Gynecology and Minimally Invasive Therapy 5 (2016) 41–43

Contents lists available at ScienceDirect

Gynecology and Minimally Invasive Therapy

journal homepage: www.e-gmit.com

Special article

New guidelines on diagnosis and treatment of endometriosis in German-speaking countries

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ARTICLE INFO

Article history:
Received 12 June 2015
Received in revised form
26 June 2015
Accepted 14 July 2015
Available online 1 September 2015

Keywords:
diagnosis and treatment
endometriosis
guidelines

Introduction

A presentation was held at the Regional Congress of the Asia-Pacific Association for Gynecologic Endoscopy and Minimally Invasive Therapy (APAGE): Endometriosis & Gynaecological Cancer—Strategies in Minimally Invasive Surgery 2015, Singapore, June 3rd–6th, 2015.

The Working Group *Guidelines for the Diagnosis and Treatment of Endometriosis* of the German, Austrian, Swiss, and Czech Societies for Obstetrics and Gynecology in collaboration with the Endometriosis Research Foundation (SEF) and the European Endometriosis League (EEL) has the following members:

O. Buchweitz M.D. (Hamburg), R. Chvatal M.D. (Znaim), Professor R.-L. De Wilde M.D. (Oldenburg), Professor A. D. Ebert M.D. (Berlin), B. Engl M.D. (Bruneck), I. von Leffern M.D. (Hamburg), Professor R. Greb M.D. (Dortmund), D. Haas M.D. (Linz), G. Halis M.D. (Berlin), Professor J. Hucke M.D. (Wuppertal), Professor J. Keckstein M.D. (Villach), Professor M. Müller M.D. (Bern), Professor P. Oppelt M.D. (Linz), S. P. Renner M.D. (Erlangen), M. Sillem M.D. (Mannheim), Professor K.-W. Schweppe M.D. (Westerstede), W. Stummvoll M.D.[†] (Linz), Professor H.-R. Tinneberg M.D. (Gießen), F. Tuttlies M.D. (Villach), Professor U. Ulrich M.D. (Berlin), Professor L. Wildt M.D. (Innsbruck).

This guideline is jointly shared by the following scientific societies and organizations:

German Society for Obstetrics and Gynecology (DGGG)
- Working Group of Gynecologic Endoscopy (AGE)
- Working Group of Gynecologic Oncology (AGO)
German Society for Gynecologic Endocrinology and Reproductive Medicine
German Society for Psychosomatic Obstetrics and Gynecology (DGPFG)
German Society for General and Visceral Surgery (DGAV)
German Society for Urology
Austrian Society for Obstetrics and Gynecology (ÖGGG)
Swiss Society for Obstetrics and Gynecology (SGGG)
Czech Society for Obstetrics and Gynecology
Endometriosis Research Foundation (SEF)
European Endometriosis League (EEL)
Endometriosis Association Germany
Endometriosis Association Austria (EVA)

Guidelines

Definition and epidemiology

Statements

Endometriosis, one of the most common gynecologic diseases, is defined as the occurrence of endometrium-like cell formations outside the uterine cavity.

The cardinal symptom is chronic pelvic pain. Infertility is common.

Conflicts of interest: All authors have no conflicts of interest to declare.

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http://dx.doi.org/10.1016/j.gmit.2015.07.004

Etiology, pathology, and staging

Statement

The etiology and pathogenesis of endometriosis are not yet fully understood. Therefore, a causal therapy is not known.

Recommendation

All staging systems known to date have their limitations. In order to ensure the international comparability of data, the use of the rASRM-staging system, and, in cases of deep infiltrating endometriosis, the additional use of the ENZIAN-classification, are recommended.

Malignancy

Statements

In rare cases, malignancy, usually ovarian cancer, may arise from endometriosis.

Aside from this, the association of other, nongynecologic malignancies with endometriosis has been described in the literature. The clinical significance of this observation is not understood.

Diagnosis and treatment—general considerations

Statements

Indications for minimally invasive diagnosis and treatment of endometriosis are chronic pelvic pain, destruction of organs, and/or infertility.

For control of symptoms, the surgical removal of endometriotic lesions is considered as *gold standard*.

Recommendations

In general, the diagnosis of endometriosis is to be established histologically. Hence, diagnostic laparoscopy is essential for the work-up.

Peritoneal disease

Statements

The diagnosis of peritoneal endometriosis is made laparoscopically.

The treatment of choice is the laparoscopic removal of the implants.

Recommendations

Following hormonal suppression of the ovarian function, endometriotic implants may undergo regression. For the reduction of endometriosis-associated symptoms, progestins, oral contraceptives, or gonadotrophin-relasing hormone (GnRH) analogs may be used in order to induce therapeutic amenorrhea.

Ovarian lesions

Statement

The diagnosis of ovarian endometriomata is primarily made by transvaginal ultrasound.

Recommendations

For primary treatment of ovarian endometriomata, the cyst wall should be removed surgically. Fenestration alone is considered insufficient.

Endocrine drug treatment alone is neither effective in eliminating an ovarian endometrioma (and, consequently, to replace its surgical removal)—nor in compensating for incomplete surgical removal. Therefore, it is not recommended.

Deep infiltrating endometriosis

Statements

Deep infiltrating endometriosis (DIE) is defined as involvement of the rectovaginal septum, vaginal fornix, retroperitoneum (pelvic side wall, parametrium), bowel, ureter, and urinary bladder.

The primary diagnosis of DIE is made clinically by rectovaginal palpation, inspection with divided specula, vaginal ultrasound, and with transabdominal ultrasound of the kidneys being mandatory.

Recommendations

For treatment, complete resection of DIE should be performed. However, compromises must be made as preservation of fertility often is imperative. Considering the disease as benign and that potentially relevant complications may occur, the extent of resection should be thoroughly discussed and a shared consent with the patient obtained.

Treatment of DIE should be carried out in specialized centers with a possible multidisciplinary approach.

If patients with DIE are to be managed conservatively, pre- and postoperative sonographic controls of the kidneys are mandatory in order to avoid overlooking silent hydronephrosis. DIE-associated hydronephrosis is an absolute indication to treat.

Adenomyosis

Statement

The diagnosis of adenomyosis is primarily established clinically by vaginal ultrasonography and/or magnetic resonance imaging. Most often, it is only the histological result after hysterectomy that is finally proving.

Recommendations

Given completion of family planning and presence of respective symptoms, hysterectomy can be recommended.

If the patient opts for preservation of the uterus, a therapeutic amenorrhea may be induced, or a progestin-releasing intrauterine device inserted.

Endometriosis and infertility

Statements

Although a causal relationship has not been resolved yet, endometriosis and infertility are often associated.

For the treatment of women with both endometriosis and infertility, appropriate skills and experience in infertility surgery, as well as cooperation with centers for reproductive medicine are required.

Recommendations

In women with both infertility and endometriosis, the implants should be surgically removed to improve fertility.

In cases of recurrence, assisted-reproductive technologies are superior to repeated surgery in terms of pregnancy rate. In repeat operations for ovarian endometriosis, the surgery-related reduction of ovarian reserve is to be considered.

Postoperative treatment with GnRH-analogs is ineffective in improving spontaneous pregnancy rates and therefore not recommended.

Any drug treatment for endometriosis alone does not improve fertility and should not be applied, from a reproductive medicine point of view.

Psychosomatic aspects

Recommendation

Psychosomatic aspects in the treatment of patients with endometriosis should be considered and integrated upfront.

Rehabilitation, follow up, and self-help

Statement

After extensive surgery, especially for DIE, after repeat endometriosis operations, or in patients with chronic pain, there often is a need for rehabilitation.

Recommendations

This need should be assessed, and measures of rehabilitation, or respectively aftercare, be initiated.

To cope with the physical and emotional problems that women with endometriosis may face, patients should be informed about the options of self-help.

Discussion

Concerning the accepted, accredited, and published new guidelines, several points of discussion were made.

The recommendation of *diagnostic laparoscopy* for every woman presenting with pelvic pain would involve a large number of diagnostic laparoscopies. In the absence of a definite endometriotic ovarian cyst on ultrasound, which would require surgical removal, patients with pelvic pain could first be given a trial of medical treatment such as progesterone derivatives, oral contraceptive pills, GnRH analogs, or nonsteroidal anti-inflammatory drugs. In the case of a good response, the laparoscopy would not be necessarily required, saving immediate healthcare costs. The choice of medical or surgical treatment can be offered to the patient after balancing the risks and benefits of both options, and carefully discussing before favoring the surgical route. In the case of a definite endometriotic cyst or mass on imaging, the first line therapy is clearly a surgical one.

In the case of DIE, the main aim in treatment should be a tailored treatment adapted to the severity of the symptoms of the patient rather than aiming for complete resection of the pathology without consideration of the complexity of the symptoms. This is especially true where radical excision would greatly increase morbidity or extensively compromise functions. Absolute radicality of treatment can be reserved for severe symptoms. Patients who cannot accept the radicality of treatment, but have severe symptoms, could be treated with a combined medical suppression and less aggressive surgical approach.

Because *adenomyosis* can be localized or diffuse, patients with the localized type of adenomyosis could be effectively treated with a wedge resection of the affected area as a treatment option. Even when not completely excising the adenomyosis, symptoms can be relieved by this treatment.

Reference

All references can be found in:
Ulrich U, Buchweitz O, Greb R, et al. National German Guideline (S2k): Guideline for the diagnosis and treatment of endometriosis. *Geburtsh Frauenheilk*. 2014;74:1104–1118.