key points

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Endometriosis, defined as the growth of endometrial-like tissue outside the uterus, affects around one in ten women of reproductive age in the UK. NICE guidance highlights the importance of symptoms in its diagnosis. A normal abdominal or pelvic examination, ultrasound, or MRI should not exclude the diagnosis. Delayed diagnosis is a significant problem. Women may wait two years before presenting to their GP. Diagnosis can be difficult because symptoms vary between patients. It can take four to ten years from first reporting symptoms to the diagnosis being confirmed. This can lead to prolonged pain and disease progression.

Endometriosis should be suspected in women and adolescents who present with one or more of: chronic pelvic pain, significant dysmenorrhoea, deep dyspareunia, period-related or cyclical GI or urinary symptoms, or infertility. If endometriosis is suspected or symptoms persist, patients should be referred for further assessment.

A history of severe dysmenorrhoea affecting daily activities and/or quality of life should prompt questioning about other symptoms of endometriosis. Women should be offered an abdominal and pelvic examination, to identify abdominal masses and pelvic signs such as reduced organ mobility, and palpable and visible endometriotic nodules in the vagina.

For women without pelvic signs, a trial of simple analgesics is appropriate, with consideration of hormonal treatments e.g. the hormonal contraceptive pill or a progestogen. Women who have suspected or confirmed deep endometriosis involving the bowel, bladder or ureter should be referred to a specialist endometriosis service. Those aged 17 years and under with suspected endometriosis should be referred to a paediatric and adolescent gynaecology service or an endometriosis centre.

Definitive diagnosis can only be made by laparoscopic visualisation. Women undergoing laparoscopy should be advised that if deep endometriosis involving the bowel, bladder or ureter is diagnosed, then this may require further planned surgery before treatment. This offers the opportunity to discuss the benefits e.g. on fertility, and risks e.g. surgery and its impact on ovarian reserve.