National Women & Infants Health Programme

QUICK SUMMARY DOCUMENT

Assessment and Management of Endometriosis

This QSD is a resource for all clinicians working in healthcare in Ireland who are involved in the care of women with Endometriosis.

Following a comprehensive literature review a number of evidence-based recommendations for the assessment and management of Endometriosis were agreed upon.

Key Recommendations

Diagnosis of endometriosis		
1.	We recommend that a diagnosis of endometriosis is considered if a woman presents with one or more of the following symptoms: • chronic pelvic pain • dysmenorrhoea interfering with daily activities • deep dyspareunia • cyclical bowel symptoms (particularly dyschezia) • cyclical urinary symptoms (particularly dysuria and/or haematuria) • infertility.	*Best practice*
2.	We recommend that abdominal and pelvic examination be offered to women whose symptoms suggest a diagnosis of endometriosis, to identify signs such as reduction in organ mobility, tender nodules in the posterior vagina, and pelvic or abdominal masses.	*Grade 1C*
3.	We recommend that the opportunity to discuss and initiate empirical treatment should not be deferred in women with suspected endometriosis, as treatment may result in an improved quality of life.	*Best practice*
4.	We recommend that women with suspected or confirmed endometriosis be referred to a Gynaecologist if: • they have severe, persistent or recurrent symptoms of endometriosis • they have signs of endometriosis on examination • they have associated infertility • initial management is not effective, not tolerated, or contraindicated • ultrasound or imaging are suggestive of a higher stage or deeply infiltrating disease (e.g. endometrioma, or disease invading other organs).	*Best practice*
5.	We recommend that women should be referred to a specialist endometriosis service if they have suspected or confirmed deeply infiltrative endometriosis involving the bowel, bladder or ureter.	*Best practice*
6.	We recommend that transvaginal ultrasound should be offered as part of the investigation for suspected endometriosis. If transvaginal ultrasound is not appropriate, consider a transabdominal approach.	*Grade 1A*

7.	We do not recommend MRI as the first-line investigative test for diagnosis of endometriosis, though it is recommended if there is a suspicion of deeply infiltrative endometriosis involving the bowel, bladder or ureter.	*Grade 1B*
8.	We do not recommend the use of computed tomography (CT) or positron emission tomography-CT (PET-CT) for the diagnosis of endometriosis.	*Best practice*
9.	We recommend that clinicians do not exclude the possibility of endometriosis based on negative findings on imaging tests.	*Grade 1B*
10.	We do not recommend the use of biomarkers (including serum CA-125 testing) to diagnose endometriosis.	*Grade 1A*
11.	We recommend that laparoscopy is considered for women with symptoms suggestive of endometriosis if empiric treatment is ineffective or inappropriate, even if imaging is reported to be negative.	*Best practice*
12.	We recommend that biopsy is taken of lesions suspected to be endometriosis at laparoscopy for histological confirmation. Clinicians should be aware that negative histology does not entirely rule out endometriosis.	*Grade 1B*
13.	We recommend that referral to a Gynaecologist with appropriate laparoscopic skills and training is important to optimise the evaluation of the pelvis and abdomen at laparoscopy.	*Best practice*
Treatment of endometriosis-associated pain		
14.	We recommend that treatment with analgesics (including paracetamol, non-steroidal anti-inflammatories, and neuromodulator therapies) is offered to reduce endometriosis-associated pain.	*Grade 2B*
15.	We recommend that hormonal treatment in the form of combined hormonal contraception or progestogens is offered as the first line treatment for treatment of endometriosis-associated pain.	*Grade 1A*
16.	We recommend that treatment with GnRH agonists or antagonists, with add-back hormone replacement therapy, is offered as second line treatment of endometriosis-associated pain.	*Best practice*
17.	We recommend that all treatment should be decided together with the woman with consideration given to the desire to conceive and to the medication side-effect profile, cost, and availability.	*Best practice*
18.	We recommend that hormonal suppression treatment should be considered following surgery for endometriosis, provided the woman does not have immediate plans to conceive.	*Grade 1A*
19.	We recommend that surgery is offered as one of the options to reduce endometriosis-associated pain.	*Grade 1A*
20.	When considering hormonal or surgical intervention for pain due to endometriosis, we recommend a shared decision-making approach between the clinician and the woman. It is important to take into account individual preferences, side effects, individual efficacy, costs, and availability of treatments.	*Best practice*
21.	We recommend that when surgery is performed for endometriosis, clinicians may consider excision instead of ablation of endometriosis for endometriosis-associated pain.	*Grade 2A*

22.	We recommend that in women with endometrioma and pain symptoms, other forms of endometriosis, including deeply infiltrative endometriosis, are commonly detected during surgery and should be anticipated.	*Best practice*
23.	We recommend that clinicians perform cystectomy or CO2 laser vaporisation, instead of drainage and coagulation, for treatment of ovarian endometrioma, as they can reduce the recurrence of endometrioma and endometriosis-associated pain. Caution should be used to minimise ovarian damage during surgery for endometrioma.	*Grade 1B*
24.	We recommend that surgical removal of deeply infiltrative endometriosis may reduce endometriosis-associated pain and improve quality of life.	*Grade 1B*
25.	We recommend that surgical removal of deeply infiltrative endometriosis should be performed by a surgeon experienced in the surgical management of deep disease, preferably in a multidisciplinary setting with a minimally invasive approach aiming to radically remove all endometriosis lesions.	*Best practice*
26.	We recommend that hysterectomy (with or without oophorectomy) be considered in women who do not plan to conceive and for whom conservative treatment has not been successful, although women should be advised that hysterectomy will not always resolve the symptoms of endometriosis.	*Grade 2B*
27.	We recommend that total hysterectomy be performed, rather than sub-total hysterectomy.	*Best practice*
28.	We recommend that if oophorectomy is being considered, the consequences of early menopause and possible need for menopausal hormone therapy (MHT) should be discussed.	*Grade 1B*
29.	We recommend a continuous oestrogen-progestogen regimen if MHT is required for women with a history of endometriosis.	*Grade 1C*
Treatment of endometriosis-associated infertility		
30.	We recommend that for women with endometriosis and infertility who are trying to conceive, hormonal suppression should not be prescribed.	*Grade 1A*
31.	We recommend that when considering surgical management of endometriosis-related infertility, the woman's age, ovarian reserve, duration of infertility, and other fertility factors should be considered.	*Best practice*
32.	We recommend that clinicians offer operative laparoscopy for women with stage I-II endometriosis and associated infertility, as it improves the chance of ongoing clinical pregnancy.	*Grade 1A*
33.	We recommend that clinicians may consider operative laparoscopy in the case of endometrioma and associated infertility, as this may improve the woman's chance of spontaneous pregnancy. This decision, made with the woman, should take into account ovarian reserve, previous surgery, presence of symptoms, results of other fertility investigations, and if any fertility treatment is planned.	*Grade 1A*
34.	We recommend that surgery for endometrioma prior to assisted reproductive technology (ART) not be performed routinely, but it may be considered for management of pain symptoms or accessibility of follicles.	*Best practice*

35.	We recommend that operative laparoscopy be considered as an option for symptomatic women with deeply infiltrative endometriosis and infertility, guided by the presence of pain symptoms and preference of the woman.	*Grade 2B*
36.	We recommend that Intra-uterine insemination (IUI) with ovarian stimulation be considered in the management of infertility and stage I-II endometriosis.	*Grade 2B*
37.	We recommend that ART be used to treat infertility associated with endometriosis, particularly where tubal function is impaired or where there is co-existing male factor infertility.	*Grade 1C*
Role of non-medical interventions for the treatment of endometriosis		
38.	While no recommendations can be made about individual non-medical interventions (traditional Chinese medicine, nutrition, electrotherapy, acupuncture, physiotherapy, and psychological interventions) to address endometriosis-related symptoms, clinicians may discuss these strategies with women to address quality of life and psychological well-being.	*Best practice*

Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this guideline include:

1. The proportion of women presenting with symptoms and signs of endometriosis who have an abdominal and pelvic examination (where appropriate). This will require the development of processes at local level (e.g. GP surgeries, gynaecology clinics, school health service, sexual health clinic, Emergency Department records) including protocols detailing the symptoms and signs of endometriosis that suggest a need to offer an abdominal and pelvic examination (where appropriate).
2. The number of working diagnoses of endometriosis following initial presentation.
3. The time from initial presentation with symptoms and signs of endometriosis to diagnosis. These items will require evidence of local arrangements to identify women with symptoms and signs of endometriosis.
4. The proportion of women in whom initial hormonal treatment for endometriosis is not effective after six months, not tolerated, or contraindicated.
    a) This will require evidence of local referral pathways to a gynaecology service for women in whom initial hormonal treatment for endometriosis is not effective, not tolerated or contraindicated.
    b) Information gleaned from this data collection will directly inform local executive management teams on the specific healthcare professionals needed in secondary and tertiary services responsible for diagnosing and treating endometriosis (e.g. general gynaecologists, adolescent gynaecologist service or specialist endometriosis service).
5. The proportion of women referred to gynaecology services who undergo laparoscopy.
6. The time from referral to a gynaecology service until laparoscopy is performed.
7. The proportion of women who are linked with an Endometriosis Nurse Specialist.
8. The proportion of women who are referred for pelvic physiotherapy assessment.
9. The proportion of women who are referred to a Pain Specialist.
10. The proportion of women who are referred to a Psychologist.
11. The proportion of women who are referred to a Dietician.

12. The proportion of women having a transvaginal ultrasound as part of initial investigations.
13. The proportion of women who are referred for fertility specialist advice. These items will directly inform the need for further service planning to ensure timely and efficient pathways of care.
14. The proportion of women with suspected or confirmed deeply infiltrative endometriosis involving the bowel, bladder or ureter who are referred to a specialist endometriosis centre. This will require evidence of local referral protocols for women with suspected or confirmed deeply infiltrative endometriosis involving the bowel, bladder or ureter.
15. The diagnosis rates of deeply infiltrative endometriosis involving the bowel, bladder or ureter. These items will directly inform the need for further service planning to ensure timely and efficient pathways of care.
16. Rates of surgical treatment for deeply infiltrative endometriosis involving the bowel, bladder or ureter.
17. The proportion of women with suspected endometriosis who have histologically-confirmed endometriosis following biopsy or excisional surgery.
18. Surgical complication rates and hospital readmission rates for surgical treatment for deeply infiltrative endometriosis involving the bowel, bladder and ureter.
19. Patient satisfaction with their surgical treatment (patient reported outcome measures).
20. Re-operation rates within 5 years of surgical treatment of endometriosis.

Recommended reading:

1. HSE nomenclature/glossary for audit www.hse.ie/eng/about/who/nqpsd/ncca/nomenclature-a-glossary-of-terms-for-clinical-audit.pdf
2. HSE National Framework for developing Policies, Procedures, Protocols and Guidelines at https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/
3. Becker CM, Bokor A, Heikinheimo O, *et al.* ESHRE guideline: endometriosis. *Hum Reprod Open.* 2022;2022(2):hoac009. doi:10.1093/hropen/hoac009
4. National Guideline Alliance (UK). *Endometriosis: Diagnosis and Management*. National Institute for Health and Care Excellence (NICE); 2017. Accessed August 9, 2023. http://www.ncbi.nlm.nih.gov/books/NBK453273/
5. Australian clinical practice guideline for the diagnosis and management of endometriosis (2021). RANZCOG, Melbourne, Australia. https://ranzcog.edu.au/wp-content/uploads/Endometriosis-Clinical-Practice-Guideline.pdf
6. Nnoaham KE, Hummelshoj L, Webster P, *et al.* Impact of endometriosis on quality of life and work productivity: a multicenter study across ten countries. *Fertil Steril.* 2011;96(2):366-373.e8. doi:10.1016/j.fertnstert.2011.05.090
7. Lee SY, Koo YJ, Lee DH. Classification of endometriosis. *Yeungnam Univ J Med.* 2021;38(1):10-18. doi:10.12701/yujm.2020.00444
8. Chen I, Veth VB, Choudhry AJ, *et al.* Pre- and postsurgical medical therapy for endometriosis surgery. *Cochrane Database Syst Rev.* 2020;11(11):CD003678. doi:10.1002/14651858.CD003678.pub3
9. Hodgson RM, Lee HL, Wang R, Mol BW, Johnson N. Interventions for endometriosis-related infertility: a systematic review and network meta-analysis. *Fertil Steril.* 2020;113(2):374-382.e2. doi:10.1016/j.fertnstert.2019.09.031
10. Schäler L, O'Leary D, Barry M, Crosby DA. National Clinical Practice Guideline: Fertility-Investigation and Management in Secondary Care. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. October 2023. www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/ncpg-fertility-investigation-guideline.pdf

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DeMaio, A, McTiernan, A, Durand O' Connor A, Reidy F, O' Neill, A. National Clinical Practice Guideline: Assessment and Management of Endometriosis. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. 2025

https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/

https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/