Endometriosis: diagnosis and management

First presentation

Suspect endometriosis in women, trans men and non-binary people registered female at birth (including in young people aged 17 and under) who have **1 or more** of:

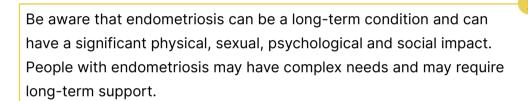
- chronic pelvic pain
- period-related pain (dysmenorrhoea) affecting daily activities and quality of life
- · deep pain during or after sexual intercourse
- period-related or cyclical gastrointestinal symptoms, in particular, painful bowel movements
- period-related or cyclical urinary symptoms, in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

Assess individual information and support needs: take into account the person's 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
- ask about family history of endometriosis
- · take into account that people express pain in different ways
- offer an abdominal and pelvic (internal vaginal) examination to identify abdominal masses and pelvic signs
- offer an ultrasound scan (see below).





Carry out additional investigations such as ultrasound, and referral if necessary, in parallel with each other, and in conjunction with initial pharmacological treatment.

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.

When fertility is a priority, the management of endometriosisrelated 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.

Diagnosis and referral

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

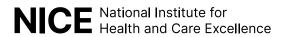
Offer transvaginal ultrasound even if pelvic or abdominal examination is normal to:

- identify ovarian endometriomas and deep endometriosis, including that involving the bowel, bladder or ureter
- identify or rule out other pathology
- guide management and referral options.

Consider a transabdominal ultrasound scan of the pelvis if a transvaginal scan is declined or not suitable.



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Refer to a gynaecology service:

- if initial management is not effective, not tolerated or is contraindicated, or
- for persistent or recurrent symptoms of endometriosis, or
- · for symptoms which impact daily life, or
- for pelvic signs of endometriosis, unless deep endometriosis is suspected

Refer to a specialist endometriosis service (endometriosis centre) if the person has suspected or confirmed:

- · endometrioma, or
- deep endometriosis including that involving the bowel, bladder or ureter, or
- endometriosis outside the pelvic cavity.

Refer young people (aged 17 and under) to a paediatric and adolescent gynaecology service or specialist endometriosis service (endometriosis centre).

Consider laparoscopy to diagnose endometriosis, even if the ultrasound (or MRI, if used after referral to a specialist) was normal.

Discuss surgical management options with people who have suspected or 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 laproscopy a gynaecologist with training and skills in laparoscopic surgery for endometriosis should perform a systematic inspection of the pelvis and record the findings, including intra-operative imaging.

If a **full systematic laparoscopy** is performed and is **normal**, explain to the person that it is unlikely that they have endometriosis and **offer alternative management of symptoms**.



Ongoing care

If fertility is a priority

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

Offer laparoscopic ovarian cystectomy or laparoscopic drainage and ablation to people with endometriomas. Take into account:

- the possible impact on ovarian reserve
- that ablation and drainage may preserve ovarian reserve more than cystectomy

Discuss the **benefits and risks** of **laparoscopic surgery for deep endometriosis** involving the bowel, bladder or ureter. This may include:

- the possible impact of deep endometriosis on pregnancy outcomes
- 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 alone or in combination with surgery to people with endometriosis who want to conceive.

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
- a 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 person what a hysterectomy is, its risks & benefits, related treatments and likely outcome.

Consider outpatient follow-up for:

- deep endometriosis including that involving the bowel, bladder or ureter, or
- 1 or more endometrioma larger than 3 cm.

