should have multidisciplinary team involvement with input from a fertility specialist and access to fertility services. Depending on the severity of the endometriosis this may be in a secondary care gynaecology service or a tertiary care specialist endometriosis service.

This should include the recommended diagnostic fertility tests or preoperative tests, as well as other recommended fertility treatments such as assisted reproduction that are included in the NICE guideline on fertility problems.

1.11.1 Offer excision or ablation of endometriosis plus adhesiolysis for endometriosis not involving the bowel, bladder or ureter, because this improves the chance of spontaneous pregnancy.

1.11.2 Offer laparoscopic ovarian cystectomy with excision of the cyst wall, or laparoscopic drainage and ablation, to women or people with endometriomas, because this improves the chance of spontaneous pregnancy. Take into account:

- the possible impact on ovarian reserve
- that ablation and drainage may preserve ovarian reserve more than cystectomy (also see the section on ovarian reserve testing in the NICE guideline on fertility problems). **[2017, amended 2024]**

1.11.3 Discuss the benefits and risks of laparoscopic surgery as a treatment option with women or people who have deep endometriosis (including endometriosis that involves the bowel, bladder or ureter) and who are trying to conceive so they can make an informed decision on its use. Topics to discuss may include:

- the possible impact of deep endometriosis on pregnancy outcomes
- whether laparoscopic surgery may alter the chance of future pregnancy
- the possible impact on fertility if complications arise
- alternatives to surgery
- other fertility factors. **[2017, amended 2024]**

1.11.4 Do not offer hormonal treatment alone or in combination with surgery to women or people with endometriosis who are trying to conceive, because it does not improve spontaneous pregnancy rates. **[2017, amended 2024]**

For a short explanation of why the committee made the updated 2024 recommendations and how they might affect practice, see the rationale and impact section on treatment of endometriosis when fertility is a priority.

Full details of the evidence and the committee's discussion are in evidence review A: treatment of endometriosis when fertility is a priority.

Terms used in this guideline

Chronic pelvic pain

Defined as pelvic pain lasting for 6 months or longer.

Paediatric and adolescent gynaecology service

Paediatric and adolescent gynaecology services are hospital-based, multidisciplinary specialist services for girls and young women (usually aged under 18).

Ovarian cystectomy

Ovarian cystectomy is a surgical excision of an ovarian endometriotic cyst. An ovarian endometrioma is a cystic mass arising from ectopic endometrial tissue within the ovary.

Managed clinical networks

Linked groups of healthcare professionals from primary, secondary and tertiary care providing a coordinated patient pathway. Responsibility for setting up these networks will depend on existing service provision and location.

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Pain management programmes

Are pain management programmes a clinically and cost-effective intervention for women with endometriosis?

Why this is important

Pain is one of the most debilitating symptoms of endometriosis. Endometriosis-related pain can be acute or chronic, and can adversely affect the woman's quality of life, ability to work, and can affect partners and their families.

Pain management programmes have been found to be effective in managing chronic pelvic pain, and can improve quality of life. However, it is unclear how much of this small evidence base can be generalised to women with endometriosis for which evidence is lacking. Furthermore, pain management programmes have not been compared with other treatments available for endometriosis. Pain management programmes promote self-management and are often provided in the community.

If found to be effective for endometriosis, pain management programmes would provide an additional or alternative treatment option for women experiencing endometriosis-related pain. Groups of particular interest are women for whom hormonal and surgical options have been exhausted, women who would prefer an alternative to a pharmacological or surgical approach, and women who may be prioritising trying to conceive.

2 Laparoscopic treatment of peritoneal endometriosis (excision or ablation)

Is laparoscopic treatment (excision or ablation) of peritoneal disease in isolation effective for managing endometriosis-related pain?

Why this is important

Isolated peritoneal endometriosis can be an incidental finding in women who may or may not experience pain or other symptoms.

Research is needed to determine whether laparoscopic treatment of isolated peritoneal endometriosis in women with endometriosis-related pain results in a clinical and cost-effective improvement in symptoms.

The current literature does not provide a clear answer because the stage of endometriosis is often not sufficiently clearly defined in research studies, and the treatment modalities used are multiple and varied. The resultant amalgamation of various stages of endometriosis and variable treatment modalities leads to loss of certainty of outcome in this specific group of women.

Establishing whether treating isolated peritoneal endometriosis is cost effective is important, because this forms a large part of the workload in general gynaecology, and uses considerable resources.

3 Lifestyle interventions (diet and exercise)

Are specialist lifestyle interventions (diet and exercise) effective, compared with no specialist lifestyle interventions, for women with endometriosis?

Why this is important

Endometriosis is a long-term condition that can cause acute and chronic pain, and fatigue. It has a significant and sometimes severe impact on the woman's quality of life and activities of daily living, including relationships and sexuality, ability to work, fertility, fitness and mental health.

Supporting self-management is critical to improving quality of life for women living with endometriosis. In order to successfully self-manage the condition, women need evidence-based, easily accessible information about the condition and ways of managing it that support surgical and medical treatment. However, no high-quality research was identified on the effectiveness of lifestyle interventions such as diet or exercise and other non-medical treatments in reducing pain, fatigue and other symptoms.

Studies should aim to provide evidence-based options to support self-management of endometriosis. This would improve the quality of life of women with endometriosis, enabling them to manage pain and fatigue, and reducing the negative impact on their career, relationships, sex lives, fertility, and physical and emotional wellbeing.

4 Information and support

What information and support interventions are effective to help women with endometriosis deal with their symptoms and improve their quality of lives?

Why this is important

This guideline has identified that women with endometriosis and their partners feel that information and support is not always provided in the way that best meet their needs. However, the direct effectiveness of different types or formats of information and support interventions on measurable outcomes such as health-related quality of life and level of function (for example, activities of daily living) have not been tested. Good practice in this area in non-specialist and specialist settings can improve satisfaction with the care provided. It may also improve quality of life and positively affect relationships between healthcare professionals and the woman with endometriosis, as well as the woman's personal family relationships.

5 Hormonal treatments for people with endometriosis where fertility is a priority

What is the effect of different doses and durations of hormonal treatments given either before, after, or both before and after surgery on fertility outcomes in people with endometriosis where fertility is a priority?

For a short explanation of why the committee made the recommendation for research, see the rationale section on treatment of endometriosis when fertility is a priority.

Full details of the evidence and the committee's discussion are in evidence review A: treatment of endometriosis when fertility is a priority.