

Episode 139 – Endometriosis and Oral Health August 22, 2025

Introduction
Endometriosis is a disease in which tissue similar to the endometrium (inner lining of the uterus) grows outside the uterus. The misplaced endometrial tissue, called implants, can irritate and inflame nearby tissues, causing scar tissue to form, sometimes as adhesions between structures in the abdomen. These adhesions cause pelvic tissues and organs to stick together. The endometrial tissue can also block the fallopian tubes, causing infertility. The exact causes and mechanisms behind the appearance of this tissue in other locations remain unclear. [1] [2] [3] [4]

Common locations for endometriosis include:
- Ovaries (when endometriosis involves the ovaries, cysts called endometriomas may form)
- Ligaments that support the uterus
- Peritoneum (tissue that lines the inside of the abdomen and pelvis) [1] [3]

Less common locations include:
- Fallopian tubes
- Outer surface of the small and large intestines
- Ureters
- Bladder
- Rectovaginal septum (area between the vagina and rectum)
- Vagina [1]

Rarely, endometrial tissue grows on the pleura (membranes covering the lungs), the pericardium (sac that envelops the heart), the vulva, the cervix, or scars from surgery in the abdomen. [1]

Endometriosis tissue responds to hormones as normal endometrial tissue does during the menstrual cycle. Consequently, endometrial implants can bleed and cause severe pain, particularly before and during menstrual periods. The severity of symptoms and the disorder's effects on fertility and organ function vary significantly from person to person.

As endometriosis progresses, the misplaced endometrial tissue typically increases in size and may spread to new areas. The amount of tissue present and the rate at which endometriosis advances also varies greatly. The tissue may remain on the surface of surrounding structures or invade deeply, forming nodules. [1]

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Endometriosis can start at the first menstrual period and last until menopause. There is no known definitive cure or way to prevent endometriosis. However, its symptoms can be managed with medications or, in some cases, surgery. [5]

Prevalence
Endometriosis affects approximately 10% of reproductive age females globally. [5] However, the true prevalence of endometriosis is uncertain because definitive diagnosis requires directly viewing the endometrial tissue via surgery, ideally through laparoscopy.

The prevalence of endometriosis ranges from:
- 2 to 11% among females without symptoms
- 5 to 50% among females experiencing infertility
- 5 to 21% among females hospitalized for pelvic pain
- 49% for adolescents with chronic pelvic pain to 75% for adolescents with pain that is unresponsive to medical treatment. [5] [6]

The average age at diagnosis is 28, but endometriosis can develop in adolescents and, rarely, young girls. [1]

Chronic pelvic pain that is unresponsive to conventional treatments develops in approximately 30% of females with endometriosis. About one third of individuals with endometriosis have infertility (approximately twice the rate among those without endometriosis). [6]

Despite its prevalence and staggering economic impact of $1.8 billion per year in Canada and $22 billion per year in the U.S., endometriosis remains misdiagnosed, misunderstood, and ineffectively treated. [7] [8]

Types of endometriosis
There are three types of endometriosis:
1. Superficial endometriosis grows on the surface of tissues.
2. Deep endometriosis (previously called deep infiltrating endometriosis) grows into the underlying tissue and can cause damage to the organs it grows on.
3. Endometriomas are when endometriosis grows on the ovaries. They are sometimes referred to as “chocolate cysts” because they are filled with dark brown fluid. [9]

A person with endometriosis may have only one type, or any combination of the three types. [9]

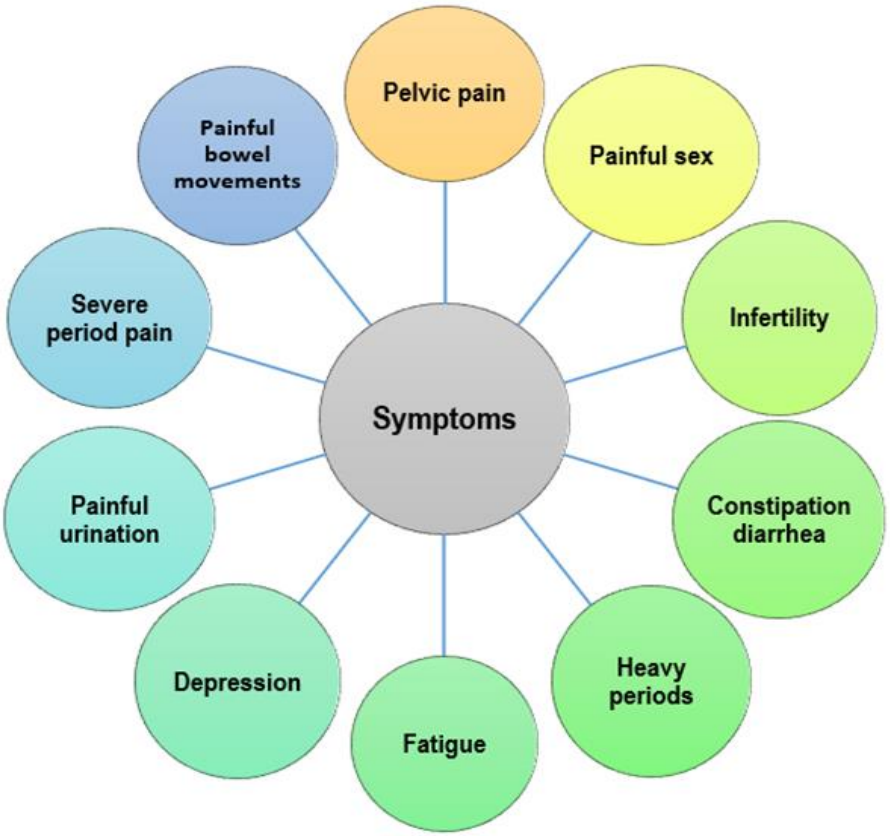
Symptoms
Symptoms of endometriosis depend on the location of the implants. The classic triad of symptoms is dysmenorrhea (painful menstruation), dyspareunia (pain during intercourse), and infertility. Severity of symptoms is not related to the stage of the disease. [2]

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Common symptoms of endometriosis include:

- Severe pelvic pain and cramping. The pain may start before a menstrual period and last for days into it and may be accompanied by lower back and stomach pain.
- Pain during intercourse or after is common with endometriosis.
- Severe endometriosis may cause infertility when the misplaced tissue or scar tissues caused by endometriosis block the egg's passage from the ovary into the uterus. Mild endometriosis may also cause infertility, but it is not clear how it does so. Endometriosis is sometimes first found during tests for infertility treatment.
- Pain in the lower abdomen and pelvic area not related to the menstrual cycle.
- Pain with bowel movements (dyschezia) or urination (dysuria), particularly before or during menstrual periods.
- Heavy menstrual bleeding and bleeding between periods.
- Depression
- Other symptoms may include fatigue, diarrhea, constipation, bloating, or nausea. These symptoms are more common before or during menstrual periods. [1] [3] [5]

Endometriosis symptoms



Symptoms often improve after menopause because estrogen and progesterone levels decrease. During pregnancy, endometriosis may temporarily go into remission or sometimes permanently. Some people with symptoms may not be aware they have the condition, and some people are asymptomatic. Those who are asymptomatic often find

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out they have the disorder when they cannot get pregnant or after they have surgery for another reason. [1] [3] [5] [10]

The severity of endometriosis symptoms does not depend on the amount of misplaced endometrial tissue. Some people with a large amount of tissue are asymptomatic. Others with a small amount have incapacitating pain. The pain typically varies during the menstrual cycle, worsening before and during menstrual periods. In many people, endometriosis does not cause pain until it has been present for several years. [1] [3]

Symptoms vary depending on the location of the endometrial tissue. Symptoms by location may include:

- Ovaries: Formation of a blood-filled mass (endometrioma), which, if it bursts, leaks, or twists, may cause pain and sometimes nausea and vomiting.
- Large intestine: Abdominal bloating, pain during bowel movements, diarrhea, constipation, or rectal bleeding during menstruation.
- Bladder: Pain above the pubic bone, pain during urination, urine that contains blood, and frequent and urgent need to urinate. [1]

The misplaced endometrial tissue and its bleeding may irritate nearby tissues. As a result, scar tissue may form, sometimes as adhesions (bands of fibrous tissue) between structures in the abdomen. The misplaced endometrial tissue and adhesions can interfere with the functioning of organs. Rarely do adhesions block the intestine. [1]

Endometriosis can often be mistaken for other conditions that cause pelvic pain, such as pelvic inflammatory disease or ovarian cysts. It may also be confused with irritable bowel syndrome (IBS), which causes bouts of diarrhea, constipation, and stomach cramps. IBS can occur alongside endometriosis, making it more challenging to determine the exact cause of the symptoms. [3]

Etiology of endometriosis

The cause of endometriosis is unclear. However, there are several theories, including:

- Endometrial cells shed during menstruation may flow backward through the fallopian tubes (i.e., retrograde menstruation) and implant in the abdominal cavity, instead of flowing through the vagina and out of the body during menstruation.
- Blood or lymphatic vessels may transport endometrial cells to another location.
- Hormones or immune factors might help transform peritoneal cells (cells that line the inner side of the abdomen) into endometrial cells.
- Endometrial cells may attach to scar tissue from a surgical incision in the abdomen, such as a C-section.
- An immune system condition where the body is unable to recognize and destroy endometriosis tissue.
- Heredity may be a factor, as indicated by large twin studies and the increased incidence in females with first-degree relatives with endometriosis. [1] [2] [3]

Other factors may also contribute to the growth or persistence of endometrial implants. For example, endometriosis is known to be dependent on estrogen, which increases the inflammation, growth and pain associated with the disease. However, the relationship

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between estrogen and endometriosis is complex since the absence of estrogen does not always mean the absence of endometriosis. [5]

Risk factors

Factors that raise the risk of endometriosis include:

- Never giving birth (nulliparity).
- Having a first baby after age 30.
- Starting to menstruate at an early age.
- Going through menopause at an older age.
- Short menstrual cycles (less than 27 days).
- Heavy menstrual periods that last longer than seven days.
- Having higher levels of estrogen or a greater lifetime exposure to estrogen produced by the body.
- Having structural abnormalities of the uterus that increase the risk of retrograde menstruation.
- Low body mass index.
- Having first-degree relatives with endometriosis (e.g., mother, sister).
- Exposure to the medication diethylstilbestrol (DES) in utero.[1] [1] [3]

Protective factors

Endometriosis seems to occur less often in females with the following characteristics:

- Have had multiple births
- Started to menstruate later than usual
- Prolonged lactation
- Long-term use of low-dose oral contraceptives
- Regular exercise (especially if started before age 15, exercise more than four hours/week, or both) [1] [2]

Complications

One of the main complications of endometriosis is infertility. Up to half of the individuals with endometriosis have difficulty conceiving. Endometriosis may block the fallopian tube, preventing the egg and sperm from uniting. The disorder also seems to affect fertility in indirect ways, such as damaging the sperm or egg. However, many individuals with mild to moderate endometriosis can still conceive and carry a pregnancy to term. Medical professionals often advise those with endometriosis not to delay having children because the condition may worsen over time. [3]

Cancer

Some studies suggest endometriosis increases the risk of ovarian cancer. However, the overall lifetime risk of ovarian cancer is low, and it remains fairly low in individuals with endometriosis. Although rare, another type of cancer called endometriosis-associated adenocarcinoma can occur later in life in those who have had endometriosis. [3]

[1] DES was prescribed to prevent miscarriage or premature delivery until 1971 in Canada and the U.S. The medication is no longer prescribed because it caused children to have various medical problems and increased risk for cancer of the cervix or vagina in females exposed to the drug in utero. [22] [23]

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Diagnosis

Diagnosis of endometriosis may include the following:

- Review of medical history, including current and past symptoms, where and when pain is felt, information about menstrual cycles, any past pregnancies, use of birth control, and sexual history.
- Physical exam to check general health.
- Pelvic exam to check for unusual changes, such as cysts, nodules, and painful areas.
- Abdominal and/or transvaginal ultrasound. A standard ultrasound will not confirm endometriosis. However, it can reveal endometriomas (ovarian cysts)
- Magnetic resonance imaging (MRI) can help with surgical planning as it gives detailed information about the location and size of endometriosis growths
- Laparoscopy, sometimes with biopsy, to check for endometrial tissue. Laparoscopy can provide information about the location, extent, and size of the endometriosis growths. A biopsy can confirm the diagnosis. [1] [11] [12]

Endometriosis is classified as minimal (stage I), mild (stage II), moderate (stage III), or severe (stage IV) based on:

- Number of implants
- Location of implants
- Depth of implant (whether it is on the surface of or deep within an organ)
- Presence and number of endometriomas and adhesions [1]

Stages of endometriosis [2]

Stage	Classification	Description
I	Minimal	A few superficial implants
II	Mild	More and slightly deeper implants
III	Moderate	Many deep implants, small endometriomas on one or both ovaries, and some filmy adhesions
IV	Severe	Many deep implants, large endometriomas on one or both ovaries, and many dense adhesions, sometimes with the rectum adhering to the back of the uterus

Diagnostic challenge

Endometriosis is challenging to diagnose because there are no available biomarkers to confirm or exclude the condition. The lesions are typically small and located within the abdominal cavity, which is why laparoscopic visualization, preferably with histologic verification, remains the standard method for diagnosing the disease. [6]

Although most adults report that their pelvic pain began during adolescence, most young females do not receive a timely diagnosis or treatment. On average, seven physicians are consulted before endometriosis is diagnosed. [6]

The complex diagnostic challenge of endometriosis is due to many factors, including:

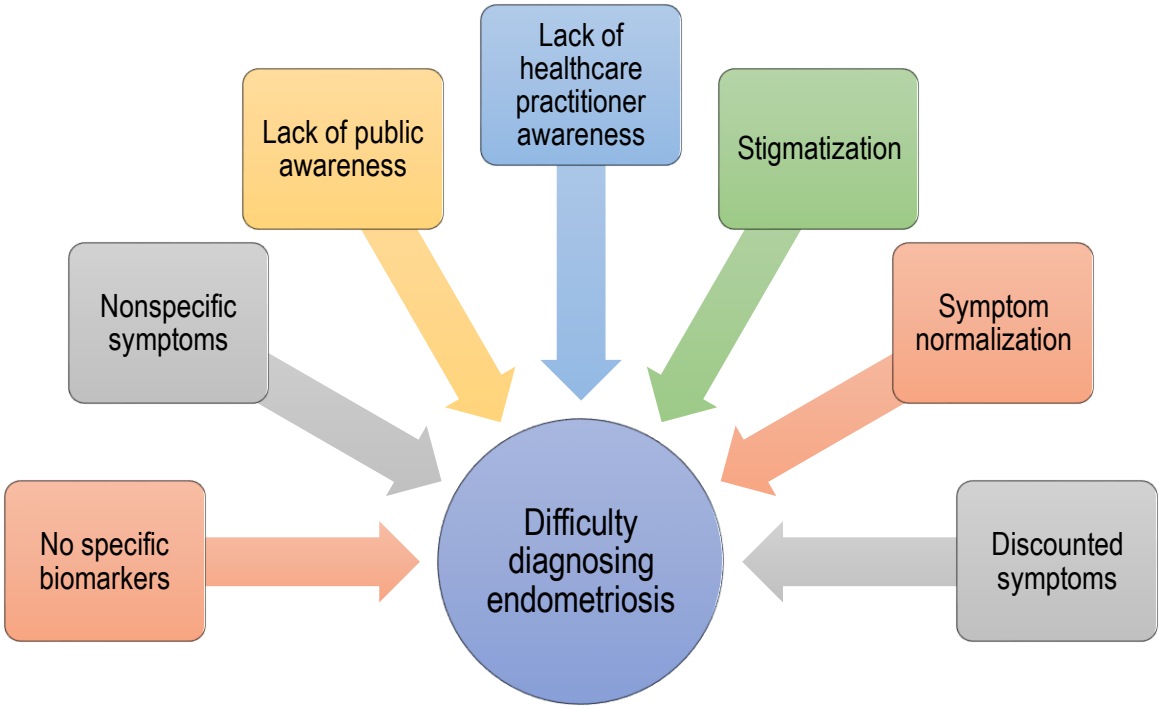
- Varied nonspecific symptoms. Symptoms, such as dysmenorrhea (painful menstruation), dyspareunia (painful intercourse), dyschezia (difficulty or pain associated with defecation), and infertility, can be attributed to other conditions.

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- Symptoms are often not discussed openly because of the fear of stigmatization.
- Lack of sensitive and specific biomarkers.
- Poor awareness of the disease by the general public, with symptoms discounted.
- Lack of awareness by healthcare practitioners, with symptoms dismissed or inadequately investigated. [6]

As a result of all these factors, the average delay between the onset of symptoms and diagnosis is seven years. The long interval between symptom onset and diagnosis results in prolonged pain, decreased quality of life, psychological stress, and impaired fertility. [6]

Diagnostic challenges in endometriosis



Treatment

Management of endometriosis includes:

- Nonsteroidal anti-inflammatory drugs (NSAIDs) for pain
- Medications to suppress ovarian function
- Surgery to excise or ablate the misplaced endometrial tissue
- Hysterectomy with or without removal of the ovaries (oophorectomy) [1] [2]

The treatment approach depends on the person's symptoms, preferences, pregnancy plans, age, extent and location of disease, previous treatment, and costs.

Endometriosis management, particularly disease involving the bowel, bladder, ureters, or extra-pelvic structures and cases with overlapping pain conditions, requires multidisciplinary care. Approximately 50% of females with endometriosis have recurrent symptoms over a period of 5 years, regardless of the treatment approach. [6] [11]

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NSAIDs
Usually, NSAIDs are used to relieve pain, such as ibuprofen (e.g., Advil, Motrin IB, etc.) or naproxen sodium (e.g., Aleve). They may be all that is needed if symptoms are mild and the person has completed childbearing. [1] [2] [11]

Medications to suppress ovarian function
Hormonal contraceptives can be used to suppress the activity of the ovaries and thus slow the growth of endometrial implants and reduce bleeding and pain. The oral contraceptives can be taken continuously, especially if pain is worse during menstrual periods. The following medications are commonly used:

- Continuous combination (estrogen-progestin) contraceptives
- Progestins (e.g., norethindrone or dienogest [Visanne]) for those who have contraindications to estrogen therapy
- Progestin-secreting intrauterine systems such as the levonorgestrel intrauterine system (e.g., Mirena, Kyleena, etc.) [2]

The following medications are usually used if symptoms are not well controlled with NSAIDs or hormonal contraceptives:

- Gonadotropin-releasing hormone (GnRH) agonists (e.g., leuprolide acetate [Lupron] or goserelin [Zoladex])
- Gonadotropin-releasing hormone (GnRH) antagonists (e.g., elagolix [Orilissa] or relugolix)
- Aromatase inhibitors (e.g., anastrozole [Arimidex], letrozole [Femara])
- Danazol (a synthetic androgen, a male sex hormone)

GnRH agonists and antagonists are medications that block the menstrual cycle and lower estrogen levels, which causes endometriosis tissue to shrink. These medications create an artificial menopause. Taking a low dose of progestin along with GnRH agonists or antagonists may ease menopausal side effects, such as hot flashes, vaginal dryness, and bone loss. Menstrual periods and the ability to conceive return when the medication is stopped.

Aromatase inhibitors are a class of medications that lower the amount of estrogen in the body. Aromatase inhibitors can be used when GnRH analogs are ineffective in suppressing endometriosis. An aromatase inhibitor, along with a progestin or combination birth control pills, may be recommended to treat endometriosis. [1] [11]

Danazol inhibits ovulation. However, it has side effects including weight gain and androgenic adverse effects such as the development of increased body hair, loss of hair from the head, reduced breast size, and lowering of the voice. These side effects limit its use. [1]

Surgical management
Endometriosis can be treated through laparoscopic surgery. The goal of laparoscopic surgery is to remove endometriosis growths and scar tissue that can prevent organs from functioning normally, while preserving the uterus and ovaries.

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Laparoscopic surgery is a minimally invasive procedure where the surgeon makes small incisions in the abdomen to insert a tiny camera and surgical instruments into the pelvis. Laparoscopic surgery is preferred for endometriosis because it is less painful and has a faster recovery than a laparotomy, which involves making a large incision in the abdomen.

The two most common techniques used in laparoscopic surgery for endometriosis are:

- Excision, where the endometriosis growth is cut out. Excision is the only technique that can completely remove deep endometriosis growths.
- Ablation, which is burning off an endometriosis growth.

Research shows excision surgery for endometriosis is better at treating pain caused by endometriosis than ablation surgery. Excision surgery not only improves pain associated with endometriosis but also enhances overall quality of life. [11] [13]

Sometimes, pain may return months or years after endometriosis surgery due to other conditions causing pelvic pain (e.g. adenomyosis or pelvic floor dysfunction) or new endometriosis growths. The likelihood of endometriosis recurring after surgery depends on the type of surgery performed and the location of the endometriosis. Endometriosis is more likely to return after ablation surgery than excision surgery. Endometriosis located on the ovaries is more prone to returning than endometriosis in other areas of the body. Endometriosis on the bowel or bladder is not likely to return if treated with excision surgery. In some cases, taking medications for endometriosis may reduce the need for additional surgeries. [13]

Hysterectomy

Removing the uterus (hysterectomy) and ovaries (oophorectomy) was once thought to be the most effective treatment for endometriosis. Today, many experts consider it to be a last resort to ease pain when other treatments have not worked. [11]

Hysterectomy with or without bilateral salpingo-oophorectomy (removal of both ovaries and fallopian tubes) is usually reserved for individuals with moderate to severe pelvic pain, severe endometriosis that has recurred, who have completed childbearing, and who prefer a definitive procedure. Hysterectomy removes adhesions or implants that adhere to the uterus. However, endometriosis can recur even after hysterectomy in premenopausal women or those on estrogen therapy.

Removing both ovaries (bilateral oophorectomy) induces the same effects as menopause due to decreased estrogen levels. Thus, females under 50 may be prescribed estrogen to alleviate menopausal symptoms following surgery. Also, it is often recommended to combine continuous progestin therapy with estrogen therapy to help prevent the growth of any remaining tissue that could lead to recurrence if estrogen is used alone. For individuals over 50, progestin therapy can be used independently to reduce persistent menopause symptoms following the removal of the ovaries. [1] [2]

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Additional support
Additional care and support may include:

- Pelvic health physiotherapy, by a registered physiotherapist trained in pelvic health conditions, is an effective treatment for some symptoms of endometriosis (e.g., dyspareunia). It can also help manage other conditions that many people with endometriosis have, either as a result of endometriosis or in addition to it.
- Mental health support. People with endometriosis often deal with mental health conditions (e.g., depression, anxiety). Receiving counselling or therapy can help improve mental health, well-being, and quality of life.
- Chronic pain care. For people who have chronic pelvic pain in addition to endometriosis, specialized chronic pain clinics offer different treatment options.
- Acupuncture may be helpful in people with endometriosis.
- Applying heat to the abdomen, pelvis, and lower back may help manage endometriosis pain.
- Meditation, breathing, and relaxation practices may help decrease pain in people with endometriosis.
- Joining a support group. These groups can provide a safe, inclusive space for connection and support. [11] [13] [14] [15]

Endometriosis and oral health
Periodontitis is a chronic inflammatory disease of the periodontium characterized by loss of periodontal tissue support and alveolar bone, clinical attachment loss, and gingival bleeding. Endometriosis, similar to periodontitis, is a chronic inflammatory disorder in the reproductive system.

Observational studies have indicated an association between these two diseases. The results from the National Health and Nutrition Examination Survey showed participants with endometriosis had a 57% higher risk of gingivitis and periodontitis. [16]

A case-control study by Thomas et al. (2018) found participants with endometriosis had a higher gingival index than normal. Additionally, moderate and severe periodontitis was more common in participants with endometriosis compared with the control group. [17]

A bidirectional Mendelian randomized study by Jin et al. (2024) investigated the relationship between periodontitis and endometriosis and its subtypes: superficial peritoneal lesions, ovarian endometriomas, and deep endometriosis.

The results showed a positive association between periodontitis and endometriosis of the pelvic peritoneum. However, no causal association was found between periodontitis and the two other subtypes of endometriosis, ovarian endometriomas and deep endometriosis.

There was no causal association of endometriosis or its subtypes on the risk of periodontitis. Currently, the etiology of endometriosis is unclear, creating an obstacle in finding effective treatments. However, the discovery of the potential causal effect between periodontitis and endometriosis of the pelvic peritoneum could offer insights into the underlying mechanisms of endometriosis. The potential mechanisms that

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explain the cause-effect of periodontitis on endometriosis may include direct invasion of periodontal pathogens, the inflammatory response, and immune dysfunction.

Oral bacteria such *as Porphyromonas gingivalis* and *Fusobacterium nucleatum* can reach the placenta and cause intrauterine infections. Similarly, periodontal pathogens may locate in the pelvic peritoneum and exacerbate endometriosis.

P. gingivalis may activate peritoneal macrophages, leading to the release of cytokines, which drive inflammation and play a key role in the progression of endometriosis. Studies show *Fusobacterium* is more common in participants with endometriosis than those without the condition, further supporting this mechanism. Animal studies also demonstrated that *Fusobacterium* from the oral cavity was a possible source of infecting the uterus through hematogenous transmission. [18]

Individuals with periodontitis often have higher leukocyte counts, increased C-reactive protein levels, and lower hemoglobin. Inflammasomes, protein complexes involved in inflammation, may also play a role. Periodontitis may raise levels of the inflammasomes, which may contribute to the progression of endometriosis. [19]

Immune dysfunction is recognized as a key factor in the development of peritoneal endometriosis. A study by Zou et al. (2021) using single-cell RNA sequencing was the first to identify T-cell receptor-positive macrophages, increased macrophages, and natural killer dendritic cells in the peritoneal fluid of individuals with endometriosis. [20]

Reducing the immune response triggered by *P. gingivalis* has shown benefits in managing some metabolic diseases associated with periodontitis. This suggests a plausible link between periodontitis and endometriosis through autoimmune dysregulation.

The findings of this study indicate a positive causal relationship between periodontitis and endometriosis of the pelvic peritoneum. However, more epidemiological studies are needed to verify the causality between these two diseases.

Additionally, reducing the risk of periodontitis may improve the prognosis for people with endometriosis of the pelvic peritoneum. Supportive periodontal therapies and routine oral hygiene interventions may produce beneficial effects in treating individuals with endometriosis of the pelvic peritoneum. Accordingly, further research on the underlying biological pathways is needed to identify if the management of periodontitis could help treat endometriosis. [19]

Studies have shown that both periodontitis and endometriosis are associated with alterations in the local microbiome composition. In periodontitis, the overgrowth of pathogenic species such as *P. gingivalis*, *Treponema denticola*, and *Tannerella forsythia* disrupts the microbial homeostasis of the gingival sulcus, contributing to tissue destruction and systemic inflammatory responses. Similarly, recent studies have identified microbial dysbiosis in the peritoneal fluid and reproductive tract of people with

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endometriosis, suggesting a possible role for microbial translocation and immune activation in disease progression. [21]

Furthermore, hormonal therapies and other medications used to manage endometriosis may exacerbate oral conditions by altering salivary flow and mucosal immunity, thereby increasing the risk of xerostomia, oral candidiasis, and mucosal inflammation, and potentially aggravating periodontal tissue breakdown. [21]

A large perspective cohort study by Agneta et al. (2025) assessed the associations between endometriosis and self-reported periodontal diseases and evaluated their impact on quality of life. The findings showed that more severe stages of endometriosis were related to increased awareness of periodontal disease (i.e., a perceived deterioration of their periodontal health), greater gingival bleeding, xerostomia, and tongue mucosal alterations.

Across all endometriosis disease stages, participants reported:
- Substantial pain and fatigue, with symptom severity escalating in advanced cases.
- An increased prevalence of dental hypersensitivity, gingival bleeding, and orofacial pain. Notably, those in advanced stages exhibited a higher incidence of temporomandibular dysfunction, suggesting a potential association between chronic systemic inflammation and musculoskeletal involvement.

Potential mechanisms underlying the association between endometriosis and oral health disturbances include:
- Chronic systemic inflammation, a defining feature of endometriosis, likely exacerbates periodontal disease and other oral pathologies by promoting a pro-inflammatory microenvironment.
- As endometriosis advances, exacerbation of oral health-related symptoms, such as gingival bleeding, xerostomia, and dentin hypersensitivity, may arise due to immune alterations, endocrine disturbances, and prolonged medication exposure.
- Hormonal dysregulation, especially estrogenic imbalance, may influence oral tissue homeostasis, given the presence of estrogen receptors in gingival and mucosal tissues, which modulate their response to injury and infection.
- Psychological burden of a chronic disease, including heightened stress levels, may contribute to oral health deterioration, as stress is a well-documented risk factor for conditions such as bruxism, periodontal inflammation, and immune dysregulation within the oral cavity.

The study highlights the interplay between endometriosis, oral health, and overall quality of life, emphasizing the need for a multidisciplinary and integrative approach to client care. Multidisciplinary care teams would include medical specialists, oral health practitioners, and mental health professionals to address the varied symptoms among individuals with endometriosis.

Routine oral health assessments and individualized therapeutic strategies may play a pivotal role in mitigating the oral manifestations frequently observed in this population, ultimately enhancing their overall quality of life. Furthermore, heightened awareness

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among medical and oral health professionals regarding the systemic and multifactorial nature of endometriosis could facilitate the implementation of holistic and client-centred treatment strategies, ultimately improving clinical outcomes and client well-being. [21]

Take home messages

- Endometriosis and periodontal disease are chronic, inflammatory diseases. There is growing evidence on the association between these two diseases.
- It is important to educate clients with endometriosis about the association with periodontal disease.
- Improving and maintaining oral health through good oral self-care and regular periodontal care is essential to reduce the inflammatory burden among clients with endometriosis, which may lead to an improvement in endometriosis symptoms.
- Various medical conditions, including endometriosis, can have a significant impact on clients both physically and mentally. Keeping this in mind helps to provide holistic care for clients with endometriosis.
- More research on the relationship between oral health and endometriosis is required to help understand the mechanisms behind their association and potentially determine a new pathway to manage endometriosis.

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