, adhesions, ovarian cysts, or blocked fallopian tubes make conception harder.

Endometriosis is not cancer. It is linked to a small increase in certain ovarian cancers, but an individual's overall risk remains low. Additional cancer screening is not generally needed solely because of endometriosis.

- Adhesions affecting how pelvic organs move

- Ovarian endometriomas
- Bowel or bladder narrowing from deep endometriosis
- Pain during sex and effects on relationships
- Difficulty becoming pregnant
- Anxiety, low mood, poor sleep, or reduced ability to work and study

Prevention

There is no proven way to prevent endometriosis through diet, exercise, pregnancy, or a particular lifestyle.

Hormonal treatments can suppress symptoms and disease activity while they are used, but this is treatment rather than guaranteed prevention. Pregnancy is not a cure, and symptoms may return after pregnancy or breastfeeding.

Early assessment cannot prevent endometriosis, but it may help reduce symptoms and their effect on daily life.

Living with it and what to expect

Endometriosis often has a long-term, changing course. Symptoms may improve, worsen, or remain stable. They can change with hormonal treatment, pregnancy, breastfeeding, stopping treatment, or approaching menopause.

Treatment may need adjustment. Medicines can become less effective or cause unwanted effects, and symptoms can return after surgery. Persistent pain may also involve pelvic muscles, nerves, the bladder, or bowel, so treating lesions alone may not resolve every symptom.

Many people use a combination of medical treatment, practical changes, and planned follow-up. Recording symptom patterns can help assess treatment and plan demanding activities for times when symptoms are usually milder.

Routine follow-up is appropriate when symptoms are stable and treatment is helping. Arrange a review if pain increasingly limits daily life, bleeding changes, side effects become difficult, or you want to discuss pregnancy. Specialist care may help with deep disease, bowel or bladder involvement, endometriomas, complex pain, or fertility concerns.

Symptoms often lessen after natural menopause, but do not always disappear. New or

returning pelvic symptoms after menopause still need assessment.

When to get medical help

Make a routine appointment if period or pelvic pain repeatedly affects school, work, sleep, exercise, sex, or normal activities. Also seek assessment for pain when passing urine or stool during periods, difficulty becoming pregnant, or symptoms that continue despite usual pain relief.

Seek prompt medical advice for rapidly worsening pain, fever, persistent vomiting, new abdominal swelling, or difficulty passing urine or stool.

Get emergency help for:

These symptoms do not necessarily mean endometriosis has worsened. They may indicate emergencies such as ectopic pregnancy, ovarian torsion, internal bleeding, or serious infection.

- Sudden, severe abdominal or pelvic pain, especially with vomiting
- Fainting, severe weakness, confusion, or trouble breathing
- Heavy bleeding with dizziness, faintness, or shortness of breath
- Severe pain or bleeding when you may be pregnant
- Sudden chest pain, coughing blood, or significant breathing difficulty

Common questions

Can endometriosis be cured?

No treatment guarantees a permanent cure. Hormonal treatment can suppress symptoms and surgery can remove visible lesions, but symptoms or lesions may return. Hysterectomy is not a guaranteed cure because disease can remain outside the uterus.

Can I get pregnant if I have endometriosis?

Yes. Many people become pregnant without assistance. Others have difficulty because of inflammation, scar tissue, ovarian cysts, or blocked fallopian tubes. A fertility assessment can check for endometriosis-related and unrelated factors.

Does endometriosis always show up on an ultrasound?

No. Ultrasound can identify ovarian endometriomas and some deep endometriosis, but small or superficial lesions may not be visible. A normal scan does not rule it out.

Is endometriosis the same as a heavy or painful period?

No. Painful or heavy periods have many possible causes. Endometriosis is more likely when symptoms follow a typical pattern, disrupt daily life, or occur with painful sex, bowel or bladder symptoms, or fertility problems.

Does pregnancy cure endometriosis?

No. Symptoms may improve during pregnancy because periods and ovulation stop, but this is not guaranteed. They can return after pregnancy or when menstrual cycles restart.

Will endometriosis go away after menopause?

Symptoms often improve after natural menopause, but endometriosis can remain active. Persistent, new, or worsening pelvic symptoms after menopause should be assessed.

Sources

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