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Maternal Pregnancy Complications brought by Endometriosis

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Abstract

Endometriosis is becoming more common. Despite a low relative risk, doctors should be aware of potential endometriosis-associated problems or complications from prior endometriosis treatment, especially during pregnancy and labour. The literature describes problems such as spontaneous intestinal perforation, ovarian cyst rupture, uterine rupture, and intraabdominal haemorrhage from decidualized endometriosis lesions or prior surgery in addition to an increased likelihood of early miscarriage. There have also been discussions about undesirable neonatal outcomes. We discuss an irreversible ovarian torsion that developed after extensive endometriosis surgery in the 16th week of pregnancy as well as an intraabdominal haemorrhage brought on by intestinal endometriosis in the 29th week of pregnancy.

Keywords: Endometriosis; Pregnancy; Complication; Delivery; Decidualization; Intraabdominal Bleeding

Introduction

Endometriosis is a condition where the endometrium tissue that typically borders the uterus grows outside of the uterine cavity. It can stick to the fallopian tubes, the ovaries, and the exterior of the uterus. It may be more challenging to conceive and maintain pregnancy when any of these organs are harmed, obstructed, or irritated by this tissue that resembles the endometrium. Your likelihood of bringing a pregnancy to term will also depend on your age, general health, and the severity of your disease [1].

Your risk for pregnancy and delivery difficulties may rise if you have endometriosis. Endometriosis-related inflammation, uterine structural damage, and hormonal factors may be to blame for this [2].

The painful periods and profuse menstrual flow that are frequently signs of endometriosis may temporarily stop during pregnancy. It could also bring about more alleviation. The elevated levels of progesterone during pregnancy are advantageous to certain persons. Endometrial growths are believed to be suppressed and maybe even shrunk by this hormone. In reality, endometriosis patients are frequently treated with progestin, a synthetic version of progesterone. Others, though, won't see any improvement. It's also possible that your symptoms get worse when you're pregnant. It can strain and stretch misplaced tissue as the uterus grows to accommodate the developing foetus. That could make you feel uneasy. Endometrial growths can also be nourished by an increase in oestrogen [3].

A persistent condition known as endometriosis affects 4-30% of all women of childbearing age. The frequency might reach 50% among women who are infertile. The primary clinical sign of the condition, which is characterized by the presence of endometrial cells outside of the uterus, is dysmenorrhea. Endometriosis often develops on the surface of the peritoneal membrane, but it can also infiltrate deeply into areas like the bladder, rectum, and other parts of the intestine. This variant of the illness that infiltrates deeply is primarily associated with serious maternal pregnancy problems. During pregnancy, endometriosis does not always regress. Numerous pregnancy issues, in particular endometrial decidualization, are caused by this condition. The cause is increased progesterone synthesis. During labour during the second half of pregnancy, there is a heightened risk of endometriosis issues. Spontaneous intraabdominal bleeding, uterine rupture, intestinal perforation, endometriosis cyst perforation, and ovarian torsion in the presence of ovarian endometrioma are among the risks [4].

In the United States, endometrial tissue that travels and lodges in other regions of the body is connected with endometriosis, which affects around 11% of women and is frequently discovered in the early stages of reproduction. Abdominal discomfort that feels like a dagger, infertility, and painful erections are a few of the symptoms.

Discussion

According to Berghella, endometriosis is known to change a woman's physiology in a way that could affect various phases of pregnancy. "There are several ways that endometriosis may impair the normal course of pregnancy, from producing inflammation at the endometrium to opposing the action of progesterone during implantation and throughout the pregnancy."

Intraabdominal Bleeding

During labour, occasionally after delivery, and during the second half of pregnancy, spontaneous peritoneal bleeding happens. Acute or subacute stomach discomfort, hypovolemic shock, and foetal distress are the main symptoms. The greatest investigation into the prevalence of haemoperitoneum during pregnancy was a retrospective review of 800 women over the course of five years. According to the study, endometriosis caused severe intraabdominal haemorrhage in three women (0.38%) during the third trimester. A few instances of fulminant hemoperitoneum-related stillbirths and early infant fatalities owing to hypovolemic shock are also available. Intraabdominal haemorrhage must be taken into account in expectant women who have the triad of acute abdominal pain, a drop in haemoglobin, and a history of prior endometriosis. Rarely, endometriosis in people who are not pregnant can lead to hemoperitoneum [5].

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Endometrioma

Adnexal tumours occur in about 4% of pregnant women, while the exact percentage varies across studies. Of these tumours, endometriomas make about 11.5%. As there are not enough instances documented, it is impossible to assess the prevalence of endometrioma-related problems. There have been four case reports of pregnant women with perforated endometriomas thus far. These are the signs and symptoms of abdominal haemorrhage [6].

Bowel perforation

Additionally, it is unclear how frequently this issue occurs. 12 occurrences of intestinal perforations during pregnancy that were brought on by endometriosis were discovered in a review study on the subject. An acute abdomen was seen in each and every instance. All of the patients underwent urgent surgeries, either segmental resections or Hartmann's procedures. The following areas of the body had perforation: 2 small bowel, 1 coecum, 3 appendix, and 6 rectum and sigmoid colon. The increasing uterus's increased pulling on adherent endometriosis lesions, together with the pressure from feces inside the body, are suggested to be the causes of bowel perforation [7].

Uterine rupture

There are just two case reports of spontaneous uterine rupture occurring during pregnancy when there is adenomyosis and no prior uterine surgery. Recent reports describe uterine rupture during pregnancy after cystic adenomyosis surgery. There is no medical proof that removing an adenomyosis would increase fertility. Future patient treatment must take uterine rupture risk into account, especially if surgery left bigger myometrial abnormalities. Following resection, a 9-15 mm myometrial thickness is considered as ideal [8].

Surgery during pregnancy

The conclusion of the first and the start of the second trimester are the times when symptomatic ovarian cysts are operated on most frequently. A retrospective investigation found that ovarian torsion was responsible for one-third of cysts becoming visible. Depending on the surgeon's skill, laparoscopic access and surgical treatment are achievable between the 26th and 28th week of pregnancy. Since there is no proof that surgical endometriosis treatment improves pregnancy or pregnancy outcomes, there is no universal advice to do so in order to prevent this issue [9].

Conclusion

The issues mentioned here are rather uncommon (around 0.4%). A thorough medical history that includes endometriosis symptoms and information about past procedures is crucial to the differential diagnosis. The degree of endometriosis (superficial or deep infiltrating) and the scope of prior surgery both influence the likelihood of various endometriosis-related problems. Additional research must be done when the clinical presentation is ambiguous, depending on gestation, and may include diagnostic or surgical laparoscopy as necessary. Instead, there should be a low barrier for caesarean sections, especially in later stages of pregnancy. Both fully operated endometriosis and partially operated, deeply infiltrating endometriosis may call for an elective caesarean section. A general advice, however, cannot be given [10].

An independent risk factor for placenta previa is endometriosis. Additionally, individuals with a history of endometriosis surgery prior to becoming pregnant, particularly those with a gap of more than 5 years between pregnancy and a prior operation, were linked to a higher risk of placenta previa. This could be because these people have a more advanced state of endometriosis. On the other hand, there was no evidence that individuals who had just had hormone treatments or who had unintentionally gotten an ovarian endometriosis diagnosis during the first trimester of pregnancy were at higher risk. Therefore, pregnant individuals with a history of surgery need to be particularly watched out for placenta previa. The link between the location and stage of endometriosis or the type of surgical procedure and placenta previa in a future pregnancy has to be further researched.

Acknowledgement

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Conflict of Interest

None

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