Editorial
Volume 9:12, 2021

Journal of Cardiovascular Diseases & Diagnosis

ISSN: 2329-9517 Open Access

An Editorial on Endometriosis and Infertility

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Editorial

Endometriosis may reflect one of the underlying factors of infertility. This estrogen-dependent disease affects up to 10% of reproductive-aged women and up to 50% of women with infertility. Infertility is a major cause of morbidity in women with endometriosis. Thirty to fifty percent of endometriosis patients face infertility, and the condition reduces fecundity from 15% to 20% per month in healthy women to 2% to 5% per month in women with endometriosis. The exact cause of infertility is not definitively known, both pathologic and iatrogenic causes may exist. It has been hypothesized that several factors (anatomical, immunological, hormonal, genetic and environmental) may play a role in the pathogenesis of this chronic disease.

The first step towards an accurate and prompt diagnosis of endometriosis includes physical examination of the pelvis and the abdomen that are followed by the imaging techniques, namely transvaginal sonography, rectal endoscopic sonography and magnetic resonance imaging (MRI) , which are mainly employed for infiltrating lesions as well as for the detection of a possible ovarian endometrioma. The ultimate diagnosis could be accomplished through the method of laparoscopy. Medical therapy can be helpful in managing symptoms, but does not improve pregnancy rates. The role of surgical treatment remains controversial. Superovulation with intrauterine insemination has shown modest improvement in pregnancy rates in women who may have endometriosis. The most effective treatment for endometriosis associated infertility is *in vitro* fertilization. Recent focus on proteomics and genetics of the disease may aid in optimizing treatment options.

Endometriosis is a serious condition with a high recurrence rate. There is no known aetiology or pathophysiology for this condition. Endometriosis is usually associated with pain and infertility, yet 20–25 percent of people have no symptoms. The main goals of therapy are to relieve symptoms, resolve current endometriotic implants, and prevent new foci of ectopic endometrial tissue. Current therapeutic techniques are far from curative; rather than addressing the disease, they concentrate on managing its clinical manifestations. Combining pharmacological, surgical, and psychological therapy can help women with endometriosis improve their quality of life. The benefits of these treatments have not been thoroughly demonstrated, particularly in terms of women's personal goals. Although it may be advantageous, there is little evidence that combining medical and surgical treatment increases fertility and it may delay further fertility therapy needlessly. Randomized controlled trials are required to demonstrate the efficacy of various treatments.

Endometriosis is a debilitating condition that affects 6 to 10% of the female population, with a prevalence of 35–50% in women suffering from pain, infertility, or both. Endometriosis affects 25 to 50 percent of infertile women, and 30 to 50 percent of women with endometriosis are infertile. According to more current data, the incidence of endometriosis has not grown in the last 30 years and is still 2.37–2.49/1000/y, equating to a prevalence of 6–8%.

Pain and a heavy feeling in the lumbo-sacral column and/or legs; nausea, lethargy, chronic fatigue; any cyclical discomfort affecting other organs; haemoptysis; scapular or thoracic pain; and acute abdomen are all signs of endometriosis. Endometriosis symptoms do not always correspond to its laparoscopic appearance. Endometriosis symptoms and the likelihood of diagnosis worsen with age, with the incidence peaking in women in their 40s. It can be difficult to distinguish endometriosis-related pelvic discomfort from that caused by irritable bowel syndrome (IBS), interstitial cystitis, fibromyalgia, and other conditions, but those visceral structures are frequently involved in endometriosis patients.

How to cite this article: Parsanezhad, Mohammad Ebrahim. "An Editorial on Endometriosis and Infertility." J Cardiovasc Dis Diagn 9 (2021): 493

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Received 07 December 2021; **Accepted** 12 December 2021; **Published** 17 December 2021