

Endometriosis often begins as a private argument between what a person feels and what everyone around her has been taught to dismiss. The calendar calls it a period. Family members may call it bad cramps. A clinician may suggest that some women simply have a low tolerance for pain. Yet the person living inside that body may be vomiting, fainting, missing school, leaving work early, avoiding sex, or planning every month around the days when her pelvis seems to turn against her. The first damage caused by endometriosis is physical, but another kind of damage appears when severe suffering is repeatedly treated as ordinary. Understanding the disease begins by separating common menstrual discomfort from pain powerful enough to interrupt a life.

Inside the uterus is a specialized lining called the endometrium. During a menstrual cycle, hormones cause this lining to thicken in preparation for a possible pregnancy. If pregnancy does not occur, much of the lining is shed through menstruation. Endometriosis develops when tissue resembling the endometrium grows outside the uterus, where it does not belong. Modern medicine uses the phrase “endometrium-like tissue” because these growths resemble the uterine lining but are not completely identical to it. The abnormal areas may be called lesions, implants, nodules, or patches. They most often appear within the pelvis, although they can occasionally develop elsewhere in the abdomen or, more rarely, the chest. The disease affects an estimated 10 percent of women of reproductive age worldwide—about 190 million people—and symptoms can begin with the first menstrual periods and continue beyond the reproductive years. The World Health Organization classifies it as a chronic disease with no known cure.

The pelvis contains several organs packed into a relatively small space. The uterus sits between the bladder and rectum, the ovaries rest on either side, and the fallopian tubes create pathways between the ovaries and uterus. Endometriosis can grow on the ovaries, fallopian tubes, outer surface of the uterus, pelvic sidewalls, tissue behind the uterus, bladder, bowel, or ligaments that support the reproductive organs. A ligament is a strong band of tissue that helps hold an organ or joint in position. Lesions on an ovary may form an endometrioma, a cyst containing old blood and inflammatory material. These cysts are sometimes called “chocolate cysts” because of their dark brown contents, although the medical term is more useful and respectful. Deep endometriosis can grow below the surface of pelvic tissue and enter the walls of organs such as the bowel or bladder.

Location helps explain why endometriosis does not feel the same in every body. A lesion near a sensitive nerve may produce severe pain even when it is physically small. Disease around the bowel may cause painful bowel movements, constipation, diarrhea, rectal pressure, bloating, or nausea, especially near menstruation. Bladder involvement may create urgency, pelvic pressure, or pain when urinating. Lesions behind the uterus can contribute to deep pain during penetrative sex, while disease around the ovaries or fallopian tubes may interfere with fertility without producing dramatic pain. Rare endometriosis involving the diaphragm or chest can cause menstrual-cycle-related

shoulder pain, chest pain, shortness of breath, or even a collapsed lung. Most people with pelvic pain do not have chest endometriosis, but its existence reveals that the disease cannot be reduced to “bad uterine cramps.”

The lesions are only one part of what the body experiences. Endometriosis can create inflammation, the immune system’s response to tissue it identifies as damaged or threatening. Inflammation releases chemical messengers that can irritate nearby nerves and make tissues more sensitive. Lesions may develop their own small blood supply and nerve fibers, allowing them to respond to hormones and communicate pain. Repeated irritation can produce fibrosis, which means the formation of thickened scar tissue. Bands of scar tissue called adhesions may then connect structures that should normally slide past one another. An ovary can become attached to the pelvic wall, the uterus may become fixed in position, or sections of bowel can be pulled toward surrounding tissue. Movement, sex, exercise, bowel activity, or an ordinary pelvic examination may become painful because the organs are no longer moving freely.

The familiar explanation that endometriosis lesions simply menstruate inside the body is incomplete. Some lesions respond to monthly hormonal changes and may swell or bleed on a microscopic level, but they do not all behave like the uterine lining, and visible trapped blood does not explain every symptom. Pain may come from inflammation, nerve irritation, organ pressure, adhesions, muscle spasms, or changes in the nervous system. Pelvic muscles often tighten protectively when pain keeps returning. Over time, those muscles may remain tense even between menstrual periods, producing another source of pain. The nervous system may also become sensitized, meaning it becomes increasingly efficient at detecting and amplifying danger signals. Once that happens, a stimulus that should cause mild discomfort can feel severe, and pain may continue even after the original trigger has been treated.

This helps explain one of the disease’s most confusing truths: the amount of visible endometriosis does not reliably predict the amount of pain. Someone with a few small superficial lesions may be unable to function, while another person with large endometriomas and extensive adhesions may have little pain. The difference does not mean the first person is exaggerating or the second person is unusually tough. Nerve location, inflammation, immune activity, pelvic muscle tension, previous pain experiences, and nervous-system sensitization all affect what the body feels. Endometriosis is often classified from stage I, called minimal, through stage IV, called severe, based largely on the number, depth, and location of lesions and adhesions. Those stages describe visible anatomy more effectively than lived suffering. A low stage is not a low-pain guarantee, and a high stage is not a measurement of personal strength. The National Institutes of Health notes that lesion size and location do not reliably correspond with pain severity.

Severe menstrual pain, called dysmenorrhea, is one of the best-known symptoms, but the disease can stretch far beyond the menstrual period. Pain may begin several days before bleeding, continue throughout the period, and remain afterward. Some experience

pelvic pain around ovulation, when an ovary releases an egg. Others develop lower-back pain, hip pain, pain traveling into the legs, abdominal bloating, fatigue, headaches, nausea, or a heavy dragging sensation inside the pelvis. Bleeding may be heavy or irregular, but some people with endometriosis have ordinary-looking periods. Pain during or after sex may last for hours or days rather than ending when intercourse stops. The pattern can be cyclical, meaning it rises and falls with the menstrual cycle, but long-standing disease may produce pain at any time of the month.

Adolescents are especially vulnerable to having early symptoms overlooked. A young person may be told that painful periods are part of becoming a woman, particularly when older relatives also experienced severe pain. A family pattern can normalize the symptoms even though family history may actually point toward increased endometriosis risk. Missing school every month, vomiting from pain, fainting, repeatedly needing to lie on the bathroom floor, or receiving little relief from properly used anti-inflammatory medicine deserves medical attention. Mild to moderate cramping can occur during normal menstruation because the uterus contracts to release its lining. The concern rises when pain steadily worsens, begins before the bleeding, continues afterward, resists ordinary treatment, or interferes with education, work, sleep, movement, eating, or relationships. A person does not have to wait until adulthood, sexual activity, or attempted pregnancy before being evaluated.

Medicine still does not know the single cause of endometriosis. Retrograde menstruation is one theory: some menstrual fluid travels backward through the fallopian tubes and enters the pelvic cavity instead of leaving entirely through the vagina. This process occurs in many people who never develop endometriosis, so it cannot explain the disease by itself. Another theory, called metaplasia, proposes that certain cells outside the uterus can transform into endometrium-like cells under particular biological conditions. Researchers are also studying genetic inheritance, immune-system regulation, stem cells, hormone signaling, environmental influences, and the movement of cells through blood or lymphatic vessels. Lymphatic vessels form part of the body's drainage and immune network and could help explain rare lesions far from the pelvis. The most likely answer is not one universal cause but several biological pathways that produce a similar disease. [NIH researchers describe multiple theories because no single explanation accounts for every location and presentation.](#)

Nothing about these theories suggests that endometriosis is caused by poor hygiene, sexual behavior, emotional weakness, abortion, delayed childbirth, or something a woman did wrong. It is not contagious and cannot be passed between sexual partners. It is not a sexually transmitted infection. It is also not cancer, although its ability to grow, attach to tissue, and sometimes return after treatment can make the language surrounding it sound frighteningly similar. Most lesions remain noncancerous. Endometriosis has been associated with a slightly increased risk of certain uncommon ovarian cancers, but the absolute risk for any one person remains low. That association does not mean endometriosis will become cancer or that everyone with the disease needs aggressive surgery.

Adenomyosis is often confused with endometriosis because the names and symptoms overlap. In adenomyosis, endometrium-like tissue grows within the muscular wall of the uterus rather than outside the uterus. This can make the uterus enlarged, tender, and painful while contributing to heavy bleeding and strong cramps. Endometriosis and adenomyosis can occur together, but they are not the same condition. Fibroids are also different; they are noncancerous tumors made from muscle and connective tissue that grow within or around the uterus. Ovarian cysts, pelvic inflammatory disease, irritable bowel syndrome, inflammatory bowel disease, painful bladder syndrome, pelvic-floor dysfunction, and nerve disorders can produce overlapping symptoms. A careful diagnosis therefore looks for patterns without assuming that every episode of pelvic pain must be endometriosis.

The history of diagnosis is also tangled with race. For generations, endometriosis was wrongly presented as a disease mainly affecting affluent White women, while Black women with pelvic pain and heavy bleeding were more likely to be evaluated for fibroids or have their symptoms minimized. Fibroids are genuinely common among Black women, but one condition does not protect against the other, and both can exist in the same body. Studies showing fewer endometriosis diagnoses among Black women cannot automatically be interpreted as proof of less disease. Diagnosis depends upon access to gynecologic care, referral patterns, the clinician's expectations, imaging, willingness to offer surgery, and whether the patient's pain is believed. Historic underrepresentation in research then reinforces the problem because medical teaching is built from incomplete samples. Systematic reviews have found that Black women have been significantly less likely than White women to receive an endometriosis diagnosis, revealing a diagnostic disparity rather than a reason to dismiss their symptoms. Research indexed by the National Library of Medicine documents this unequal pattern.

Diagnosis begins with a serious conversation about symptoms. A useful menstrual history includes the age when periods began, timing and length of bleeding, pain before and after menstruation, bowel and bladder changes, discomfort during sex, pregnancy history, family history, missed work or school, and which treatments have been attempted. A symptom diary can make the pattern visible when memory becomes blurred by months or years of recurring pain. It helps to record not only a pain number but what the pain prevented: walking normally, driving, sleeping, eating, concentrating, working, exercising, or having sex. Descriptions such as burning, stabbing, pulling, cramping, pressure, or electric pain may help identify different contributors. A pelvic examination may reveal tenderness, nodules, an ovarian mass, or organs that do not move normally, but a completely normal examination does not eliminate the possibility of endometriosis.

Ultrasound is commonly the first imaging study. A transvaginal ultrasound uses a narrow probe placed inside the vagina to create pictures with sound waves, while a transabdominal ultrasound sends sound waves through the lower abdomen. Ultrasound can identify ovarian endometriomas, some deep lesions, fibroids, cysts, and structural changes that may explain symptoms. Its accuracy depends partly upon the equipment and the experience of the professional performing and interpreting the scan. Small

superficial lesions frequently remain invisible, so a normal ultrasound cannot prove that endometriosis is absent. Magnetic resonance imaging, usually called MRI, can provide more detailed mapping when deep disease involving the bowel, bladder, or other structures is suspected. Imaging is valuable, but it must be interpreted together with the person's history rather than used to cancel that history.

For years, many patients were told that laparoscopic surgery was the only legitimate path to diagnosis. Laparoscopy is an operation in which a surgeon inserts a small camera through an incision in the abdomen to examine the pelvic organs. Suspicious tissue can be removed and sent to a pathologist, a physician who examines tissue under a microscope. Surgery remains the most definitive way to identify and confirm lesions, and it can diagnose and treat disease during the same procedure. Yet requiring every patient to undergo an operation before acknowledging probable endometriosis created expense, risk, and years of delay. Current guidance allows clinicians to make a presumptive or clinical diagnosis from symptoms, history, examination, and appropriate imaging and to begin treatment without first demanding surgery. "Presumptive" means the evidence strongly supports the diagnosis even though tissue has not been surgically confirmed. ACOG's 2026 diagnostic guideline formalized this broader clinical approach.

That change does not mean every pelvic symptom should automatically receive an endometriosis label. It means a patient's report is considered medical evidence rather than an unproven complaint. A clinician can begin reasonable treatment while continuing to evaluate other possible causes. If treatment improves the pain, that improvement may support the working diagnosis, although it does not prove it because hormonal medicines can help several gynecologic conditions. If symptoms continue, fertility is affected, imaging shows complex disease, or the diagnosis remains uncertain, surgery may become appropriate. The decision should consider the patient's priorities rather than treating an operation as a required entrance fee to care. Worldwide, diagnosis still commonly takes between four and twelve years, allowing pain, educational disruption, employment problems, relationship strain, and distrust of health care to accumulate. WHO identifies those delays and states that surgery is not always required before treatment begins.

Treatment is not a single ladder in which every patient must climb the same steps. The plan depends upon the main problem, whether that problem is pain, heavy bleeding, bowel symptoms, painful sex, infertility, an ovarian endometrioma, or several concerns together. Age, other health conditions, previous treatments, medication risks, tolerance for side effects, disease location, and plans for pregnancy all matter. A person trying to conceive immediately requires a different strategy from someone who wants to suppress menstruation for several years. Good treatment also separates three goals that are often blurred together: reducing symptoms, removing visible disease, and improving fertility. One intervention may help one goal while doing little for another. No available treatment guarantees that every lesion will disappear permanently or that pain will never return.

Nonsteroidal anti-inflammatory drugs, known as NSAIDs, include medicines such as ibuprofen and naproxen. They reduce the production of prostaglandins, chemicals that help the uterus contract and contribute to inflammation and pain. They may work best when taken early in the pain cycle rather than after pain has already become severe, but dosing should follow medical instructions and the product label. Long-term or heavy NSAID use can cause stomach bleeding, kidney problems, elevated blood pressure, and other complications, particularly in people with certain medical conditions or those taking interacting medications. Pain relief is valuable, but continually increasing over-the-counter medicine while the underlying problem remains unexamined is not a complete treatment plan. When ordinary doses no longer allow normal functioning, the answer should not automatically be to endure more.

Hormonal treatment attempts to reduce the stimulation that keeps endometriosis active. Combined hormonal contraceptives contain estrogen and a progestin and may be delivered through pills, patches, or vaginal rings. They can sometimes be used continuously so that menstrual bleeding happens less often or stops. Progestin-only treatment may come as a pill, injection, implant, or hormone-releasing intrauterine device, commonly called an IUD. These medicines can reduce bleeding and pain, but responses vary: one person may experience major relief while another develops irregular bleeding, mood changes, headaches, or other unacceptable effects. Hormonal suppression does not remove existing adhesions, and improvement usually lasts only while the disease remains suppressed. It is management rather than proof that the disease has been cured.

Gonadotropin-releasing hormone medicines, shortened to GnRH medicines, act higher in the hormonal control system. The brain normally uses GnRH to signal the ovaries through a chain of other hormones. GnRH agonists and antagonists interrupt that signaling in different ways, lowering ovarian estrogen and temporarily creating a state resembling menopause. Pain may improve, but low estrogen can produce hot flashes, vaginal dryness, sleep problems, mood changes, and loss of bone density. Clinicians sometimes prescribe “add-back therapy,” a carefully selected low dose of hormone that reduces these side effects without completely cancelling the treatment’s purpose. Because of their risks, these medicines require medical supervision and are generally limited by duration. Aromatase inhibitors, which further reduce estrogen production, may be considered in difficult cases under specialist care rather than treated as casual first-line medicine.

Hormonal treatment during use generally prevents or delays pregnancy, but it does not mean that the person has surrendered the possibility of future pregnancy. Ovulation often returns after the medicine is stopped, although the timing depends on the specific drug. These medications manage pain; they do not treat infertility while someone is actively attempting conception. Pregnancy itself is not a cure. Some symptoms may improve while menstruation is absent, but lesions and adhesions do not reliably vanish, and pain can return after delivery. The old advice to “just get pregnant” is medically

inadequate and emotionally careless. Pregnancy is a major life decision, not a prescription, and no one should be pressured into it as treatment.

Surgery may become valuable when medication does not provide enough relief, an endometrioma is large or concerning, organs appear affected, fertility planning requires it, or the person prefers a surgical approach after understanding the risks. During laparoscopy, a surgeon may excise lesions by cutting them out or ablate them by destroying visible tissue with heat or another form of energy. Excision can provide tissue for microscopic examination and may allow deeper disease to be removed, while ablation may treat selected surface lesions. Neither word should be treated as a magical guarantee. The surgeon's ability to identify different appearances of endometriosis, protect healthy tissue, manage deep disease, and coordinate with bowel or urinary specialists can be as important as the name of the technique. Surgery can bring meaningful relief, but lesions, adhesions, pelvic-floor pain, or nervous-system sensitization may persist or return.

Ovarian surgery deserves special planning because removing an endometrioma may also remove or damage healthy ovarian tissue. Ovarian reserve describes the remaining supply of eggs and the ovary's ability to respond during fertility treatment. Repeated ovarian operations can lower that reserve, even when each operation is performed for understandable reasons. A person who may want children should discuss age, cyst size, symptoms, ovarian-reserve testing, and fertility options before surgery whenever time allows. This does not mean every endometrioma should be left alone. It means pain relief, disease control, cancer evaluation, and future fertility must be considered together rather than one at a time.

A hysterectomy removes the uterus, but endometriosis exists outside the uterus. For that reason, hysterectomy is not an automatic cure. It can stop uterine bleeding and may greatly help when adenomyosis or uterine pain is also present, yet lesions on the bowel, bladder, pelvic walls, nerves, or other structures can remain unless separately treated. Removing both ovaries sharply lowers estrogen but causes surgical menopause, bringing consequences for bones, cardiovascular health, sexual function, temperature regulation, sleep, and quality of life. Even removal of the uterus and ovaries does not guarantee permanent relief in every patient. Major irreversible surgery therefore deserves a careful discussion of what is being removed, why it is being removed, which symptoms it is expected to improve, and which symptoms may remain. NIH guidance describes hysterectomy and ovary removal as last-resort decisions rather than guaranteed cures.

Fertility is one of the most emotionally charged parts of endometriosis, but diagnosis does not equal infertility. Many women with the disease conceive without fertility treatment. Others experience difficulty because inflammation can affect the interaction among sperm, eggs, fallopian tubes, and pelvic tissue. Adhesions may prevent the ovary from releasing an egg normally or make it harder for the fallopian tube to collect and transport that egg. Endometriomas and ovarian surgery can affect ovarian reserve, while deep disease may distort pelvic anatomy. Fertility also depends upon age, ovulation,

sperm health, tubal condition, pregnancy history, and other factors unrelated to endometriosis. The disease is one part of the picture, not a prediction carved into the future.

When conception is difficult, options may include carefully selected surgery, ovulation medication, intrauterine insemination, or in vitro fertilization. Intrauterine insemination places prepared sperm directly into the uterus near the time of ovulation. In vitro fertilization, usually called IVF, involves retrieving eggs, combining them with sperm in a laboratory, allowing embryos to begin developing, and transferring an embryo into the uterus. The best path depends upon age, ovarian reserve, fallopian-tube function, semen results, disease severity, previous surgery, duration of infertility, cost, and personal values. Another surgery is not always the best step before IVF, especially after previous ovarian operations. A reproductive endocrinologist, a physician specializing in hormones and fertility, can help place those competing concerns into one plan rather than treating pregnancy as an afterthought.

Pain care sometimes needs to continue even after lesions have been medically suppressed or surgically removed. Pelvic-floor physical therapy can help muscles learn to relax, coordinate, and move without constantly guarding against expected pain. A physical therapist trained in pelvic health may work on breathing, posture, hip movement, abdominal tension, scar mobility, and internal pelvic muscles when appropriate and consented to. Heat, sleep support, gradual movement, bowel management, and treatment of overlapping bladder or digestive conditions may also reduce the total burden. Cognitive behavioral therapy does not imply that the disease is imaginary. It teaches ways to reduce the fear, stress, avoidance, and nervous-system activation that chronic pain can create. Effective multidisciplinary care accepts that lesions, muscles, nerves, hormones, sleep, mental health, and daily circumstances can all participate in the same pain experience.

Food is often presented online as though one perfect diet can starve endometriosis. Research has not established a universal endometriosis diet or a food plan that cures the disease. Some people discover that particular foods worsen bloating, constipation, diarrhea, or inflammation-related discomfort, and individualized changes may help those symptoms. A dietitian can be useful when digestive restrictions are becoming complicated, especially because eliminating many foods can create nutritional deficiencies or make eating unnecessarily stressful. Exercise may reduce pain for some and worsen flares for others, so movement should be adjusted rather than used as a test of toughness. Supplements, herbs, detoxes, and essential oils should not be assumed harmless simply because they are labeled natural. They may interact with medication, affect bleeding, strain the liver or kidneys, or delay treatment that has stronger evidence.

Living with endometriosis changes more than the pelvis. A person may begin calculating clothing, transportation, bathroom access, work schedules, sexual activity, and social plans around an unpredictable body. Repeated pain can interrupt sleep, and poor sleep can intensify pain sensitivity the following day. Painful sex may create fear before

intimacy begins, making pelvic muscles tighten and increasing the likelihood of further pain. Fertility concerns can affect identity and relationships even before anyone knows whether conception will actually be difficult. Medical appointments, imaging, medication, missed work, and surgery create financial pressure. Depression and anxiety may develop around the disease, but their presence does not mean they created the physical condition. They are understandable responses to living with pain, uncertainty, disbelief, and repeated disruption.

A strong medical conversation therefore needs more than the statement “my periods hurt.” It may include how many days pain lasts, whether it begins before bleeding, whether bowel movements or urination become painful, whether sex causes deep pain, whether symptoms are worsening, and exactly what daily activities are being lost. Bringing a written timeline, medication history, family history, imaging reports, and previous surgical records can prevent each new appointment from beginning at zero. Asking what diagnoses are being considered, what a normal scan can and cannot exclude, and what goal each treatment is meant to achieve can reveal whether the plan is thoughtful. A second opinion is reasonable when symptoms are repeatedly dismissed, complex surgery is proposed, fertility may be affected, or the explanation does not match the lived experience. Self-advocacy does not require hostility; it means refusing to let vagueness replace medical reasoning.

Endometriosis is chronic, but chronic does not mean hopeless or untreatable. Some people gain long periods of relief from simple hormonal suppression, while others need combinations of medication, surgery, pelvic-floor therapy, fertility care, and long-term pain management. Treatment may change as the body, relationships, symptoms, health risks, and pregnancy goals change. Menopause often reduces hormonal stimulation, but it does not guarantee that every symptom will end, especially when scar tissue, pelvic-floor dysfunction, or sensitized nerves remain. Researchers are pursuing better imaging, blood and menstrual-fluid markers, immune-based treatments, nonhormonal medicines, and clearer ways to predict which treatment will help which patient. Those advances matter because trial and error has carried too much of the burden for too long.

Sudden severe pelvic or abdominal pain should not automatically be blamed on known or suspected endometriosis. Fainting, fever, persistent vomiting, new severe one-sided pain, chest pain, difficulty breathing, unusual heavy bleeding, or pain accompanied by a possible pregnancy can signal emergencies such as ectopic pregnancy, ovarian torsion, a ruptured cyst, infection, or internal bleeding. Those symptoms require prompt medical evaluation. Endometriosis may explain a long pattern, but it should never become a label that causes a dangerous new symptom to be ignored.

The disease ultimately teaches an important difference between what is common and what should be accepted. Menstruation is common. Mild cramping is common. A life repeatedly shut down by pelvic pain should not be accepted merely because millions of others have been taught to endure the same silence. Endometriosis deserves more than a pain score, more than a normal ultrasound, and more than advice to wait until

pregnancy or menopause changes the situation. It requires the body's full story to be heard, the limits of medical knowledge to be admitted, and treatment to be built around the person rather than forcing the person to disappear inside the diagnosis.