EM CASES SUMMARY

Episode 214 Endometriosis Recognition & ED Management

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Endometriosis is a chronic, estrogen-dependent inflammatory disease in which endometrial-like tissue implants outside the uterus. It can involve the ovaries and uterosacral ligaments, but also the bowel, bladder, ureters, diaphragm, and—rarely—the thorax. In the ED, the most important reframing is that endometriosis is not simply "bad periods." It is a multisystem inflammatory condition capable of severe, incapacitating pain, and it can mimic surgical emergencies with unnerving precision. Many patients present in physiologic distress—vomiting, diaphoretic, unable to stand upright—while labs and imaging appear reassuring. That mismatch can tempt clinicians toward premature closure; instead, it should trigger pattern recognition.

Endometriosis affects at least 1 in 10 people of reproductive age and is a common driver of recurrent ED presentations for pelvic pain. The diagnostic delay is long—often 7–10 years—and patients frequently see multiple clinicians before anyone names endometriosis as a serious possibility. Along the way, they collect labels like "primary dysmenorrhea," "bad periods," "IBS," "anxiety," or "recurrent ovarian cysts." Those labels become cognitive anchors that lower vigilance, raise the threshold to investigate and treat pain, and erode trust. The predictable ED story is a patient who returns repeatedly with severe cyclical pelvic pain, a "normal" workup, and no plan that advances care.

From an emergency medicine perspective, presentations fall into three overlapping categories:

- True inflammatory flares
- Delayed or missed diagnoses
- Acute complications

Most are true inflammatory flares—hormone- and prostaglandin-mediated disease activity that can be profound even when objective testing is normal. A substantial minority are delayed or missed diagnoses—patients with classic patterns who have never had the diagnosis named or acted upon. A small but clinically important fraction are true acute complications that require escalation, advanced imaging, admission, and/or urgent consultation. The ED challenge is that these categories are not easily distinguishable at triage: a flare can look like ovarian torsion; a complication can initially look like a flare.

Why Endometriosis Patients Present to the ED

Patients with endometriosis present to the ED because:

- Their pain is severe and escalates rapidly.
- They cannot distinguish a flare from an emergency.
- They lack access to timely outpatient care.
- Their prior concerns were dismissed or minimized.

Patients with endometriosis present to the ED for reasons that are both medical and systemic. The pain can escalate rapidly, often reaching 10/10 severity with nausea and vomiting. Early in the disease, before diagnosis and before individualized outpatient planning, uncertainty drives repeated ED visits: each episode feels like it might be "the one" that is catastrophic.
Access barriers amplify this cycle. Delayed gynecology care, lack of primary care attachment, and long waits for subspecialty services mean patients are often discharged into the same environment that produced the flare: inadequate analgesia, no disease-modifying therapy, and no actionable follow-up. Many describe ED care as inconsistent—sometimes validating and organized, sometimes dismissive or stigmatizing. The clinician's framing matters. When a visit is framed as "just chronic pain," patients leave without direction and return when symptoms inevitably recur. When the visit is framed as "we ruled out emergencies today and your history fits endometriosis strongly," patients leave with an explanation that aligns with lived experience and a plan that moves care forward.

When to Suspect Endometriosis in the ED

High-yield features that should raise suspicion:

- Severe dysmenorrhea beginning in adolescence, especially if described as "always been terrible" or "worse than my peers."
- Progressive worsening of pelvic pain over years, extension of pain outside menses, and/or transition to daily pain.
- Deep dyspareunia, cyclical dyschezia or dysuria, or cyclical GI/urinary symptoms (including cyclical rectal pain, tenesmus, dysuria, haematuria).
- Missed school/work due to periods, functional impairment around menses, or recurrent ED visits with similar presentations.
- Family history of endometriosis.
- Prior labels ("primary dysmenorrhea," "recurrent ovarian cysts")

Endometriosis should rise high on the differential when the history suggests severe, cyclical, progressive pelvic pain—especially when repeated workups have been reassuring. Primary dysmenorrhea exists, but it typically responds to first-line measures and does not progressively worsen in severity and functional impact over years. Endometriosis commonly does.
Start with onset and trajectory. Dysmenorrhea beginning in adolescence should raise suspicion, particularly when described as severe from early on, "always terrible," or "worse than my peers." Progression is the key discriminator: patients often report pain that began as one or two difficult days per cycle, expanded to four or five days, then to half the month, and eventually became daily. That evolution—from cyclical pain to intermenstrual pain to persistent pain—is highly suggestive of secondary dysmenorrhea and chronic pelvic pathology.

Ask directly about deep dyspareunia and about bowel and bladder symptoms that fluctuate with the menstrual cycle. Cyclical dyschezia, rectal pain, tenesmus, dysuria, urgency, or cyclical hematuria/hematochezia point toward deep disease or extra-uterine involvement. You do not need to define disease extent in the ED, but you do need to recognize that these symptoms strengthen the probability of endometriosis and increase concern for bowel, bladder, or ureter involvement—especially when red flags appear.

Recurrent ED visits with similar presentations are a powerful signal. Many patients have been repeatedly told they have "ovarian cysts," despite ultrasounds showing only small cysts and no free fluid. Being "lost to follow-up" is common and should not be interpreted as a character flaw; it is often a reflection of access barriers and the emotional burden of repeated dismissal. Family history can support suspicion, but its absence does not exclude disease. A normal pelvic exam does not rule out endometriosis either—many patients with significant disease have minimal exam findings, especially in the ED setting where pain limits tolerance and exam conditions are suboptimal.

A practical ED framing is to treat "severe cyclical pelvic pain with a reassuring workup" as possible endometriosis until proven otherwise—not as nonspecific chronic pain. That does not mean declaring a definitive diagnosis; it means acknowledging a high-probability pattern, avoiding misleading labels, and building management and discharge around safety plus momentum.

Key Clinical Features of Endometriosis Flare

A flare can present like an acute abdomen. Pain may be severe enough to mimic ovarian torsion, appendicitis, or bowel obstruction. It often coincides with menses but may occur mid-cycle or become constant in advanced disease. Nausea and vomiting are common, particularly when pain is severe, and pain may radiate to the back, rectum, or thighs. Exam can range from diffuse lower abdominal tenderness to focal tenderness that legitimately raises concern for alternate diagnoses.

The hallmark ED pattern is severe pain layered on top of a long history of cyclical suffering—with labs and imaging that are surprisingly reassuring. The correct interpretation of normal tests is not "nothing is wrong." It is "we have not found evidence of today's catastrophe," while recognizing that endometriosis remains a plausible and serious pain driver.

Hemorrhagic Cyst vs Endometrioma: A High-Yield Imaging Pearl

Many patients with endometriosis are told they have a "hemorrhagic cyst." Physiologic hemorrhagic cysts can occur around ovulation and resolve spontaneously. Endometriomas, however, can appear similar on standard pelvic ultrasound, particularly outside specialized endometriosis imaging programs. In the ED, the most practical distinction is time: A hemorrhagic cyst should resolve within 8–12 weeks. Persistence on repeat imaging suggests an endometrioma, which is an ovarian manifestation of endometriosis and often a marker of deeper disease. This is one of the most actionable ED pearls in endometriosis care: explicitly recommending

repeat ultrasound in 8–12 weeks can change the patient's diagnostic trajectory. Without follow-up imaging, patients may be repeatedly mislabeled for years while disease progresses. If your system allows, arranging follow-up imaging or linking it to referral pathways is an ED intervention with outsized downstream benefit.

Distinguishing Endometriosis Flare from Complication: Red Flags That Matter

Most ED visits for endometriosis represent inflammatory flares with normal vitals, labs, and often normal imaging. But a clinically important minority have complications that require escalation, imaging beyond pelvic ultrasound, admission, and/or urgent consultation. The key is identifying features that suggest infection, obstruction, hemorrhage, thoracic involvement, or renal compromise, or that represent a true break from the patient's baseline pattern.

Deep infiltrating endometriosis can cause:

- Bowel obstruction in less than 1% of patients.
- Spontaneous hemoperitoneum from rupture of utero-ovarian vessels is rare but life-threatening, presenting with acute abdominal pain, hypotension, and falling hemoglobin.
- Catamenial pneumothorax should be considered in patients with chest pain or dyspnea during menses.

Red flags for endometriosis complications include fever or systemic toxicity, leukocytosis with escalating pain, persistent vomiting with distension, obstipation, hypotension or falling hemoglobin, and chest pain or dyspnea temporally linked to menses.

Flank pain, oliguria/anuria, elevated creatinine, or hydronephrosis suggests ureteric obstruction. Endometriosis can compromise the ureters insidiously; renal injury may develop quietly until advanced.

Labs, Imaging and Endometriosis: What They Can and Cannot Do

In endometriosis flares, CBC, CRP, electrolytes, urinalysis, and pelvic ultrasound are commonly normal. Normal objective testing does not rule out endometriosis as the pain generator; it simply reduces the likelihood of infection, hemorrhage, or obstruction—assuming the evaluation is appropriate and the patient is clinically stable.
Abnormal labs should shift thinking toward complication or alternate diagnosis. Leukocytosis, elevated inflammatory markers, and fever point toward infection or abscess. Falling hemoglobin raises hemorrhage concerns. Elevated creatinine or hydronephrosis suggests ureteric obstruction. Electrolyte derangements plus distension and vomiting should prompt concern for bowel obstruction.

Pelvic ultrasound (transabdominal plus transvaginal with Doppler when indicated) remains first-line imaging for gynecologic emergencies. It can identify large cysts, adnexal masses, torsion clues, tubo-ovarian abscess, and endometriomas. But a normal ultrasound does not exclude endometriosis, particularly peritoneal disease, uterosacral involvement, or deep infiltrating lesions that require specialized imaging protocols and expertise.
CT has a role when a non-gynecologic etiology is suspected (appendicitis, bowel obstruction, perforation, renal stone complications) or when red flags mandate a broader abdominal assessment. CT is not a recommended diagnostic test for

endometriosis itself, but it is often the right ED test to rule in/out alternate emergencies. MRI pelvis is valuable for characterizing deep infiltrating endometriosis and mapping disease extent, but it is usually done on an outpatient basis.

Augmented pelvic ultrasound techniques (evaluating "kissing ovaries" and dynamic uterine sliding) improve detection of deep endometriosis (sensitivity 88.4%, specificity 78.8%) but are not widely used in North America.

Pitfall: Labeling Endometriosis as "Just Chronic Pain"

One of the most harmful cognitive shortcuts is labeling these presentations as "just chronic pain." Endometriosis pain is chronic-recurrent, but it is tied to inflammatory and structural pathology and carries a non-trivial risk of acute complications. This label raises the threshold to investigate, increases the risk of missed complications, delays diagnosis, undermines trust, and contributes to undertreatment of pain—often driven by stigma or clinician frustration with repeated visits.

A safer approach is to separate the label from the plan. If today's evaluation is reassuring, make that explicit: "Today we did not find evidence of ovarian torsion, ectopic pregnancy, or infection." Then name the likely underlying pattern: "Your history is strongly consistent with endometriosis, which can cause severe pain even when tests are normal." This maintains safety while validating suffering and creates a coherent narrative that supports follow-up.

Evidence-Informed Acute Pain Management for Endometriosis Flares

In endometriosis, inadequate analgesia is not merely uncomfortable; it drives repeat ED visits, increases distrust, and can lead to unnecessary imaging or consultation driven by uncontrolled pain.

A pragmatic ED strategy is early multimodal analgesia rather than incremental under-dosing over hours. NSAIDs and acetaminophen remain first-line therapies for prostaglandin-mediated pain. When vomiting limits oral intake, use antiemetics early and consider parenteral NSAIDs or acetaminophen if available. Severe flares may require short-acting opioids as a bridge when non-opioids are insufficient. The key is to document time-limited intent, avoid chronic prescribing from the ED, and pair opioids with a non-opioid foundation rather than using them as stand-alone therapy.

Endometriosis First Line Treatment: Hormonal Therapy

Hormonal suppression is first-line outpatient disease-modifying therapy for suspected or confirmed endometriosis.
Whether to initiate therapy from the ED depends on local protocols, clinician comfort, contraindications, and follow-up reliability. In patients with classic cyclical symptoms and a reassuring workup—particularly where access to care is delayed—ED initiation may be reasonable.

1. Progestins (progestin-only pill – e.g., drospirenone/Slynd)

Contraindications:

- Breast cancer (personal history, not family history)
- Severe liver disease
- Current pregnancy
- Undiagnosed abnormal vaginal bleeding

2. Combined Oral Contraceptive Pill (OCP)

Contraindications:

- Migraine with aura
- Thromboembolic disease / history of VTE (blood clot in lungs or legs)
- Hypertension
- Smoking (age 35 and older)

Important points about prescribing progestins or OCPs for endometriosis from the ED

- Consider *continuous* combined OCP (no placebo week).
- Document the indication (suspected endometriosis with severe cyclical pain), specify the regimen, and ensure a clear follow-up plan within weeks.
- Counsel that therapy controls symptoms rather than cures disease: 11–19% will not improve, and 25–34% have recurrence within a year of stopping.

Endometriosis Communication Pearls: Validate Without Overpromising

Many patients have experienced dismissal for years. That history shapes how they present, how they advocate, and how they interpret normal test results. A patient who seems frustrated or insistent may be responding to repeated invalidation rather than attempting to "game" the system.
Validation should be explicit: "What you're experiencing is severe and real." Explain the meaning of normal tests: "Today's tests reduce the likelihood of an emergency like a twisted ovary or infection, but they do not rule out endometriosis." Name the pattern without overstating certainty: "Your history fits endometriosis strongly."
Avoid speculative diagnoses that misdirect care, such as labeling every episode as a "ruptured cyst" when the pattern is repetitive and imaging is minimal. Then provide a specific next step: referral timeline, follow-up imaging if relevant, a written pain plan, and clear return precautions. Patients who leave with a plan are more likely to engage in longitudinal care.

Endometriosis Disposition and Follow-Up

Admission or urgent consultation is appropriate when severe pain requires ongoing parenteral analgesia, when red flags suggest complication, or when social circumstances make safe discharge impossible. Concern for ovarian torsion, complex adnexal masses, significant anemia, renal compromise, or bowel obstruction should prompt escalation.
When discharge is appropriate, it should be structured. A patient discharged after a suspected flare should leave with clarity about

what was ruled out, what remains likely, what to do for pain over the next 48–72 hours, and what to do next for disease management.

Safe discharge checklist:

- Return precautions: fever/rigors, syncope, heavy bleeding, worsening unilateral pain, persistent vomiting/inability to hydrate, abdominal distension/obstipation, flank pain/urinary changes, new chest pain or dyspnea around menses, "different" pain pattern
- Short-term pain plan: scheduled NSAID + acetaminophen if safe, antiemetic strategy, rescue analgesia when appropriate
- Documentation: "suspected endometriosis flare" or "recurrent cyclical pelvic pain—endometriosis high on differential"
- Follow-up: clear primary care/gyne instructions; referral placed where possible
- Imaging follow-up: repeat ultrasound in 8–12 weeks if "hemorrhagic cyst" reported to assess resolution vs endometrioma

Even small improvements—like consistent documentation and a simple care plan for frequent visitors—reduce variability, speed analgesia, and improve patient experience.

Key Take Home Points on Endometriosis Recognition, Risk Stratification and Management

- Endometriosis is common and frequently missed with diagnostic delay of 7–10 years, resulting in chronic disability; labeling as "just chronic pain" delays diagnosis and increases harm.
- Severe dysmenorrhea beginning in adolescence and progressive worsening and pain beyond menses strongly predict endometriosis
- Normal ultrasound does not rule out endometriosis.
- A hemorrhagic cyst should be reassessed in 8–12 weeks, because if it persists, endometriosis is the likely diagnosis.
- Complications include bowel obstruction, ureteric obstruction, intraperitoneal hemorrhage and pneumothorax
- Most flares have normal labs; abnormal labs suggest complication.
- The ED can change the disease trajectory through recognition, analgesia, initiation of hormonal therapies when appropriate and structured follow-up.

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