First presentation

Suspect endometriosis (including in young women aged 17 and under) with 1 or more of:

- chronic pelvic pain
- period-related pain (dysmenorrhoea) affecting daily activities and quality of life
- deep pain during or after sexual intercourse
- period-related or cyclical gastrointestinal symptoms, in particular, painful bowel movements
- period-related or cyclical urinary symptoms, in particular, blood in the urine or pain passing urine
- infertility in association with 1 or more of the above.

Assess women's individual information and support needs

Take into account their circumstances, symptoms, priorities, desire for fertility, aspects of daily living, work and study, cultural background, and their physical, psychosexual and emotional needs.

Also:

- discuss keeping a pain and symptom diary
- offer an abdominal and pelvic examination to identify abdominal masses and pelvic signs
- consider an ultrasound scan (see page 2).

Be aware that endometriosis can be a long-term condition and can have a significant physical, sexual, psychological and social impact. Women may have complex needs and may require long-term support.

Initial management

Offer **initial management** with:

- a short trial (for example, 3 months) of paracetamol or a non-steroidal anti-inflammatory drug (NSAID) alone or in combination
- hormonal treatment (combined contraceptive pill or a progestogen)
- refer to the NICE guideline on neuropathic pain for treatment with neuromodulators.

If **fertility is a priority**, the management of endometriosis-related subfertility should have multidisciplinary team involvement with input from a fertility specialist. This should include recommended diagnostic fertility tests or preoperative tests and other recommended fertility treatments such as assisted reproduction.
Also see **Fertility is a priority** on page 2.

Consider referral to a **gynaecology**, **paediatric & adolescent gynaecology**, or **specialist endometriosis service** (endometriosis centre) if:

- a trial of paracetamol or NSAID (alone or in combination) does not provide adequate pain relief
- initial hormonal treatment for endometriosis is not effective, not tolerated or is contraindicated.

Referral

Consider referral to a **gynaecology service**:

- for severe, persistent or recurrent symptoms of endometriosis
- for pelvic signs of endometriosis, **or**
- if initial management is not effective, not tolerated or is contraindicated.

Refer women to a **specialist endometriosis service** (endometriosis centre) if they have suspected or confirmed deep endometriosis involving the bowel, bladder or ureter.

Consider referring young women (aged 17 and under) to a **paediatric & adolescent gynaecology service**, **gynaecology service** or **specialist endometriosis service** (endometriosis centre), depending on local service provision.

Do not use pelvic MRI or **CA-125** to diagnose endometriosis.

Consider transvaginal ultrasound:
- to investigate suspected endometriosis even if pelvic and/or abdominal examinations are normal
- for endometriomas and deep endometriosis involving the bowel, bladder or ureter.

Consider a transabdominal ultrasound scan of the pelvis if a transvaginal scan is not appropriate.

Do not exclude the possibility of endometriosis if the **abdominal** and/or **pelvic examinations** or **ultrasound** or **MRI** are **normal**.

Consider referral for **assessment & investigation** if clinical suspicion remains or symptoms persist.

Consider laparoscopy to diagnose endometriosis, even if the ultrasound was normal.

Discuss surgical management options with women with suspected/confirmed endometriosis:
- what laparoscopy involves, and that it may include surgical treatment (with prior patient consent)
- how laparoscopic surgery could affect endometriosis symptoms
- the possible benefits and risks of laparoscopic surgery
- the possible need for further surgery, including the possible need for further planned surgery for deep endometriosis involving the bowel, bladder or ureter.

During diagnostic laparoscopy, a gynaecologist with training and skills in laparoscopic surgery for endometriosis should perform a systematic inspection of the pelvis.

If a **full systematic laparoscopy** is performed and is **normal**, explain to the woman that she does not have endometriosis and **offer alternative management**.

Diagnosis

If fertility is a priority

Offer excision or **ablation plus adhesiolysis** to women with endometriosis not involving bowel, bladder or ureter.

Offer laparoscopic ovarian cystectomy to women with endometriomas.

Discuss the **benefits and risks** of **laparoscopic surgery for deep endometriosis** involving the bowel, bladder or ureter. This may include:
- effect on the chance of future pregnancy
- the possible impact on ovarian reserve
- the effect of complications on fertility
- alternatives to surgery
- other fertility factors.

Do not offer hormonal treatment to women with endometriosis who want to conceive.

Consider outpatient follow-up for:
- deep endometriosis involving the bowel, bladder or ureter, or
- 1 or more endometrioma larger than 3 cm.

If fertility is not currently a priority

During diagnostic laparoscopy consider laparoscopic treatment of (if present):
- peritoneal endometriosis not involving the bowel, bladder or ureter
- uncomplicated ovarian endometriomas.

Consider excision rather than ablation to treat endometriomas.

For **deep endometriosis** involving the **bowel**, **bladder** or **ureter, consider**:
- pelvic MRI before operative laparoscopy
- 3 month course of GnRHa before surgery.

Consider hormonal treatment after laparoscopic excision or ablation.

If **hysterectomy** is indicated:
- excise all visible endometriotic lesions at the time of hysterectomy
- discuss with the woman what a hysterectomy is, its risks & benefits, related treatments and likely outcome.

Care