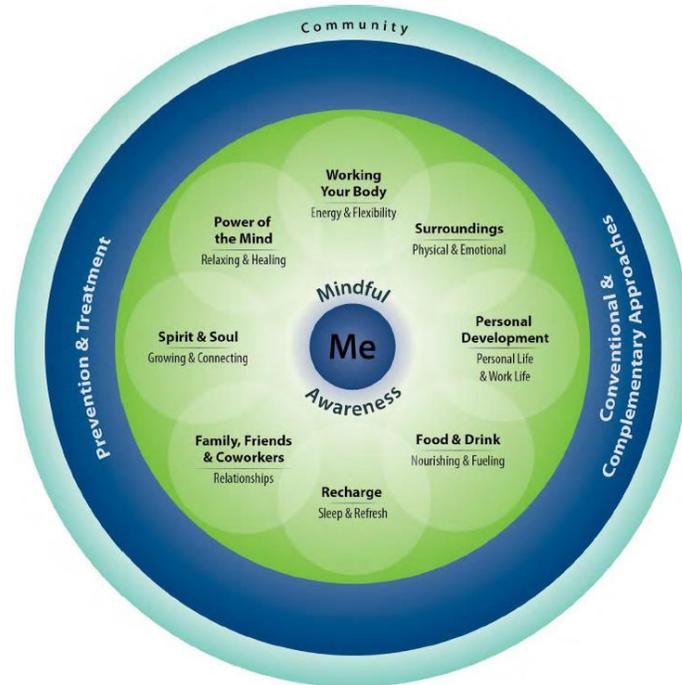


# WHOLE HEALTH: CHANGE THE CONVERSATION

Advancing Skills in the Delivery of  
Personalized, Proactive, Patient-Driven Care

## Endometriosis Clinical Tool



This document has been written for clinicians. The content was developed by the Integrative Medicine Program, Department of Family Medicine, University of Wisconsin-Madison School of Medicine and Public Health in cooperation with Pacific Institute for Research and Evaluation, under contract to the Office of Patient Centered Care and Cultural Transformation, Veterans Health Administration.

Information is organized according to the diagram above, the *Components of Proactive Health and Well-Being*. While conventional treatments may be covered to some degree, the focus is on other areas of Whole Health that are less likely to be covered elsewhere and may be less familiar to most readers. There is no intention to dismiss what conventional care has to offer. Rather, you are encouraged to learn more about other approaches and how they may be used to complement conventional care. The ultimate decision to use a given approach should be based on many factors, including patient preferences, clinician comfort level, efficacy data, safety, and accessibility. No one approach is right for everyone; personalizing care is of fundamental importance.

# WHOLE HEALTH: CHANGE THE CONVERSATION

## Endometriosis

### Clinical Tool

Endometriosis is the presence of endometrial tissue outside of the uterus. The diagnosis of endometriosis is often made clinically based on history, with women reporting dysmenorrhea, pelvic pain, dyspareunia, and fertility issues. Endometriosis can sometimes be detected on transvaginal ultrasound. However, definitive diagnosis requires laparoscopy with biopsy.

Approximately 10% of women are affected by this condition.<sup>1</sup> Risk factors include an affected first-degree relative, Caucasian race, nulliparity or delayed childbearing, menstrual flow greater than five days, and menstrual cycle less than 28 days.<sup>1,2</sup>

There are many theories regarding the pathogenesis of endometriosis. The most commonly accepted theory is that it results from retrograde reflux of menstrual tissue back through the fallopian tubes into the pelvis. Other theories include hematologic or lymphatic spread of menstrual tissue, or direct transplantation of cells during surgical procedures.<sup>3</sup> Endometriosis involves overproduction of local estrogen from increased aromatase activity, and pain results from the production of inflammatory prostaglandins and development of lesions near nerve fibers.<sup>4</sup>

Conventional treatment approaches depend on whether future fertility is desired. Options include anti-inflammatory approaches such as NSAIDs and medical suppressive therapies including hormonal contraceptives, danazol, and gonadotropin-releasing hormone (GnRH) agonists. If painful symptoms persist, surgical intervention includes ablation or excision of the endometriomas or hysterectomy. The American College of Obstetricians and Gynecologists reviews these interventions in their guidelines for the management of endometriosis.<sup>4</sup>

Despite a lack of research on integrative approaches to treating endometriosis, they offer potential benefits with limited risks and should be considered.

#### **1. Exercise and dairy for prevention**

Research has shown that exercising for more than four hours each week was associated with a reduced risk of developing endometriosis.<sup>5</sup> Additionally, women in the Nurses' Health Study who ate three or more servings of dairy per day were 18% less likely to be diagnosed with endometriosis.<sup>6</sup> For women at risk of developing endometriosis with an affected first-degree relative, consider recommending frequent daily exercise and moderate dairy intake, with caution because increased saturated fat intake can also increase systemic inflammation.

## WHOLE HEALTH: CHANGE THE CONVERSATION

### Clinical Tool: Endometriosis

#### **2. Inflammation**

Reduce inflammation with an anti-inflammatory diet. See **The Anti-Inflammatory Diet** clinical tool. Reduce intake of processed foods, red meat, and dairy foods that are high in saturated fat. Consider anti-inflammatory botanicals such as ginger (*zingiber officinale*) and turmeric (*curcuma longa*), in addition to omega-3 fatty acid supplementation of 1,000 milligrams of EPA (*eicosapentaenoic acid*) and DHA (*docosahexaenoic acid*) daily if dietary intake is inadequate.

#### **3. Estrogen dominance**

Consider lifestyle changes to decrease estrogen dominance in the body, because estrogen has been shown to support the growth of endometriomas. Approaches include a diet high in cruciferous vegetables, omega-3 supplementation, avoidance of xenoestrogens, and promotion of a healthy intestinal microbiome. See the clinical tool, **Estrogen Dominance**.

#### **4. Botanicals**

**Note:** Please see the module on **Dietary Supplements** for more information about how to determine whether or not a specific supplement is appropriate for a given individual. Supplements are not regulated with the same degree of oversight as medications, and it is important that clinicians keep this in mind. Products vary greatly in terms of accuracy of labeling, presence of adulterants, and the legitimacy of claims made by the manufacturer.

Botanicals may help improve the symptoms of endometriosis, because they are often used in dysmenorrhea. Although little research supports their use for endometriosis, many women prefer a trial due to low risk and few side effects.

- **Chaste tree berry** (*vitex agnus-castus*) is used to treat menstrual irregularities, including menometrorrhagia. The exact mechanism of action is unknown, but it has effects on multiple neurotransmitters and hormones, including a progestogenic effect on the endometrial lining.<sup>7</sup> The typical dose is 20-240 milligrams per day of crude herb. It is generally well tolerated; side effects include headache, gastrointestinal disturbance, acne, and rash.<sup>8</sup>
- **Ginger** (*zingiber officinale*) and **turmeric** (*curcuma longa*) may be beneficial due to their anti-inflammatory activity. Ginger is often used to decrease heavy menstrual flow. Ginger dose is typically 1-4 gram(s) per day of dried powder or 100 milligrams per day of ginger root extract.<sup>9</sup> Turmeric dose is typically 500 milligrams twice daily.<sup>10</sup>
- **Black haw** (*viburnum prunifolium*) is a shrub often used, despite limited research, to treat dysmenorrhea because of its tonic, uterine sedative, and antispasmodic properties. The typical dose is 2 teaspoons of dried bark in 1 cup of water, boiled and simmered for 10 minutes, taken three times daily. Tincture should be taken 5-10 milliliters three times daily. It has GRAS status, or is Generally Recognized As Safe, with no reported adverse reactions. Use may decrease absorption of minerals

## WHOLE HEALTH: CHANGE THE CONVERSATION

### Clinical Tool: Endometriosis

including calcium, iron, and zinc. Black haw should be avoided in women with an aspirin allergy due to possible cross-reactivity. It should also be avoided in people with a history of kidney stones.<sup>11</sup>

#### **5. Muscle tension and chronic pain**

Chronic muscle tension may contribute to pain. Consider recommending regular movement, stretching, massage, osteopathic manipulation, and even targeted pelvic floor physical therapy. Use of heat, such as placing a castor oil pack over the pelvis for 20-30 minutes, may increase blood flow and improve pain.<sup>12</sup> Explore the relationship between chronic pelvic pain and well-being. Consider mind-body practices such as meditation, breathing exercises and relaxation, hypnosis, guided imagery, and biofeedback. These techniques help to decrease stress, improve coping skills, and allow for relaxation.

#### **6. Other healing modalities**

If women are interested, consider traditional Chinese medicine, Ayurveda, and homeopathy. Acupuncture may be helpful, as some research suggests it reduces pain in dysmenorrhea.<sup>2</sup>

### Whole Health: Change the Conversation Website

Interested in learning more about Whole Health?  
Browse our website for information on personal and professional care.

<http://projects.hsl.wisc.edu/SERVICE/index.php>

*This clinical tool was written by Anne Kolan, MD, Clinical Assistant Professor and integrative medicine family physician in the Department of Family Medicine, University of Wisconsin-Madison School of Medicine and Public Health.*

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WHOLE HEALTH: CHANGE THE CONVERSATION  
Clinical Tool: Endometriosis

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