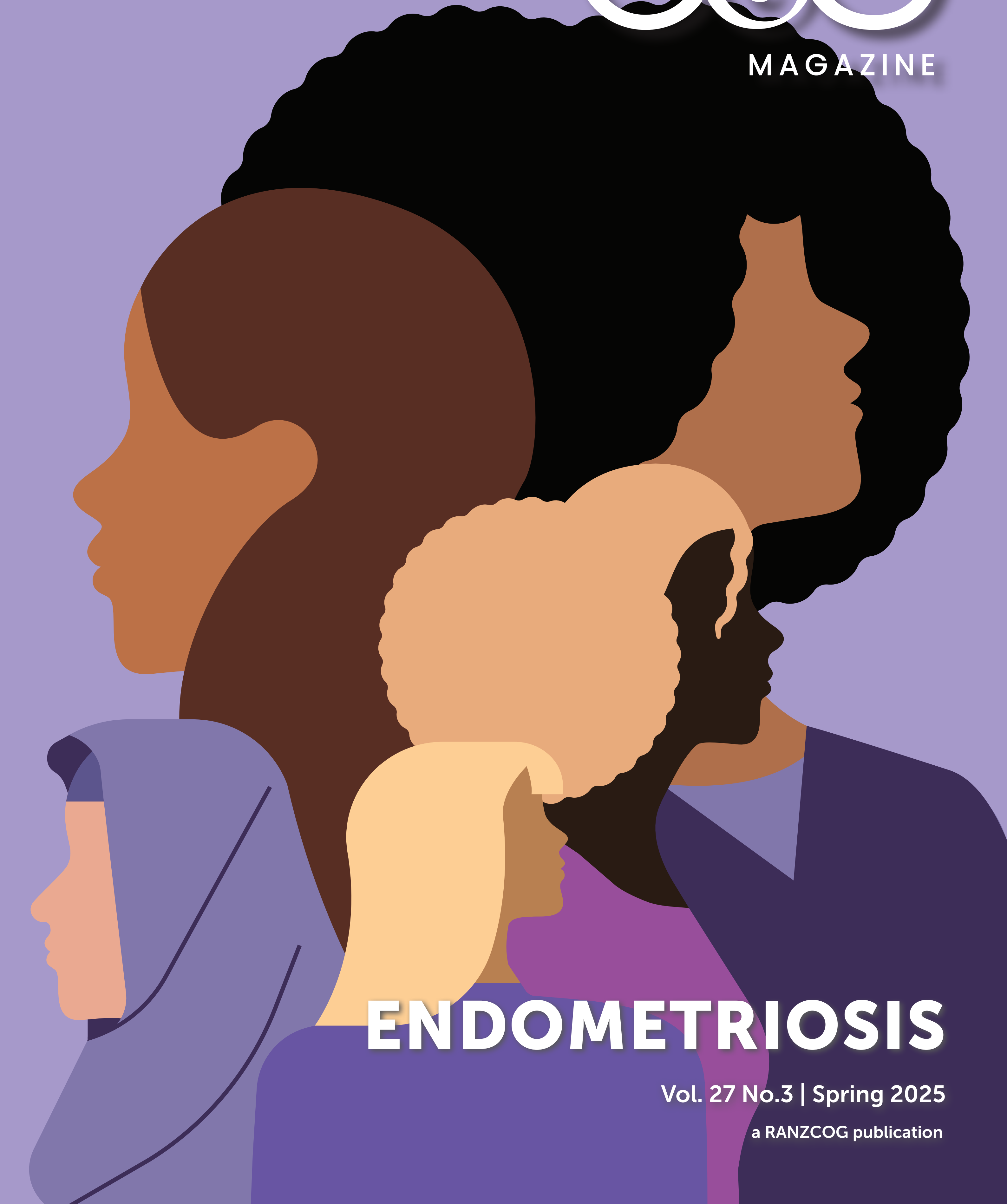
O&G MAGAZINE



ENDOMETRIOSIS

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Vol. 27 No. 3 Spring 2025

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Contents

The College

Endometriosis

RANZCOG acknowledges and pays respect to the Traditional Custodians of the lands, waters and communities across Australia, on which our members live and work, and to their Elders, past, present and future. RANZCOG recognises the special status of Māori as tangata whenua in Aotearoa New Zealand and is committed to meeting its obligations as Te Tiriti o Waitangi partners.

Vol. 27 No. 3 Spring 2025

From the President

Dr Gillian Gibson
FRANZCOG, RANZCOG President

President's Introduction to the Advocacy Report

Advocacy in Action

I write not only as a clinician, nor solely as the President of RANZCOG, but as a passionate advocate for change—toward a future in which every woman, regardless of her postcode, ethnicity, or income, receives the care she deserves.

RANZCOG has firmly established itself as a leading voice in advocacy for women's health. In a climate marked by critical workforce shortages, growing clinical complexity, and entrenched systemic barriers that continue to delay or deny care, our mission is more urgent than ever.

To all of you—our Fellows, trainees, and members—thank you. Your daily commitment to prioritising women's health, often under immense pressure, exemplifies the College's unwavering dedication to delivering high-quality, compassionate care.

We must continue to demand a system that listens—truly listens—to women and clinicians alike, values lived experience, and delivers timely, culturally safe, and equitable care.

This year, the College has made over 180 formal submissions—an extraordinary effort that reflects our active role in shaping policies that affect our profession and our patients. I acknowledge the expertise and time generously contributed by our members, trainees, consumers, and staff. Your work ensures that the College remains a visible and respected voice in policy conversations.

In Aotearoa New Zealand, we've made significant strides. From partnering with Te Whatu Ora to contributing clinical insights across national forums, RANZCOG continues to advocate strongly for improved health outcomes for women and whānau.

As clinicians, our voices matter—and we must keep raising them. We need more than rhetoric from decision-makers. We need long-term investment, a strategic approach to workforce planning, and bold, sustained action on health equity.

As my presidency draws to a close, I reflect with pride on how far we've come. The following advocacy report in this issue of O&G Magazine is a testament to what we can achieve when we unite around a shared purpose.

Thank you for walking alongside me—and for everything you do to champion women's health.

Advancing Women's Health: RANZCOG's Advocacy Priorities Throughout Winter 2025

The College has maintained a robust advocacy agenda throughout 2025, addressing critical challenges. As the healthcare sector navigates ongoing workforce pressures, funding constraints, and access issues, the College has continued to focus on four priority areas: specialist health workforce, sexual and reproductive health, the financial crisis in private practice, and shortages of medicines and devices. In addition, the College's advocacy for better endometriosis care is starting to bear fruit.

Specialist Health Workforce: Building Capacity

Health workforce remains a pressing issue and advocating for the support of the O&G specialist workforce is at the forefront of RANZCOG's efforts.

The College's pursuit of funding for the Obstetrics and Gynaecology Education and Training Program (OGET) has encountered setbacks at the federal level, with pre-budget submissions proving unsuccessful. The project has been granted an extension to continue within the current funding stream. However, RANZCOG has pivoted to pursue state-based funding whilst maintaining focus on gaining federal support in the long-term. This dual approach reflects the urgency to expand training pathways, given the geographic necessity for training in rural and regional centres, and the success of the OGET program.

Workforce challenges have been highlighted during on-the-ground site visits, including Logan and Toowoomba Hospital in Queensland, Wagga Wagga Base Hospital and Albury Wodonga Women's Health Services. Recurring themes emerged around burnout, skills maintenance challenges, and the need for better accommodation support for trainees undertaking regional rotations. These visits have informed the College's advocacy for workforce solutions that address both recruitment and retention.

The College's participation in the National Maternity Workforce Strategy consultation forums has provided opportunities to influence national policy direction. RANZCOG has continued to push for increased representation on the Steering Committee, while also continuing to participate in this work through other avenues.

In Aotearoa New Zealand, similar workforce pressures exist; shortages and wellbeing of specialists, as well as plans for surgical training outsourcing. The College's trans-Tasman structure recognises the shared nature of these challenges while advocating for solutions tailored to each country's specific healthcare system.

Sexual and Reproductive Health: Expanding Access

RANZCOG's advocacy in sexual and reproductive health has focused on both legislative and practical reform. The College's support for the NSW Abortion Law Reform Amendment (Health Care Access) Bill 2025 exemplifies this dual approach. Through extensive engagement with over 100 NSW MPs, RANZCOG successfully advocated for expanded prescribing rights for MS 2-Step to nurse practitioners and endorsed midwives.

Although the original bill underwent significant revision, with provisions for effective referral pathways and reasonable distance requirements removed, the passage of expanded prescribing rights represents meaningful progress.

RANZCOG also participated in the early stages of development of a national sexual and reproductive health data monitoring framework by the Australian Institute of Health and Welfare. This multi-year project will provide the evidence base for future policy advocacy and service planning. Data on sexual and reproductive health is known to be insufficient.

Private Practice Crisis: Under Pressure

The financial crisis in private obstetrics and gynaecology has intensified, culminating in the entry of Healthscope into receivership in late May 2025. This has created uncertainty for thousands of patients at the 37 Healthscope hospitals and highlighted the systemic issues facing private maternity care.

RANZCOG's opposition to Private Healthcare Australia's bundled maternity care payment model released in the autumn has been unwavering, with significant member engagement in consultation processes uniformly opposing the proposal. The College's strategic response has involved collaboration with allied organisations including the National Association of Specialist Obstetricians and Gynaecologists (NASOG), Avant, and the Australian Medical Association to present a united front against policies that could further destabilise private practice viability.

The College's engagement with federal officials has focused on securing representation in policy development processes. Despite the Private Hospital Sector Financial Health Check identifying private obstetrics as one of two 'services under particular pressure', RANZCOG has been excluded from the Minister’s Private Health CEO Forum. The College continues to meet with the Department on this point.

The broader implications extend beyond individual provider concerns to encompass patient choice and public system capacity. As private maternity units close or reduce services, pressure on the public system will increase at a time when capacity constraints are already significant. RANZCOG's advocacy has emphasised this system-wide impact while calling for comprehensive policy responses that recognise the interdependence of public and private health care.

Medicines and Devices: Ensuring Essential Supplies

Ongoing shortages of essential medicines and devices have required sustained advocacy. RANZCOG's advocacy with the Pharmaceutical Benefits Advisory Committee (PBAC) and Therapeutic Goods Administration (TGA) has focused on both immediate shortage responses and longer-term supply security measures.

The TGA's medicines repurposing program presents opportunities to support older, off-label medications that are highly effective in pregnancy but face commercial viability challenges in the Australian market. RANZCOG's engagement with this program reflects the College's proactive approach to identifying policy mechanisms that can address supply challenges while maintaining clinical effectiveness. Despite making applications to this program in the past, the College has had limited success in having specific medicines ‘repurposed’, but this has provided a platform for RANZCOG to continue pushing for refinements in the program. The College has established a closer ongoing dialogue with the TGA and Department of Health, Disability and Ageing which has been useful in pushing for advancements in public system support for medications in sexual and reproductive health and pregnancy.

Endometriosis Care Makes Advances

As a final point, it is valuable to call attention to the results of persistent College advocacy in the area of endometriosis care, spotlighting some tangible policy and funding improvements that are working their way into the Australian health care system.

First, on 1 July 2025, two new items were added to the MBS that to support longer specialist gynaecological consultations of 45 minutes or more. Funded in the May 2024 budget, these items will support complex gynaecological presentations, including persistent pelvic pain and endometriosis. These items are a result of College advocacy leading into last year’s federal budget, and RANZCOG has continued to work collaboratively with the government to ensure they include clinician input and best address longstanding inequities in the MBS.

Second, the federal budget presented in March 2025 continued to show investments in women’s health through the addition of funding to establish dedicated endometriosis clinics across the country. New funding has been allocated to open 11 new clinics and extend services at the existing 22.

Finally, the publication of the College’s “Australian Living Evidence Guideline: Endometriosis” launched in May 2025 will marry best clinical practice advice with these substantial advocacy wins to deliver the best quality care possible.

Looking Forward: Advocacy Priorities for Spring

As we move into spring 2025, RANZCOG's advocacy priorities remain focused on these critical areas while adapting to evolving policy landscapes. Success will ultimately depend on sustained engagement across all levels of government, continued collaboration with allied organisations, and the ongoing commitment of RANZCOG members to translating policy advocacy into improved patient care outcomes across Australia and Aotearoa New Zealand.

RANZCOG Historical Collection: Dr Lorna Lloyd-Green

Greg Hunter
Archivist and Historical Collections Administrator, RANZCOG

In this issue of O&G Magazine, we look back at one of Australia's pioneering women in medicine – the remarkable and inspirational, Dr Lorna Lloyd-Green.

Born in Melbourne in 1910, Lloyd-Green was a talented and dedicated student. She attended Lowther Hall, where she was dux and school captain in 1929. In 1933, she graduated from the University of Melbourne with a Bachelor of Medicine and Bachelor of Surgery. Soon after, she became one of the first female obstetricians and gynaecologists in Melbourne, undertaking residencies at three different hospitals before being appointed Medical Superintendent at the Queen Victoria Memorial Hospital in 1939.

Lloyd-Green's extraordinary work ethic and devotion to duty, evident since her school days, was to be called upon to full effect during this period of her career. While working at the Queen Victoria Memorial Hospital during World War II, she was on call 24 hours a day for two years. Her dedication was such that she famously "never missed a delivery."[1] Flesch and McPhee note that her dedication "led her to spend every night of World War II at the Queen Victoria Hospital, on occasions snatching only a few hours' sleep between births."[2]

Fig. 1 Dr Lorna Lloyd-Green (1910-2002) at Queen Victoria Hospital, MHM04581, courtesy of the Medical History Museum, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne © 2025

This was only part of what made Lloyd-Green extraordinary. Alongside her medical abilities, she was a fierce advocate for the rights of women in the medical field, pushing for equal pay for equal work as well as advocating for increased training opportunities for medical women to enable them to acquire the skills they needed to take up senior positions.[3] She founded the sterility clinic at the Queen Victoria Hospital and ran it for 25 years, a program "which became the infertility clinic and later the IVF Clinic at Queen Victoria Monash."[4] Over the course of her career, Lloyd-Green received numerous honours. She was awarded an Order of the British Empire (OBE) in 1968 and a Commander of the Order of British Empire (CBE) in 1979. She was also the first woman to be made a Fellow of the Australian Medical Association in 1969, and was named "Woman of the Year" in 1970.[1]

Lorna Lloyd-Green retired from medicine in 1983, but did not retire from the duty she felt she had to help and care for others. A talented musician who had once considered a career as a music teacher, Lloyd-Green retrained as a music therapist, and from 1989, worked in this role at Bethlehem Hospital, helping to care for patients in palliative care. For Lloyd-Green, it was an immensely rewarding and fulfilling role. As she put it, "the power and scope of music are tremendous, and it crosses all barriers of race, colour, creed, and language, and it is a great communicator. It can relieve anxiety and depression as well as pain and can add much to the happiness of the terminally ill patient."[5]

A passionate advocate for both palliative care and music therapy, Lloyd-Green once described them as "two bright stars in the galaxy of the medical firmament", which have "a great impact on acute medicine as a philosophy of care when cure is no longer possible."[5]

RANZCOG is fortunate to be the recipient of several artefacts donated by Lorna Lloyd-Green. These include the case book submitted to the College for her admission as a Foundation Fellow of RANZCOG in 1947, as well as a range of medical equipment including a stethoscope, sphygmomanometers, a set of Neville-Barnes obstetric forceps, and various other instruments.

From a gynaecological perspective, perhaps the most historically significant item in this collection is a tubal insufflator used by Lorna Lloyd-Green. Invented in 1919 by American gynaecologist, Dr Isidor Clinton Rubin (1883-1958), this device formed "a standard part of infertility investigations for many years," until it was "gradually replaced by an X-ray technique involving radio-opaque

Fig. 2. A selection of objects donated to the College by Lorna Lloyd-Green.

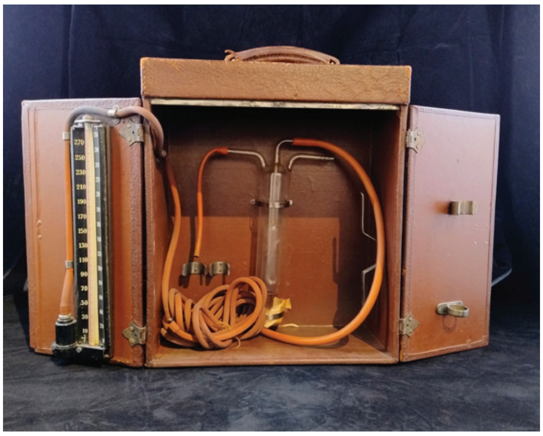

Fig. 3. Tubal insufflator donated by Lorna Lloyd-Green, c. 1919-1930s.

'dye'[6] It was used to detect blockages in the fallopian tubes, and operated by blowing "carbon dioxide, via a cannula, into the uterus."[6] A pressure gauge on the device, called a manometer, recorded the ease with which gas was able to escape the fallopian tubes, which in turn indicated the presence of any potential blockages.

The exact date of this model is unknown, but ranges from between 1919 and the 1930s. It provides a fascinating historical insight into gynaecological practice.

Dr Lorna Lloyd-Green remains an inspirational figure in Australian medicine. A pioneer for women in medicine, an exceptional medical practitioner (and late in life, musical therapist) whose dedication to duty and a sense of care for others was truly remarkable. It is a privilege for the College to be able to play a small part in preserving her story through our historical collections.

A selection of items relating to Lorna Lloyd-Green are currently on display at Djeembana College Place in Naarm Melbourne. Members and trainees are invited to visit the College to view these fascinating artefacts from the history of obstetrics and gynaecology.

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A RANZCOG Connection: Supporting Women's Health Education in Laos

Professor Amanda Henry
PhD MPH FRANZCOG,
RANZCOG Councillor

Mel Yean
States and Territories Support
Coordinator, RANZCOG

Over the past two decades, Laos has made remarkable progress in improving maternal health outcomes, achieving one of the fastest reductions in maternal mortality globally. Thanks to investments in midwifery training, free universal maternal services, and strengthened national health strategies, Laos has reduced maternal deaths by over 80% since 2000. Despite this progress, challenges remain — particularly in reaching remote communities where access to skilled birth attendants and well-equipped facilities is still limited. As Laos continues to build on these gains, the country's experience highlights the importance of community-based care and targeted support for equity in maternal health.

Professor Amanda Henry is a clinical academic and obstetrician based in Sydney, with a career dedicated to improving women's health through both clinical care and research. She is the Program Head for Women's Health at The George Institute for Global Health, Professor of Obstetrics in the Discipline of Women's Health at the University of New South Wales, and practices as an obstetrician at St George Public Hospital in Sydney.

This year, Amanda was invited to speak at the Laos O&G Society Annual Congress. In this article, Amanda describes her experience in Laos, the insights she shared, and what she took away from her time at the Congress.

What inspired you to accept the invitation to speak at the Laos O&G Society Annual Congress this year?

Professor Donald Marsden, who for many years was a Sydney-based CGO (including during my FRANZCOG training at the Royal Hospital for Women), has been living and working in Laos for about 15 years and runs regular education for Laotian O&G trainees. Each year, to coincide with the Laos O&G society conference, he organises a special workshop at Setthathirath Hospital in the capital, Vientiane. In the days surrounding the Congress, trainees from across Laos gather for teaching from both local specialists and international visitors.

Over the last 15 years, many FRANZCOGs have made the trip to Laos for these events, including RANZCOG Past-President, Dr Rupert Sherwood, the late Dr Peter Scott, Associate Professor Richard Millard, and Dr Michael Campion. Donald first invited me a few years ago, but unfortunately that coincided with the emergence of the COVID-19 pandemic. So, when he and Dr Keokedthong Phongsavan, the current President of the Laos O&G Society, extended the invitation again this year, I was ready to take up the challenge!

What inspired me most was the opportunity to contribute at the pre-Congress workshops for trainees, and to hopefully pay forward some of the excellent teaching I've received over the years. It also aligned well with my current role as Program Head for Women's Health at the George Institute for Global Health in Sydney—our program's mission is to improve the health of millions of women and girls worldwide. I decided to use my learning and development allowance this year to attend. Plus, I've never been to Laos before and it was a great opportunity to experience a country that I knew very little about and gain more than a "tourist" or "casual conference goer" perspective.

Professor Amanda Henry and Dr Keokedthong Phongsava

O&G Trainees and Faculty

What were some of the key themes or messages you wanted to share with the trainees and colleagues in Laos?

For the workshops one of the most important things was reinforcing the fundamental principles of pregnancy care – history-taking, examination, and core principles of diagnosis and management. These apply in any setting and support high-quality care, even when there are resource constraints.

For example, encouraging women to enter pregnancy care before 16 weeks, taking a thorough history and checking blood pressure can help identify a significant proportion of those at risk of preterm preeclampsia. Even without access to full multi-modal screening, initiating preventative strategies such as aspirin, calcium and exercise can make a meaningful difference.

> *"Doing the basics and promoting first trimester care and then regular ongoing antenatal care means many issues can be picked up early and managed before they become a crisis — regardless of the setting."*

I also wanted to emphasise that *"do a Caesarean"* is not the answer to every medical complexity in pregnancy! Another key message I shared, with both trainees and colleagues at the Congress, was the importance of considering long-term maternal health after pregnancy complications. In particular, the understanding that chronic diseases like cardiovascular disease and type 2 diabetes are much higher for women after hypertensive pregnancy and gestational diabetes. These women need ongoing follow-up and support to improve their health across the life course.

You led sessions on proactive care across pregnancy — from preconception to hypertensive disorders. How did the participants engage with this theme in a local context?

The participants engaged really well. Before I arrived, Donald was quite concerned that no one would ask questions— whether due to cultural sensitivities, concerns about saying the "wrong thing" or not wanting to challenge anything said by the "expert." But in fact, I received a lot of thoughtful questions — especially about how to apply proactive care principles in the local context, where a particular test might not be available, or a certain treatment option might be located hours away.

What were some of the most insightful or surprising questions you received from trainees during the workshops?

We had a vigorous discussion about gestational diabetes and how to diagnose it. Some of the local specialists joined in, which was great. The conversation started with a question about how to approach cases where women can't tolerate a glucose tolerant test (GTT), and then moved to the lack of consensus in Laos about diagnostic thresholds.

That gave me a chance to speak about the broader international uncertainty about what's considered "correct" (The updated ADIPS guidelines hadn't been published yet while I was there, but I knew they soon would be). I think it was quite challenging for some in terms of that lack of certainty. However, I think we all agreed that for each country or region to have a rationale to make the diagnosis and management decisions that they do, and then have consistency in those policies, was where we needed to get to.

What stood out to you most about the strengths or challenges within Laos' maternity care system?

In terms of strengths, there is absolutely a determination to reduce Laos's maternal mortality, which was nearly 600 per 100,000 in 2000 and had reduced to 126 per 100,000 as COVID arrived. While that's still many times higher than Australia or Aotearoa New Zealand, it shows just how much progress is possible.

Challenges remain. There is still significant reliance on foreign money in healthcare. To the extent that hospitals are commonly referred to by their donor country (e.g. "the [X country] hospital").

The healthcare landscape is a mix of public and private providers, with insufficient universal screening and care availability. Some challenges would sound quite familiar to those of us in Australia and Aotearoa New Zealand, such as disparities in care between cities and remote or regional areas.

Setthathirath Hospital, Vientiane, Laos

Could you share a moment or lesson that particularly stayed with you?

There wasn't a single defining moment, but what really stayed with me were the various contrasts between what is available in Laos and what we often take for granted in Australia. For example, access to universal cervical screening programs is something we rarely stop to question, yet in many settings it simply doesn't exist. That contrast really drove home how privileged we are.

How did your experience in Laos shape your views on global collaboration in women's health?

My experience reinforced just how vital global collaboration in women's health really is — especially in a time when so much funding for low- and middle-income countries has been, or is in the process of being withdrawn by the current US administration.

How do you see your experience in Laos influencing your future work in education or policy development?

It has certainly given me insights into the need to spend time in specific settings if you plan to undertake meaningful education, research or policy work in a particular country or region. Just as we see with culturally and linguistically diverse patients in Australia — where there are shared challenges, but also important differences depending on background — the same is true across low- and middle-income countries. There are common themes, but it is definitely not "one size fits all."

> *"Nothing beats time on the ground and learning from the locals about what their needs are to help ensure that what you are contributing is both meaningful and lasting."*

If you had one message for Australian colleagues about international women's health engagement, what would it be?

Contribute, with humility, where you can. High-quality women's healthcare and standards are absolutely achievable in resource-constrained settings. Reinforce the positives and the capabilities of our global colleagues through education and collaboration.

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Updates from our Research and Policy Team

Professor Cindy Farquhar
MB ChB, MD, FRCOG, FRANZCOG, CREI, MPH, MNZM, PMMRC

Acknowledging the theme of this issue, current RANZCOG clinical guidance that helps inform the topic of endometriosis include:

- Australian Living Evidence Guideline: Endometriosis

The *Australian Living Evidence Guideline: Endometriosis*, an update to the 2021 RANZCOG Endometriosis clinical practice guideline, was launched in May (2025). The Living Guideline supports the assessment and management of people with suspected or confirmed endometriosis or adenomyosis with evidence-based recommendations. Useful clinician and consumer resources have also been developed to accompany this important work. Further information about the *Australian Living Evidence Guideline: Endometriosis* can be found on pages 16 & 17.

Recent Research and Policy publications include updates to RANZCOG's *Birth After Caesarean Clinical Guideline (C-Obs 38)* and *Vasa Praevia Clinical Guideline (C-Obs 47).*

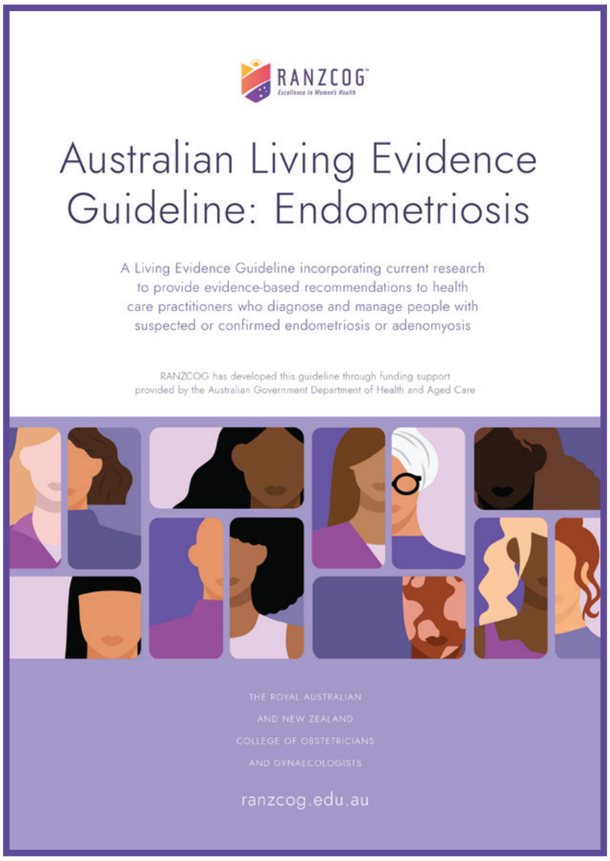
The 2025 *Birth After Caesarean Clinical Guideline (C-Obs 38)* marks the fourth update to RANZCOG guidance on caring for people who have previously given birth by caesarean and are currently pregnant or planning another pregnancy. This is an important, and increasingly common, clinical scenario with caesarean birth rates continuing to rise in both Australia and Aotearoa New Zealand.

Version three of the *Vasa Praevia Clinical Guideline (C-Obs 47)* covers topics including:

- Screening, diagnosis and risk factors for vasa praevia
- Hospital admission versus outpatient management
- Timing of birth

The Research and Policy Team and Women's Health Committee would like to thank all Guideline Development Group Chairs and members for their valued contributions.

Opportunities to contribute to guideline development and to provide feedback on draft documents are advertised in Connect. Please keep an eye out—and to access the full suite of our clinical guidance documents, please visit the RANZCOG website under the **Resource Hub** tab.



RANZCOG
Excellence in Women's Health

Australian Living Evidence Guideline: Endometriosis

A Living Evidence Guideline incorporating current research to provide evidence-based recommendations to health care practitioners who diagnose and manage people with suspected or confirmed endometriosis or adenomyosis

RANZCOG has developed this guideline through funding support provided by the Australian Government Department of Health and Aged Care

THE ROYAL AUSTRALIAN
AND NEW ZEALAND
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AND GYNAECOLOGISTS

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Australian Living Evidence Guideline: Endometriosis

Professor Cindy Farquhar
MB ChB, MD, FRCOG, FRANZCOG,
CREI, MPH, MNZM, PMMRC

Kate Smith
Implementation Lead,
RANZCOG

RANZCOG is dedicated to the establishment of high standards of practice in obstetrics and gynaecology and women's health. As outlined in the College's Strategic Plan, RANZCOG continues to publish and update its evidence based clinical guidelines to raise standards and support the O&G workforce in delivering high quality patient care, based on the latest research and evidence.

Evidence-based clinical guidelines are central to the delivery of high value health care. RANZCOG guidelines follow the process described in the RANZCOG Handbook with robust evidence appraisal systems using the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) approach. The College has a strong history of producing high-quality clinical guidance and maintains a growing portfolio of clinical guidelines and supporting resources for use by both medical practitioners and consumers.

For each clinical questions, the GRADE of evidence informs the Evidence to Decision (EtD) framework which reviews seven domains:
1. Benefits and harms
2. Certainty of the evidence
3. Values and preferences
4. Resources
5. Equity
6. Acceptability
7. Feasibility

Each clinical guideline includes two forms of guidance:
- Recommendations, which are evidence-based and graded
- Good Practice Statements, which provide practical advice and information based on clinical opinion and expertise

All recommendations are presented with a background of the clinical question, a rationale for the recommendation, any relevant considerations (such as limited evidence), and identification of research gaps.

As a medical college, RANZCOG is well placed to continue to develop the most reliable evidence-based clinical guidelines.

Endometriosis

Endometriosis is a chronic, inflammatory, gynaecologic disease marked by the presence of endometrial-like tissue outside the uterus and it afflicts as many as 1 in 7 women and people assigned female at birth in Australia.

For many, endometriosis is associated with debilitating pain, significant diagnostic delays after symptom onset, and the persistence or recurrence of symptoms despite optimal medical and surgical treatments.

The Australian Living Evidence Guideline: Endometriosis

RANZCOG developed the first Australian clinical practice guideline for the diagnosis and management of endometriosis in 2021, as part of the Australian Government's overarching *National Action Plan for Endometriosis (2018)*. This plan focuses on three priority areas: awareness and education, clinical management and care, and research.

In 2022, the Australian Government invited RANZCOG to update the original (Foundation) Guideline and transition it into a living evidence format (Living Guideline). The resulting *Australian Living Evidence Guideline: Endometriosis* incorporated a complete update of the evidence for all the clinical questions from the Foundation Guideline.

The Living Guideline also updated all recommendations with standardised wording using GRADE methodology. Each Recommendation or Good Practice Statement now reflects the strength of the recommendation in relation to the certainty of the evidence.

The Living Guideline includes:
- 9 Strong Recommendations
- 29 Conditional Recommendations
- 40 Good Practice Statements

Launched in May 2025, the Living Guideline has already successfully raised awareness of endometriosis and highlighted the importance of early recognition of symptoms with the options for early diagnosis and management.

Why is it called a living guideline?

A living guideline is continuously updated to incorporate the latest, high-certainty evidence as it becomes available. For the *Australian Living Evidence Guideline: Endometriosis*, systematic literature searches were repeated in January 2025 and April 2025. Hundreds of new papers were identified and screened to determine whether any new evidence would lead to a change in existing recommendations.

Box 1: Example of living evidence

Diagnosis of endometriosis

January 2025 Search:
- 240 titles and abstracts screened
- 59 full-texts assessed
- 6 systematic reviews identified, four assessing imaging (one published in two parts) and one assessing biomarkers for the diagnosis of endometriosis.

April 2025 Search:
- 109 titles and abstracts screened
- 9 full texts assessed
- 1 systematic review identified

Outcome: Recommendation did not change.

Highlights from the *Australian Living Evidence Guideline: Endometriosis* include:

Signs and Symptoms of Endometriosis:
The most common symptoms associated with endometriosis are severe painful periods, pain with sex, infertility, pelvic pain or heavy menstrual bleeding.

First-Line Diagnosis of Endometriosis:
Patients with symptoms suggestive of endometriosis should be offered a transvaginal pelvic ultrasound as the first-line investigation. A pelvic MRI can be offered if ultrasound is not available, or if deep endometriosis is suspected. If transvaginal ultrasound is not possible or not appropriate, due to age or sexual history, and MRI is not available, a transabdominal ultrasound could be suggested. Surgery is not required as a first-line option to diagnose endometriosis.

First- and Second-Line Hormonal Treatment for Endometriosis:
Offer any of the first-line hormonal treatments, including combined oral contraceptives and progestogens (oral, injection, implant or IUD), and if there is no improvement after three months, discuss an alternative first-or second-line hormonal treatment (GnRH agonist or GnRH antagonist).

Treatment:
Explain findings of diagnostic imaging and offer first-line hormonal treatment. Consider additional interventions including analgesics, physiotherapy or psychological interventions.

Adolescents:
For young people with significant period pain, ultrasound should be used to assess causes including endometriosis. Use transabdominal ultrasound when transvaginal ultrasound is not suitable. MRI or transperineal ultrasound also may be considered by a specialist experienced in these modalities.

All hormonal and simple analgesic options are suitable for young people. IUD is safe to use in young people and may be inserted under general anaesthetic (if necessary). Other management as outlined in this guideline may also be suitable for young people.

Guidance for Cancer Risk:
For people with endometriosis requesting information about cancer risk in reproductive organs, it is recommended to inform them that although they may have a small increase in ovarian and endometrial cancer, the increase in absolute risk compared with women in the general population is low; and that they may have a reduced risk of cervical cancer.

As there is no screening test that can accurately detect early ovarian or endometrial cancer, the Guideline Development Group (GDG) does not recommend additional testing for people with endometriosis.

Resources to support the *Australian Living Evidence Guideline: Endometriosis*:

- Summary of Diagnosis and Management Flowchart
- Quick Reference Guide for Primary Care
- RANZCOG eLearning Advanced Training Module
- Consumer Patient Information Pamphlet (PIP)
- Consumer Video Resources
  - Video 1: You are not alone
  - Video 2: How was the guideline developed?
- RATE tool

Dissemination Events:

- Launch at the RANZCOG Education and Engagement Day, Melbourne, 10 May 2025
- World Congress on Endometriosis, Sydney, 21 May 2025
- RANZCOG Education and Engagement Day, Cairns, 28 June 2025
- RANZCOG Education and Engagement Day, Perth, 29 August 2025
- RANZCOG Annual Scientific Meeting (ASM), Adelaide, 18 -22 October 2025,
- Affiliate college booths and events including Royal Australian College of General Practitioners (RACGP) and Australian College of Rural and Remote Medicine (ACRRM)
- Clinical Champions from the GDG presenting to their local audiences including hospital or primary health network (PHN)

Update of Living Guideline Recommendations:
Recommendations and Good Practice Points will be updated according to the process described in the *RANZCOG Handbook*.

Australian Living Evidence Guideline: Endometriosis – Guideline and Resources

An Australian First – Decommissioning Piped Nitrous in a Maternity Hospital

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Nitrous oxide (N_2O) is a potent greenhouse gas and the most significant ozone-depleting substance. It remains in the atmosphere for over 100 years.[1] Despite this, N_2O has long been accepted as an effective analgesic, commonly used in maternity services.

The Problem:

The main concern with N_2O delivery in hospitals is leaks within the often extensive piping system that transports N_2O from a pressurised set of canisters in a manifold through the hospital to the patient's location. An inhalational device is then attached to a wall outlet and nitrous flows to the patient as required. These pipelines are highly prone to developing leaks and studies have demonstrated losses of 70-95% of N2O before any gas reaches the patient.[2]

Even regular leak tests, as per the Australian standard, have been shown to be ineffective at discovering and addressing this issue. Leakages can also be intermittent, further complicating monitoring efforts. These substantial fugitive emissions contribute significantly to environmental harm. Our bottom line – the health of our community is at risk. There are growing calls to eliminate the use of piped N_2O systems in new hospital builds and to decommission lines in existing hospitals.

In anaesthetics, piped N_2O can be replaced with cylinders attached directly to anaesthetic machines, eliminating the need for piped systems. This transition has already occurred in several non-maternity hospitals across Australia. However, it has been assumed that dealing with piped N_2O in maternity units poses additional challenges that have delayed decommissioning in these settings.

Our experience challenges that assumption and demonstrates that switching away from piped N_2O is relatively easy, financially and carbon-cost effective, and carries additional advantages to patient care.

A Solution:

The good news is that N_2O is also available in smaller, mobile tanks that can be placed near the patient to deliver the same analgesia without the excessive atmospheric losses associated with pipes. Rather than compromising patient care, mobile delivery units may enhance the birthing experience by enabling greater mobility during labour, which is associated with reduced interventions and a more positive patient experience.[3]

What We Did:

Motivated by strong local support from medical, midwifery and nursing staff, our maternity unit committed to transitioning fully to mobile N_2O delivery systems and decommissioning the hospital's piped N_2O infrastructure. This was a hospital-wide initiative with executive support, coordinated by our Environmental Sustainability Officer with practical input from maintenance staff. Our community is climate-conscious and this strong community value provided further incentive for the project.

Our unit consists of two birth suites and we care for more than 300 women each year during childbirth. To facilitate transition, our unit purchased three mobile units and commenced clinical use. Once the team felt comfortable with the mobile units, and the theatre transition had occurred concurrently, maintenance staff began decommissioning the piped N_2O throughout the hospital. Wall outlets were capped and de-labelled. Over the course of several months, staff and equipment were monitored for any issues, and so far, no concerns have been raised.

What's Next:

Feedback from both maternity and theatre services is being collected with the support of our Environmental Sustainability Officer. The transition has been smooth so far, and patients have been happy to hear about our efforts to minimise our footprint and support a healthier environment.

Currently, a work instruction guide and an FAQ troubleshooting document for decommissioning are being developed to support decommissioning at other sites. There has been interest from many maternity healthcare sites both within the state and around the country. Supporting that process with our learnings is one of our priorities. We welcome any input, questions and feedback from sites around Australia.

Summary:

Piped N_2O delivery systems are inherently leaky and responsible for significant greenhouse gas emissions from the healthcare sector. This contributes to the negative impacts of climate change on health. Maternity services are a major user of N_2O, and opportunities exist to decommission piped N_2O systems in favour of mobile units. We have successfully implemented this transition with minimal impact.

We now have N_2O units that are closer to the patient and can improve patient care, while reducing the negative impact on the environment, the health of the patients we care for and their children. Each baby born in a maternity unit is a poignant reminder of our collective responsibility.

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From Conception to Curtain Call: RANZCOG ASM 2025 Challenges Inequity in Women's Health

Dr Anthea Lindquist
Scientific Chair

Associate Professor Louise Hull
Chair, Organising Committee

There's a temptation, living in the relative comfort of present-day Australia and Aotearoa New Zealand, to believe that the battle for women's rights is mostly behind us. But history tells a different story. Until 1971, Australian women could only access the contraceptive pill if they were married. Until 1974, they couldn't take out a mortgage or a credit card without a man's co-signature. The Sex Discrimination Act changed that, but these milestones are not distant historical footnotes. They are the lived experience of our mothers, mentors and many of our patients. And while we should take stock of how far we've come, we also cannot lose sight of how far we still have to go – especially when it comes to equity in women's health.

Since its inception, the Royal Australia New Zealand College of Obstetrics and Gynaecology (RANZCOG) has been a leading body, committed to promoting excellence and equity in women's and reproductive health care across Australia and Aotearoa New Zealand.

The College advocates for equitable access for all the communities it serves, supports the safe adoption of emerging fem-tech innovations, shapes policies that transform clinical practice, and develops educational programs that strengthen the skills of doctors and health care professionals alike.

This commitment has been central to shaping the theme of the RANZCOG 2025 ASM, *From Conception to Curtain Call*. The Organising Committee has intentionally crafted a program that reflects the full arc of RANZCOG's work, from clinical excellence to advocacy and education. The three-day Scientific Program charts a thoughtful journey – from reproductive rights through to menopause, and the future of women's health. It also explores how technological advances are transforming care and how innovation can move us closer to equity, insight, and accountability in how we deliver care.

The program aims not merely to inform, but to challenge. What does equity look like in women's health care? And what can we do, as clinicians, advocates, and changemakers, to help bring us closer to it? From disparities faced by First Nations peoples, and Māori, as well as other underserved populations such as refugees, migrants, and members of the LGBTQIA+ community, to birth trauma and access to sexual and reproductive health services, and the future of our specialty in a tech-driven world, the RANZCOG ASM 2025 will engage with the complex questions facing O&G.

In seeking forward-thinking speakers, the Organising Committee has taken a direct approach, engaging keynote speakers who challenge assumptions and speak to the heart of issues. Dr Matthew Leonardi and Professor Laura Magee, along with featured speaker Professor Linda Brubaker, will bring world leading research, innovation and insight across the spectrum of women's health — from endometriosis to long-term maternal health outcomes, to the intersection of the microbiome and the wider world of women's health.

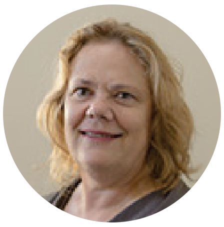
Championed by trail blazing advocates and doctors, the program also includes Ian McDonald Memorial Orator and RANZCOG President-Elect Dr Nisha Khot, RCOG President Dr Ranee Thakar, Ella Macknight Memorial Lecturer Dr Clare Whitehead, podcast powerhouse and clinician Dr Kara Thompson, and GP advocate Dr Mariam Tokhi. A roundtable will bring together leaders from RCOG, ACOG, AOFOG, PSRH and SLCOG to explore how we can tackle global inequities, with a particular focus on improving birth outcomes in low resource countries through upskilling women's health practitioners and collaboration.

At its core, the RANZCOG ASM 2025 serves as a statement of intent. A recognition that despite progress, systemic inequities in women's health remain deeply entrenched. Whether shaped by race, gender identity, socioeconomic status, geography, or cultural barriers, these ongoing disparities demand action. This year's program champions the voices and experiences of those affected. In doing so, it challenges every one of us — as clinicians, educators, leaders and advocates — to examine the roles we play in dismantling structural inequities.

We are looking forward to continuing these vital conversations with you at the RANZCOG ASM 2025, taking place at the Adelaide Convention Centre, from 18-22 October. If you haven't yet registered, visit ranzcogasm.com.au to book your spot and explore more program highlights.

Thanks and congratulations to the Organising Committee for their dedication and contributions, and the RANZCOG Events Team who have been integral to organising this event. They have worked hard to ensure there is something for everyone and that all our members will learn new things and enjoy those essential interactions that occur in the O&G community.

Insights from He Hono Wahine



Dr Leigh Duncan
MBChB (Otago), Dip. Obs (Auckland), MRCOG,
FRANZCOG, Chair or He Hono Wahine

Bailey Parata Thomas
Indigenous Development Lead - Hauora Māori,
RANZCOG

As we reflect on the past year, the mahi (work) of He Hono Wāhine has continued to grow in both depth and impact. Our commitment to improving outcomes for wāhine Māori and advancing cultural safety across the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has driven several key achievements.

A central focus this year has been the implementation of the updated Te Rautaki Māori me te Ara Whakamua 2024–2026. This rautaki (strategy) guides RANZCOG's efforts across three interconnected areas: Wāhine Māori, Members, and Organisation. In 2024-2025 we continued to act, achieving milestones that strengthen equity in measurable ways.

One of our proudest accomplishments has been completion of research into Māori experiences of FRANZCOG training to develop recommendations. A vital step in supporting both current and future Māori trainees, aiding in recruitment and retention of a Māori O&G workforce. You can read more about this research in the previous edition of O&G Magazine, themed 'The Vulva.'

He Hono Wāhine continues to prioritise support for Māori trainees with a standing agenda item dedicated to their wellbeing. This ensures Māori trainees feel seen, valued, and connected throughout their training journey. In response to recommendations from our recent research, we are exploring the development of a Kaiāwhina role — a dedicated support person to help Māori trainees navigate cultural load and unsafe environments. Representation within RANZCOG continues to grow. In the 2024 FRANZCOG intake, 24% of incoming trainees in Aoteoroa New Zealand identified as Māori, a promising indication that targeted recruitment, outreach at Te the Māori Medical Practitioners Association (Te ORA) and Te Oranga conferences, and improvements to the selection process continue to evolve to meet the needs of all applicants.

Cultural safety remains a central theme across our work. In 2025, we made significant progress on the development of a cultural safety self-reflection tool for Fellows and trainees. This resource will help members critically assess their own practice and challenge the biases and assumptions that can compromise culturally safe, respectful care. This work has also been progressed by the First Nations Women's Health Committee in Australia.

We've continued to embed cultural safety into the FRANZCOG curriculum, examinations, and Continuing Professional Development (CPD), working in close partnership with the University of Otago's Māori Indigenous Health Innovation (MIHI) Department. All Specialist International Medical Graduates (SIMGs) can complete the Otago University MIHI401 and MIHI501 cultural competence course throughout the vocational registration process in Aotearoa. At the same time, Fellows and training supervisors are expected to refresh their cultural safety education every three years.

This year also marked a historical moment for RANZCOG: my election to the RANZCOG Board for the 14th Council — the first time an Indigenous person has held this position. While this milestone is not about one individual, it represents an important step forward for Māori and First Nations representation in College leadership. It also reflects a growing recognition that Indigenous voices are essential to shaping the future of our profession and ensuring the College reflects the communities it serves.

He Hono Wāhine also deepened our trans-Tasman connections. Members of He Hono Wāhine and the First Nations Women's Health Committee in Australia gathered at the Pacific Region Indigenous Doctors Congress (PRIDoC) 2024 conference to share insights and ways to support each other in navigating cultural load experiences. Our ongoing relationships with Te ORA and the Australian Indigenous Doctors' Association (AIDA) continue to provide guidance, strengthen partnerships, and ensure our work is grounded in culture.

While we are proud of our achievements over the past year, we recognise there is still much more to do. We will continue our advocacy for equitable health outcomes for wāhine Māori, and building on the foundations already laid—from supporting culturally safe hospital training environments, to increasing kaupapa Māori research opportunities and amplifying patient voices through lived-experience storytelling.

> *"He Hono Wāhine exists because equity for wāhine Māori cannot be left to chance; it must be designed into our systems, supported by our workforce, and embedded in our culture."*

This work is not only about transforming outcomes for Māori, but also about building a more equitable, safer, and more inclusive system that benefits all women and their whānau.

My sincere thanks to all the members of He Hono Wāhine, our colleagues across RANZCOG, and our many partners who walk alongside us. Together, we are shifting the dial toward true equity in women's health.

RANZCOG Māori Women's Health Award 2025 - Te Aukume a Hine te Iwaiwa

Bailey Parata Thomas
Indigenous Development Lead - Hauora Māori,
RANZCOG

At this year's RANZCOG Aotearoa Annual Scientific Meeting, the RANZCOG Māori Women's Health Award was proudly presented to Te Aukume a Hine te Iwaiwa, a powerful collective working to transform perinatal health outcomes for wāhine Māori and their whānau. This award recognises individuals or research groups that have made a significant contribution to Māori women's health.

But their story did not begin in a boardroom. It began in the mauri, the life force of their people.

Following a national ON TRACK Network survey, it was revealed that the top 20 perinatal research priorities identified were all specific to Māori. This finding became a catalyst for change, facilitated by Diane Wihongi, challenging attendees to pause, sit in the discomfort of silence, and truly listen to the solutions already being offered by Māori.

From that second, momentum grew. Dr Felicity Ware, Dr Wendy Burgess, Professor Katie Groom and others rallied around the vision and secured a Health Research Council (HRC) Research Activation Grant. This grant laid the foundation for a new collective: Te Aukume a Hine te Iwaiwa. The name honours Hine te Iwaiwa, the atua (God) of childbirth, weaving, tides, and moonlight, symbolising the natural forces that pull people together, in rhythm and purpose.

The collective draws Māori researchers from across Aotearoa into a shared kaupapa (purpose): to reclaim and lead the space of perinatal research for and by Māori.

During the COVID-19 lockdown, the collective found innovative ways to connect. Online whakawhanaungatanga (relationship building), led by Dr Ware and Hāpai Selby-Law, created space for deep, meaningful connection. In parallel, Stephanie Shankar and Kaniwa Kupenga-Tamarama conducted a scoping review, identifying Māori-led research publications in perinatal health. The findings confirmed what many already knew, Māori knowledge and research in this space is rich, robust, and ready to lead.

A defining moment for the rōpū (group) came with their kanohi ki te kanohi wānanga (face to face meeting) at Papakura Marae, held in the narrow window between Cyclones Hale and Gabrielle. With pēpi (babies) in arms and kaumātua (elders/leaders) like Papa Tuta Haereroa embracing the gathering, the marae became the womb of the kaupapa. It was an intergenerational space where Māori research across disciplines, clinical, non-clinical, and rongoā Māori (Māori medicine/health practices), was shared within a whare (house/building) that breathes with the community it serves.

It was at this wānanga (meeting) that Māori perinatal research priorities were set. These priorities will not only guide the mahi (work) of the collective but also help shape the future of Māori-led clinical trials and health strategies.

The rōpū's scoping work has now been captured in a landmark report: Mātātuhi Whakatere a Hine te Iwaiwa – The Navigation Charts of Hine te Iwaiwa. This taonga (treasure), carried forward by Hāpai te Hauora (Māori Public Health Organisation), provides a vital resource, a roadmap of Māori-authored research that will guide both current and future researchers in the perinatal space.

Their efforts stand as a reminder of what is possible when kaupapa Māori is centred, resourced, and trusted to lead.

In accepting the award, the rōpū extended acknowledgements to the Massey University of New Zealand for its ongoing support, to He Hono Wāhine for the nomination, and to RANZCOG for making space for kaupapa Māori within the scientific forum. But most importantly, they dedicated the award to wāhine Māori, whānau, tamariki (children), kaimahi (workers), and researchers across the motu (country), those who have walked alongside them and those yet to come.

> *"Mā te huruhuru, ka rere te manu – with the right feathers, our bird will soar."*

Te Aukume a Hine te Iwaiwa is more than a research group. They are a reclamation, a reconnection, and a reminder that the answers have always been within us.

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A Day in the life of a Private Practicing Obstetrician and Gynaecologist: More than Delivering Babies and Surgery

Dr Jenny Dowd
MD, FRANZCOG

Dr Heather Waterfall
FRANZCOG MBBS (Hons)
B.Ap.Sci (Med Rad)

Dr Precious Lusumbami
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Continuing Professional Development (CPD) is a professional requirement set by key regulatory bodies including the Australian Health Practitioner Regulation Agency (AHPRA), Medical Board of Australia (MBA), Australian Medical Council (AMC), and the Medical Council of New Zealand (MCNZ).

For private practitioners, particularly those working in obstetrics & gynaecology (O&G), many of the activities already performed in the course of daily work can contribute meaningfully to CPD hours.

This article explores how RANZCOG supports private practitioners in claiming CPD hours—including Outcome Measurement (OM) and Performance Review (PR)—using the RANZCOG CPD App or via the RANZCOG Integrate platform.

Morning

A typical day often begins early, either in consulting rooms or in theatre — where private O&Gs meet with patients for consultations, antenatal checks, or scheduled surgeries. But beyond these clinical interactions, lies a commitment to audit and quality improvement that underpins each decision.

Many clinicians dedicate time each week to auditing their own practice and maintaining high standards of patient care. These efforts may include:

- Reviewing patient satisfaction through surveys and individual feedback (PR – Self-Adapted Patient Satisfaction Questionnaire)
- Monitoring surgical outcomes and complication rates (OM – Audit Flyer and Template and Quality Improvement Cycle Flyer and Template)

Midday

In private practice, O&Gs play an active role beyond individual patient care. For clinicians involved in committee work, a day might involve some time spent:

- Reviewing or updating clinical guidelines or protocols on topics like induction of labour or post-operative care (OM - Guideline and Protocol Development and Review Template)
- Reviewing incident reviews such as a Root Cause Analysis (RCA) or reports on healthcare outcomes (OM - Incident Report Review Template)
- For those involved in training, developing exam questions for RANZCOG exams (OM/PR – these hours will be uploaded on your behalf by College Staff).

Afternoon

Amid a busy clinical schedule, education and peer engagement remain fundamental to the role of any specialist. For O&Gs, this often includes:

- Maintaining skills and knowledge via professional reading (EA - Professional Reading and Viewing)
- Supervising, teaching and assessing trainees (EA Teaching Flyer and Template and Supervision Mentoring Flyer and Template)
- Hosting and attending clinical meetings, including case reviews, M&M, MDT and clinicopathological meetings – both within their team and in a multidisciplinary setting to discuss complex cases. (OM/PR - Clinical Meetings Template)
- A retrospective audit of surgical or clinical practices (e.g., embryo transfer procedures conducted over a specified period, comparing clinical pregnancy rates against national benchmarks or internal historical data). (OM – Audit Flyer and Template and Quality Improvement Cycle Flyer and Template).
- Opportunities to operate jointly with colleagues to develop and refine skills. (PR – Operating and/or performing procedures with a peer)

Evening

Evenings might involve reviewing the multitude of resources to maintain knowledge and keep skills up to date.

- Completing medico-legal reports. (OM - Medical Legal Work Template)
- Involvement in reviewing and developing patient education resources (OM) to ensure best patient outcomes.
- Participation in RANZCOG's quality assurance programs (e.g., CQUIP, NTUEMP and FSEP), (EA) providing an opportunity to be involved in quality improvement programs, and FSEP Certification (EA) awarded on completion of, or updating Fetal Surveillance Education Program training.

Reflection: A Lifelong Learner (PR)

Being a private practicing obstetrician and gynaecologist is much more than delivering babies and performing surgery, it's about leadership, mentoring, system improvement, and lifelong learning. From auditing their work, mentoring and training the next generation of doctors, to contributing to system-level safety and fostering collaboration, these specialists wear many hats. Each day is grounded in a commitment to safer, more responsive, and compassionate patient care.

Self-reflection plays a critical role here (PR). Time dedicated to developing case review reports for complex or challenging cases can be logged under OM using the Clinical Case Review Template. Time dedicated to reflection on one's practice of the activities they have completed can be logged by completing the Self-evaluation and Reflection Worksheet online.

Private practitioners have a wealth of CPD opportunities often embedded in day-to-day work. By adopting a reflective mindset and documenting engagement, practitioners not only meet CPD requirements but continuously enhance the quality of care they provide.

For more tools and templates, visit the Resource section of the RANZCOG CPD Portal or contact the CPD team via cpd@ranzcog.edu.au or +61 3 9412 2910.

Health and Wellbeing:

Taking care of ourselves allows us to be in the best physical and emotional state to look after our patients. Health and wellbeing courses that teach us skills can be included in EA hours, or with reflection and review can become PR hours. Courses are regularly promoted on RANZCOG's Events website. Please check individual listings for eligible CPD hours and domains.

For a full list of recognised CPD activities and templates, visit the Resources section on RANZCOG Integrate.

LEADERS IN FOCUS

Dr Magdalena Halt
BMBS, BSc, FRANZCOG,
MastMIS

Dr Anna Kearney
MBBS, DCH,
DRANZCOG adv, FRACGP

This feature sees Dr Magdalena Halt in conversation with Dr Anna Kearney, a GP Advanced Obstetrician at the Yorke Peninsula Pelvic Pain Clinic.

Join the conversation on Instagram
#Celebratingleadership
@RANZCOG

In 2022, I had the pleasure of meeting Dr Anna Kearney at a pelvic pain network meeting. At the time, she had recently started working as an Advanced GP Obstetrician at Kadina Medical Associates and Wallaroo Hospital and Health Service and was interested in expanding care for women experiencing pelvic pain. For context, Wallaroo is located on the Yorke Peninsula, approximately 160 km northwest of Adelaide and is classified as a Modified Monash Model 5 area.

Introducing Dr Anna Kearney

Anna was born in Port Lincoln but spent part of her childhood in Oodnadatta, in outback South Australia — which if you consult your map, is about as remote as you can get (around 1,000 km from Adelaide). She later completed her schooling and medical degree in Gawler and Adelaide. After obtaining her GP qualifications in 2020, Anna took a medical gap year working as a locum in the Northern Territory, a year which she remembers fondly. Hearing about her past, I was struck by the variety, her travels to remote locations and her adaptability. All excellent traits for a busy, sub-specialised country GP.

In 2023, thanks to Anna's hard work and vision for women's health, Kadina Medical Associates was recognised as one of the first rural endometriosis and pelvic pain clinics in Australia, and the very first in South Australia. The clinic is widely praised by patients and is a welcome respite from the long trips to Adelaide. Anna hopes to continue her current work and expand the clinic's scope to encompass pelvic floor disorders, such as incontinence, and menopause care.

After learning about her work and the development of the rural pelvic pain clinic,I asked Anna about her approach to women's healthcare, and how she's navigating the unique challenges and opportunities of rural practice.

Congratulations on being the first Endometriosis Clinic in South Australia. Can you describe your pathway for caring for women with endometriosis and pelvic pain?

Our clinic encourages a multidisciplinary team approach, with pelvic physiotherapy and dietetics on site. All patients have a 45-60 minute consultation with a GP who has a special interest in pelvic pain, and they also see our pelvic health physiotherapist. Around half of our patients are also seen by the dietitian. Follow-up appointments with each clinician are usually undertaken every three months, depending on need.

We also run community women's education nights with guest speakers covering topics such as pain psychology, gynaecology and exercise physiology — each session ends with relaxation yoga. In addition, we participate in community events and have developed an outreach clinic at Point Pearce Aboriginal Health Service. Over the past year, this has substantially grown into a full-day event involving multiple health providers. It brings care closer to home for the community in a culturally safe space, helping to break down some of the barriers to access.

What is the catchment area for your clinic?

Our patients travel from the bottom of the Yorke Peninsula, across the Spencer Gulf in Whyalla, Eyre Peninsula, north of Orroroo and as far south as the Adelaide Hills.

The clinic was established in 2023 with support from a federal government grant. From the outset, our focus was on building a sustainable, long-term service led by local clinicians.

What kinds of presentations do you commonly see?

Pelvic pain presentations may be related to period pain, dyspareunia, cyclical bowel or urinary symptoms and more. We are fortunate to have the time to take a detailed history, which allows us to diagnose not only endometriosis and PCOS, but also pelvic organ prolapse, inflammatory bowel disease and even bowel and ovarian cancer.

What are your numbers for attendance? How has this changed over time?

We currently have 284 patients on our books, 60 of whom have “graduated” and this number continues to increase. Our aim is to equip and educate women with the tools to self-manage period pain and persistent pelvic pain.

Did you choose women’s health, or did women’s health choose you?

Women’s health definitely chose me — I’m the third of four sisters! The variety of rural generalism had always appealed to me. As a medical student, a senior obstetric registrar once told me the best I could offer in rural areas was helping people “have a choice” in their pregnancy care, and whether they wanted to deliver locally.

I completed my Advanced Diploma of Obstetrics at Flinders Medical Centre before moving to Port Lincoln to complete my GP training. I then took a gap year caravanning with my husband and two young boys. We never found anywhere as wonderful as Wallaroo and returned in 2022 for the long term.

What do you love about your job and what could you live without?

I love the variety of rural generalism. Last week I delivered babies, provided palliative care and saw patients with a wide range of presentations encompassing the lifespan in-between.

What I could live without is when patients return with the same issue, having done none of the recommendations I made during their last appointment. Over time, I have learnt to reflect on this lack of engagement with them as recovery or improvement is so dependent on this commitment, particularly in chronic conditions.

How do you decompress?

Outdoors and exercise! Camping, swimming, running or netball. Anything outside.

What is your vision for the future of healthcare for women with endometriosis and pelvic pain?

Funding services like ours — where patients can access holistic care, close to home, for free — is making a huge difference in people’s lives. It would be amazing to see more of these clinics established in primary care, with the funding and workforce to support them.

I hope we reach a point where I no longer hear stories of dismissal, gaslighting and medical trauma in women’s health. I would love for more resources to be poured into primary care to support research and training in women’s health, where the initial consult is had, and where the greatest effect can be made.

What advice would you give other practitioners interested in women’s health focused GP practice in a rural setting?

Take time off to follow your interests and bring more knowledge back to better your community.

> *"Don’t be scared to try and create something for your community, for they will support you!"*

Can you recommend a book that you’ve found helpful or simply really enjoyed?

I read purely for pleasure! I return to read *The Miniaturist* by Jessie Burton, or *People of the Book* by Geraldine Brooks multiple times to switch off before bed.

Thank you Anna, and we wish you and your clinic a bright future ahead!


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Editorial

Dr Magdalena Halt
BMBS, BSc, FRANZCOG,
MastMIS

Welcome to the Spring Edition of *O&G Magazine*, which focuses on endometriosis. Endometriosis or simply 'endo' as its commonly referred to by us as clinicians and our patients, is a complex, heterogenous disease with a wide spectrum of symptomatology. It is extremely common, with 1 in 10 women being diagnosed at some point in their lifetime. Given its prevalence, endometriosis often forms the cornerstone of daily practice in gynaecology clinics. In some respects, a lot has changed in this field and in others, very little. This is in part the reason why we commissioned endometriosis as the theme for the current edition of the magazine. Allow me to expand on this.

In Australia, the progressive increase in media and government coverage of the disease since the mid-2010s has brought improved awareness across public and professional domains. As a result of this, in addition to tireless advocacy from the Australian Coalition for Endometriosis (Pelvic Pain Foundation, Endometriosis Australia, EndoActive, QENDO and Endometriosis Western Australia) and other organisations such as RANZCOG and Pelvic Pain Victoria amongst others, we have seen a gamut of government funding including, most recently, new MBS rebates for complex gynaecology consultations.

For the first time in 20 years, women's health medications such as Visanne (dienogest), Slinda (drosperidone), Ryeqo (relugolix/ estradiol/norethisterone), Prometrium (micronized progesterone), Yasmin/ Yaz (estradiol/ drosperidone) are subsidised on the PBS, making them more affordable. We now have cheaper MR scans and better rebates for sub-specialised endometriosis ultrasound imaging.

New incentivised funding is available at a primary healthcare level for multi-disciplinary endometriosis and pelvic pain clinics. Across Australia, state government health departments are launching inquiries into the current status of disease treatment and giving voice to patients' stories. In fact, since the release of the federal National Action Plan for Endometriosis in 2018, over $87 million dollars has been committed to various clinical, educational and research initiatives related to the disease.

We've seen developments in clinical guidance. RANZCOG's *'Australian Living Evidence Guideline: Endometriosis'* published in May 2025 presents a cohesive summary of current evidence for assessment and treatment with the aim of ensuring consistency of care (read more on this in this edition). ANZCA's Pain Faculty chapter also released a complementary statement (ANZCA, 2025) on the current approach to persistent pelvic pain, at the same time identifying the existing deficiency in our understanding of some of its aetiologies.

Whilst we proudly celebrate these wins for endometriosis care, we recognise that progress on the ground is still very slow. The chronic underfunding of GPs has resulted in deficiencies in primary care, such as poor access and the perception that women's health care is difficult, too complex and under rewarded.

Existing generalised healthcare inequities in rural and remote areas are compounded for endometriosis. Access to quality imaging, physiotherapy, mental health services and pain specialists can be difficult and costly. Availability of multidisciplinary endometriosis care is rare in public healthcare settings, let alone outside major metropolitan centres.

In healthcare settings, improved awareness has resulted in increased rates of diagnosis and treatment but has also caused over attribution of female abdominal and pelvic symptoms to endometriosis. Emergency departments struggle with presentations of acute-on-chronic pain flares in patients with poorly managed disease and, upon admission to hospital, persistent pelvic pain patients experience the same roadblocks to care as any other chronic pain patients.

Patient expectations around care are higher on account of increased availability of education and information about the disease – expectations that are sometimes insurmountable due to resource limitations. Like most chronic conditions, good endometriosis care involves self-care including engagement in multidisciplinary therapy. With all these demands and the concurrent increase in diagnoses of other systemic conditions such as ADHD, POTS, ASD, MCAS amongst others, both patients and clinicians can find it hard to navigate the multitudes of therapies and recommendations.

Increased awareness and patient health literacy has reinforced the need to address the fundamental questions about endometriosis which we still don't have answers to, such as:

- Better understanding of the pathophysiology
- Factors affecting susceptibility to persistent disease
- Immune aspects of disease onset and progression
- Optimal treatment for fertility, etc

Presenters at the recent World Endometriosis Congress in Sydney stressed the importance of collaboration and multi centre data gathering to advancing research in this field. In clinical settings, we are finding gaps in data collection which result in inaccurate or outdated epidemiological statistics. This, in turn, affects resource allocation; if you cannot prove how many patients present to your public clinic with endometriosis symptoms, pursuing funding for better treatment is difficult.

The Minister for Health & Ageing, the Hon. Mark Butler, has committed funding through the Medical Research Future Fund and National Health and Medical Research Council (NHMRC), and in May 2025 a $50 million-dollar philanthropic donation was made to the University of Sydney for endometriosis dedicated research. Hot off the press, the Victorian Premier, the Hon. Jacinta Allen, has pledged $1.5 million in the Women's Health Research Catalyst Grants program (Victorian State Govt., 2025) to support research projects in women's health across the board. Since the inception of the National Action Plan for Endometriosis, we have seen an increase in research output as documented by a spike in publications (Abbott, 2024). We eagerly await the results of their work as we grapple with this complex disease spectrum. We would also like to acknowledge and support the research already undertaken and currently taking place in this field.

This edition of O&G Magazine explores endometriosis care and advocacy, featuring case studies, patient perspectives, and clinical updates from across Aotearoa New Zealand and Australia. We examine the lived experience of endometriosis through powerful contributions, including a Q&A with Bindi Irwin, the account of a physician navigating their own endo journey, and the transformative journey *"Over It to Empowered"*, highlighting the impact of a multidisciplinary care approach. Clinical insights include an in-depth look at the medical management of invasive rectal endometriosis and a case study on ethnic disparities in diagnosis and treatment.

We also spotlight advances in ultrasound, dietary interventions and emerging nutrition research, and the roles of physiotherapy and psychology in holistic care. Endometriosis in children and adolescents is explored alongside a review of Dr Susan Evans' book *Endometriosis & Pelvic Pain for Teens* tailored to this patient population. We revisit Stage 4 disease and its management with a focus on fertility, and in our regular '*Leaders in Focus*' section, we speak with a rural practitioner about delivering care in their corner of this vast country. To round out the issue, Dr Marilla Druitt reviews Peta Wright's book *Healing Pelvic Pain*, reinforcing the importance of holistic care.

As we celebrate Endometriosis Awareness Month with its yellow theme every March, we are reminded of just how far we have come and, by the same token, of the long road ahead. We hope to revisit this theme in the near future to update you on more incredible milestones and discoveries, which result in improved understanding and better management of the disease. For now, we invite you to enjoy this edition and, as always, look forward to your feedback.

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In Conversation with Bindi Irwin on Living with Endometriosis

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Diagnosed after more than a decade of symptoms, Bindi Irwin shares her experience of living with endometriosis. She reflects on the early signs and on managing ongoing pain while juggling motherhood and conservation advocacy, all under the scrutiny of life in the public eye. She also shares what she hopes healthcare professionals will take from her story.

Let's start at the beginning. What were some of the early signs that something wasn't right with your health, and what helped you trust your instincts when answers weren't easy to find?

Pain, nausea, gastrointestinal upset, and fatigue were all symptoms that were in the driver's seat of my life every day. Even when I wasn't on my period, I didn't have a 'good day.' I felt 'grey' every day, and I spent most of my time telling myself to put one foot in front of the other. Looking back now, from my very first period, it wasn't normal. The snowball effect was tremendous, my symptoms continued to worsen after every cycle.

What was the turning point for you, when you knew you needed to seek out answers and have your symptoms acknowledged and taken seriously?

Having my beautiful daughter changed everything. My symptoms became so much worse after pregnancy. I remember laying on the floor in agonising pain, unable to get up and crying my heart out because I couldn't be present for our daughter. I was struggling to stay afloat. I wanted to remain a strong, involved-in-life person with my family and my job, but I was in so much pain and fighting an invisible battle daily.

My husband, mum and brother were the only ones that knew what was going on with me. The reason behind every cancelled plan and inability to participate in life. They are the ones that really helped me to stand up and fight for answers. I knew I had to figure out what was wrong with me for Grace and my entire family.

"Having my beautiful daughter changed everything. My symptoms became so much worse after pregnancy. I remember laying on the floor in agonising pain, unable to get up and crying my heart out because I couldn't be present for our daughter."

Photo credit - Australia Zoo

Photo credit - Australia Zoo

When you did decide to seek out help, on your pathway to a diagnosis? Was there a particular moment, a conversation or interaction that has stayed with you?

After my incredible surgeon, Dr Seckin, had operated on me he asked me, “How did you live in this much pain?” The validation from that one conversation healed so many years of agony. I think it’s so incredibly important to listen when someone is in pain, to genuinely care means so much more than I can possibly describe. Dr Seckin removed my endometriosis lesions, but he also helped me heal from years of feeling unheard and unseen.

Living with a chronic condition like endometriosis can affect every part of life. What has helped you find moments of balance, even on difficult days?

I feel incredibly grateful that our work and our family are both so intrinsically linked. From our family run business, Australia Zoo, to our conservation work through our nonprofit, Wildlife Warriors, we do everything together as a family. Decisions are made together, our travel is usually together, our lives are dedicated to protecting wildlife and wild places.

My passion in life is our conservation work, and my heart revolves around my family. It’s incredible that in a way, it’s self-balancing. Are we incredibly busy? Yes. However, our work is our entire lives, and time together is my most treasured.

We always prioritise time off whenever we can. For example, family road trips, visiting our conservation properties or just an afternoon at the beach. Having our daughter who is now four years old, makes it much, much easier to plan time away. We are always finding fun activities for her and planning places we want to take her; she reminds me and our entire family of the importance of slowing down and enjoying life every day.

You’ve spoken about how having your daughter Grace prompted you to seek a diagnosis. Has becoming a parent to a daughter changed the way you think about endometriosis and how you talk about it?

Absolutely. There is a very real possibility that Grace will have endometriosis. I want to raise as much awareness as I can so that her journey may be less difficult.

Your decision to speak so openly about your experience clearly resonated with many. What made you decide to go public with your story initially, and has the public response surprised you?

My journey to discovering I have endometriosis was a very rocky road. It took more than 10 years to be diagnosed. The anxiety, pain and depression that comes with an undiagnosed, invisible illness was extremely difficult to navigate. I decided that if my story could help even just a few more people feel less alone, then it was worth sharing.

I was incredibly nervous to share my story. Over the last two years I’ve had two surgeries, 51 endometriosis lesions removed, my appendix removed, and a hernia repaired. I had no idea what to expect when I shared my experiences with endo, but I certainly could not have imagined the number of women who reached out sharing their own heartbreaking stories. So many who have felt alone and debilitated by the pain. It feels more important than ever to share our stories, because the more this disease is discussed the more people can find the help they desperately deserve.

Given that many of our readers are women's healthcare professionals who see patients with endometriosis every day, what would you like them to better understand about what it's like to live with the condition?

Two things:
Laparoscopic excision surgery is widely considered the "gold standard" for treating endometriosis. Look into this, learn more about it.

Listen and genuinely care. I felt so utterly alone and ashamed as a teenager and young adult being told that my pain was just part of being a woman. I felt lesser. I felt hurt. I felt weak. That is not ok. I had a terrible disease causing more than fifty lesions in my body, including a chocolate cyst that ravaged my ovary. If someone is brave enough to share their pain with you, please don't brush it aside. Your validation for what they are going through may very well save their life.

> *"Listen and genuinely care. I had a terrible disease causing more than fifty lesions... your validation may very well save someone's life."*

What do you hope your advocacy will achieve, not just for others living with endometriosis, but for how we talk about women's health more broadly?

My grandmother and mother never talked about their periods or women's health. It wasn't what was done back then in our family. My mum was left to face her period and basic women's health alone. That breaks my heart. My beautiful, courageous, wonderful mum worked hard to make things different for me. She made sure I felt safe talking to her and she's the one who found the surgeon that discovered my endo. Young girls and women shouldn't feel alone with these things. We need to take away the stigma of talking about women's health. It's time to have open discussions and change the tide for women's health on a global scale. And that will only happen by raising awareness in every way we can.

I hope sharing my story in the most honest way will open the door to a greater discussion. Endometriosis is such a misdiagnosed disease, and the symptoms can be vastly different for each person which makes it difficult to discover. I am in awe of every person who has found the strength to discuss their own battles. I hope that together we can encourage positive change for girls' and women's health everywhere.

Photo credit - Australia Zoo

Photo credit - Australia Zoo

History of Endometriosis

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Clinical understanding of endometriosis has evolved significantly over the last decade. Once thought to be an idiopathic disorder of female maturity,[1] earlier theories proposed embryological origins or transtubal regurgitation.[2] Today, endometriosis is recognised as a hormone-mediated disease, though we cannot accurately predict who will suffer from the disease. Some patients report little to no pain despite having extensive disease found during laparoscopy for alternate indications. Others experience chronic, debilitating pain.

The burden of disease in Australia is considerable. In 2024, endometriosis was estimated to cost the Australian economy $9.3 billion, not including Medicare expenditure on medications, surgical management, and fertility treatment.[3, 4] In response, the Australian Government has committed $573 million to women's health initiatives.[5]

However, this money can only be put to good use if we understand where the biggest deficits are in terms of our diagnosis and management of endometriosis, as well as our knowledge of the disease itself, and if we optimise the resources we already have.

Global History of Disease

Endometriosis was first described in 1690, when German physician Daniel Schroen, described 'peritoneal ulcers' in sexually mature females.[6-8] This definition, of course, overlooks the key characteristic of endometriosis; that stromal tissue resides outside the uterus.[9]

This key description came in 1860, when Austrian pathologist Carl Freiherr von Rokitansky identified tissue resembling endometrial glands outside the uterus.[1, 9-11] He correctly identified that endometriotic tissue invades the muscular wall of the uterus.[12] However, some of his interpretations, including his classification of ovarian endometriomas as sarcomas, reflect the limited understanding of the time.

Theories on the pathological basis of endometriosis emerged in the late 19th century. Freidrich von Recklinghausen proposed an embryological explanation origin of endometriosis suggesting endometriotic lesions derived from remnants of the Wolffian duct.[11, 13]

Shortly after, Canadian surgeon Thomas Cullen provided a clinical picture of endometriosis, listing the key symptoms as 'severe pain in the lower part of the abdomen' and 'menstruation that lasts beyond two weeks.'[14]

The term 'endometriosis' was introduced in 1927 by Dr John Sampson who proposed that endometriotic tissue is transmitted to the abdominal cavity via regurgitation of the uterine tubes during menstruation.[2] The fact that this regurgitation only occurred during menstruation underpinned what we now recognise as the hormonal theory of endometriosis; that it is an oestrogen-dependent condition. This led to the widespread advice that pregnancy would provide good symptomatic management in endometriosis. He also identified chocolate cysts – ovarian lesions filled with old blood, which are a characteristic feature of endometriosis.

Sampson is also responsible for identifying that endometriosis is responsible for infertility in many women, [15] sparking long-standing advice that women diagnosed with endometriosis should have children early to preserve fertility. [18, 19]

Sampson also reported that total hysterectomy provided a substantial symptomatic benefit for patients, though this was not amenable to many patients of childbearing age.(17) Despite these early insights, our understanding has progressed minimally since the 1940s. While we now recognise endometriosis as an inflammatory condition capable of affecting distant sites including the abdominal and chest cavities, key questions remain unanswered. We cannot yet reliably predict who is at risk of developing endometriosis, nor have we developed preventative strategies – after all, how can we prevent a disease that we do not understand?

The answer to why a commitment to developing further knowledge and educating patients about endometriosis never happened in the 20th century is multifactorial, wrapped up in entrenched sexism and dismissal of women's health concerns, and frankly, is a PhD topic of its own.

Medical Perspectives of Endometriosis in Australia

In Australia, endometriosis was historically viewed as a barrier to fertility. When it first appeared in national media in 1949, a Catholic Weekly article cited a US women's health conference blaming the 'hectic pace of the modern woman's life,' for the rise in cases of endometriosis, and infertility.[20] The article then went on to state that 'delaying the normal function of childbearing' through contraception was responsible for the disease, and that pregnancy was the only viable non-surgical treatment option.[20]

This narrative persisted into the 1970s, where media coverage continued to focus on fertility.[21]

Diagnosis

Diagnosis has always been a major barrier for individuals with endometriosis. Until the introduction of laparoscopic gynaecological surgery in Australia, diagnostic options were included laparotomy, or transvaginal ultrasound, neither of which have a perfect diagnostic yield for the condition.[22] Throughout the 1900s, diagnosis was almost always made to explain a patient's infertility, and not due to unexplained pelvic pain that so many with endometriosis experience.

The introduction of laparoscopy in the early 1960s, and laparoscopic hysterectomy in 1989 revolutionised the diagnosis and management of endometriosis in Australia.[23] The prospect of a minimally invasive procedure in which patients could be both diagnosed and managed was far more appealing to patients than open laparotomy. It quickly became the gold standard for diagnosing endometriosis, though it still remains highly invasive, and only takes place after transvaginal ultrasound, which is not diagnostically perfect, especially in deep endometriosis.[24] Many individuals have therefore been faced with a difficult choice: have invasive surgery with a recovery time of 4-8 weeks or go without a diagnosis. It was this choice that is seen to have led to the average diagnostic delay of 6.5 years.

Recent shifts toward non-surgical diagnosis have been supported by evolving clinical guidelines. RANZCOG's *2021 Australian Endometriosis Clinical Practice Guideline (Foundation Guideline)* recommended pelvic MRI as a second-line investigation following transvaginal ultrasound, instead of laparoscopy.[25] The *Australian Living Evidence Guideline: Endometriosis* launched in May 2025, further promotes early, primary care-based diagnosis and treatment. Specialist imaging techniques, such as the deep infiltrating endometriosis ultrasound has also allowed women to avoid surgery but remains cost prohibitive.

Finally, the RANZCOG *Australian Living Evidence Guideline: Endometriosis* advocates for primary care providers to empower themselves in managing endometriosis. Free eLearning modules and diagnostic flowcharts are amazing resources that have been created to build confidence among primary care providers in recognising endometriosis and initiating treatment.[4]

Treatment

For much of the 20th century, pregnancy was widely promoted as a viable symptomatic treatment for endometriosis, following Sampson's proposal in 1949.[26] It was believed that by ceasing menstruation, pain would resolve. In 1959, the induction of a 'pseudopregnancy' through contraception was suggested by Dr Robert Kirstner, a prominent Australian gynaecologist.[27]

This belief persisted well into the 21st century. It was not until 2018 that the Human Reproduction Update challenged this myth, highlighting the lack of uniformity in the behaviour of endometriosis in pregnancy, as well as the lack of a precise understanding of the pathophysiology of endometriosis which could underpin the prescription of pregnancy as a treatment option.[28] Even so, a 2023 Australian study showed that nearly half of people with endometriosis had been advised by a healthcare provider to "have a baby" to manage their pain.[29]

Fortunately, treatment options have expanded in the last decade. The RANZCOG *Australian Living Evidence Guideline: Endometriosis* outlines a pathway for medical management of endometriosis with hormonal contraceptives, as well as gonadotropin-releasing hormone (GnRH) agonists.[4] In May 2025, Ryeqo was added to the PBS, offering a new option to those with persistent symptoms.

The Guideline promotes early intervention by general practitioners to prevent progression to advanced disease requiring surgery. It also emphasises a multidisciplinary approach to care, including input from GPs, fertility specialists, physiotherapists, psychologists, and gynaecologists, to manage the full biopsychosocial impact of endometriosis.

From Neglect to National Recognition: The Interplay Between Advocacy and Government Action on Endometriosis

Having outlined the long and arduous tale of how endometriosis has evolved from being a poorly understood and managed pathology, to a pathology that can be further demystified, but whose management is now underpinned by evidence-based guidelines, the question begs as to how we got here.

Endometriosis Australia [30], established in 2012, catalysed national conversations around endometriosis, aiming to reduce diagnostic delays, and provide better resources for persons presumed female at birth (PFAB) living with the condition. Working with QENDO [31], they played a pivotal role in the development of Australia's National Action Plan for Endometriosis, launched in 2018.

Since then, both organisations have continued to advocate for awareness, education, and support. QENDO has broadened its focus to include related conditions like adenomyosis, polycystic ovary syndrome (PCOS), and chronic pelvic pain. Their community initiatives include substantial outreach work, through a peer mentor program, support line, and the QENDO App — a free tool for symptom tracking, menstrual monitoring, and resource sharing. Users report fewer emergency presentations and a greater ability to advocate for themselves in healthcare settings.

These efforts have empowered individuals with endometriosis to better manage their condition and reduce feelings of isolation, while building community resilience and capacity for self-advocacy.

In response to advocacy from these groups and people living with the disease, the Australian Government has made a significant investment in endometriosis and broader women's health. Key initiatives include:

- *Australian Endometriosis Clinical Practice Guideline (2021)* and *Living Evidence Guideline (2025)*, developed by RANZCOG with government funding
- $58.3 million allocated in the 2022–23 federal budget to establish specialised pelvic pain and endometriosis clinics
- Subsidised 45-minute consultations for endometriosis diagnosis and management
- Integration of endometriosis priorities into the National Women's Health Strategy (2020–2030)

While these commitments mark important progress, a notable gap remains, requiring long-term investment in research and preventative strategies. Without targeted research funding, the ability to understand and prevent endometriosis remains limited.

Conclusion

The diagnosis and management of endometriosis has come leaps and bounds since the days of 'peritoneal ulcers.' A new degree of sophistication has been brought to women's health through the long-term commitments of organisations and the Australian government. Their efforts to provide evidence-based resources to both patients and healthcare providers aim to reduce the long-standing diagnostic delay and improve access to effective treatment.

However, what is missing from this outline is a firm commitment to research. The pathophysiology of endometriosis remains poorly understood, and our current knowledge does not match up to the potentially devastating impact that the disease can have on those affected — particularly regarding chronic pain, heavy menstrual bleeding, and fertility challenges.

Despite greater access to diagnosis and treatment, there can be no hope for preventative medicine in this space, until the root cause of endometriosis is better understood.

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Dietary Interventions for Endometriosis – Research Update on the FODMAP Diet



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Introduction

Endometriosis is incredibly common, affecting up to 14% of Australian women aged under 50 years.[1] Characterised by a range of often chronic, unpredictable and often severe symptoms, the condition can have vast negative impacts on daily life and quality of life, affecting women's finances, relationships, mental health and their ability to work, learn, socialise, exercise and have children.[2, 3]

Gastrointestinal Symptoms in Endometriosis

Gastrointestinal symptoms are extremely common in endometriosis, affecting over 75% of sufferers.[4-6] Bloating (81%), constipation (86%), diarrhoea (78%) and abdominal pain (80%)[5] are frequently reported and often overlap with irritable bowel syndrome (IBS), which has a pooled prevalence of 23.4% in this population.[7] This overlap amplifies the pain experience (due to lower pain thresholds and more severe menstrual cycles), and increases the risk of misdiagnosis, drives healthcare utilisation, and further diminishes quality of life.[8, 9]

Despite the high prevalence and significant impact of gastrointestinal symptoms in endometriosis, treatment options remain vastly inadequate. Some pharmacological treatments (such as progesterone, opioids and non-steroidal anti-inflammatory medications) can make symptoms worse. Patient dissatisfaction with treatment options is common. Surgical excision is linked to long wait times and the likelihood of repeat procedures, whereas pharmacological approaches, including hormonal therapies and analgesics, are associated with high out-of-pocket costs and persistent pain.[11, 12] As a result, many turn to self-management approaches, such as diet therapies and nutritional supplements in an effort to manage symptoms and take charge of their illness.[15]

Evidence for Nutritional Interventions

Nutritional supplement use is widespread in women with endometriosis, with multiple studies indicating that the majority of sufferers take or have taken nutritional supplements in an attempt to manage their symptoms, despite relatively low rates of self-perceived efficacy.[16-19] For instance, a recent international survey of 2,388 women with endometriosis revealed that >58% had used nutritional supplements, despite only 43% reporting an improvement in pain. In Australia, data collected from 303 women with endometriosis revealed frequent use of fish oil (75%), multivitamins (36%), vitamin B (29%) and vitamin D (28%).

Despite this, the quality of evidence supporting the practice of nutritional supplementation is poor. A recent scoping review that included six randomised controlled trials (RCTs) evaluating the effect of commonly used nutrition supplements (garlic; combined vitamins C and E; combined trace elements; omega-3; curcumin, and resveratrol) on endometriosis related pain revealed only the garlic, trace element and the combined vitamin C and E interventions showed any promise for improving pain. Omega-3, curcumin and resveratrol supplementation did not lead to improvements in endometriosis-related pain, and none of the studies reported improvements in quality of life or gastrointestinal symptoms. Notably, the authors cautioned about the poor quality of studies in this area, with several studies failing to follow intention-to-treat principles (which risks over-stating the findings), none having controlled for background dietary intake and a lack of reporting on adherence and adverse events.[20]

FODMAP Diet for Endometriosis – Research Update

A clear disconnect exists between patients' expectations of nutritional interventions for endometriosis and the scientific evidence supporting their effectiveness. To address this, Monash University researchers recently published the first randomised controlled crossover feeding study in patients with endometriosis (EndoFOD).[50] The EndoFOD study evaluated a 28-day low FODMAP diet in 35 women with endometriosis and poorly controlled gastrointestinal symptoms. Participants received either a supplied low FODMAP diet or a supplied control diet, both of which were modelled on Australian Dietary Guidelines and nutritionally matched, except for FODMAPs. Participants consumed the supplied diet for 28 days, before washing out for at least 28 days and crossing over to the alternate diet. To control for the known effect of the menstrual cycle on gastrointestinal symptoms, participants commenced each diet on day one of a menstrual cycle. By the end of the intervention, 60% of participants responded to the low FODMAP diet, and experienced clinically significant improvements in gastrointestinal symptom severity. Improvements were also seen for abdominal pain, bloating, stool form (fewer loose stools) and quality of life. When gastrointestinal symptoms were compared over the four weeks on each diet, improvements were apparent by week two of the low FODMAP diet, after which time improvements continued (albeit more gradually) until the end of the intervention. By contrast, symptom improvements on the control diet, diminished by week four.

Future Dietary Research

Results from the EndoFOD study are encouraging, so where to from here for dietary research in endometriosis? The FODMAP diet should be tested in a real-world, multi-centre trial that involves dietitians teaching the diet and patients with endometriosis modifying their diet based on this advice. While the Monash study robustly confirmed the efficacy of the FODMAP diet for endometriosis by supplying most food to participants for the four-week intervention, thus ensuring a high degree of control and good adherence, this does not reflect real-world conditions when patients face barriers to intervention adherence, such as motivation, understanding the prescribed intervention, food availability and convenience.[51]

There is also much interest in the role of ‘anti-inflammatory’ diets in endometriosis. While uncontrolled studies have reported improvements in endometriosis related pain on the Mediterranean diet[49] (a diet high in anti-inflammatory components such as antioxidants, mono-and polyunsaturated fatty acids, dietary fibre and polyphenols), well-designed studies, in a similar vein to the EndoFOD study[50], measuring the effect of this diet in endometriosis are much needed. The Mediterranean diet is of particular interest given high rates of mental health comorbidity in women with endometriosis[22] and evidence that adherence to a Mediterranean diet reduces depressive symptoms in people with moderate to severe depression.[52]

Recommendations for Practice

What can clinicians recommend to patients wishing to explore dietary management options for their endometriosis?

1. While there is insufficient evidence to recommend a specific nutritional supplement for endometriosis-related pain, if patients are wishing to try a nutrition supplement, they should be advised to take one supplement at a time, at the recommended dose, for a time-limited period (e.g. four weeks), and to monitor symptom response. If the desired symptom response is not achieved, the supplement should be discontinued. Before making recommendations regarding supplement use, consider the safe upper limit of intake, potential drug-nutrient interactions and cost.
2. In patients with endometriosis and poorly controlled gastrointestinal symptoms (e.g. abdominal pain, gas, bloating and altered bowel habit), a FODMAP diet can be considered. This diet should be followed in three steps. In the first step, patients eat mostly low FODMAP foods for 2-6 weeks. In the second step they complete a series of food challenges to identify which FODMAPs trigger their gastrointestinal symptoms. In the third step they reintroduce well tolerated FODMAPs and only restrict a small number of FODMAPs that trigger their gastrointestinal symptoms. Long term, the idea is to follow a minimally restrictive diet that strikes a balance between good symptom control and adequate expansion of the diet. Given gastrointestinal symptoms frequently fluctuate over the course of the menstrual cycle, for patients who get a period, it might be that they only need to limit their FODMAP intake immediately before and during menstruation.
3. Patients should be advised to avoid unnecessary restrictive diets (e.g. gluten free, dairy free) due to a lack of evidence for efficacy, and due to the risks associated with dietary restrictions such as food-related anxiety, difficulties socialising around food and disordered eating behaviours.
4. Instead, patients should be counselled about following a healthy eating pattern consistent with Australian Dietary Guideline recommendations. Despite a lack of strong evidence for efficacy, a Mediterranean diet can be considered for endometriosis, given it is safe and non-restrictive with broad health and mental health benefits.
5. Where possible, refer patients seeking dietary advice to an Accredited Practising Dietitian, and ideally, to a dietitian working in a multidisciplinary endometriosis care team.

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Ethnic Disparities in Endometriosis: Insights From a Tertiary Australian Cohort

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Why Ethnicity Matters in Endometriosis

Endometriosis affects around one in nine women worldwide and manifests in the familiar triad of dysmenorrhoea, pelvic pain, and infertility.[1] However, there are meaningful differences across ethnic groups not captured in the data. Emerging studies from North America and Europe show variation in prevalence, symptom presentation, and diagnostic delay.[2-4] Australia's National Action Plan for Endometriosis highlights the need for data on culturally and linguistically diverse communities[5]—yet Australian-specific evidence remains limited. Our study aimed to address that gap.

What We Undertook

We conducted a retrospective review of 570 laparoscopic gynaecological cases at a single tertiary pelvic-pain service (July 2019 – June 2021). Ethnicity was self-identified and categorised per ABS standards: Oceanian, Asian, European, African/Middle Eastern, and People of the Americas. Demographic details, surgical indication, symptom profile and histology were extracted from the electronic record. Statistical analysis was performed with Stata 17; $p < 0.05$ was considered significant.

Exploring the Drivers

1. Cultural pain narratives

Some cultures emphasise endurance or downplay of menstrual symptoms.[6] We found Asian women reporting mild symptoms despite extensive disease.

Clinical tip: Use open-ended questions ("How does this affect your daily life?") and multilingual pain tools.

2. Access and health priorities

Migration studies indicate that women arriving to Australia as adults often prioritise family and employment over personal health, which may delay seeking care until infertility arises.[7] Barriers include Medicare eligibility, language, rural access, specialist availability and health literacy.

Clinical tip: Routinely incorporate endometriosis screening into reproductive/ family planning health visits, especially in migrant populations.

3. Bias in diagnosis

Historical literature frames endometriosis as a "white, nulliparous" disease.[8] Implicit bias may still influence patterns and interpretation of imaging. The higher

Box 1: Key Findings – Snapshot for Practice

Finding	Clinical Relevance
65% had histologically confirmed endometriosis	Reinforces the role of laparoscopy where endometriosis is suspected
Asian (84.7%) and South American (88.9%) women had higher histological rates than Oceanians (68.8%, p=0.041)	Suggests under-recognition in some groups and possible referral bias
Non-Oceanians presented older (mean 33 vs 29.7 y; p<0.001)	May indicate delayed diagnosis with subsequent fertility and cost implications
Infertility as main indication was higher in Asian (36.4%) and African (25%) women vs 6.8% of Oceanians (p<0.001)	Highlights need for early fertility planning in diverse populations
Pain severity less in Asian women, despite disease burden (p=0.026)	Cultural pain expression differences must inform diagnostic vigilance
Visual diagnosis accurate in 97.6% of suspected cases	Supports surgical diagnosis in line with RANZCOG's recommendation for histological confirmation[7]

prevalence we observed in Asian and South American women could partly reflect growing clinician awareness and lower diagnostic thresholds in these groups.

Clinical tip: Regularly reflect on individual practice by performing a "bias check" – consciously apply identical criteria for imaging or laparoscopy regardless of ethnicity or socioeconomic status.

Box 2: Practice Challenges and Strategies

Challenge	Strategy
Under-recognition of symptoms	Use culturally adapted checklists, enlist interpreters, invite family perspectives
Late infertility presentation	Offer early counselling, and fertility referrals
Language barriers	Provide translated patient materials, partner with infographics
Indigenous data paucity	Advocate for targeted funding research and community led-research to close the data-gap

Where to Next?

1. **Multicentre, prospective studies** to explore ethnic differences in diagnostic timelines and disease severity.
2. **Socioeconomic mapping** of participants to clarify the role of social determinants.
3. **Integrated care models** combining pain, fertility, mental health, and cultural safety training for providers.
4. **Education initiatives** for trainees and GPs on cultural narratives and implicit bias.

Conclusion

Ethnicity matters in endometriosis - not because the disease is biologically confined to one group, but because culture shapes how patients tell their stories, access care, and interact with clinicians. Our cohort demonstrated that Asian and South American women had higher diagnosed disease burden yet presented later and with subtler symptoms. Bridging this gap requires culturally informed history-taking, proactive fertility planning, and equitable referral pathways—fully aligned with RANZCOG's patient-centred guidelines.[7] When every consultation begins with curiosity and humility, we move closer to true equity beyond the statistic of "one in nine."

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Code Yellow: Trained to Treat, Taught to Endure

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Navigating endometriosis, the gender pain gap[2] and racial bias from both sides of the curtain, it's not often I catch myself looking at my reflection in the patients of the emergency department (ED), but recently, I did.

Same age. Same skin colour; she's Aboriginal, I'm African. Both Geminis (important). Familiar hunched-over position. Hands clutching a hot pack, placed directly onto her skin (relatable)."I have endo," she said. "Ah, yep," I said. "This is gonna sound so weird," she said, "but my pain feels like a hot-"..."Poker up the a**?!" We both said. Then giggled, because honestly, with endometriosis, sometimes if you don't laugh, you'll cry.

I am an emergency physician working on Gadigal land (Sydney) who, like my patient and one in seven of us assigned female at birth, is affected with the delightful ailment known as endometriosis. This chronic, inflammatory condition of an elusive aetiology is characterised by tissue that resembles that of the endometrium growing beyond the uterus. It can have a variety of clinical symptoms, including pelvic pain, menorrhagia, dyspareunia, infertility, fatigue and gastrointestinal disturbance.[1]

I am encouraged by the considerable attention presently being given to women's pain, because for me, endometriosis has been the reason I have repeatedly put down my stethoscope and put on a patient gown. Due to systemic medical gaslighting, women frequently receive inadequate treatment.[2] As a healthcare professional, I think it's important to share my experience as a person of colour who has this condition, which has been systematically under-recognised or dismissed for us.

From Doubt to Delay

In healthcare, a phenomenon known as the gender pain gap[2] exists, where women's pain is routinely downplayed when compared with men's. The pathway to diagnosis serves as a stunning example – it takes roughly eight years to diagnose endometriosis, an acutely painful condition. Here, the gap is created from damaging gender stereotypes that reinforce notions of feminine hysteria and the belief that biological processes like menstruation entail a certain but undefined level of "normal" pain.

Personally, aside from being conditioned by society to believe that crippling menstrual pain is normal, my stoic cultural upbringing and the stigma around discussing periods contributed to the more than a decade it took for me to get diagnosed with endometriosis, which until recently, required a laparoscopy for confirmation.

As someone who has played both patient and physician roles within the ED, I know we still have work to do when it comes to improving female patients' pain. A small-scale Australian study[3] demonstrated that men were more likely to receive combined opioid and non-opioid medication as their initial analgesic (p=.049). Women were more often given their first analgesic more than 90 minutes after ED presentation, compared to men (p=.029), and experienced longer waits before receiving a second analgesic (p=.032).

I've observed colleagues of all genders and races react with raised eyebrows when a young woman presents in pain. I've been that woman, overthinking my behaviour. If I cry and scream, I'm being hysterical; if I'm blank-faced, then surely, I don't really need that Endone?

The gender pain gap often intersects with other marginalised demographics, including gender-diverse patients, non-Caucasian individuals (like me), and people experiencing poverty, further exacerbating pain disparities.[4]

The Intersection of Pain and Prejudice

Unfortunately, systemic racism is deeply rooted within the medical profession. Although most of the data in this area comes from the US, it is shocking, and I believe it is relevant to the Australian context when it comes to treating people of colour. In an extensive study[5] comparing non-white to white patients, non-white individuals were more likely to report severe pain ($p < .0001$). However, they were less often given analgesia ($p < .0001$) and less frequently received opioids ($p < .0001$). Among those who received pain relief, non-white individuals waited significantly longer for their medication ($p = .004$). A 12-year cross-sectional study[6] with a weighted sample of 1,065,936,835 ED visits showed black patients were also 10% less likely than white patients to be admitted and were 1.26 times more likely to die in the ED or hospital. There are plenty more studies with similar findings. This scares me. At work, I often rely on System 1 thinking,[7] but I've learned that even brief moments of reflection can make a difference. By recognising our unconscious patterns and staying curious about our own biases, we can take small, practical steps that contribute to fairer, more patient-centred care.

A Legacy of Exclusion, Experimentation and Erasure

Interestingly, the history of endometriosis is a melting pot of racism and classism, having once been wrongly believed only to affect Caucasian women. If you are interested in this discourse, I recommend Olga Bougie's[8] writings. But to provide an overview: between 1845 and 1849, the renowned "father of modern gynaecology," and inventor of the speculum, Dr Marion Sims, performed gynaecological experiments (operations) without anaesthesia on enslaved Black women, who could not consent. These horrific acts were justified by the false notion that Black women had a much higher pain threshold than white women.[9]

In the 1920s and 1930s, Dr Joseph Meigs, another openly racist celebrity gynaecologist, claimed on TV that only women who could afford contraception developed endometriosis, dismissing its occurrence in those he called "fertile monkeys." His interest in the condition was linked to eugenics, specifically the goal of preserving the fertility of the Caucasian race. Studies of endometriosis at that time lacked scientific rigour, and mostly excluded Black women, which further bolstered the myth that only white women could be affected by the disease.[10]

Even in the 1980s, endometriosis was still seen as the "career woman's disease," a somewhat prejudicial term for the time.[11] Many early medical textbooks kept reinforcing these stereotypes until very recently; a lingering influence that I believe contributes to the stark difference in diagnosis rates in the US: 5% among Black people compared to 72% among white people.[10,12] The baseless idea that people of African heritage feel less pain still exists in both the medical field and the wider community.[12,13]

For every doctor caring for someone with this condition, I believe it's crucial to understand the complex link between race and endometriosis. Healthcare systems have historically overlooked the pain of individuals who don't match the typical image of endometriosis sufferers, so raising awareness and understanding can make a meaningful difference.

I have only recently begun researching this history myself, and it has profoundly influenced how I view my own experiences and those of my patients.

Relief Begins with Recognition

While I have sometimes felt demoralised by my experiences, I have also encountered exceptional care, reminding me how powerful compassion can be in guiding someone through illness. When clinicians take a moment to validate my pain, it is compelling. In my view, humour is a surprisingly effective remedy.

As a patient managing a chronic condition, knowledge is power. As a clinician, it's equally important to stay informed and communicate clearly as a shared understanding can make all the difference. The RANZCOG *Australian Living Evidence Guideline: Endometriosis*[1] is an excellent resource to support evidence-based, empathetic care. And remember to provide written information, as it's often difficult to absorb details when overwhelmed by pain. I advocate for patients, especially those from minority backgrounds, to discuss seeing a gynaecologist with their GP whenever they present to the ED with acute pelvic pain, as I know the desperation that can come before diagnosis.

Recognising the complex interplay between race, gender, and pain is not just an academic exercise; it is of the utmost importance to provide tangibly better treatment. I believe the silence around reproductive health discussions in African cultures also needs to be addressed at a community level. Historically, women, and particularly women of colour, have been excluded from pain research and clinical trials[2]. This lack of diversity must end so that we can provide effective and culturally responsive care.

Living with this condition has given me a deep understanding of invisible illnesses and a profound sympathy for the anxiety and second-guessing that often accompany a visit to the ED. Endometriosis is the only time I've felt enough pain to wonder: "do I have appendicitis, or is it just another Tuesday?" And I've diagnosed appendicitis countless times in my career!

As a clinician and a woman of colour with endometriosis, I carry both the privilege of prescribing care and the burden of being dismissed. The pain gap will only close when we stop asking women to prove they're in pain and start listening as if their lives depend on it.

Because they do.

Disclaimer: I acknowledge that endometriosis is not exclusive to women. In this piece, I use the term "women" to reflect my own lived experience, but I recognise and respect the diversity of all people affected by the condition.

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Ultrasound in Endometriosis: Advancing Non-Invasive Diagnosis and Patient-Centered Care

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Introduction

Endometriosis is a chronic, estrogen-dependent condition, in which endometrium-like tissue grows outside the uterus, and the most common symptoms are severe painful periods, dyspareunia, infertility, pelvic pain and heavy menstrual bleeding.

It affects approximately one in seven women in Australia.[1] It is associated with a substantial individual and economic burden, estimated between $7.4 and $9.7 billion annually. [2-3]

Identifying endometriosis can be difficult because its symptoms often overlap with other conditions, and menstrual pain is frequently dismissed as normal by both patients and healthcare professionals. This contributes to prolonged periods of discomfort and delays in receiving appropriate care, leaving many individuals to suffer unnecessarily.

Historically, laparoscopy with histopathological confirmation was considered the gold standard for diagnosis, but the landscape has changed somewhat: advances in transvaginal ultrasound (TVUS) and international consensus on systematic imaging have repositioned ultrasound as the preferred first-line diagnostic investigation for most patients.[4-5]

The Evolution of Imaging Techniques in Recent Years

Until recently, diagnosis of endometriosis was often delayed by a reliance on surgery. Major guideline revisions, such as those from the European Society of Human Reproduction and Embryology (ESHRE) and the International Deep Endometriosis Analysis (IDEA) Group, as well as the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) *Australian Living Evidence Guideline: Endometriosis*, now recommend imaging - primarily TVUS, as the first-line investigation for people with symptoms suggestive of endometriosis.[4-6]

MRI is a valuable option, especially as a second-line imaging tool when TVUS is inconclusive or unable to be performed but symptoms persist. MRI is also a valuable tool for preoperative surgical mapping as it provides excellent soft tissue contrast and three-dimensional anatomical detail with a large field of view (including extra pelvic regions) that can be extremely helpful for pre-operative planning of complex cases.

Recent updates to the European Society of Urogenital Radiology (ESUR) guidelines emphasise MRI's role in evaluating parametrial, ureteric, and bladder involvement, which can be challenging for ultrasound.

Meta-analyses show TVUS and MRI have comparable diagnostic performance for detecting DE in key pelvic sites, especially the rectosigmoid area, though each modality has strengths for different lesion locations.

TVUS is favoured for initial, accessible screening given its lower cost, faster acquisition, ability for dynamic and real-time assessment, and relatively better clinical availability.

Overall, recent years have seen a paradigm shift towards non-invasive imaging diagnosis of endometriosis, with TVUS as the cornerstone management, supplemented by advanced MRI techniques in selected cases. This progression promotes earlier diagnosis, precise disease mapping, and improved patient-centred care while reducing reliance on invasive surgery.

Current Australian Guidelines for Endometriosis Diagnosis and Medicare Changes

Recent advancements in Australian clinical guidelines and Medicare support will further streamline the diagnosis and management of endometriosis.

The RANZCOG *Australian Living Evidence Guideline: Endometriosis*, released in May 2025, recommends "Patients with symptoms suggestive of endometriosis should be offered a transvaginal pelvic ultrasound as the first-line investigation. A pelvic MRI can be offered if ultrasound is not available, or if deep endometriosis is suspected... surgery is not required as a first-line option to diagnose endometriosis."[5]

Complementing these guidelines, the Australian Government has made several key changes to the Medicare Benefits Scheme (MBS) in recent times, which include:

- A new item number specific to complex gynaecological ultrasound being added to the MBS in November 2025
- A new MBS items related to extended gynaecology consultations to support the time needed for in-depths and thorough patient discussion (July 2025)
- The addition of an MBS item specific to gynaecological related MRI imaging (November 2023)

The new MBS item number for specialised ultrasounds targeting endometriosis, and this advanced imaging, will become more accessible, with a higher schedule fee reflecting the complexity and expertise required. These ultrasounds can play a crucial role in timely and accurate diagnosis, as well as treatment planning for patients with this disease.

These Medicare updates align with broader federal initiatives, including establishment and now further expansion of Endometriosis and Pelvic Pain Clinics nationwide.

Together, the evolving diagnostic guidelines and expanded Medicare provisions signal support for a comprehensive, multidisciplinary approach to improving outcomes and quality of life for Australians living with endometriosis.[9]

Why and How Ultrasound is Useful for Diagnosis?

TVUS is highly accurate for ovarian and deep pelvic disease, offers real-time assessment, is accessible, low-cost, and delivers results relevant both for diagnosis and for detailed surgical mapping.[7] MRI is reserved for cases where TVUS is not feasible (e.g., those not comfortable with vaginal examinations), or for suspected extra-pelvic or complex disease.

Feature	TVUS	MRI
Invasiveness	Minimally Invasive	Non-invasive
Radiation	None	None
Cost	Low	High
Accessibility	High	Moderate
Best for	Ovarian endometriomas, Pelvic DIE	Complex, extra-pelvic, inconclusive USG
Limitations	Operator-dependent, poot detection of superficial/extra-pelvic lesions	

Table 1. Comparison of TVUS with MRI.

Routine vs. Endometriosis-Focused Ultrasound Protocols

Traditional "routine" pelvic ultrasound - focused on uterus and ovaries, can miss many key endometriosis features. The 2016 IDEA consensus delivered an international, stepwise protocol for detailed evaluation ("eTVUS"), which is now incorporated into both Australian and global best practice.[6-7]

The IDEA Four-Step Protocol:

1. Assessment of uterus and ovaries, considering features of adenomyosis and ovarian endometriomas
2. Evaluation of "soft markers": Ovarian mobility (immobility may suggest adhesions) and site-specific tenderness (SST)
3. Dynamic assessment of the pouch of Douglas: Using the "sliding sign" to detect adhesions/obliteration
4. Compartmental search for DIE nodules: Including USLs, posterior vaginal fornix, bladder, rectovaginal septum, and bowel

Structure/Parameter	rTVUS	eTVUS (comprehensive)
Uterus and ovaries	✓	✓
Organ mobility	x	✓
Anterior compartment deep endometriosis nodules	x	✓
Posterior compartment deep endometriosis nodules	x	✓
Appointment time (min)	~20	30–45

Table 2.

Note: "✓" denotes routinely assessed; "x" not assessed.

As is clear from the table above, while a routine TVUS should detect endometriosis, an extended imaging protocol must be undertaken by sonographers in order to detect deep endometriosis sonographically. Efforts are currently underway to upskill the sonography workforce across Australia and New Zealand, however, this is understandably a large task which takes time. A recent study from the University of South Australia revealed that when patients present with symptoms of endometriosis, only 1 in 5 will receive a comprehensive eTVUS due to factors such as scanning time limitations, lack of sonographer education and lack of radiologist education to report the findings.

Furthermore, this study revealed access in bulk-billing clinics and public hospitals was extremely limited with most clinics providing eTVUS being private specialist obstetric and gynaecological imaging centres. It is likely that the new MBS rebates to soon come into effect will help expand access and reduce the financial burden on patients to access eTVUS. Additionally, as more awareness, both publicly and amongst health care professionals occurs, education for imaging professionals will hopefully follow.

For clinicians utilising ultrasound for their patients in the work-up of suspected endometriosis, it is important to recognise the difference between rTVUS and eTVUS, and note the limitations of both. It is especially critical to note that a normal ultrasound cannot exclude endometriosis- even a very high quality eTVUS pperformedby an expert.

How Endometriosis Presents and What Can Be Seen on Ultrasound?

Endometriosis manifests in several key forms, each with implications for imaging:

- Superficial peritoneal endometriosis: Lesions on the peritoneal surface, often undetectable with current imaging, however new evidence is emerging related to the detection of superficial disease with ultrasound
- Ovarian endometriomas: Endometriosis cysts within the ovaries, readily identified as "chocolate cysts" on ultrasound
- Deep endometriosis Ultrasound: Endometriotic lesions that penetrate deep to the peritoneum and those typically affecting the uterosacral ligaments (USLs), pouch of Douglas (POD) rectum etc - are most visible on high-quality TVUS[6]

Stage	Description
I (Minimal)	Few small superficial lesions, little/ no scar tissue
II (Mild)	More lesions, some deeper; mild adhesions possible
III (Moderate)	Endometriomas and more deep lesions/adhesions
IV (Severe)	Multiple deep implants, large endometriomas, dense adhesions

Table 3. American Society for Reproductive Medicine (ASRM) staging.

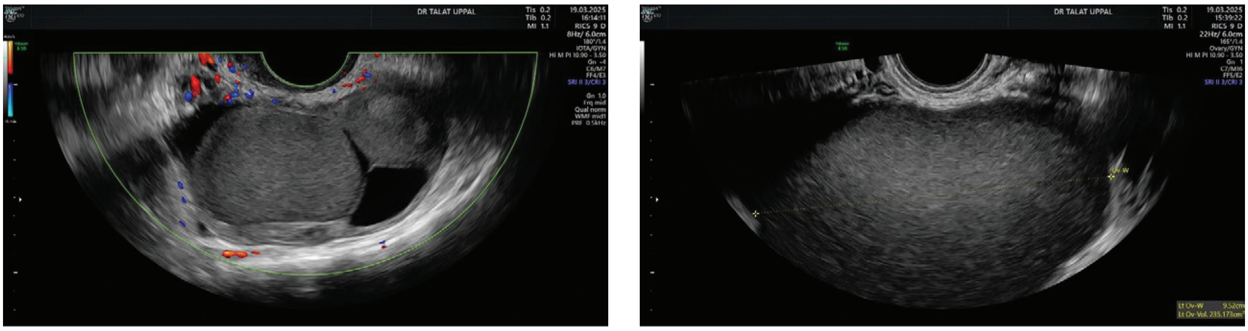

Fig 1.Endometriomas, a type of cyst formed by endometriosis in the ovary, often exhibits a "ground glass" appearance on ultrasound imaging.

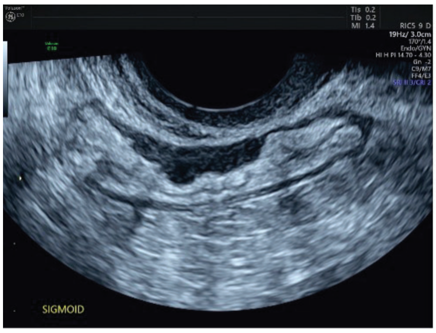

Fig 2.Bowel endometriosis

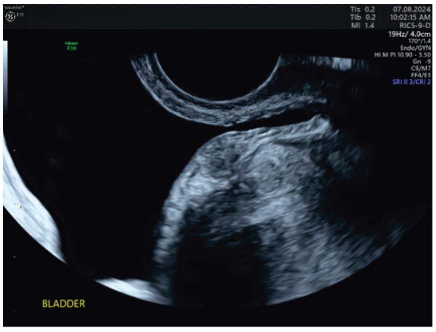

Fig 3.Bladder Endometriosis

Fig 4.Endometriosis uterosacral ligament

Conclusion

Ultrasound — when used systematically and with current protocols — is now the mainstay of non-invasive diagnosis for ovarian and deep endometriosis in Australia. This, supported by government policy, updated national guidance, and continued research and education in the field hold great potential to reduce diagnostic delays and improve care for people with endometriosis. Improvements in extending ultrasound techniques, which are being integrated into first-line practice for pelvic pain and suspected endometriosis enables timely interventions, optimises surgical planning, reduces diagnostic delays, and empowers patients in their own care.

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Not Just "Bad Periods": Understanding and Treating Endometriosis in Paediatric and Adolescent Patients

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You're in a consult with a 14-year-old girl, accompanied by her mother. The young patient describes experiencing cyclical, severe dysmenorrhoea. She is lethargic, her school grades are slipping and she takes days off school to lie in bed with a heat pack and takes paracetamol and ibuprofen, which provide only slight relief. She has dropped out of her sports team due to ongoing fatigue and has missed many training sessions.

Her mother interjects, "I tell her it's just what periods are like. They were exactly the same for me. She needs to stop using the same excuse over and over again to miss school!"

Sound familiar? You are not alone.

Introduction

One in seven (14%) females and those assigned female at birth in Australia are now estimated to live with endometriosis, an increase from the previously quoted statistic of one in nine (11%). While diagnosis rates are rising, it still takes at least 6-8 years from symptom onset to diagnosis. The additional challenge to this disease is that the degree of symptoms does not necessarily correlate with the severity of disease.[1] Heavy, painful cycles and cyclical irregularity are part of the picture in this cohort, and treating these generally is the first important step in acknowledging and validating the suffering associated with menstruation[2], and possibly mitigate disease progression.[3]

Endometriosis is a chronic, inflammatory, gynaecologic disease marked by the presence of endometrial-like tissue outside the uterus. It is increasingly recognised in adolescent populations. While some are asymptomatic, some have a significant impairment in quality of life due to chronic pelvic pain, dysmenorrhoea, and potential impact on their future fertility. The approach to diagnosis and management in adolescents must be tailored, considering their developmental stage, family history, and long-term implications.[1]

While the exact cause(s) of endometriosis remains unknown, several theories exist:

Retrograde Menstruation

Endometrial tissue refluxes through the fallopian tubes into the pelvic cavity during menstruation. This theory is particularly relevant in adolescents who often experience anovulatory cycles with unopposed estrogen leading to a thickened endometrial lining. Coupled with anatomical maturation, the uterus is still growing and the cervical os is narrow and tight. During menstruation the pressure of the menstrual egress through the very narrow cervical os increases the risk of reflux.[4]

Genetic Predisposition

Endometriosis appears to run in families, suggesting a genetic component to the aetiology. If a patient has a close female relative with endometriosis, their risk is up to seven times higher.[1]

Immune Reaction

Antibodies targeting endometrial cells can be found in blood which can lead to an immune response and inflammation in the affected areas, damaging surrounding tissues. However, it is still unclear whether this immune change causes endometriosis or is a response to endometriosis already present in the body.

Coelomic Metaplasia

Cells in the pelvic peritoneum, ovaries, rectovaginal septum, bladder and bowel share the same embryonic origin as endometrial cells. Under specific circumstances, they may transform into endometrial cells, hence becoming endometriosis.

Diagnosis in Paediatric and Adolescents

History and examination

H – Home
- Who is at home with them?
- Do they have siblings? Do they get along with them?
- If they have older sisters, do they have similar issues?

E – Education/Employment
- What year in school are they?
- What school?
- Have they got good friends at school?
- Do they enjoy school?
- Are they experiencing bullying?

A – Activities
- What do they like to do for fun?

D – Drugs (including alcohol, tobacco, vaping)
S – Sexuality
S – Safety/suicidality/depression

Adolescents often require a different approach to consultation compared to adults. Establishing rapport and creating a safe environment for the patient and their family can often change how the rest of the consult continues and how accepting they are of your recommendations. Rather than immediately focusing on the presenting complaint, beginning with a structured psychosocial assessment, such as the HEADSS assessment can help clinicians better understand the patient's context and family dynamics. This sets the tone for a more effective and collaborative consultation.

As part of the initial consult and good history taking, it is also important to consider other causes for pelvic pain and to do investigations as appropriate.

Pelvic and abdominal pain, urinary discomfort or pain with bowel motions, are common in this age group and taking a detailed history around symptom exacerbation or change during menses is key. It's important to establish whether pain is actually related to menstruation or indeed bowel or bladder related. Often, and particularly with heavy menstrual bleeding which is a frequently associated symptom with pain, bladder and bowel discomfort is from retrograde menstruation. Management of heavy menstrual bleeding often alleviates pain in most adolescents.[2] Retrograde menstruation within this setting in the first five years with anovulatory cycles following menarche is a significant contributor to pain and distress within the paediatric and adolescent age group. Recognising that much of the distress is due to anovulation from an immature hypothalamicpituitary axis function and not necessarily a pathologic cause is vital to appropriate management.

The Role of Early Diagnosis

Early diagnosis and initiating treatment and management is important to mitigate disease progression and alleviate symptoms.[3] In adolescents, symptoms may be non-cyclical or subtle, requiring a high index of suspicion. This is not limited to patients with chronic pelvic pain unresponsive to non-steroidal anti-inflammatory drugs (NSAIDs) or hormonal therapy.

Non-invasive tools such as pelvic ultrasound and MRI have moderate sensitivity and high specificity in early or superficial lesions, but high sensitivity and specificity for endometriomas. While transvaginal ultrasound is highly specific for most locations and depths, this may not always be applicable to the paediatric and adolescent age group. Transabdominal ultrasound is then the recommended imaging modality.[5] If a young patient is intellectually impaired or unable to tolerate any imaging, this would add an additional layer of complexity. Laparoscopy, due to its invasive nature, should be considered to diagnose patients with suspected endometriosis preferably after a treatment trial, despite negative imaging. Biomarkers and novel imaging modalities are under investigation but are not yet routine, and not recommended.[3]

Examination would usually only include an abdominal examination in the paediatric group. However, if an adolescent is sexually active, a pelvic examination could be performed (after discussion and consent) to assess for palpable nodules or pelvic floor muscle spasm.

Management

With public waitlists sometimes taking up to a year for patients to be seen, the modified flowchart above is a useful starting point for the management process.[6]

Imaging is recommended to rule out any outflow tract obstructions, with initial ultrasound, followed by MRI if a Mullerian anomaly is identified. This is important to consider in cases of primary amenorrhoea, or in adolescents who have reached menarche but have worsening cyclical pain, as there could be a mullerian abnormality with a unilateral outflow obstruction.[7]

The images on page 55 were taken during a laparoscopy in a 16-year-old patient with uterine didelphys, featuring a patent left hemivagina but an obstructed right hemivagina. There is also ipsilateral right renal agenesis. The photos demonstrate the damage retrograde menstruation from the obstructed side can cause, compared with the unobstructed side of the pelvis.

Medical or surgical treatment may relieve symptoms. However, if pain persists despite treatment, it could be the way the brain is processing the pain. As such, early referral to a local chronic pain service can help patients manage pain flares more effectively and reduce emergency presentations.

Medical Management

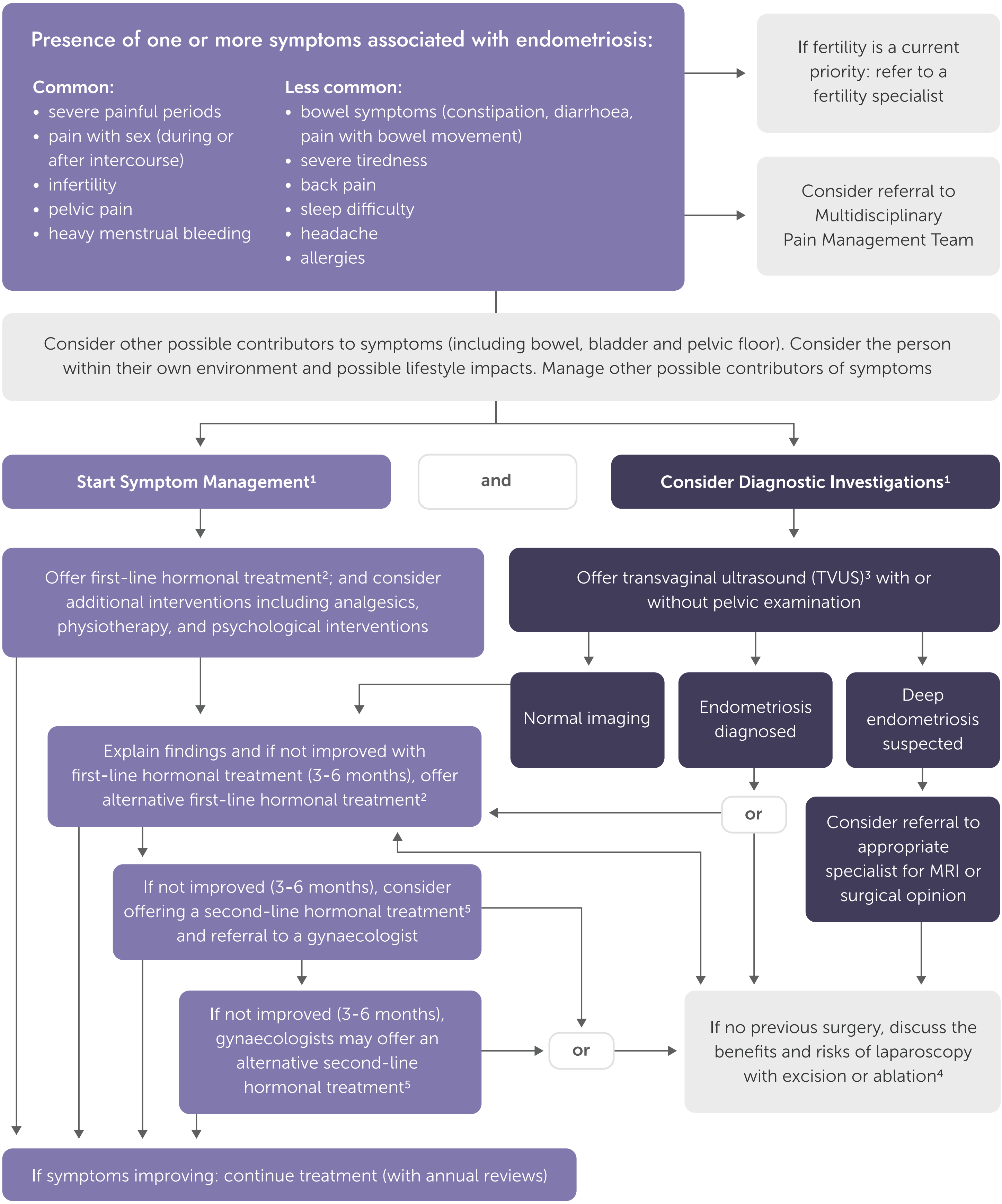
There is no known way to prevent endometriosis. Enhanced awareness, early diagnosis and management may slow or reduce the long-term impact, but no cure exists.[8] Hormonal therapies aim to suppress the growth of endometrial cells and stop menstruation.[9] Treatment should be tailored to the patient's age, symptom severity and duration of symptoms.

Non hormonal medications

- NSAIDs: Preferred first line analgesics for dysmenorrhoea. While often insufficient alone, effective pain relief can be achieved with appropriate dose and frequency. No single NSAID is proven to be superior. If menses can be predicted, NSAIDs can be commenced 1-2 days prior.[10]

It is important to reiterate to our young patients and their families that analgesia is important for pain relief but that there is no evidence to suggest that analgesics influence disease progression.[11]

Summary of Diagnosis and Management of Endometriosis



Presence of one or more symptoms associated with endometriosis:

Common:

- severe painful periods
- pain with sex (during or after intercourse)
- infertility
- pelvic pain
- heavy menstrual bleeding

Less common:

- bowel symptoms (constipation, diarrhoea, pain with bowel movement)
- severe tiredness
- back pain
- sleep difficulty
- headache
- allergies

If fertility is a current priority: refer to a fertility specialist

Consider referral to Multidisciplinary Pain Management Team

Consider other possible contributors to symptoms (including bowel, bladder and pelvic floor). Consider the person within their own environment and possible lifestyle impacts. Manage other possible contributors of symptoms

Start Symptom Management[1]

and

Consider Diagnostic Investigations[1]

Offer first-line hormonal treatment[2]; and consider additional interventions including analgesics, physiotherapy, and psychological interventions

Offer transvaginal ultrasound (TVUS)[3] with or without pelvic examination

Normal imaging

Endometriosis diagnosed

Deep endometriosis suspected

Explain findings and if not improved with first-line hormonal treatment (3-6 months), offer alternative first-line hormonal treatment[2]

or

Consider referral to appropriate specialist for MRI or surgical opinion

If not improved (3-6 months), consider offering a second-line hormonal treatment[5] and referral to a gynaecologist

If not improved (3-6 months), gynaecologists may offer an alternative second-line hormonal treatment[5]

or

If no previous surgery, discuss the benefits and risks of laparoscopy with excision or ablation[4]

If symptoms improving: continue treatment (with annual reviews)

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1. At presentation with symptoms suggesting endometriosis, treatment and diagnosis may begin at the first consultation.
2. Offer hormonal treatment according to patient preferences (including adolescents). First-line treatments are combined hormonal contraceptives and progestogens (oral, injection, implant or IUD).
3. TVUS is the preferred option as first-line investigation, if not possible or appropriate due to age or sexual history, then a transabdominal ultrasound could be suggested. If any clinical concern, an additional specialist ultrasound may be required and should be performed and/or interpreted by a healthcare professional with specialist expertise in gynaecological imaging.
4. In adolescents, laparoscopy should be discussed with a gynaecologist with expertise in young people.
5. Second-line hormonal treatment include gonadotrophin-releasing hormone (GnRH) agonists and antagonists, and should be offered on specialist recommendation.

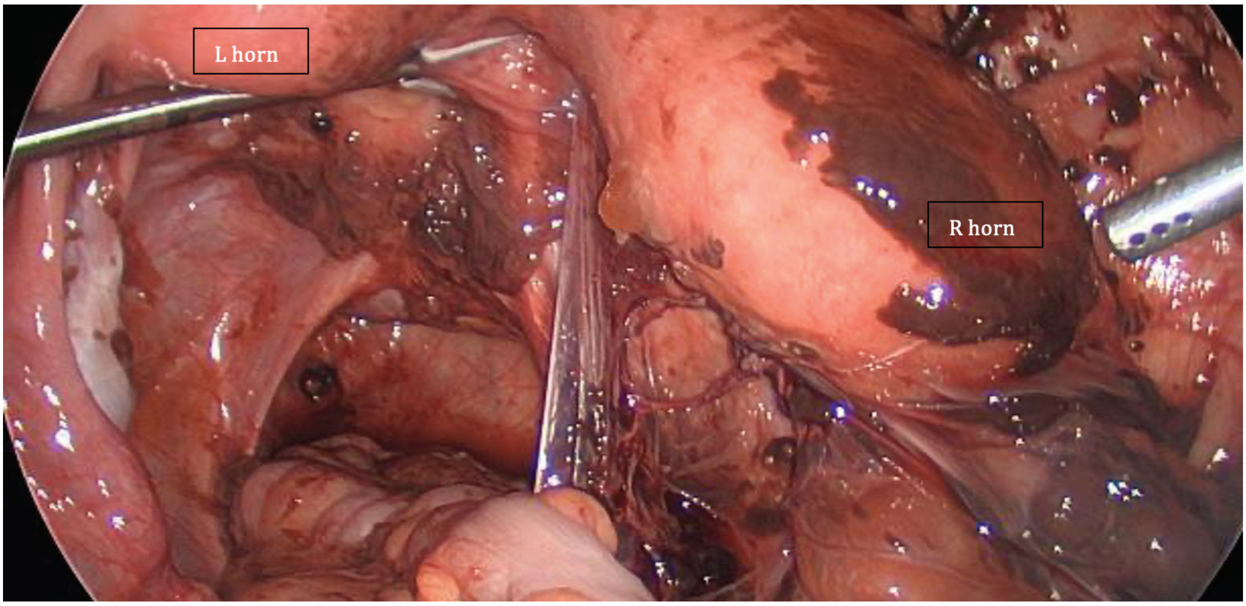

Figure 1: Distended right uterine horn as a result of the obstructed right-hemivagina, retrograde menstruation and extensive adhesions, dilated fallopian tube and endometriotic lesions. Image courtesy of R Kimble

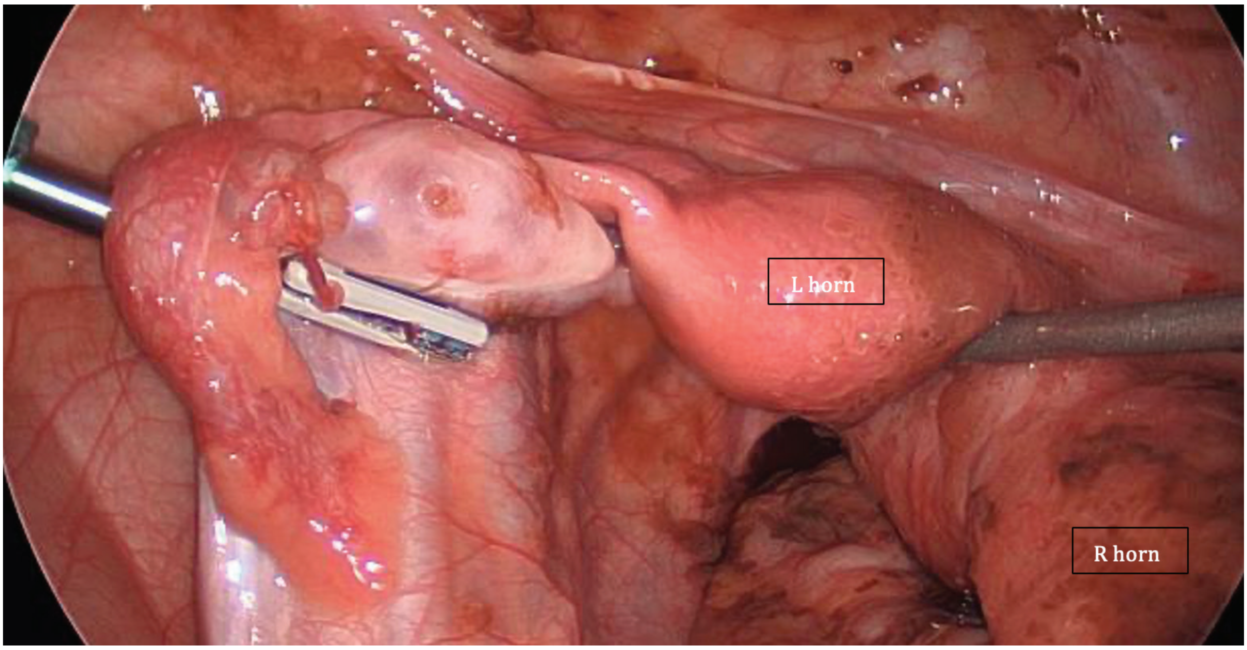

Figure 2: Patent left uterus and hemivagina, fallopian tube and ovary – notice the absence of any adhesions and minimal impact compared to Figure 1. Image courtesy of R Kimble

Hormonal medications

- Progestogens: Administered orally, by injection or via implant/intrauterine device. They are effective for anovulation by opposing estrogen by downregulating endometrial estrogen receptors, thereby reducing glandular proliferation and inducing endometrial atrophy[12]
  - Tablets:
    - Medroxyprogesterone (Provera®) is well tolerated and effective. If normal BMI, recommend 20mg Provera daily continuously to achieve menstrual suppression, or cyclically with a seven day break every 1-3 months. Dose can be adjusted according to response and BMI
    - Drospirenone (Slinda®) may be considered if contraception is required
    Disadvantage: requires daily adherence and ability to swallow tablets.

- Injectable: Depo-Provera® has benefits of reduction of blood loss and dysmenorrhoea, often achieving amenorrhoea by one year in 50% of users, and is also an effective contraception.
  Disadvantage: requires intramuscular injection every 12 weeks. Long term use could result in bone mineral density reduction (which is reversible following cessation)[13]

- Progesterone releasing intrauterine device: Levonorgestrel IUS eg: Mirena®: Reduction in dysmenorrhoea, effective contraception. 70-95% reduction in menstrual blood loss and achieves amenorrhoea in 54-59% of users.
  Disadvantage: Often requires general anaesthetic for insertion in adolescents and does not eliminate ovulation. Ensure uterine cavity is adequately grown to accommodate the device by organising an ultrasound scan to assess uterine cavity length

(internal fundus to internal os) before attempting insertion.[4]

- Combined Oral Contraceptive Pill (COCP): Effective in suppressing ovulation and menstruation. Pill packets can be taken continuously by skipping the sugar pills. It can result in 40-50% reduction in blood loss and is an effective, non-invasive form of contraception. Disadvantage: increased risk of venous thromboembolism, and it is unclear whether the risk is increased in adolescents who are immobile, as there is insufficient data available. It can also interfere with enzyme-inducing antiepileptic drugs. The additional estrogen of the OCP may be counterproductive to attempts at estrogen down regulation.

- Gonadotropin-releasing hormone agonists (GnRH): Reserved for refractory cases due to potential bone density loss, often paired with add-back therapy.

- GnRH antagonists and aromatase inhibitors: This is still under evaluation in adolescents; concerns exist about long-term effects.[14]

Treatment should be individualised, considering efficacy, side effects, patient preferences, and impact on bone health.

Surgical Management

Surgery is considered for patients with persistent or severe symptoms refractory to medical therapy. Laparoscopic excision of endometriotic lesions including cysts provide pain relief and confirm diagnosis. In adolescents, conservative techniques that preserve reproductive anatomy is an important consideration. Recurrence of symptoms associated with endometriosis, and/ or endometriosis lesions is not uncommon; hence, post-operative medical therapy is often recommended.[15] Consider adding cystoscopy to the surgical consent as interstitial cystitis (part of painful bladder syndrome) can often be found and is a common cause for pelvic pain which often overlaps with endometriosis symptoms.[16]

Endometriosis and Future Fertility

The importance of finding endometriosis early lies not only in the relief of symptoms but also in the preservation of reproduction potential and suppression of possible natural disease progression. Infertility can result from endometriosis due to anatomic distortion of pelvic organs and/or the fallopian tubes.[17] Given its progressive nature, pelvic pain should be evaluated in an expedient fashion and if diagnosed, should be treated aggressively until childbearing is complete.

Multidisciplinary Approach and Future Directions

Managing adolescent endometriosis may be well supported with a multidisciplinary team including paediatric and adolescent gynaecologists, gynaecologists, pain specialists, psychologists, and physiotherapists. If symptoms include bowel and bladder function, early input from other specialties is ideal. Chronic pain can severely impact mental health, schooling, and social functioning. Psychological support, coping strategies, and education are crucial components of care.[18]

Research is ongoing into biomarkers, non-hormonal treatments, and strategies for early detection. Increased awareness among primary care providers and school-based education can also help in early identification. Future personalised medicine approaches, considering genetic and molecular profiles, may revolutionise future treatment paradigms.

In summary, managing endometriosis in adolescents requires timely recognition, individualised treatment, and holistic support, validating the young person's suffering. Medical therapy remains first-line, with psychosocial interventions playing a pivotal role. With ongoing research and education the goal is to predict which patients are at risk for disease progression and infertility, enabling true prevention to become a standard of care.

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Pelvic Health Physiotherapy: An Integral Part of Endometriosis Care

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> "I often imagine a world where adolescents who experience pelvic pain, are educated and treated early, with the hope that they don't spend years searching for answers and treatments that work."

Introduction

Endometriosis is increasingly recognised as a complex, systemic condition that impacts far more than just the reproductive system. With its effects extending to the nervous, gastrointestinal, musculoskeletal, and even psychological domains, the management of endometriosis requires an integrated, whole-person approach to care. Among the deeply impactful members of the care team are physiotherapists, particularly those with advanced expertise in pain science and pelvic health.

As a pelvic health physiotherapist with a special interest in persistent pelvic pain and endometriosis, I've seen firsthand how targeted physiotherapy can dramatically improve quality of life for those navigating this chronic condition. In this article, I will explore the unique role physiotherapists play in endometriosis care, how digital health solutions can complement our work, and why we must continue to foster interdisciplinary collaboration.

Endometriosis: A Whole-Body Disease

Far from being a localised gynaecological issue, endometriosis is now understood to be a systemic inflammatory condition. It is characterised by symptoms including pain, bladder and bowel dysfunction, heavy and/or painful bleeding, fatigue, and infertility.

The literature suggests that one of the most common symptoms of people with endometriosis is pain, with many also reporting pain during urination, bowel movements, intercourse, and general abdominal or pelvic discomfort.

The average global diagnostic delay for endometriosis remains high at around 6.5 years, during which time patients often consult multiple providers and receive fragmented care. Within this fragmented landscape, physiotherapists can offer a consistent, evidence-based and compassionate foundation, and hopefully disrupt the cycle of persistent pain, which can sometimes result in a sensitised nervous system.[2]

The Unique Role of Physiotherapy in Endometriosis Care

Physiotherapists play an integral role in endometriosis care.

Often spending the most time with patients, physiotherapists are uniquely positioned to listen, validate, and guide. Their expertise extends beyond muscles and movement— they help individuals understand their pain, restore function, and reconnect with their bodies.

With the understanding of the complex interplay between pelvic floor dysfunction, musculoskeletal imbalances, nervous system sensitisation, and emotional health, physiotherapists are often among the first to identify issues requiring further referral. They collaborate closely with gynaecologists, psychologists, and dietitians, and empower patients with tools they can use daily, such as breathwork, graded movement, or pain education.

Physiotherapists contribute to endometriosis management across several domains:

- **Regulating the Nervous System:**
  Some people with endometriosis who have experienced persistent pain can develop central sensitisation, a state where the nervous system becomes hyper responsive to stimuli.[2] This can be likened to a security light that is "ultra-sensitive" to perceived threat. Physiotherapists trained in pain science can help patients understand their pain[3], build safety in movement, and provide strategies to calm the nervous system. This approach has been associated with reduced pain catastrophising and improved function.
- **Pelvic Floor Muscle Assessment and Treatment:**
  Pelvic floor dysfunction, difficulties with contracting and/or relaxing the pelvic floor muscles, is common in those with endometriosis and can contribute to dyspareunia (pain during intercourse), bowel or

bladder symptoms, and general pelvic discomfort. Physiotherapists use internal and external techniques such as manual therapy, biofeedback, and functional retraining, to address these issues.

- **Bladder and Bowel Optimisation:** Endometriosis often impacts gastrointestinal and urogenital function. Physiotherapists provide guidance on toileting posture, pelvic floor control and diet and laxative recommendations (in collaboration with a dietitian) to improve symptoms like constipation, bloating, urinary and/or faecal urgency, urinary incontinence or incomplete voiding.
- **Movement and Exercise Prescription:** Tailored exercise programs improve circulation, reduce inflammation, and foster pain resilience.[1] A graduated movement plan, often integrating yoga, breath-work, and/or low-intensity cardio (walking or swimming), can be life-changing, particularly when fear of movement is a barrier.
- **Lifestyle and Behavioural Coaching:** Physiotherapists often spend more time with patients than other clinicians, allowing for deeper exploration of stress, sleep, nutrition, and pacing strategies. This positions them to 'connect the dots' and refer appropriately, facilitating a truly biopsychosocial approach.
- **Prehabilitation and Postoperative Recovery:** For patients undergoing laparoscopic surgery for diagnosis or excision of endometriosis, physiotherapists support optimal outcomes both before and after surgery by preparing tissues, reducing anxiety, and guiding safe return to activity.

Digital Health as a Companion Between Appointments

Despite best efforts, physiotherapy appointments are often constrained by time, location, and cost. Digital tools, such as Matilda's Surgery Optimisation Program and QENDO's endometriosis support app, provide an invaluable adjunct.

Diving deeper into one of these options, Matilda's eight-week program, delivered through a user-friendly mobile platform, supports patients in the four weeks before and four weeks after surgery, delivering:

- Educational content on movement, nutrition, mental wellbeing, and sleep
- Guided sessions for movement and mindfulness to regulate the nervous system
- Weekly community support calls and peer connection
- Tools for habit tracking and self-monitoring

From a physiotherapy perspective, Matilda acts as a clinical extension, reinforcing key messages around movement safety, nervous system regulation, bowel and bladder health, and patient empowerment through education. It's especially beneficial for:

- Reinforcing exercises and strategies between appointments
- Providing daily support when flare-ups occur outside of clinic hours
- Bridging access gaps for patients in rural or regional areas
- Enhancing patient engagement through confidence and shared language before consultations

Physiotherapists can confidently refer patients to programs like Matilda, knowing they are grounded in multidisciplinary input and designed to complement, but not replace face-to-face care. This hybrid model of digital and in-person care represents the future of chronic condition management.

A Collaborative, Whole-Person Model is the Future

Endometriosis care is gradually evolving from a primarily surgical and hormonal-only model to a multidisciplinary, biopsychosocial approach. In this new paradigm, physiotherapists are not optional extras but essential team members.

With expertise in pain modulation, pelvic floor rehabilitation, movement science, and whole-person care, physiotherapists:

- Reduce pain and improve quality of life
- Optimise surgical outcomes
- Address modifiable lifestyle factors
- Empower patients to take an active role in their care

We also act as "super connectors", linking gynaecologists, GPs, dietitians, psychologists, and surgeons around the patient's needs. With longer and often more frequent sessions, physiotherapists build relationships that can uncover important diagnostic and therapeutic clues.

Conclusion

As healthcare evolves towards more integrated, equitable, and patient-centred models, physiotherapy must be recognised as a frontline—not downstream—component of endometriosis care.

Digital health innovations, such as Matilda, help extend this care beyond the clinic walls, ensuring patients are supported at every step of their journey.

Whether it's regulating the nervous system, restoring pelvic muscle balance, improving bladder and bowel health, or simply listening with compassion, physiotherapists play a vital role.

As endometriosis continues to be recognised as a whole-body disease, it is clear: we need a whole-body team.

Disclaimer: This article was written by Joanna Morris in her capacity as a pelvic health physiotherapist with a special interest in persistent pelvic pain. As co-founder of Matilda Health, she references Matilda as an example of how physiotherapy and digital technologies can work together to support people with endometriosis. While Matilda is used as a case example, this article is intended for general education and reflection and does constitute clinical advice or product endorsement.

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The Role of Psychology in the Treatment of Endometriosis: An Integrative Approach

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Endometriosis is a multifactorial condition characterised by the presence of endometrial-like tissue outside the uterus, leading to chronic pelvic pain, fertility issues, and severe psychosocial burdens. Traditionally conceptualised through a biomedical model, recent research underscores the importance of social and psychological factors such as stress, trauma, and adverse experiences in the pathogenesis and symptomatology of endometriosis. Integrating psychological interventions early into treatment regimens can enhance patient outcomes, improve quality of life, and address the underlying biopsychosocial contributors to the disease.[1,2]

Comorbidities and Psychological Impact

Patients with endometriosis frequently experience multiple comorbidities, both immune-mediated and autoimmune, including rheumatoid arthritis, systemic lupus erythematosus, and Crohn's disease. These comorbid conditions often share a stress-related pathogenesis and symptomatology. Mood disorders are present in approximately 30–50% of people with endometriosis, and PTSD or CPTSD reported in around 20–25%.[3,4]

Endometriosis imposes a significant strain on individuals seeking treatment, affecting physical, emotional, and social well-being. The complexity of endometriosis, coupled with frequent delays in diagnosis and treatment, exacerbates these issues. Many patients report experiences of medical trauma, such as feeling dismissed or misunderstood by healthcare providers, which further undermines their mental health. Managing a chronic condition like endometriosis also takes a financial and emotional toll on those affected.[5]

It is increasingly evident that therapeutic interventions should focus on addressing the underlying stress contributing to the cluster of symptoms associated with endometriosis, rather than solely alleviating the distress caused by the disease. Targeting overall life stress can potentially disrupt the cycle of symptom exacerbation. A growing body of evidence supports the efficacy of various therapies aimed at reducing stress in the management of endometriosis.[6]

Evolving Psychological Treatments

The landscape of psychological treatments for endometriosis has evolved significantly over the past decade. Cognitive Behavioral Therapy (CBT) remains a cornerstone of psychological intervention, with robust evidence supporting its efficacy in helping patients identify and modify maladaptive thoughts and behaviors related to pain and stress. CBT is effective in reducing pain catastrophising, improving coping skills, and fostering adaptive stress responses. Tailored CBT programs have demonstrated success in decreasing pain severity and enhancing quality of life for women with endometriosis.[7,8]

Beyond CBT, Mindfulness-Based Stress Reduction (MBSR) has gained traction as an effective intervention. MBSR promotes present-moment awareness and acceptance, helping to reduce emotional reactivity to pain and stress. Studies indicate that MBSR can significantly decrease pain intensity, anxiety, and depression, facilitating a more balanced emotional response to chronic illness.[9,10] In addition, therapies such as relaxation, grounding techniques, and meditation are all effective in reducing stress.

Addressing Trauma and Emotional Processing

Avoidance is a common coping mechanism among individuals with chronic pain and can hinder the processing of emotions and trauma. Emotional Processing Therapy (EPT) is a recent addition to the therapeutic toolkit for endometriosis. It is designed to help patients process intense emotions in a safe and supportive environment. EPT focuses on confronting traumatic memories, improving emotional regulation, and reducing symptoms such as hyperarousal and avoidance.

Addressing unresolved trauma through therapies like EPT, Eye Movement Desensitisation and Reprocessing (EMDR), somatic therapies, and CPT can decrease symptom severity and improve emotional regulation, thereby mitigating the impact of trauma-related dysregulation on pain perception.[11]

Promoting Lifestyle Changes

Psychological interventions also play a crucial role in promoting lifestyle changes that are essential for managing endometriosis. Techniques such as motivational interviewing and health coaching empower patients to adopt healthier lifestyle practices, including regular physical activity, balanced nutrition, and effective stress management. These interventions support patients in setting achievable goals, enhancing motivation, and sustaining long-term behavioral changes, ultimately improving overall well-being and disease management.[12]

Sexual Health and Relationship Therapy

Sexual dysfunction is a common challenge for individuals with endometriosis, often arising from pain, hormonal fluctuations, and psychosocial factors. The World Health Organisation defines sexual health as a state of physical, emotional, mental, and social well-being in relation to sexuality. For many with endometriosis, sex therapy is helpful to achieve this state of well-being. Therapy addresses issues such as dyspareunia, loss of libido, body image concerns, and relationship stress. By fostering open communication and exploring flexible sexual norms, sex therapy can significantly enhance sexual health and relationship satisfaction.[13]

Relationships can promote emotional regulation and stress reduction when functioning well. They are a primary regulation method for humans, starting in utero and continuing outside the womb. Positive, supportive relationships can reduce stress, enhance emotional wellbeing and even modulate the experience of pain. This is particularly relevant in cases of dyspareunia (pain during intercourse), where the quality of intimate relationships can significantly affect pain intensity. Conversely, poor relationship quality, characterised by conflict or lack of support, can increase stress and emotional distress, potentially exacerbating pain. Emotional intimacy and effective communication are key factors in managing chronic pelvic pain and improving overall quality of life.[14]

Support Groups and Peer Support

Support groups provide a vital — yet often underused — platform for individuals with endometriosis to share experiences, reduce feelings of isolation, and learn coping strategies from peers. Peer support complements individual therapy and fosters resilience, enabling patients to navigate the challenges of living with a chronic condition more effectively.[14]

Domestic Violence Assessment, Treatment, and Safety Planning

People with endometriosis report a higher incidence of domestic violence, making it crucial to provide a safe space for disclosure. Domestic violence is a major ongoing global issue and has wide-ranging impacts, including the exacerbation of pain perception. Providing resources, safety planning, and trauma-informed care is essential for these individuals.[15,16]

Conclusion

As clinicians, we have long been aware that multidisciplinary care is an important part of endometriosis management. The challenge has always been to facilitate strong multidisciplinary teams and normalise psychology (and physiotherapy) as essential first-line components of treatment. An integrative approach to endometriosis management that incorporates psychological and allied health interventions early in treatment improves patient outcomes.

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From 'Over It' To Empowered

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Ninah Christie
No longer living with chronic pelvic pain,
instead I'm living my life

For many women living with pain attributed to endometriosis, their journey is often marked by frustration, repeated hospital visits, and a series of biomedical solutions that provide little lasting relief. While international guidelines, including the recent RANZCOG *Australian Living Evidence Guideline: Endometriosis,*[1] recommend a multidisciplinary team (MDT) approach, current funding models continue to prioritise biomedical interventions.

Ninah's story exemplifies the transformative benefits that investing in MDT pain services can offer, not only for women living with persistent pelvic pain (PPP), but for the health system more broadly.

Ninah's History

We first met in the pelvic pain clinic when Ninah was 24 years old. She shared her history of pelvic pain that had begun around age 15, and which had progressively worsened. Her medical records showed 4-5 Emergency Department (ED) admissions annually from age 20 for abdominal pain, with extensive investigations failing to identify a clear cause. Ninah often felt her severe pain was not believed by healthcare providers in the hospital. She reflected that this lack of belief was one of the most damaging aspects of her experience.

The previous year Ninah had undergone laparoscopy with excision of superficial peritoneal endometriosis and Mirena intrauterine system insertion. Sadly, this surgery not only failed to improve her pain but also saw the affected area expand, radiating into her back. This pain led to another four ED admissions in the year following her procedure. This experience is concordant with a study from the local hospital that found laparoscopic surgery did not reduce ED attendance for women living with PPP.[2]

Ninah's Presentation

Ninah described her pelvic pain as a complex mix of stabbing and muscular ache, accompanied by episodes of hot and ripping sensations. Her back pain was an aching sensation, radiating into both legs. She also reported headaches, worsening with stress and tension, and abdominal bloating during pelvic pain flares. The pain had wide-reaching impacts on her life: she had taken seven months off work, experienced disrupted sleep and poor appetite. During pain flare-ups, she was confined to bed with a wheat bag. She was prescribed a range of analgesia, including oral morphine.

Understandably, Ninah described feeling "over it" and reported deep frustration that when she sought medical attention for her pain was told "it was all attributed to endometriosis", especially when surgery had not helped and "I doubt that it would have grown back that fast".

A Different Approach

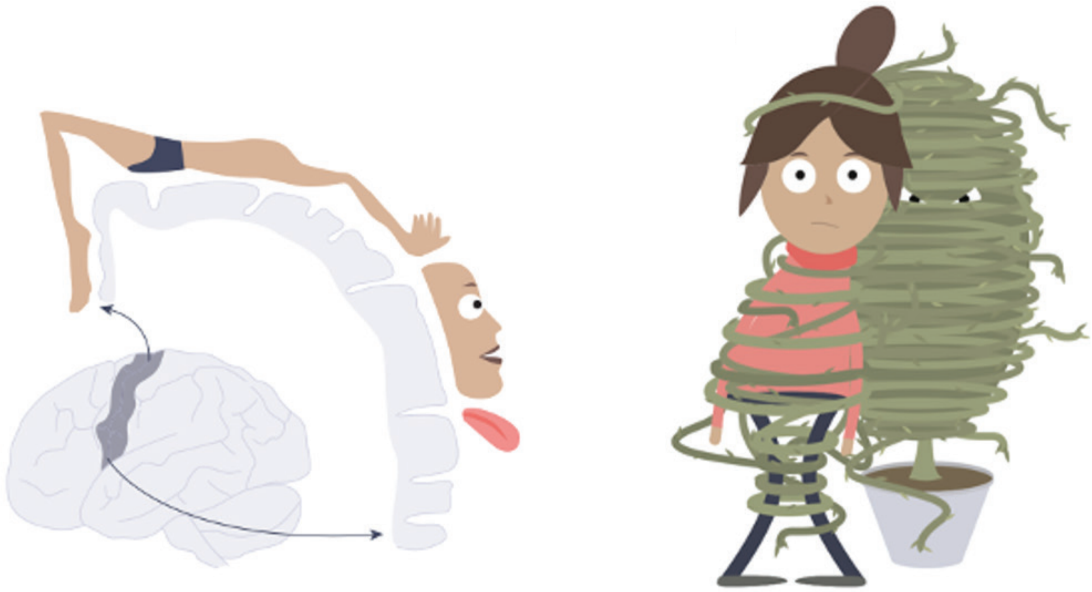
Seeking a different approach, Ninah enrolled in our small-group, MDT-supported pelvic pain self-management program.[4] For six weeks, Ninah joined five other women living with pelvic pain for half a day a week at the pain clinic, working with an MDT including a pain physician, pain physiotherapist, gynaecologist, pelvic health physiotherapist, psychologist, and dietician.

Together, they gained a comprehensive understanding of contemporary pain science concepts, pelvic anatomy, physiology, and pathology. The program also equipped them with pain management techniques, cognitive behavioural therapy (CBT) concepts, and practical exercises in gentle functional movements and relaxation techniques.

As is standard for all patients attending MDT pain programs, Ninah completed a battery of Patient Reported Outcome Measures (PROMs). Prior to the program she reported a mean pain intensity of 6.8/10 (severe). Her scores also indicated a low confidence in managing activity and a high degree of worry about her pain.

This constellation of low self-efficacy and high worry is a recognised risk factor for poor outcomes in women with pelvic pain, including persistent pain following surgery for endometriosis, greater menstrual pain intensity, increased pain-related disability, elevated distress, and lower quality of life. Notably, an audit of attendees to the gynaecology clinic for pelvic pain revealed that 75% had this presentation.[3]

Upon graduation from the program Ninah reported a clinically significant reduction in average pain intensity and in the impact of pain on her daily life. She also demonstrated increased confidence to undertake activity despite pain and a marked reduction in her worry about pain. At three, six and twelve months after completing the program she reported having essentially no pain and great confidence to manage her activity should her pain return. Ninah has not attended the ED for pelvic pain in the 6 years since completing the program. Other program participants reported similar successes, with over 80% achieving clinically significant improvement across multiple domains, and no participants reporting any clinically significant deterioration on any measure.[4]



Program participants learn about the nervous system and how to untangle their pain [Picture credit: Pelvic Pain NZ]

Ninah's Story In Her Own Words

It is hard to describe my experience with the program without sounding like a cliché from an infomercial to be honest. In a nutshell, I went from taking incredibly strong opioids nearly every day, coming off the back of having nearly a year off work due to horrible pain, to no longer experiencing the pelvic pain I did when entering the program.

I am now 30, and I have completed postgraduate study, I am working as a teaching assistant at university, and I am still living free from persistent pelvic pain. While I do have a few days of pain, it is truly night and day to what I was experiencing.

Admittedly, I was quite dubious of pain clinics before this program. Clearly coming from a place of assumption rather than experience, I wrongly thought that this program might be superficial lip service and yet another way that the system disregards people with chronic pain. I soon realised I could not have been more wrong.

I think most people dealing with chronic pain, particularly chronic pelvic pain, feel quite rejected, disenfranchised, isolated and essentially not believed quite a lot of the time. This program alleviated all of this for me and my fellow group members. There is an MDT of specialists who you work with, focusing on all aspects of the experience of pain, and each of them really cared about us as individuals and most of all, they believed that what we were experiencing was in fact legitimate.

But what helped me most was understanding how pain actually works—how my brain and nervous system were involved. That knowledge was empowering. It gave me practical tools to "rewire" parts of myself that were misfiring and causing so much distress.

I joined the program hoping to learn how to cope with pain. And I did. But now, I don't have to cope, because the symptoms I arrived with are gone. I'm blown away and incredibly grateful for that.

A Path Forward

Despite the transformative effects of MDT pain programs, as demonstrated by this low-cost, low-risk intervention; health system investment in New Zealand continues to focus predominantly on biomedical approaches—often yielding suboptimal outcomes, and very limited investment into MDT pain services.

We hope that sharing Ninah's experience will help with the momentum needed to effect meaningful change for the one-in-four women living with PPP.

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Conflicts

Dr Joseph is a partner in Pelvic Pain NZ which owns the PIPPI programme, and a medical advisor for the Ella Health App.

Fertility Preserving Stage IV Endometriosis Surgery: Considerations, Tips and Tricks

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Endometriosis is a chronic inflammatory condition that significantly contributes to pelvic pain and infertility in women of reproductive age. Up to 50% of women struggling to conceive have endometriosis.[1] Characterised by the presence of endometrial-like gland cells outside the uterus, endometriosis disrupts the entire pelvic region. This disorder creates adhesions, anatomical distortions, and scarring on the ovaries, fallopian tubes, and pelvic sidewalls.

To illustrate this, think of the pelvis as a car engine. For optimal performance, every component must operate smoothly, much like a well-oiled machine. In endometriosis, endometriotic deposits act like sand in the gears, reducing lubrication and causing friction severely impacting pelvic mobility. This 'stickiness' and inflammation caused by the endometrial-like glands has a profound impact on fertility. It poses risks such as reduced ovarian reserve, significant anatomical distortion, and a decrease in the quality of eggs and embryos, all of which adversely affect fertilisation and implantation.[2] Understanding these effects is crucial for addressing the challenges associated with endometriosis and fertility.

Moderate to severe endometriosis, specifically stage III and stage IV, is characterised by the presence of deeply invasive endometriosis with moderate to extensive adhesions between the uterus and the bowels, as well endometrioma cysts that involve the ovaries and fallopian tubes. Stage IV, the focus of this article, extends to the bowel, bladder or ureter and is often termed "frozen pelvis." Surgical intervention for Stage IV endometriosis carries immanent risks, including the potential for irreversible damage to the gastrointestinal tract or genitourinary system. However, benefits such as pain relief and improved fertility often outweigh these risks, particularly when these complex pelvic surgeries are undertaken by highly specialised and experienced endometriosis surgeons.[3] In terms of fertility outcomes, expectant management of stage III and stage IV endometriosis yields minimal favourable results. For Stage III endometriosis, the spontaneous pregnancy rate is approximately 33%, while for stage IV, almost an insignificant chance.[4]

When managing patients with stage IV endometriosis, a multidisciplinary approach is essential. A comprehensive medical history, particularly regarding fertility, is crucial and should be correlated with the patient's pain profile, along with findings from advanced imaging techniques such as a deep infiltrating endometriosis scan or a pelvic MRI. Referrals to specialists, such as a colorectal surgeon or a urologist, may be necessary based on the specific organs affected by the endometriosis. Additionally, it is advisable to schedule an early fertility consultation, considering the patient's age and all fertility investigations such as Hy-Co-Sy and anti-Müllerian hormone levels. If the patient experiences pain alongside difficulties in conceiving, involving a pain specialist in their care is important. Furthermore, a pelvic floor physiotherapist can play a significant role in managing pelvic pain.

Surgery should be carried out only after a comprehensive review of all imaging modalities, with the most effective approach being a formal pre-operative multidisciplinary team meeting dedicated to complex pelvic surgery cases. In this critical forum, surgeons collaboratively assess potential risks and determine the necessity of pre-operative procedures such an examination under anaesthesia, colonoscopy, sigmoidoscopy, or cystoscopy.

As the surgical plan takes shape, adopting a coordinated approach that involves multiple surgeons, alongside a comprehensive informed consent process, represents the gold standard for patient care. Pictorial and video documentation also plays a vital role for both the patient and the fertility specialists involved, particularly when preparing for egg retrievals. This visual documentation not only enhances the surgeon's ability to explain the extent of the disease affecting couples striving to conceive but also acknowledges their struggles, while validating the pain experienced by patients suffering from chronic pelvic pain. Such comprehensive planning and documentation ensure that patients receive the highest quality of care and support during their journey.

Post-operative care should be conducted at regular intervals for patients who are trying to conceive. It is crucial for the endometriosis surgeon to evaluate symptoms in detail every three to six months, especially for couples on their journey to parenthood. Symptoms of recurrences should be monitored especially when there will be no hormonal suppression due to the desire of pregnancy. In individual cases where spontaneous conception does not occur within the desired timeframe, the early implementation of assisted reproductive technology should be strongly advocated to significantly enhance fertility outcomes.

In conclusion, it is recommended that patients facing infertility with pelvic pain should undergo early tertiary imaging, and this can be organised by general practitioners. A deep infiltrating endometriosis scan or pelvic MRI is essential, even if there is minimal pain. If stage IV endometriosis is diagnosed, an immediate referral to an endometriosis surgeon with credentials for complex pelvic surgeries—working alongside co-surgeons such as a colorectal surgeon or a urologist—is crucial. Furthermore, involving a fertility specialist in the management of these complex cases is vital to maximise the chances of achieving successful fertility outcomes.

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Medical Management of Invasive Recto Endometriosis: A Case Study

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In this case, a 51-year-old G1P1 presented with a nine-month history of abnormal uterine bleeding and dysmenorrhoea, as well as cyclical bowel symptoms including painful constipation and tenesmus.

Initially, the woman reported intermenstrual bleeding lasting up to two weeks, which progressed to almost two months of continuous bleeding. Vaginal examinations were not undertaken at the time of initial presentations to primary and secondary care. She presented to the emergency department at a tertiary referral hospital following an acute heavy bleeding episode, provoked by transvaginal ultrasound.

The patient's past medical history is significant for irritable bowel symptoms, having had a colonoscopy the year prior to presentation which was normal. She had a caesarean delivery and does not take medications. Her gynaecological history is unremarkable, with a prior regular menstrual cycle, no dysmenorrhoea, dyschezia, heavy menstrual bleeding, or other abnormal uterine bleeding. Her cervical screening was up to date and normal.

Speculum examination revealed an irregular mass on the posterior vaginal wall. Digital vaginal examination determined this posterior vaginal wall irregularity was notably separate from the cervix. On rectal examination, a large mass was palpable anteriorly, approximately 6cm in size, but the overlying rectal mucosa palpated normally at a combined recto-vaginal examination.

An ultrasound demonstrated an anteverted uterus measuring 10 x 4 x 6cm with features of adenomyosis, and an endometrial thickness of 3.4mm. The ovaries were unremarkable. A hyperechoic lesion measuring 52 x 52 x 36mm appeared to arise from the vaginal wall, with a solid appearance and increased vascularity.

The woman underwent an examination under anaesthesia as a combined case with gynaecology and colorectal surgery. On vaginal examination, the posterior and right lateral vaginal wall was eroded by invasive process, with small volume bleeding and copious debris from this region. On rectal examination, a 5cm mass was palpable, 4cm cephalad to the anal verge, displacing the rectal wall anterolaterally. A flexible sigmoidoscopy did not reveal any mucosal lesion. Vaginal biopsies were taken with histopathology confirming endometriosis.

Following the patient's diagnosis, medical and surgical management options were discussed. It was advised that surgical management would have conferred significant morbidity, requiring ultra-low anterior resection and a stoma. The patient preferred to avoid surgical treatment, instead choosing initiation of the GnRH analogue Goserelin 3.6mg implant (Zoladex, AstraZeneca Pty LTD). Progress was assessed clinically and symptomatically during follow up visits.

After 6 months of treatment, amenorrhoea was achieved, and there was no longer a discernible mass on vaginal examination. A 1cm region of persistent erosion was also noted on speculum exam without contact bleeding. While she had improvements in the pain and dyschezia, she experienced ongoing faecal urgency and urge incontinence, although the severity fluctuated throughout the treatment duration.

The patient experienced expected side effects such as anxiety, depression, dry eyes and vasomotor symptoms. She ceased employment due to cognitive and mood effects impacting on her function. At her preference, add-back hormone therapy was not used. She was advised to pursue management for her mental health symptoms, facilitated by her primary care provider.

At age 53 years, after 15 months, Goserelin was ceased. An ultrasound demonstrated no recurrence of the rectovaginal disease. Symptoms of faecal urgency and tenesmus increased again, and heavy menstrual bleeding returned three months after cessation. The colorectal surgeons repeated her flexible sigmoidoscopy with abnormal appearance of the rectal mucosa noted, however biopsy did not reveal any abnormality. She was referred for physiotherapy and a further discussion regarding medical management was initiated.

A trial of drospirenone 4mg (Slinda, Besins Healthcare Australia Pty Ltd) reduced the severity of rectal symptoms, however she developed persistent bleeding. After three months she underwent a hysteroscopy where she was noted to have blood and copious debris in the vagina again.

Histopathology confirmed recurrence of invasive vaginal endometriosis, with a 4cm palpable mass again evident.

A pelvis MRI with gadolinium contrast was performed which confirmed deep infiltrating endometriotic mass invading the right posterior wall of the vagina anteriorly and the mesorectal fascia posteriorly, with involvement of the levator ani, and direct contact with the rectal wall. She again declined surgical intervention.

Due to recurrence of the rectovaginal lesion and symptoms, it was recommended to recommence a GnRH analogue for medical management. Due to the side effect profile of the patient's previous treatment, the decision to commence Relugolix/Estradiol/Norethisterone (Ryeqo, Gedeon Richter Pty Ltd) was made. Her bleeding ceased almost immediately with significant improvement in pain symptoms.

She continues to see pelvic physiotherapy for management of ongoing tenesmus, and reports improvement in these symptoms when on treatment and with ongoing physiotherapy. Menopausal side-effects did not recur with Relugolix. She remained symptomatic of mood disturbance and had engaged with psychologists and commenced anti-depressants. At time of writing of this report, she has been on Relugolix for 11 months.

Rectovaginal endometriosis affects up to 37%[1] of those with endometriosis. Vaginally invasive lesions are very rare with some reports suggesting a prevalence of 0.02%.[2] A holistic approach to treatment options requires consideration of the patient's symptoms, preferences, and the potential side effects and risks of each option.

This is a case study of a 51-year-old pre-menopausal woman with vaginally invasive rectovaginal disease which was managed medically for over two years. It highlights the importance of thorough investigation of endometriosis patients to identify vaginal and rectal disease with digital and speculum examinations. It also emphasises the importance of care provision via a surgical and allied health multidisciplinary team with experience in endometriosis.

In this case, the patient declined surgical management of endometriosis due to risk. A large case series of 363 women over ten years reports an 8.5% risk of rectovaginal fistula in cases where there has been significant rectovaginal disease resected, particularly less than 8cm from the anal verge, regardless of the formation of a protective stoma.[3] In this case, the lesion was lower than this level and the potential morbidity was not acceptable to the patient.

Medical management with progestogens or GnRH analogues are recognised options, and this case highlights the effectiveness of GnRH analogues in reducing the size of deep endometriosis lesions. The side effect profile of GnRH analogues, and arguably of any hormonal suppression, cannot be discounted, as they can impact quality of life. Therefore, treatment decisions should be based on evaluating the most favourable outcomes that are both tolerable and acceptable to the patient.

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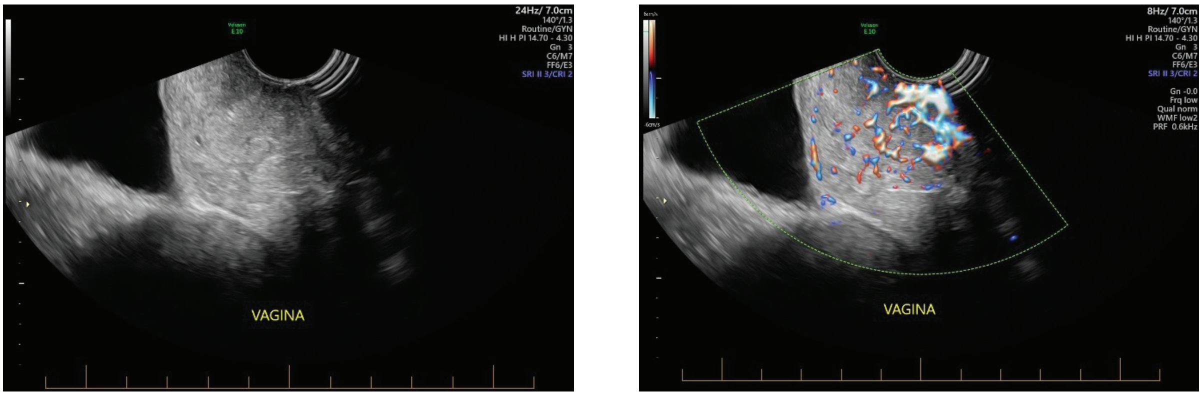
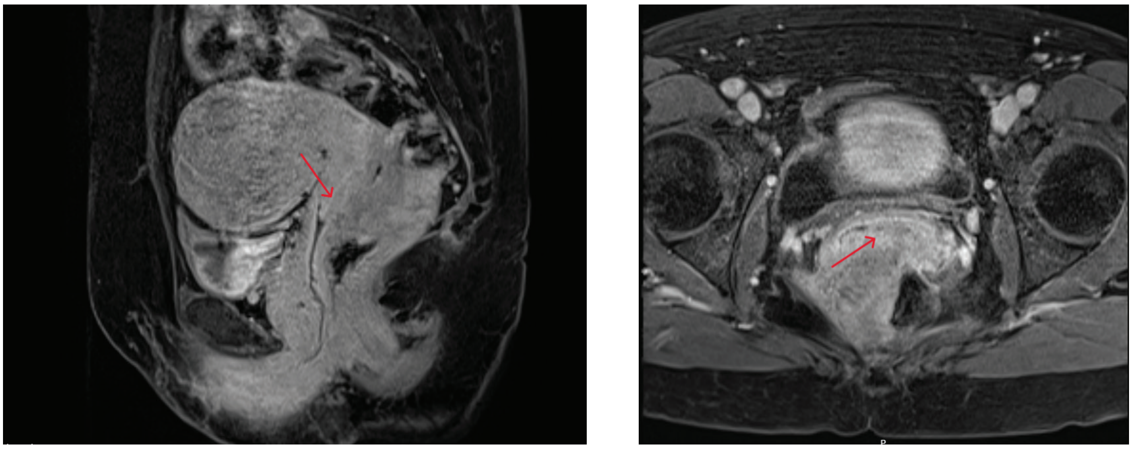


Pelvic US 1 and Pelvic US 2: Transvaginal pelvic ultrasound at initial diagnosis demonstrating highly vascular hyperechoic lesion



MRI 1 and MRI 2: Pelvic MRI after diagnosis of recurrence demonstrating vaginal invasion of deep endometriotic lesion

When Periods Hurt - A Guide to Periods, Pain and Endometriosis for Teens by Dr Susan Evans

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In this quarter's book review, we highlight two resources aimed at those affected by pelvic pain (with or without a diagnosis of endometriosis). These books are primarily written for teenagers, their families, and carers, but also serve as practical tools for clinicians supporting this group.

The first and most recent book, *When Periods Hurt - A Guide to Periods, Pain and Endometriosis for Teens,* is by Dr Susan Evans, whose work and advocacy in this space is well known and respected.

This self-published book edited by pelvic pain-friendly linguist and long-time collaborator Professor Roly Sussex, builds on Dr Evans earlier work '*Endometriosis and Pelvic Pain,*' offering a simplified and updated guide.

Aimed at teenagers, particularly girls and those assigned female at birth (AFAB), the book avoids medical jargon, offering simple explanations to navigate various topics related to pelvic pain. It is also a great resource for those who know someone with pelvic pain and want to understand more.

It begins with the foreword: "be your own 'pain boss'," setting the tone for empowering people to take charge of their symptoms. This message and encouragement to have one's own agency is repeated throughout the book in various forms (e.g. "You are the boss of your own story") (p6).

The book is divided into short chapters, each addressing an area or component of pain with included explanations of our current understanding of the aetiology and contributing factors and ending with treatment options. Content is further broken-down using colour codes for 'medical words', 'fun facts' and 'top tips' to help sub-divide and brings attention to different messages, and it is further divided into coloured icons which refer to treatment options and resources.

There is a dedicated chapter on surgical options (focusing on laparoscopy), as well as one for gender-diverse and trans people. I particularly appreciated the section specifically tailored to school – useful for pupils and teachers, caregivers and family.

Dr Evans includes just enough medical information to make the book relevant and helpful. I especially liked the inclusion of other common conditions of the ovaries in young people such as haemorrhagic and functional cysts, polycystic ovary syndrome (PCOS) and ovarian torsion, as well as irritable bowel syndrome (IBS).

The book makes the important distinction between the diagnosis of endometriosis and the symptoms of endometriosis, though I would have liked this distinction to be made a little more obvious and encourage proper nomenclature. I appreciated the frequent reassurance that the pain although real is: 1. not life threatening or dangerous, and 2. can be treated or made better.

Importantly, the book addresses common fears such as:
- What if I have a negative laparoscopy?
- Am I stuck with this pain forever?
- Am I doomed to have endometriosis because my mother had troublesome menses?

Chapter seven is directed at parents and caregivers and aims to dispel and address some myths around care for a child in pain, particularly when there is a history of the same in the mother. Dr Evans skilfully navigates and gently discourages enabling maladaptive sickness behaviour while providing practical alternatives. Reading this chapter I found myself thinking of several parents in my own practice who would benefit from reading this.

As it is written by the founder of The Pelvic Pain Foundation of Australia (PPFA), it frequently references to the PPFA's online resources and Dr Evans' previous book, aimed at adults. Personally, I would have liked to see more diversity in the resources, especially for teenagers who are so well e-read. Similarly, TENS machines, heat packs, etc., are widely available and may be more affordable elsewhere than those listed through the PPFA. These are potentially impressionable teenagers, so putting financial barriers in front of them by making them believe that there is only one source of these aids, could be problematic.

At the end of the book, Dr Evans includes self-management plans (blank copies of which can also be downloaded from the Pelvic Pain Foundation website), including daily and flare-up pain plans. Sample plans are included to make it easy to understand and guide readers. There is also a

"What I've tried so far" section that encourages readers to document treatments, benefits and side effects which is helpful for future doctor appointments. As a clinician who treats endometriosis, this practical component is very welcome.

If anything, I feel the language sometimes oversimplifies issues, but perhaps this is a function of pitching it for the younger audience, with menarche now occurring an average age of 11.9 years in high income countries.[1] The book covers a broad range of topics across 140 pages, though I would have liked the contribution of biopsychosocial factors, particularly comorbid psychiatric disorders (e.g., anxiety), the impact of trauma, and whether self-care/menstrual care is discussed at home.

In this vein, I would have liked to see more on the following:

- Other trusted resources, particularly online
- The possibility that pain may not always be gynaecological in origin
- Co-morbidities such as Attention Deficit Hyperactivity Disorder (ADHD), Postural Orthostatic Tachycardia Syndrome (POTS), Autism Spectrum Disorder (ASD) medications and whether they are safe to mix with medical treatment options for pelvic pain (or not, or counterintuitive)
- Greater context in the 'should I go gluten free' section (p37), linking processed food more broadly rather than solely on wheat or gluten containing foods for non-coeliacs.

Overall, this book is an excellent resource for young women and AFAB who have pelvic pain. It succeeds in being empowering without reinforcing the common belief that all pain must be active endometriosis and hence resulting in the over-servicing which that receives.

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Message from the author:

Individual copies of the print book ($33.95) or e-book ($27.50) are available from the Pelvic Pain Foundation of Australia online shop at www.pelvicpain.org.au.

Medical practices can purchase a box of books (50 copies) at discount directly from susan@drsusanevans.com. You are also welcome to email this address if you have helpful comments or suggestions for future print runs.

Healing Pelvic Pain by Dr Peta Wright

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At the recent World Endometriosis Congress in Sydney, a session entitled, "*The Great Debate: To Make Progress We Must Rethink Our Approach to Endometriosis Research,*" gave me the most hope.

Professor Michel Canis, grandfather of surgical techniques, thought leader and highly respected Giant in the Field, submitted that the greatest oversight in our current understanding of pelvic pain is our failure to acknowledge the contribution of trauma.

In an awkward segue, the "debate" proceeded as separate orations and this historical moment passed.

Rethinking your approach to pelvic pain and endometriosis? Read this book.

Dr Peta Wright's thesis, supported by strong evidence, is that pain as a disability is, in part, a social problem, and that we ignore the contribution of the brain and environment at our peril. Focusing on endometriosis and adenomyosis is a nocebo which disempowers women, and a narrow biomedical, reductionist approach contributes to suffering. We cannot simply cut out inflammation.

Part one of the book covers endometriosis, medicines and surgery. Chapters 7-9 explain the neuroscience of pain, the role of the autonomic nervous system, trauma, polyvagal theory, which although a theory does pull it all together. Dr Wright is clear to detail the enormous benefits of hormonal treatments, but she urges people to not swap one bunch of awful symptoms for another – the advantages must outweigh the disadvantages, and we must employ shared decision making.

Part two covers an action plan for healing with clear explanations of the role of pelvic health physiotherapists and psychologists trained in pain and trauma. Part three is the tip of Maslow's hierarchy – making meaning and self-actualisation. The flare toolkit is comprehensive and a great resource for patients.

Her beautiful writing is full of metaphors, storytelling and visual imagery. It is easy to read, and there is little I don't agree with. I suspect the book is written as much for a medical audience as for patients, and it will certainly be recommended reading for the new Pelvic Pain Special Interest Module for RANZCOG trainees.

For future editions, I'd like to see the references clearly indicated alongside the text and further explanation about the role of vaginal diazepam which is creeping into Australian practice. My anaesthetic colleagues tell me the dose for muscle relaxation typically requires intubation. If we are using this medicine as an anxiolytic, oral administration is cheaper and more predictable (also can we please stop putting untested things into people's vaginas?)

A call to action: what year will it be when a doctor in Australia or Aotearoa New Zealand can clearly outline to a patient seeking care for pelvic pain the interconnected roles of the body, mind and environment? Let's shorten the "Green Gap" detailed by Lawrence in 2014 and grab yourself a copy!

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