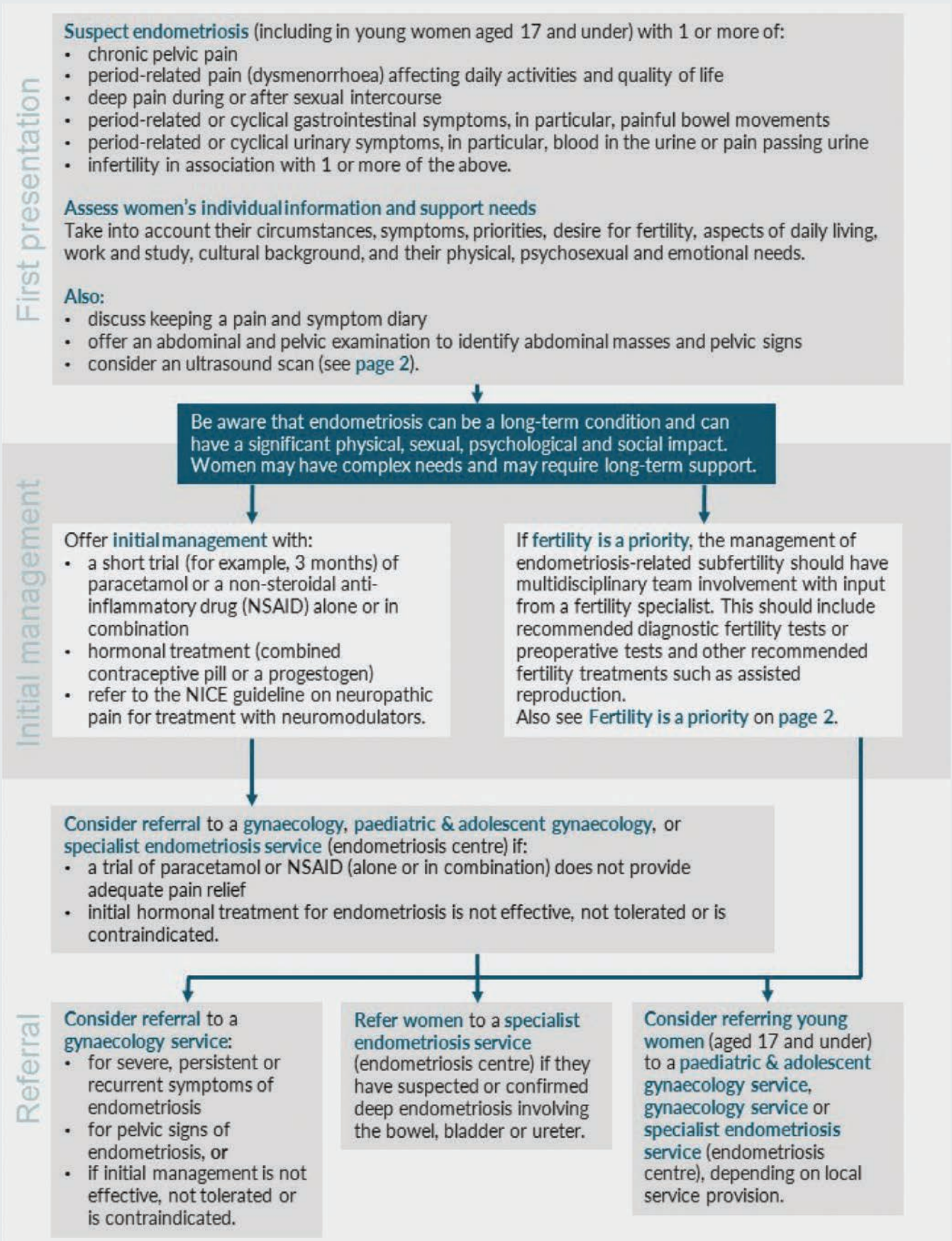
Figure 2

NICE NG73 Endometriosis: diagnosis and management algorithm[2]



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

Consider transvaginal ultrasound:
- to investigate suspected endometriosis even if pelvic and/or abdominal examinations are normal
- for endometriomas and deep endometriosis involving the bowel, bladder or ureter.

Consider a transabdominal ultrasound scan of the pelvis if a transvaginal scan is not appropriate.

Do not exclude the possibility of endometriosis if the abdominal and/or pelvic examinations or ultrasound or MRI are normal.

Consider referral for assessment & investigation if clinical suspicion remains or symptoms persist.

Consider laparoscopy to diagnose endometriosis, even if the ultrasound was normal.

Discuss surgical management options with women with suspected/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 laparoscopy, a gynaecologist with training and skills in laparoscopic surgery for endometriosis should perform a systematic inspection of the pelvis.

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

Diagnosis

If fertility is a priority

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

Offer laparoscopic ovarian cystectomy to women with endometriomas.

Discuss the benefits and risks of laparoscopic surgery for deep endometriosis involving the bowel, bladder or ureter. This may include:
- 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 to women with endometriosis who want to conceive.

Consider outpatient follow-up for:
- deep endometriosis involving the bowel, bladder or ureter, or
- 1 or more endometrioma larger than 3 cm.

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

Care

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