Diagnostic laparoscopy

Also refer to the section on surgical management and the section on management if fertility is a priority.

1.5.9 Consider laparoscopy to diagnose endometriosis in women with suspected endometriosis, even if the ultrasound was normal.

1.5.10 For women with suspected deep endometriosis involving the bowel, bladder or ureter, consider a pelvic ultrasound or MRI before an operative laparoscopy.

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

1.5.12 During a diagnostic laparoscopy, consider taking a biopsy of suspected endometriosis:

- to confirm the diagnosis of endometriosis (be aware that a negative histological result does not exclude endometriosis)
- to exclude malignancy if an endometrioma is treated but not excised.

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

1.6 Staging systems

1.6.1 Offer endometriosis treatment according to the woman's symptoms, preferences and priorities, rather than the stage of the endometriosis.

1.6.2 When endometriosis is diagnosed, the gynaecologist should document a detailed description of the appearance and site of endometriosis.

1.7 Monitoring for women with confirmed

endometriosis

1.7.1 Consider outpatient follow-up (with or without examination and pelvic imaging) for women with confirmed endometriosis, particularly women who choose not to have surgery, if they have:

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

1.8 Pharmacological pain management

Analgesics

1.8.1 For women with endometriosis-related pain, discuss the benefits and risks of analgesics, taking into account any comorbidities and the woman's preferences.

1.8.2 Consider a short trial (for example, 3 months) of paracetamol or a non-steroidal anti-inflammatory drug (NSAID) alone or in combination for first-line management of endometriosis-related pain.

1.8.3 If a trial of paracetamol or an NSAID (alone or in combination) does not provide adequate pain relief, consider other forms of pain management and referral for further assessment.

Neuromodulators and neuropathic pain treatments

1.8.4 For recommendations on using neuromodulators to treat neuropathic pain, see the NICE guideline on neuropathic pain.

Hormonal treatments

NICE has produced a patient decision aid on hormonal treatment for endometriosis.

1.8.5 Explain to women with suspected or confirmed endometriosis that hormonal treatment for endometriosis can reduce pain and has no permanent negative effect on subsequent fertility.

1.8.6 Offer hormonal treatment (for example, the combined oral contraceptive pill or a progestogen) to women with suspected, confirmed or recurrent endometriosis.

In September 2017, this was off-label use for some combined oral contraceptive pills or progestogens. See NICE's information on prescribing medicines.

1.8.7 If initial hormonal treatment for endometriosis is not effective, not tolerated or is contraindicated, refer the woman to a gynaecology service (see the recommendation on gynaecology services), specialist endometriosis service (see the recommendation on specialist endometriosis services [endometriosis centres]) or paediatric and adolescent gynaecology service for investigation and treatment options.

1.9 Non-pharmacological management

1.9.1 Advise women that the available evidence does not support the use of traditional Chinese medicine or other Chinese herbal medicines or supplements for treating endometriosis.

1.10 Surgical management

1.10.1 Ask women with suspected or confirmed endometriosis about their symptoms, preferences and priorities with respect to pain and fertility, to guide surgical decision-making.

1.10.2 Discuss surgical management options with women with suspected or confirmed endometriosis. Discussions may include:

- what a laparoscopy involves
- that laparoscopy 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 (for example, for recurrent endometriosis or if complications arise)
- the possible need for further planned surgery for deep endometriosis involving the bowel, bladder or ureter.

1.10.3 Perform surgery for endometriosis laparoscopically unless there are contraindications.

1.10.4 During a laparoscopy to diagnose endometriosis, consider laparoscopic treatment of the following, if present:

- peritoneal endometriosis not involving the bowel, bladder or ureter
- uncomplicated ovarian endometriomas.

1.10.5 As an adjunct to surgery for deep endometriosis involving the bowel, bladder or ureter, consider 3 months of gonadotrophin-releasing hormone agonists before surgery.

In September 2017, this was off-label use for some gonadotrophin-releasing hormone agonists. See NICE's information on prescribing medicines.

1.10.6 Consider excision rather than ablation to treat endometriomas, taking into account the woman's desire for fertility and her ovarian reserve. Also see the section on ovarian reserve testing in the NICE guideline on fertility problems.

Combination treatments

1.10.7 After laparoscopic excision or ablation of endometriosis, consider hormonal treatment (with, for example, the combined oral contraceptive pill), to prolong the benefits of surgery and manage symptoms.

In September 2017, this was off-label use for some hormonal treatments (including some combined oral contraceptive pills). See NICE's information on prescribing medicines.

Hysterectomy in combination with surgical management

1.10.8 If hysterectomy is indicated (for example, if the woman has adenomyosis or heavy menstrual bleeding that has not responded to other treatments), excise all visible endometriotic lesions at the time of the hysterectomy.

1.10.9 Perform hysterectomy (with or without oophorectomy) laparoscopically when combined with surgical treatment of endometriosis, unless there are contraindications.

1.10.10 For women thinking about having a hysterectomy, discuss:

- what a hysterectomy involves and when it may be needed
- the possible benefits and risks of hysterectomy
- the possible benefits and risks of having oophorectomy at the same time
- how a hysterectomy (with or without oophorectomy) could affect endometriosis symptoms
- that hysterectomy should be combined with excision of all visible endometriotic lesions
- endometriosis recurrence and the possible need for further surgery
- the possible benefits and risks of hormone replacement therapy after hysterectomy with oophorectomy (also see the NICE guideline on menopause).

1.11 Management if fertility is a priority

The recommendations in this section should be interpreted within the context of NICE's guideline on fertility problems. The management of endometriosis-related subfertility