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Guide to Attribute and Manage Upper GI Symptoms to Endometriosis!

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Abstract

Multifaceted impact of endometriosis on women's health, emphasizing its association with neuropathic pain, cognitive dysfunction, migraine, mental health disorders, and reduced quality of life. Cognitive impairments, characterized as "brain fog", involve disrupted brain connectivity, neuroinflammation, and hormonal imbalances, contributing to daily functional challenges. The coexistence of migraine exacerbates disease burden, sharing inflammatory pathways and hormonal sensitivities, yet remains under-treated. Anxiety and depression are prevalent, mediated by neuroinflammatory processes, chronic pain, and psychosocial stressors, significantly impairing mental health and social functioning. Furthermore, endometriosis substantially decreases quality of life across physical, emotional, and social domains, often surpassing other chronic conditions. Gastrointestinal (GI) symptoms in women, such as cyclical abdominal pain, bloating, constipation, diarrhoea, and pain during bowel movements, surprisingly lead frequently to underlying endometriosis. Often misdiagnosed as irritable bowel syndrome (IBS), these GI issues worsen during menstruation due to endometriosis lesions on the bowel, necessitating a holistic approach.

Sigmoid colon and rectum are the most common sites for bowel involvement, followed by the ileum and appendix. Most patients present with abdominal pain which intensifies during menstruation, with "endo belly" (bloating), constipation, and diarrhoea alternately. Diagnosis is challenging due to non-specific symptoms, imaging like pelvic ultrasound (USG), CT scan or MRI, or sometime even laparoscopy is crucial for identifying masses or strictures.

Material & Methods: *Two emergency GI symptoms cases referred in 2025 taught this author the vagaries of endometriosis. First case clinically diagnosed as intestinal obstruction or carcinoma of colon, after a laparotomy, histopathological examination of resected segment of sigmoid colon's proved it to be a case of endometriosis. The second case with a two-day history of vomiting, abdominal distention and absolute constipation, CT scan abdomen indicating a distal small bowel obstruction close to the terminal ileum. Laparotomy confirmed a small bowel stricture approximately 20 cm from the caecum, macroscopically consistent of endometrial deposits and histopathology confirmed extensive endometriosis.*

Outcomes: *Both patients made an uneventful post-operative recovery and referred to gynaecology department for ongoing management of endometriosis.*

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Keywords: Gastrointestinal Symptoms Painful and Cyclical Bowel Dyschezia, Coinciding with the Menstrual Cycle, Severe Abdominal Bloating and Distension, Chronic Constipation, Diarrhoea, or both Alternately, Nausea & Acid Reflux Accompanied with Digestive Distress and Deep Pelvic Pain Either During Intercourse or After Bowel Movements

Introduction

Endometriosis has a multifaceted impact of on women's health. A lot is documented about neuropathic pain, cognitive dysfunction, migraine, mental health disorders, and reduced quality of life. However, there is not much about its association with Gastrointestinal symptoms (GI) symptoms in Indian women, frequently leading to underlying endometriosis. Cognitive impairments, characterized as "brain fog", the coexistence of migraine exacerbates disease burden, Anxiety & Depression prevalent, mediated by neuroinflammatory processes, chronic pain, and psychosocial stressors, significantly impairing mental health and social functioning and endometriosis substantially decreasing the quality of life across physical, emotional, and social domains, are well documented. Often misdiagnosed as irritable bowel syndrome (IBS), these GI issues worsen during menstruation due to endometriosis lesions on the bowel, necessitating a holistic approach [1].

Common Gastrointestinal Symptoms Linking to Endometriosis include i) Painful and cyclical bowel movements pain called dyschezia, coinciding with the menstrual cycle ii) Severe abdominal bloating & distension, often worsened by food sensitivities or inflammation iii) Irritable Bowel Syndrome (IBS) Symptoms like Chronic constipation, diarrhoea, or both alternately iv) Nausea & Acid Reflux accompanied with digestive distress v) Deep Pelvic Pain either during intercourse or after bowel movements. [2,3].

Sigmoid colon and rectum are the most common sites for bowel involvement, followed by the ileum and appendix. The patients present with abdominal pain which intensifies during menstruation, with "endo belly" (bloating), constipation, and diarrhoea alternately. Diagnosis is challenging due to non-specific symptoms; imaging pelvic ultrasound (USG), CT scan or MRI, or sometime even laparoscopy is crucial for identifying masses or strictures [4].

Pathophysiology

GI symptoms are often mistaken for IBS, causing misdiagnosis due to a significant overlap, as both conditions cause similar, debilitating abdominal pain as endometrial tissue outside the uterus triggers an immune response, causing inflammation of the gut and pelvic organs. Endometrial tissue attached to the intestines, causes pain & irregular bowel movements especially during menstruation. An impaired intestinal barrier may allow pathogens to cause higher inflammation and contribute to pain [4].

This article is an attempt to update general practitioners and Gynaecologists on the multifaceted impact of endometriosis on women's health, especially emphasizing its association with Gastrointestinal symptoms.

Case Reports

Case Report 1

A 25-year-old female patient admitted to the surgical gastroenterology department of a private medical college hospital with complaints of vomiting, constipation and lower abdominal pain for 2 months. She had normal, regular menses with no history of dyspareunia, dysmenorrhea, and rectal bleeding. Physical examination revealed mild lower abdominal tenderness. Blood biomarkers like, liver function tests, urea, creatine, electrolytes all were within normal limits. Clinically diagnosed as intestinal obstruction. Differential diagnosis considered was carcinoma of colon. After a laparotomy a segment of sigmoid colon measuring 15 cm long was sent to pathology department in 10% formalin for immediate histopathological examination.

It showed stricture of 3 cm, 2 cm away from nearest resected margin. Distal part of intestine was dilated. Microscopic examinations of stricture site of colon revealed mucosa lined by columnar epithelium, lamina propria showed, benign mucosal glands, chronic mononuclear inflammatory cell collection. Submucosa and muscularis showed endometrial glands with decidualized endometrial stromal transmural collections, chronic mononuclear cells and congested blood vessels. Based on the histopathology a final diagnosis was made of endometriosis. The patient made an uneventful post-operative recovery. Following discharge, she was referred to gynaecology for ongoing management of endometriosis.

Case Report 2

46-year-old female with a two-day history of vomiting, abdominal distention and absolute constipation presented to the emergency department. She previously had a laparoscopic cholecystectomy. Her presentation was consistent with an acute small bowel obstruction. There was no previous history of lower abdominal pain or bowel obstruction. Her vital sign observations, urinalysis and full blood count were normal. Her physical examination demonstrated a soft but distended abdomen with lower abdominal tenderness, maximally over the right-lower quadrant. CT abdomen demonstrated a distal small bowel obstruction with faecalisation close to the terminal ileum, without any discrete mass. As this site was remote to her prior surgery, an early diagnostic laparoscopy was performed on the day of admission. Laparoscopy confirmed a small bowel stricture approximately 20 cm from the caecum, macroscopically to consist of endometrial deposits. The strictured small bowel segment was resected with a stapled functional end-to-end anastomosis. Histopathology confirmed extensive endometriosis of the small bowel involving the serosa and muscularis propria. The patient made an uneventful post-operative recovery. Following discharge, she was referred to gynaecology for ongoing management of endometriosis.

Case Report 3

Rectosigmoid Stricture: A 42-year-old female presented with a 2-year history of dysmenorrhea, crampy abdominal pain, vomiting, and a 5 kg weight loss. Imaging indicated a stricture, and laparoscopic anterior resection confirmed intestinal endometriosis.

Case Report 4

Appendicular Endometriosis: A young woman with a history of infertility presented with symptoms mimicking acute appendicitis. A 2 cm mass at the tip of the appendix was identified as endometrial tissue.

Discussions

Gastrointestinal symptoms (GI) symptoms in Indian women, are surprisingly leading to underlying endometriosis [1]. Some nonspecific complaints like stomach intestinal discomfort, cyclic diarrhoea, constipation, nausea, and vomiting, cause confusion and make diagnosis challenging, especially to attribute it to endometriosis, the chameleon among gynaecological diseases. Apart from these general bowel symptoms, there are also specific symptoms like cyclic bloating of the abdomen, known as endo-belly during the second half of the menstrual cycle leading up to menstruation, the abdomen becomes increasingly bloated causing discomfort & pain due to elevated sensitivity of the intestinal wall, as such patients exhibit a reduced stretch pain threshold of the intestinal wall [2].

Endometriosis is a chronic inflammatory disease that presents with a range of symptoms, with severe dysmenorrhea, cyclic and acyclic lower abdominal pain, cyclic dysuria and dyschezia, dyspareunia, and pain and infertility being the most common. Women with endometriosis are significantly more likely to present with upper gastrointestinal (GI) symptoms such as nausea and vomiting, epigastric or right upper quadrant abdominal pain and gastroparesis, and higher utilization of health facilities [5].

While central sensitization plays a crucial role in the persistence and severity of neuropathic pain in endometriosis, driven by glial activation, neuroplasticity, and microbial dysbiosis, often leading to heightened pain sensitivity beyond ectopic tissue presence [2,3]. Madison Simons from the Digestive Disease Institute, Cleveland Clinic Foundation, Cleveland, Ohio and colleagues conducted a retrospective chart review to explore possible associations or differences in GI symptoms and healthcare utilization between 3236 adult women with endometriosis (GYN) and 3500 without endometriosis (GI) who visited Gastroenterology OPD at a tertiary hospital between 2010 and 2022, GI diagnoses was based on ICD-10 codes.
The two groups differed in terms of age and racial composition. The GYN complaint group was younger,

with an average age of 49.5 years compared to 57.8 years in the GI group.

The GYN group had fewer outpatient visits (ranging from 0-61) compared to those who did not have endometriosis (0-122). However, they experienced significantly more emergency department visits (0-327 vs 0-88), hospitalizations (0–147 vs 0–66), and abdominal surgeries.

Women with endometriosis exhibited a higher prevalence of i) abdominal pain such as right upper quadrant (332 vs 202), epigastric (824 vs 737), ii) abdominal distention (813 vs 609), iii) nausea and vomiting (568 vs 513), iv) change in bowel habits (231 vs 144) ,v) iron deficiency anaemia (206 vs 147) and vi) gastroparesis (208 vs 164). Women without endometriosis had more of Crohn's disease (556 vs 27) & abnormal weight loss (136 vs 244).

This study underscores the significance of also considering gynaecologic conditions in the evaluation of perimenopausal or postmenopausal women with upper GI symptoms. When digestive symptoms and gynaecologic symptoms occur simultaneously, there is a risk of delaying diagnosis and appropriate treatment. Clinicians should therefore maintain a high index of suspicion for gynaecologic overlap when assessing women with upper GI symptoms and consider gynaecologic conditions such as endometriosis in the differential diagnosis, especially among women older than 50 years where the perimenopausal or postmenopausal changes can further obscure symptom presentation and diagnosis.

Diagnosis

Endometriosis is a medical condition where endometrial tissue and glands are found outside the uterine cavity: on ovaries, pelvic peritoneum, rectovaginal septum, bladder, bowel and more. The ectopic tissue is estrogenic dependent & cause inflammation and immune response which is responsible for chronic pain, infertility and disability of these patients. Without a specific biomarker and with a wide range of symptoms, the diagnosis is often overlooked or delayed. Abdominal and pelvic pain together with dysmenorrhea, dyspareunia, irregular bleeding, and cyclic alteration of intestinal habits are a challenging combination of symptoms that characterise endometriosis. One of the less recognized yet significant causes of abdominal pain is intestinal endometriosis [3,4]. Gastroenterologists and gynaecologists must solve the intricate puzzle of gynaecological, gastrointestinal and nonspecific symptoms that are present in patients with intestinal endometriosis; Better if managements are decided by a multidisciplinary team.

Traditional Gold Standard (Definitive Diagnosis); Laparoscopy with Biopsy: A surgeon visually inspects the pelvic cavity, identifies endometriotic lesions, and takes a tissue sample (biopsy) for a pathologist to confirm under a microscope. This confirms the diagnosis and can assess disease extent. As Laparoscopy is invasive, costly, and carries risks, leading to significant delays in diagnosis (often years), recent guidelines promote using imaging and clinical acumen for earlier, less invasive workups, with surgery potentially avoided or planned more effectively.

Emerging Non-Invasive Approaches (Presumed Diagnosis): Clinical Diagnosis is based on symptoms (pain, infertility) and findings from pelvic exams, often leading to a presumed diagnosis for early treatment.

Imaging: Specialized Transvaginal Ultrasound (TVUS) are highly accurate for detecting deep infiltrating endometriosis and endometriomas (ovarian cysts). Magnetic Resonance Imaging (MRI) is also excellent for deep endometriosis and mapping disease extent, but less effective for superficial implants. Biomarkers: Blood tests for CA-125 are not specific enough; therefore, research continues for new markers in menstrual fluid or blood.

Management

Endometriosis management often causes gastrointestinal (GI) symptoms through side effects of hormonal treatments (e.g., bloating, nausea from GnRH agonists) or medication-induced issues like constipation from opioid pain relievers. Sometimes, GI symptoms lead to laparotomy finding Bowel endometriosis itself, or adhesions from previous surgeries, causing severe pain, diarrhoea, constipation, and nausea.

Common Treatment-Related GI Side Effects

One of the less recognized yet significant causes of abdominal pain is intestinal endometriosis. The pathogenic mechanisms, diagnostic challenges and treatment while highlighting the importance of recognizing

intestinal endometriosis as a potential differential diagnosis in patients with gastrointestinal symptoms. Sometimes Hormonal Therapies (GnRH Agonists/ Antagonists) used to suppress estrogenic and shrink tissue, cause gastrointestinal dysmotility, bloating, and nausea [4]. Pain Medications NSAIDs can cause irritation, while opiates often cause severe constipation and bowel dysfunction. Surgical interventions to remove endometrial tissue, particularly in the bowel, can result in adhesions that lead to long-term GI distress, such as constipation and pain with bowel movements.

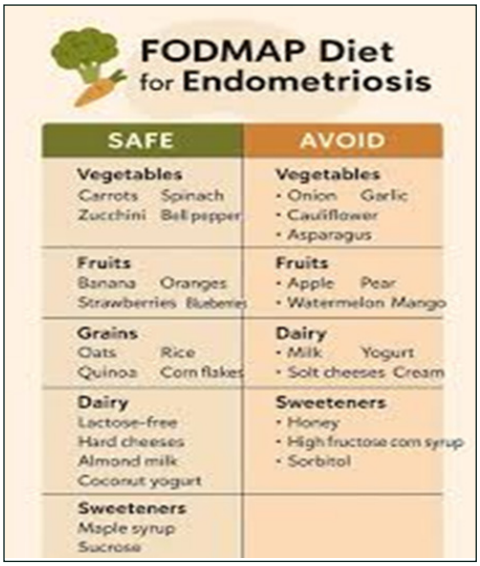
Management Strategies to Alleviate GI Symptoms

Dietary Adjustments by adopting a low-FODMAP diet to reduce bloating and gas. Anti-inflammatory Diet of Increasing intake of omega-3s and antioxidants to decrease lesion-related inflammation. Probiotics supplementation to restore healthy gut flora and manage potential Small Intestinal Bacterial Overgrowth (SIBO) and Pelvic Floor Physical Therapy treat non-relaxing pelvic floor dysfunction to improve bowel movement ease.

Switching Medications: Exploring alternative hormone therapies or, if necessary, surgical intervention for severe, localized bowel lesions.

Management by lifestyle changes, such as adopting a low FODMAP diet can significantly reduce gastrointestinal (GI) symptoms like bloating, pain, and diarrhoea in women by 50% or more, particularly for those with co-existing IBS by eliminating fermentable carbohydrates (FODMAPs) that cause gas and water retention.

A recent study involved four weeks of FODMAP diet elimination, followed by a reintroduction-period of at least ten weeks, varying by patient. The primary outcome was constipation change and Secondary outcomes included changes in bloating, QoL and abdominal pain, assessed by Endometriosis Health Profile-30 (EHP-30). P-value<0,05 indicated statistical significance, after the reintroduction period compared to baseline, assessed by Groningen-De-FeC-questionnaire (0–30 scale) with paired-T-test or Wilcoxon-signed-rank-test. Of 34, patients' studies 24 (71%) completed the diet. Constipation scores improved significantly after low-FODMAP diet compared to baseline from 7.0 to 5.0 (p=0.023). There was no significant difference observed in bloating, however 53% of patients that completed the diet mentioned a decrease.



The pain reduced from 47.8 to 29.2 (p=0.002)), control and powerlessness (from 69.4 to 36.7 (p=0.000)), emotional well-being (from 45.2 to 29.2 (p=0.001)), social support (from 46.4 to 31.3 (p=0.0017)), self-image (from 51.2 to 40.5 (p=0.035)), work-life (from 35.0 to 21.7 (p=0.003)) and sexual intercourse (from 61.6 to 45.7 (p=0.023)). 65% of patients that completed the diet mentioned a decrease in chronic pelvic pain [6].

This approach helps to manage bowel symptoms, and it does not treat the underlying endometriosis tissue [4,6]. As reported in our case reports hospitals may have to offer a range of treatments, including medication, hormonal therapy, and surgical (laparoscopic) options tailored to alleviate symptoms and improve quality of life. Therefore, there is an urgent need to empower primary care doctors, general practitioners and consulting a gynaecologist with endometriosis expertise with this phenomenon. A multidisciplinary team is crucial for proper diagnosis in India in Multi-speciality hospitals

Conclusion

Gastrointestinal symptoms (GI) symptoms in Indian women, are reported to be leading to underlying endometriosis. Apart from some nonspecific complaints of stomach / intestinal discomfort, cyclic diarrhoea, constipation, nausea, and vomiting, specific symptoms like cyclic bloating of the abdomen, during the sec-

ond half of the menstrual cycle are leading up to the diagnosis of endometriosis. The abdomen becomes increasingly bloated during second half of the menstrual cycle with discomfort & pain due to elevated sensitivity of the intestinal wall exhibiting a reduced stretch pain threshold of intestinal wall.

The Low FODMAP Diet for Endometriosis, reduces symptoms of abdominal bloating, pain, and altered bowel habits (constipation/diarrhoea) that often-mimic IBS, improving overall quality of life. It is not a permanent diet but involves a strict elimination phase (2-6 weeks) followed by a personalized reintroduction phase to identify specific trigger foods. High-FODMAP Foods to Limit include Garlic, onions, wheat, rye, barley, fruits like apples, pears, watermelon, mushrooms, cauliflower, asparagus, and honey. Similarly, Low-FODMAP Foods to enjoy are most meats, fish, eggs, firm tofu, rice, oats, quinoa, lactose-free dairy, and vegetables like zucchini, carrots, cucumber, and leafy greens.

Though about 72% of women saw improvements in bowel symptoms, strict, long-term elimination can be challenging and unnecessary. In addition, promoting lifestyle Factors like Eating calmly, chew food thoroughly, manage stress, and limit caffeine and alcohol would benefit. Combining the low FODMAP approach with an overall anti-inflammatory diet, emphasizing whole grains, healthy fats, and limiting processed foods give best results.

It is important to remember that this diet is intended to manage GI symptoms and do not to cure the condition itself.

As reported in our case reports hospitals may have to offer a range of treatments, including medication, hormonal therapy, and surgical options (laparoscopic), tailored to alleviate symptoms and improve quality of life.

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