



Endometriosis Care: One Size Doesn't Fit a Lifetime

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A SESSION titled 'Endometriosis and Adenomyosis' at the International Society for Gynecological Endocrinology (ISGE) Congress 2026 offered an in-depth overview of the background and current treatments for endometriosis throughout the lifespan, including medical treatment, surgery, and assisted reproduction, with a focus on how to personalise treatment according to the patient's symptoms, age, and desire for pregnancy. The session was chaired by Katerina Exacoustos, University of Rome Tor Vergata, Italy; and Gabriele Merki, University Hospital of Zürich, Switzerland.

TREATING SYMPTOMS

Felice Petraglia, University of Florence, Italy, started with a short summary of the evolution of medical treatments, providing an overview of the two classic options: surgery and drugs. Petraglia stressed the importance of treating endometriosis according to the symptoms, as no drug or guideline will work for everybody. The first step should be to distinguish between patients with pain but no desire for pregnancy and patients with infertility who have a desire for pregnancy.

First-Line Hormonal Treatments

If the patient does not wish to get pregnant, hormonal drugs are the first line of treatment. Compared to 20 years ago, Petraglia explained, we now have a much wider range of drugs available, each working towards the primary goal of blocking menstruation.^{1,2} Crucially, these hormonal drugs are effective for different endometriosis phenotypes, including endometrioma, superficial peritoneal endometriosis, and deep infiltrating endometriosis.

The first-line treatment in endometriosis consists of progestins, which have an antiestrogenic effect and induce endometrial decidualisation. The most modern example of this is

dienogest, but other options such as medroxyprogesterone acetate, noretindrone acetate, and danazol, are also available, and levonorgestrel intrauterine devices or progestogen-only pills are commonly used. Oral gonadotropin-releasing hormone antagonists represent a new option for long-term treatment of endometriosis.



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Their advantages include rapid reversibility, immediate luteinising hormone and follicle-stimulating hormone suppression, and dose-dependent oestrogen suppression, and they are used in combination with add-back treatments such as oestradiol and norethindrone acetate. Combined oral contraceptives remain an option, and their use is effective in reducing dysmenorrhoea and pain symptoms; however, it is recommended to use the lowest possible dose (15/20 mg ethinylestradiol or 1.5 mg oestradiol) and to take these continuously.^{1,2} Petraglia highlighted the lack of randomised double-blind studies when it comes to



hormonal drug use in endometriosis; however, observational studies have suggested that hormonal drugs can be used long term, and can reduce endometriosis-associated pain significantly for up to 9 years of follow-up.³

Petraglia went on to present a few clinical cases, stressing the importance of being open to change when treatments do not have the desired effect. For example, a 20-year-old with endometriomas, dysmenorrhoea (visual analogue scale [VAS] 9), and dyspareunia (VAS 6) was given dienogest for 12 months. While this treatment provided good control of pain symptoms and amenorrhoea, it reduced libido, prompting a switch to desogestrel, which suited the patient's need better while minimising side effects.

Surgical Treatment

Petraglia stressed that for a patient with pain and no desire for pregnancy, the first-line treatment should always consist of hormonal drugs with or without anti-inflammatory drugs. If medical treatment fails, however, surgery should be considered, in which case fertility

preservation should occur. He stated that surgery remains a very valid option, and should always be considered in cases of obstructive uropathy, symptomatic bowel stricture, resistance to medical therapy after multiple failures, absolute contraindications for medical therapy, or suspicion of cancer.

Assisted Reproductive Technology

European Society of Human Reproduction and Embryology (ESHRE) guidelines state that in cases of infertility associated with endometriosis, assisted reproductive technology can be performed, especially if tubal function is compromised, if there is male factor infertility, in case of low Endometriosis Fertility Index (EFI), and/or if other treatments have failed.⁴ Research has suggested that in patients with endometriosis, deferred embryo transfer could increase the success rate.⁵ This technique, which involves collecting oocytes, making the embryos, then postponing implantation, has been associated with significantly higher cumulative ongoing pregnancy rates.

Summary

Petraglia concluded that endometriosis should always be treated according to symptoms and age. In an adolescent with no desire for pregnancy, healthcare professionals should proceed with hormonal treatment, and if this fails, follow up with surgery after fertility preservation. In patients of reproductive age with a desire for pregnancy and/or associated uterine/reproductive disorders, assisted reproductive technology and surgery should be considered, followed by hormonal treatment to prevent recurrence. In a premenopausal patient with no desire for pregnancy and systemic comorbidities, one should consider multidimensional treatments and hormonal treatment, although some patients will prefer surgery.

TREATMENT IN THE PERIMENOPAUSE AND POSTMENOPAUSE

Tevfik Yoldemir, Marmara University, Istanbul, Türkiye, provided an overview of treatment for patients in perimenopause and postmenopause. Yoldemir explained that while endometriosis mainly occurs in the reproductive age, there is a 2–4% chance of occurrence postmenopause. The most likely symptoms of endometriosis change throughout the years, as the woman ages, and postmenopause, they are more likely to present with non-menstrual pain and dyspareunia, rather than menstrual pain.⁶ It is important to note that women with endometriosis are more likely to have either natural or surgical menopause early, compared to women without endometriosis.⁷ Furthermore, due to the wide range of symptoms that endometriosis can cause, many of which overlap with other conditions, Yoldemir reminded the audience that healthcare professionals should always consider differential diagnoses, such as pelvic floor tension, pudendal

neuralgia, and coccydynia, which may need alternative treatments.⁸

Hormonal Treatment

To manage symptoms, Yoldemir stated that hormonal contraception should be offered until the age of 50 years, after which hormonal treatments should be considered. However, he stressed the importance of assessing cardiovascular and cancer risk before prescribing hormonal treatment, placing the patient in one of three categories, low, intermediate, or high risk, with associated indications for, cautions with, and contraindications to hormone therapy.⁹ This is especially crucial due to the increased risk of thyroid, ovarian, and breast cancer in this population.

Surgical Treatment

In postmenopausal women, surgery is indicated for symptomatic relief or managing complications from pelvic adhesions, endometriomas, and deep infiltrating endometriosis; anatomical concerns such as ureteral or bowel obstruction due to endometriosis lesions; the presence of pelvic pain resistant to medical therapy or development of complications such as ovarian torsion or rupture; identification of suspicious adnexal masses to rule out malignancy; and refractory urinary symptoms such as haematuria, recurrent urinary tract infections, or hydronephrosis secondary to ureteral involvement by endometriosis.¹⁰





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In case of endometriomas, surgery is indicated, and can include drainage, drainage plus gonadotropin-releasing hormone antagonists, fenestration and coagulation, stripping, three-step treatment, laser vaporisation of the cystic wall, combined treatment, or laparoscopic sclerotherapy. Two RCTs have confirmed a benefit dependant on excision technique,^{14,15} while other studies have suggested an increased risk of recurrence with vaporisation or coagulation.^{16,17}

Angioni stressed that an important consideration is the impact that surgery can have on ovarian reserve. Ovarian damage can occur depending on the type of surgery, number of surgery, size of cyst and age of the patient, method of bleeding control, bilaterality, and surgical experience, and caution should be used to minimise this damage and maintain ovarian reserve.

He concluded that surgery should only be performed in patients with persistent pain on medical treatment, or functional problems, using an approach that is as minimally invasive as possible, aiming to minimise the decrease of ovarian reserve, and personalised according to age, symptoms, and pregnancy desire.

FERTILITY-SPARING SURGERY

Stefano Angioni, University of Cagliari, Italy, concluded the session with a presentation on fertility-sparing endometriosis surgery. While 25–40% of women struggle with infertility, this number rises to 30–50% in women with endometriosis, with research showing a lower monthly fecundity as well as a lower live birth rate.¹¹ A few pathogenic mechanisms are believed to contribute to this number, including ovulation, gamete transport, disordered myometrial contractions, and endometrial receptivity.¹² Furthermore, the occurrence of endometriomas can entail space-compression effects, adverse changes in blood flow, and local inflammation, which reduces the amount of functional ovarian tissue available.

For Stage I–II endometriosis, some data have suggested a small but slight improvement in live birth rates after laparoscopic ablation of endometrial implants. The technique used during surgery seems uninfluential;¹³ however, Angioni stressed the lack of randomised trials supporting these data.

CONCLUSION

The recurring theme throughout these presentations was the importance of personalised treatment. Each presenter supported the idea that ‘one-size-fits-all’ is not an effective way to treat endometriosis, and that the symptoms and wishes of the patient should always be taken into consideration. Finally, as highlighted throughout this session, there is still a lack of double-blind randomised trials for endometriosis treatment, highlighting a great unmet need in this field.

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