GEM PATIENT EDUCATION CENTER

Pain That Persists After Endometriosis Treatment

Why pain may continue or return – and how to investigate it carefully

Version 1.2 · September 2026



THE MOST IMPORTANT POINT

Persistent pain does not automatically mean that endometriosis has returned, and it does not automatically mean that surgery failed. The cause should be investigated before another operation is considered.

Why can pain persist?



Pain after medical or surgical treatment can have more than one cause. Possibilities include **residual or recurrent endometriosis**, adenomyosis, adhesions or scar tissue, ovarian conditions, bowel or bladder problems, pelvic-floor muscle dysfunction, nerve or musculoskeletal pain, and changes in the way the nervous system processes pain. More than one cause may be present at the same time.

Assess disease and other pain contributors



The evaluation should begin by reviewing what disease was originally found, what was resected, what was intentionally left behind, the pathology results, and the surgeon's description of the pelvis and abdomen. New or changing symptoms may justify another examination and expert imaging. **A normal ultrasound or MRI does not exclude every form of endometriosis, particularly superficial disease.**

Why the complete operative video matters

When pain persists, GEM advocates preservation of the **complete, unedited operative video**, with the patient's informed consent and appropriate privacy safeguards, as part of the surgical record. If another operation is being considered, the next surgeon can review the original disease map, organs involved, adhesions and anatomical distortion, what was resected, how the resection was performed, and what may have been left behind. This can help determine what additional testing is needed and allow the next surgeon and multidisciplinary team to plan before another operation. **This is a GEM quality-of-care position and is not currently a universal legal or guideline requirement.**

NEW OR SEVERE SYMPTOMS AFTER SURGERY

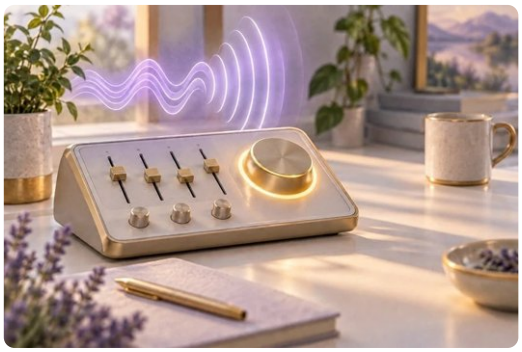
This guide addresses persistent pain. Fever, worsening abdominal pain, vomiting, difficulty passing urine, chest pain or breathlessness after surgery requires prompt contact with the surgical team; severe symptoms or collapse need emergency care.

When Pain Persists: Overlapping Causes

THE PAIN IS REAL

Pain can continue after treatment, and several mechanisms can coexist. Persistent pain is real; it does not mean that the patient is imagining it.

Central sensitization – a simple explanation



Central sensitization means increased responsiveness in the nervous system's processing of pain. It can contribute to persistent pain and can coexist with endometriosis, pelvic-floor problems or other painful conditions. It cannot be diagnosed simply because a scan is normal.

The pain is real. It does not mean the patient is imagining it.



Assess possible residual/recurrent disease and other contributors alongside pain-processing mechanisms. Treatment of overlapping problems can proceed together rather than waiting for every possible cause to be excluded.

GEM KEY MESSAGE

LONG-LASTING PAIN CAN CHANGE THE WAY THE NERVOUS SYSTEM PROCESSES PAIN.

Sometimes treating the original disease is not enough – the pain system itself may also need treatment.

What else should be checked?



Persistent pain can also come from pelvic-floor muscle spasm, adenomyosis, bowel or bladder disorders, adhesions, the abdominal wall, hips or spine, or irritation of pelvic nerves. A careful evaluation should look for these possibilities rather than assuming that every episode of pain is recurrent endometriosis.

Why another operation may not always help

A repeat operation may help when there is a likely treatable target and benefits outweigh risks. Persistent pain alone does not establish that more surgery will help. Discuss what imaging can miss, other pain contributors, nonsurgical options and realistic goals before deciding.

A Systematic Reassessment

1. Reconstruct the original disease map



Review the operative report, pathology, previous imaging, photographs and, when available, the complete operative video. Determine where disease was found, what was resected, what remained, and whether the bowel, bladder, ureters and upper abdomen were systematically inspected.

2. Define the pain now

Is the pain cyclical or constant? Is it the same pain as before surgery or something different? Where is it located? Is it related to menstruation, intercourse, bowel movements, urination, sitting, walking or other activity? These details can help identify the source.

3. Look for a current physical cause

A careful gynecologic examination and expert ultrasound or MRI may be appropriate depending on the symptoms. Evaluation may also be needed for adenomyosis, pelvic-floor problems, bowel or bladder disease, musculoskeletal conditions or nerve-related pain.

4. Consider central sensitization

Consider sensitization and other pain-processing mechanisms when clinically appropriate, including when active endometriosis is present. There is no single definitive test. Questionnaires can support assessment but do not prove the mechanism or rule out other disease.

5. Build the right team

Depending on the findings, care may involve an endometriosis surgeon, pelvic-floor physical therapist, pain specialist, gastroenterologist, urologist, reproductive specialist or other clinician. The goal is to treat the causes that are actually present – not simply repeat the same treatment.

> **GEM CLINICAL PRINCIPLE**
>
> **ASSESS AND TREAT THE RELEVANT PAIN MECHANISMS TOGETHER.**

Questions to Ask When Pain Continues

1. Was all visible endometriosis resected during my previous operation, and was anything intentionally left behind?
2. Can my doctor or next surgeon review my complete operative video, photographs, pathology and operative report?
3. Could adenomyosis or another pelvic condition explain my symptoms?
4. Do I need expert ultrasound or MRI?
5. Has my pelvic floor been evaluated?
6. Could bowel, bladder, musculoskeletal or nerve-related problems be contributing?

7. Could central sensitization be contributing to my persistent pain?
8. If another operation is proposed, what specific problem is the surgery intended to correct?
9. What nonsurgical treatments might help the other causes of my pain?
10. How will we know whether the treatment plan is working?

> **GEM RESEARCH PRIORITY**
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> More research is needed to understand why some patients develop central sensitization after years of endometriosis-associated pain, whether earlier effective treatment can reduce this risk, and which treatments can best reduce or reverse persistent changes in pain processing.

What the research can and cannot say

A prospective cohort of 239 patients found that higher preoperative Central Sensitization Inventory scores were associated with worse pain after surgery. This association does not prove a cause or predict an individual result.

A later systematic review included five studies and 1,271 patients; only three studies contributed to its surgical meta-analysis. Different assessment methods and observational evidence limit certainty.

These findings support individualized counseling, not a rule that surgery cannot help a person with sensitization.

GEM continues to advocate careful review of prior records and complete operative video when available.

Evidence & references

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Overlapping mechanisms

Residual/recurrent disease, pelvic-floor dysfunction and altered pain processing can coexist. A normal scan does not establish that the pelvis is clear. Assessment and treatment need not wait for every alternative to be excluded.

Study limitations

Orr's 239-person cohort found an association between preoperative questionnaire scores and postoperative pain, not a definitive diagnostic test or causal prediction. Gomez-Llerena included five studies/1,271 patients; the surgical meta-analysis used three studies. Heterogeneity and observational designs limit certainty.

Clinical approach

Repeat surgery requires a plausible target and a favorable individual benefit-risk balance. New or worsening postoperative symptoms need timely assessment rather than automatic attribution to sensitization.

Full references

- **[S01]** ESHRE. Endometriosis guideline. 2022. Freely available
- **[R36848090]** Orr NL, Huang AJ, Liu YD et al. Association of Central Sensitization Inventory Scores With Pain Outcomes After Endometriosis Surgery. JAMA Netw Open. 2023;6(2):e230780. doi:10.1001/jamanetworkopen.2023.0780. PMID 36848090. Freely available
- **[RNOCI]** Gentles A, Goodwin E, Bedaiwy Y et al. Nociplastic Pain in Endometriosis: A Scoping Review. J Clin Med. 2024;13(24):7521. doi:10.3390/jcm13247521. PMID 39768444. Freely available
- **[R40721059]** Gomez-Llerena A, Shekawat P, Pradeep A et al. The Impact of Targeted Endometriosis Treatment On Patients With Central Sensitization: Systematic Review and Meta

Analysis. J Minim Invasive Gynecol. 2026;33(3):258-265. doi:10.1016/j.jmig.2025.07.020. PMID 40721059. Freely available

- **[R41684533]** Burghaus S, Schäfer SD, Bär KJ et al. Diagnosis and Therapy of Endometriosis. Guideline of the DGGG, OEGGG and SGGG (S2k-Level, AWMF Registry No. 015/045, April 2025). Geburtshilfe Frauenheilkd. 2026;86(2):133-188. doi:10.1055/a-2760-4867. PMID 41684533. Freely available
- **[S08]** NHS. Laparoscopy (keyhole surgery). Reviewed 20 December 2023. Freely available

No listed institution endorses GEM.

Medical information

Do not delay care; seek emergency help for a suspected emergency.

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