FACT SHEET — WOMEN'S HEALTH

Endometriosis and Back Pain

How endometriosis causes lower back and pelvic pain — a frequently missed diagnosis in women

■ See your GP if you are a woman with:

- Lower back or pelvic pain that is worse around your period
- Painful periods (dysmenorrhoea) alongside back pain
- Pain during or after sex
- Difficulty conceiving
- Cyclical bowel or bladder symptoms alongside pelvic pain
- Back pain that has been investigated without a clear mechanical cause

What endometriosis is

Endometriosis is a condition in which tissue similar to the lining of the womb (endometrium) grows outside the uterus — most commonly on the ovaries, fallopian tubes, the tissue lining the pelvis, and occasionally on the bowel, bladder, and rarely beyond the pelvis. This tissue responds to the menstrual cycle, thickening and breaking down with each period, but has nowhere to go, causing inflammation, scarring, and pain.

Endometriosis affects approximately 1 in 10 women of reproductive age. The average time from first symptoms to diagnosis is 7–8 years — a reflection of how commonly it is dismissed, misdiagnosed, or attributed to other causes including back pain.

How endometriosis causes back pain

Direct sacral nerve involvement	Endometriosis deposits on the sacral nerves or uterosacral ligaments cause deep pelvic and lower back pain, often with a cyclical pattern.
Bowel endometriosis	Deposits on the bowel can cause cyclical back pain, particularly at the time of menstruation when bowel contractions increase.
Bladder endometriosis	Deposits on the bladder cause pelvic and lower back pain with cyclical urinary symptoms.
Posterior compartment disease	Deep infiltrating endometriosis in the posterior pelvis causes severe lower back, sacral, and leg pain, often with sciatic distribution.
Inflammation and sensitisation	Chronic pelvic inflammation from endometriosis can sensitise the central nervous system, producing widespread pain beyond the specific deposit locations.

Diagnosis

Endometriosis is notoriously difficult to diagnose from symptoms and examination alone. Transvaginal ultrasound and MRI can identify ovarian cysts (endometriomas) and deep infiltrating disease but cannot reliably detect superficial peritoneal deposits. Definitive diagnosis requires laparoscopy (keyhole surgery).

Treatment

Pain management	NSAIDs around the time of menstruation. Hormonal treatment to suppress the menstrual cycle.
Hormonal therapy	Combined oral contraceptive pill, progestins, GnRH analogues, and the Mirena coil all suppress endometrial activity.
Surgery	Laparoscopic excision of endometriosis deposits. More effective than ablation for deep disease. Significant symptom improvement in most patients.
Physiotherapy	Pelvic floor physiotherapy addresses the secondary pelvic floor dysfunction that frequently develops alongside endometriosis.
Multidisciplinary care	Complex endometriosis is best managed in specialist centres with input from gynaecology, colorectal surgery, urology, and pain management.

Related fact sheets

Sacroiliac joint dysfunction	Mechanical SIJ pain that can coexist with or be confused with endometriosis.
Pelvic girdle pain	Pelvic pain in women of childbearing age.
Central sensitisation and chronic pain	Neurological sensitisation from chronic pelvic pain.
Sciatica	Sciatic endometriosis — rare but important to consider in women with cyclical sciatica.

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