



# Managing Endometriosis-Associated Pain: A Two-Step Approach

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AT THIS year's International Society of Gynaecological Endocrinology (ISGE) Congress 2026, held in Rome, Italy, Vitaly F. Bezhenar, Head of the Department of Obstetrics, Gynaecology, and Neonatology at First Pavlov State Medical University of St. Petersburg, Russia, reviewed the current approach to the management of endometriosis-associated pain. He explored the recommended two-step treatment strategy, compared different postoperative hormonal therapies, and discussed the role of long-term medical management in reducing recurrence and improving quality of life in women with endometriosis.

## THE BURDEN AND LONG-TERM MANAGEMENT OF ENDOMETRIOSIS

Recent research indicates that deep infiltrating endometriosis requires a structured approach and long-term postoperative treatment.<sup>1</sup> Such treatment helps slow the pathological processes that create an aggressive peritoneal environment, drive cellular changes, and ultimately contribute to recurrence.

Endometriosis has a major impact on women's quality of life. Around 70% of women with the condition experience chronic pelvic pain of varying severity, and one in two experience infertility.<sup>2,3</sup>

## SURGERY AND RISK OF RECURRENCE

Most patients with endometriosis undergo surgery, although it does not address the underlying cause of the disease.<sup>4</sup> Surgery aims to remove as much diseased tissue as possible, relieve pain, improve quality of life, and reduce the risk of recurrence.<sup>4</sup>

Surgery can lead to complications, particularly when the bowel, bladder, or uterus is involved.<sup>4</sup> It may also reduce

ovarian reserve, increasing the risk of iatrogenic premature ovarian insufficiency.<sup>4,5</sup> Recurrence rates can reach 50%, even after successful surgery.<sup>4,6</sup> Bezhenar noted: "Unjustified repeat surgeries without long-term anti-recurrence therapy may worsen the disease and reduce ovarian reserve."<sup>7,8</sup>

## POSTOPERATIVE HORMONAL THERAPY

Bezhenar presented data showing that postoperative treatment plays a key role in preventing endometriosis recurrence.<sup>9-12</sup> His analysis linked repeat surgery to the absence of hormonal therapy. In the study, fewer than half of patients had not undergone previous surgery, while 14% had one prior operation, 11% had two, and 2% had three or more.<sup>9-12</sup>

Most recurrences occurred after hormonal therapy was discontinued. Around 80% of patients stopped treatment themselves, while in 22% of cases it was stopped by the gynaecologist.<sup>13</sup>

## TWO-STEP APPROACH

The Russian Society of Obstetricians and Gynaecologists (RSOG) recommends a

combined two-step approach: surgery when indicated, followed by postoperative hormone-modulating therapy for at least 6 months if pregnancy is planned, and longer if it is not.<sup>14</sup> Laparoscopic surgery is preferred for deep endometriosis, and treatment should always be individualised.<sup>14</sup>

Treatment decisions should be based not only on clinical factors, but also on the morphological features of the excised tissue. In Bezhenar's study, microscopic foci of endometrioid heterotopia were found in 50% of samples taken from macroscopically intact peritoneum.<sup>15</sup> Bezhenar concluded: "These findings support the need for postoperative hormonal therapy to prevent disease recurrence."

## CONSERVATIVE MANAGEMENT AND PAIN CONTROL

In a separate study of conservative strategies for endometriosis-associated pain, including non-pharmacological, anti-inflammatory, and hormonal treatments, 71% of women reported no symptom improvement.<sup>13</sup> A further 23% reported only slight improvement, while significant pain reduction was seen in just 5% of patients.<sup>13</sup> Complete pain relief was achieved in only 4%.<sup>13</sup>

Bezhenar compared these findings with another study of 178 patients who had undergone surgery for endometriosis.<sup>11</sup> After surgery, 82 patients (46.1%) received gonadotropin-releasing hormone (GnRH) agonists, 58 (32.6%) received dienogest, and 21 (11.8%) received combined oral contraceptive (COC) pills containing dienogest. A further 17 women (9.5%) were planning pregnancy and therefore received no hormonal therapy. Postoperative treatment lasted 4–6 months.<sup>11</sup>

The study assessed the proportion of patients reporting significant reductions in endometriosis-associated pain after different treatments. The highest rates were seen with GnRH agonists (40%) and dienogest (38%). Patients receiving these treatments also reported improved quality of life and sexual function.<sup>11</sup>

## PROGESTAGENS AS FIRST-LINE THERAPY

According to the RSOG, progestagens are recommended as first-line therapy.<sup>14</sup> They can be given continuously to promote glandular epithelial atrophy and stromal decidualisation, although cyclic use may be considered for patients planning pregnancy.<sup>16</sup>

Bezhenar and colleagues reported that COCs are not suitable for anti-relapse therapy in endometriosis and should be used only for contraception.<sup>17</sup> In their study, patients who received cyclic COCs containing 30 mcg ethinylestradiol (EE) and dienogest had the lowest pregnancy rates and the highest recurrence rates of pelvic endometriosis.

All recurrences after cyclic therapy with 30 mcg EE and dienogest were associated with endometrioid infiltrates identified during repeat laparoscopy that had not been detected at the initial surgery.<sup>17</sup>

## DIENOGEST VERSUS COCs

The authors compared the effects of dienogest 2 mg with those of COCs. Dienogest was associated with a moderate reduction in oestrogen levels while maintaining concentrations within the therapeutic window (30–60 pg/mL).<sup>18</sup> It was also shown to reduce several forms of endometriosis-associated pain, including pelvic pain, dysmenorrhoea, dyspareunia, dysuria, and dyschezia.

In contrast, COCs may disrupt the oestrogen–progestin balance when oestrogen doses exceed physiological levels, potentially promoting endometriosis progression.<sup>18</sup> Although COCs may reduce dysmenorrhoea, they were not shown to relieve dyspareunia or non-cyclical pelvic pain. Women using COCs for dysmenorrhoea were later diagnosed with severe infiltrative endometriosis.<sup>18</sup>

## QUALITY OF LIFE AND RECURRENCE OUTCOMES

A real-world study showed that dienogest 2 mg was associated with a significant reduction in chronic pelvic pain and improved quality of life in women with endometriosis.<sup>19</sup> The ENVISION study included 865 Asian women from 36 clinics across Asia.<sup>19</sup>

Improvements were reported across all quality-of-life domains during treatment with dienogest 2 mg.<sup>19</sup> Quality of life was measured using the Endometriosis Health Profile-30 (EHP-30), which assessed pain, self-control, emotional status, social function, and self-esteem.<sup>19</sup> The greatest improvement was seen in pain scores (78.4%), followed by self-control (70.5%), emotional status (61.3%), social function (55.4%), and self-esteem (42.1%).<sup>19</sup>

A systematic review and meta-analysis found that postoperative treatment with dienogest 2 mg was associated with a significantly lower risk of endometriosis recurrence than no hormonal therapy.<sup>20</sup> Recurrence occurred at a rate of 0.89 per 1,000 woman-months in women receiving dienogest, compared with 5.46 per 1,000 woman-months in controls who received no therapy.<sup>20</sup>

Over a mean follow-up of 28.5 months, only two recurrences per 100 treated women were reported in the dienogest group. By comparison, 29 recurrences per 100 women were observed over a mean follow-up of 35.7 months in women who received no treatment.<sup>20</sup>

Overall, the probability of recurrence after surgery was significantly lower in patients treated with dienogest than in those who did not receive hormonal therapy ( $p < 0.001$ ).<sup>20</sup>

## CONCLUSION

Bezhenar concluded that endometriosis is a chronic, inflammatory, hormone-dependent condition that requires long-term, comprehensive management, including postoperative therapy. Progestogens remain the first-line treatment, and continuity between inpatient and outpatient care is essential to optimise outcomes and reduce recurrence risk. He emphasised that postoperative therapy should continue for at least 6 months, and that there is no such thing as 'mild' endometriosis.

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