Rationale and impact

This section briefly explains why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Treatment of endometriosis when fertility is a priority

Recommendations 1.11.2 to 1.11.4

Why the committee made the recommendations

There was no evidence of an important difference in the pregnancy rate between laparoscopic cystectomy and laparoscopic ablation and drainage of ovarian endometriomas larger than 3 cm, but drainage and ablation may lead to increased ovarian reserve (measured in terms of anti-Mullerian hormone levels, ovarian volume and antral follicle count) compared to laparoscopic cystectomy, so ablation and drainage has been included as an option if ovarian reserve is a priority.

Based on the committee's knowledge and experience and stakeholder feedback, the definition of deep endometriosis has been clarified to state that it includes endometriosis involving the bowel, bladder or ureter but is not limited to these sites, so that people are not excluded from treatment inappropriately. The need to discuss that deep endometriosis can impact on pregnancy outcomes has been added to the topics to discuss to provide a broader consideration of the benefits and risks of surgery.

There was some limited evidence of increased rates of clinical pregnancy and live birth with combinations of hormonal treatments with laparoscopic surgery compared to surgery alone, but the evidence was mixed, with other evidence showing no difference. As there was mixed evidence, the committee made a recommendation for research on hormonal treatments. The committee clarified that this recommendation applied to hormonal treatment alone or in combination with surgery.

How the recommendations might affect practice

The inclusion of ablation and drainage as a treatment option is not expected to have a resource impact as the cost of the 2 treatment options (cystectomy and ablation/drainage) are similar. This change will allow the option of a treatment which may have less of an impact on ovarian reserve.

Return to recommendations

Context

Endometriosis is one of the most common gynaecological diseases needing treatment. It is defined as the growth of endometrial-like tissue (the womb lining) outside the uterus (womb). Endometriosis is mainly a disease of the reproductive years and, although its exact cause is unknown, it is hormone mediated and is associated with menstruation.

Endometriosis is typically associated with symptoms such as pelvic pain, painful periods and subfertility. Endometriosis is also associated with a lower quality of life. Women with endometriosis report pain, which can be frequent, chronic and/or severe, as well as tiredness, more sick days, and a significant physical, sexual, psychological and social impact. Endometriosis is an important cause of subfertility and this can also have a significant effect on quality of life.

Women may also have endometriosis without symptoms, so it is difficult to know how common the disease is in the population. It is also unclear whether endometriosis is always progressive or can remain stable or improve with time.

Delayed diagnosis is a significant problem for women with endometriosis. Patient self-help groups emphasise that healthcare professionals often do not recognise the importance of symptoms or consider endometriosis as a possibility. In addition, women can delay seeking help because of a perception that pelvic pain is normal. Delays of 4 to 10 years can occur between first reporting symptoms and confirming the diagnosis. Many women report that the delay in diagnosis leads to increased personal suffering, prolonged ill health and a disease state that is more difficult to treat.

Diagnosis can only be made definitively by laparoscopic visualisation of the pelvis, but other, less invasive methods may be useful in assisting diagnosis, including ultrasound. Management options for endometriosis include pharmacological, non-pharmacological and surgical treatments. Endometriosis is an oestrogen-dependent condition. Most drug treatments for endometriosis work by suppressing ovarian function, and are contraceptive. Surgical treatment aims to remove or destroy endometriotic lesions. The choice of treatment depends on the woman's preferences and priorities in terms of pain management and/or fertility.

Endometriosis can be a chronic condition affecting women throughout their reproductive lives (and sometimes beyond). Women's priorities and preferences may change over time,

and management strategies should change to reflect this.

Women with endometriosis typically present to community services (including GPs, practice nurses, school nurses and sexual health services) with pain, and may then be referred to gynaecology services for diagnosis and management. Some women may present to fertility services. Complex surgical treatment is carried out in specialist endometriosis services (endometriosis centres), which incorporate a multidisciplinary team.

This guideline makes recommendations for the diagnosis and management of endometriosis in community services, gynaecology services and specialist endometriosis services (endometriosis centres).

The guideline also covers the care of women with confirmed or suspected endometriosis, including recurrent endometriosis. It includes women who do not have symptoms but have endometriosis discovered incidentally. Special consideration was given to young women (aged 17 and under). The guideline does not cover the investigation of fertility problems related to endometriosis, care of women with endometriosis occurring outside the pelvis, nor postmenopausal women.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic pages on gynaecological conditions and fertility.

For full details of the evidence and the guideline committee's discussions, see the full guideline and evidence review. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see resources to help you put guidance into practice.