

Recurrent Endometriosis : An Unknown Enemy

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Endometriosis is a disease in which the endometrium is present outside of the uterus. Endometriosis most commonly occurs in the lower abdomen or pelvis but it can appear anywhere in the body. Symptoms of endometriosis include lower abdominal pain, pain with menstrual period, pain with intercourse and difficulty getting pregnant. 5-10% of women of reproductive age group have endometriosis. Recurrent endometriosis is a benign disorder which is seen frequently and it affects the quality of life. Morbidity is in the form of pain, infertility, sexual dysfunction and recurrent Surgeries. Recurrence is defined as reappearance of pain after one year of surgery, which is around 45%. Reappearance of the disease by USG or clinical examination is around 9-15%. After conservative surgery and six months of medical treatment, one year later 26% had pain recurrence and 8% had detectable disease.

Recurrence occurs because of newer lesions developing after surgery, reactivation and persistence of existing lesions. Surgery is only cyto reductive rather than curative. Lympho-vascular involvement could also be another reason for recurrence. Though surgery corrects only the lesions that are seen and the basic immunological reason for the origin endometriosis, retrograde spill and coelomic metaplasia are not corrected. Treatment either medical or surgical will not address the etiological factors but can reduce only the burden of the disease. Medical treatment increases the apoptotic index, decreases the proliferative activity of the cells and estrogen biosynthesis by the ovary. Whereas biosynthesis of estrogen in the peripheral tissue and endometriotic implants which are controlled by aromatase are not inhibited. Aromatase activity is high

in endometrium of endometriotic patients, endometriotic lesions, fat, bone and adrenal tissue. Hence aromatase inhibitors are used a second line in the medical management. Risk factors for recurrence are initial r AFS score > 70, bilateral mass, suboptimal surgery, no post-operative medical management, younger age, family history, H/O ovulation induction drugs usage are considered to be high risk.

Recurrence is diagnosed by USG, MRI and elevation of CA 125. The recurrence rate seems to be higher in patients treated for ovarian endometrioma and deep endometriosis. Patients should be followed up for a minimum period of 3 years. Laparoscopy is the gold standard in diagnosis as well as for treatment of recurrent endometriosis if medical management fails. We have to balance the surgery which can reduce the ovarian reserve Vs preservation of ovarian reserve. Doing laser for superficial endometriosis. Cystectomy for ovarian endometrioma and complete excision for deep endometriosis will reduce the risk of recurrence.

Surgery should be done during the follicular phase. Recurrence was twice and remission was shorter in patients who had the surgery in the luteal phase after one year.

Post-operative medical management should be instituted to minimize the risk of recurrence for at least a period of 1 year. Combined oral pills, GnRH analogues, progestins like depot MPA, norethiesterone, dienogest and LNG IUS are used to prevent recurrence.

Medical management is always preferred over surgical management and repeat surgery especially in infertile women can reduce the ovarian reserve. If surgery is planned it should be a definite surgery like hysterectomy with BSO in women who have completed the family. In the event of unilateral endometrioma, salpingo oophorectomy followed by LNG-IUS gives excellent relief. LUNA and Pre Sacral Neurectomy are of not much use. Retaining the ovary during hysterectomy may increase the risk of recurrence of three fold. HRT increase the incidence of recurrence by 30%. Tibolone is suitable for HRT.

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References

- Chen YJ, Hsu TF, Huang BS, Tsai HW, Chang YH, Wang PH. Postoperative maintenance Levonorgestrel-releasing intrauterine system and endometrioma recurrence : A randomized controlled study. *Am. J. Obstet. Gyn.* 2017;216:582.e1-582.ep.
doi: 10.1016/j.ajog.2017.02.008.[PubMed][CrossRef][Google Scholar].
- Marcello C, Valentina EB, Roberto C, Daniele M, Mohamed M. Recurrent Endometriosis : A Battle against an unknown enemy. *The European Journal of Contraception & Reproductive Health Care.* 2019;24(6):44-474.
Doi: 10.1080/13625 187. 2019.1662391.
- Guo SW, Martin DC. The perioperative period : A critical yet neglected time window for reducing the recurrence risk of endometriosis? *Hum. Reprod.* 2019;34:1858-1865.
Doi: 10.1093/humrep/dez 187. (PubMed) (CrossRef) (Google Scholar).
- Konstantino S N, Lijuan Ma, Brett Mc, Michael DM. Recurrence Patterns after Surgery in Patients with Different Endometriosis Subtypes : A Long Term Hospital Based Cohort Study. *J Clin Med.* 2020;9(2):496.
Doi: 10.3390/jcm 9020496.
- Misal, Wasson MN. Histologic Proven Recurrence of Endometriosis after Previous Ablation Vs. Excision Surgery. *Journal of Minimally Invasive Gynecology.* 2021;28(11 Suppl) : S108-S109.