Summary of guidance on the diagnosis and management of endometriosis and adenomyosis

Type of recommendation	Description
Evidence-based recommendation	Recommendation formulated with evidence from source guideline and/or new literature searches
Consensus-based recommendation	Recommendation formulated by consensus, where evidence was sought but none was identified, or the identified evidence was limited by indirectness
EEWG Committee opinion	Guidance that is outside the scope of the evidence search and is based on consensus of the Endometriosis Expert Working Group (EEWG)

Signs and symptoms of endometriosis

No.	Recommendation	Type of recommendation
1	Suspect endometriosis in people (including those aged 17 and under) presenting with 1 or more of the following: • persistent pelvic pain • period-related pain (dysmenorrhoea) affecting daily activities and quality of life • deep pain during or after sexual intercourse • period-related or cyclical gastrointestinal symptoms, in particular, painful bowel movements • period-related or cyclical urinary symptoms, in particular, blood in the urine or pain passing urine • infertility in association with 1 or more of the above.	Evidence-based recommendation
2	Inform people with suspected or confirmed endometriosis that keeping a pain and symptom diary can aid discussions.	Consensus-based recommendation
3	Offer an abdominal and pelvic examination to people with suspected endometriosis to identify abdominal masses and pelvic signs, such as reduced organ mobility and enlargement, tender nodularity in the posterior vaginal fornix, and visible vaginal endometriotic lesions.	Consensus-based recommendation
4	If a pelvic examination is not appropriate in people with suspected endometriosis, offer an abdominal examination to exclude abdominal masses.	Consensus-based recommendation

Information and support for people with endometriosis

No.	Recommendation	Type of recommendation
5	Be aware that endometriosis can be a long-term condition, and can have a significant physical, sexual, psychosocial, emotional and social impact. People with endometriosis may have complex needs and require long-term support.	Evidence-based recommendation
6	Assess the individual information and support needs of people with suspected or confirmed endometriosis, taking into account factors such as the person's circumstances; symptoms; co-existing conditions; priorities; desire for fertility; constraints of daily living, work and study; cultural background; and physical, psychosexual and emotional needs.	Evidence-based recommendation
7	Provide comprehensive and ongoing information and support to people with suspected or confirmed endometriosis, to promote their active participation in care and self-management. For example, provide information on: • what endometriosis is • endometriosis signs and symptoms • how endometriosis is diagnosed • treatment options including care, follow-up, anticipated waiting times and out-of-pocket expenses • national and local support groups or networks, and resources (hard copy and online).	Consensus-based recommendation
8	If the person agrees, involve their partner (and/or other family members or people important to them) and include them in discussions.	Consensus-based recommendation

No.	Recommendation	Type of recommendation
9	For people in rural and remote areas with suspected or confirmed endometriosis, offer consultation and investigative options. Services should be equitable to those in metropolitan centres. In rural and remote areas, telehealth consultations should be made available, and access to imaging services should be prioritised.	EEWG Committee opinion

Prompt diagnosis of endometriosis and early intervention

No.	Recommendation	Type of recommendation
10	Community, gynaecology and specialist endometriosis services (endometriosis centres) should provide coordinated care for people with suspected or confirmed endometriosis.	Consensus-based recommendation
11	People with suspected or confirmed endometriosis should be offered comprehensive coordinated care from their clinical team, with processes in place for prompt diagnosis and treatment of endometriosis, because delays can affect quality of life and result in disease progression.	Consensus-based recommendation
12	A GP chronic disease management plan can help access appropriate assessment and access to services.	EEWG Committee opinion

Organisation of care

No.	Recommendation	Type of recommendation
13	Set up a managed clinical network[1] for people with suspected or confirmed endometriosis, comprising community services (including general practitioners [GPs], practice nurses, school nurses and sexual health services), gynaecology services and specialist endometriosis services (endometriosis centres).	Consensus-based recommendation
14	People with suspected or confirmed endometriosis may require access to: • a gynaecologist with expertise in diagnosing and managing endometriosis, including training and skills in laparoscopic surgery • a gynaecology specialist nurse with expertise in endometriosis (if available) • a multidisciplinary pain management service • a healthcare professional with an interest in gynaecological imaging • fertility services.	Consensus-based recommendation
15	People with suspected or confirmed severe endometriosis may require additional services and access to: • gynaecologists with expertise in diagnosing and managing endometriosis, including advanced laparoscopic surgical skills • a colorectal surgeon with an interest in endometriosis • a urologist with an interest in endometriosis • an endometriosis specialist nurse • a multidisciplinary pain management service with expertise in pelvic pain • a healthcare professional with specialist expertise in gynaecological imaging of endometriosis • advanced diagnostic facilities (for example, radiology and histopathology) • fertility services.	Consensus-based recommendation

[1] A managed clinical network is one in which linked groups of healthcare professionals from primary, secondary and tertiary care provide a coordinated patient pathway. Responsibility for setting up such a network depends on existing service provision and location.

Referral of people with endometriosis to secondary care

No.	Recommendation	Type of recommendation
16	Consider referring people with suspected or confirmed endometriosis to a gynaecologist if: • ultrasound or imaging are suggestive of a higher stage or infiltrating disease (e.g. endometrioma, adenomyosis, or disease invading other organs) • they have severe, persistent or recurrent symptoms of endometriosis • they have pelvic signs of endometriosis • initial management is not effective, not tolerated, or contraindicated.	Consensus-based recommendation
17	Refer people with suspected or confirmed endometriosis to a gynaecologist with an interest in endometriosis if they have suspected or confirmed deep endometriosis involving the bowel, bladder, or ureter.	Consensus-based recommendation
18	Consider referring young people (aged 17 and under) with suspected or confirmed endometriosis to a paediatric and adolescent gynaecologist with an interest in endometriosis depending on local service provision, or to a gynaecologist who is comfortable treating adolescents with possible endometriosis.	Consensus-based recommendation

Interdisciplinary care to manage endometriosis

No.	Recommendation	Type of recommendation
19	Gynaecologists may consider multidisciplinary input to manage people with endometriosis, for example, where: bladder, bowel, ureter involvement is suspected based on history, examination or investigations medical or surgical treatments have failed to improve symptoms musculoskeletal or neuropathic contributions to pain are suspected pain affects daily functioning there are diet and bowel related issues there are mental health and social impacts.	EEWG Committee opinion

Diagnosis of endometriosis

No.	Recommendation	Type of recommendation
20	A normal abdominal or pelvic examination, ultrasound, CT, or MRI does not exclude the possibility of endometriosis. If clinical suspicion remains or symptoms persist, consider referral for further assessment and investigation.	Evidence-based recommendation
	Clinical examination	
21	A clinical pelvic examination is an important part of an initial assessment to investigate suspected endometriosis – offer a pelvic examination or, if this is not appropriate, offer an abdominal examination.	Consensus-based recommendation
	Ultrasound	
22	Consider transvaginal ultrasound: to investigate suspected endometriosis even if the pelvic and/or abdominal examination is normal. to identify endometriomas.	Evidence-based recommendation
23	Consider specialised ultrasound to assess the extent of deep endometriosis involving the bowel, bladder, or ureter.	Evidence-based recommendation
24	Specialised ultrasound scans are best interpreted by a healthcare professional with specialist expertise in gynaecological imaging.	Evidence-based recommendation
25	If a transvaginal scan is not appropriate, consider transabdominal ultrasound scan of the pelvis.	Consensus-based recommendation
	Biomarkers	
26	Do not use serum CA125 to diagnose endometriosis.	Evidence-based recommendation
27	If a coincidentally reported serum CA125 level is available, be aware that: • a raised serum CA125 (that is, 35 IU/ml or more) may be consistent with having endometriosis • endometriosis may be present despite a normal serum CA125 (less than 35 IU/ml).	Evidence-based recommendation

No.	Recommendation	Type of recommendation
	Magnetic resonance imaging (MRI)	
28	Do not use pelvic MRI as the primary investigation to diagnose endometriosis in people with symptoms or signs suggestive of endometriosis.	Evidence-based recommendation
29	Consider pelvic MRI to assess the extent of deep endometriosis involving the bowel, bladder or ureter.	Evidence-based recommendation
30	Pelvic MRI scans are best interpreted by a healthcare professional with specialist expertise in gynaecological imaging.	Evidence-based recommendation
	Computed tomography (CT)	
31	Do not use CT scanning as the primary investigation to diagnose endometriosis in people with symptoms or signs suggestive of endometriosis.	Consensus-based recommendation
32	CT scanning may be used to assess the extent of deep endometriosis involving the bowel, bladder, or ureter if MRI is not accessible.	Consensus-based recommendation
33	CT scans are best interpreted by a healthcare professional with specialist expertise in gynaecological imaging.	Consensus-based recommendation
	Laparoscopy – surgical diagnosis	
34	Consider laparoscopy to diagnose and treat people with suspected endometriosis, even if the ultrasound is normal.	Evidence-based recommendation
35	For people with suspected deep endometriosis involving the bowel, bladder, or ureter, consider a detailed pelvic ultrasound or MRI before operative laparoscopy.	Evidence-based recommendation
36	During a laparoscopy for suspected endometriosis, a gynaecologist with training and skills in laparoscopic surgery for endometriosis should perform a systematic inspection of the pelvis and abdomen.	Evidence-based recommendation
37	During a laparoscopy where no visible endometriosis is apparent, consider taking a biopsy(ies) of the peritoneum for histological assessment. Where there is apparent endometriosis, consider a biopsy: • to confirm the diagnosis of endometriosis (note: a negative histological result does not exclude endometriosis) • to exclude malignancy if an endometrioma is treated but not excised.	Evidence-based recommendation
38	If a full, systematic laparoscopy is performed and no endometriosis is found, explain to the person that they do not have endometriosis, and offer management of persistent symptoms.	Evidence-based recommendation

Diagnosis of adenomyosis

No.	Recommendation	Type of recommendation
39	Consider ultrasound for the diagnosis of adenomyosis because it may provide useful information, even though features are variable and diagnostic performance is limited by the lack of agreed diagnostic criteria.	Evidence-based recommendation
40	Do not use MRI as a first-line method to diagnose adenomyosis. MRI may be appropriate for specific situations where transvaginal ultrasound is not feasible.	Consensus-based recommendation

Factors that can guide treatment of endometriosis

No.	Recommendation	Type of recommendation
41	Offer endometriosis treatment according to the person's symptoms, preferences and priorities, rather than the stage of the endometriosis. Factors to consider include the person's circumstances; symptoms; co-existing conditions; priorities; desire for fertility; constraints of daily living, work and study; cultural background; and physical, psychosexual and emotional needs.	Consensus-based recommendation
42	When endometriosis is diagnosed, the gynaecologist should document a detailed description of the appearance and site of endometriosis. Documentation should be in line with the data dictionary developed by the National Endometriosis Clinical and Scientific Trials (NECST) Network.[7].	Consensus-based recommendation

Pharmacological management of endometriosis-associated pain using analgesics

No.	Recommendation	Type of recommendation
43	For people with endometriosis-associated pain, consider a short trial (for example, 3 months) of a non-steroidal anti-inflammatory drug (NSAID) alone or in combination with paracetamol, if not contraindicated. If such a trial does not provide adequate pain relief, consider other forms of pain management and referral for further assessment.	Consensus-based recommendation

Pharmacological management of adenomyosis-associated pain using analgesics

No.	Recommendation	Type of recommendation
44	For people with adenomyosis-associated pain, consider a short trial (for example, 3 months) of a non-steroidal anti-inflammatory drug (NSAID) alone or in combination with paracetamol, if not contraindicated. If such a trial does not provide adequate pain relief, consider other forms of pain management and referral for further assessment.	Consensus-based recommendation

Pharmacological management of endometriosis-associated pain using neuromodulators

No.	Recommendation	Type of recommendation
45	Treatment of endometriosis-associated pain should be individualised (noting that the effectiveness of systemic neuromodulators is uncertain).	Consensus-based recommendation
46	The effectiveness of the chosen pain relief method should be regularly assessed and monitored.	Consensus-based recommendation
47	People with endometriosis should be referred to a pain specialist and/or a condition-specific specialist at any stage if: • pain is severe and unresponsive to simple analgesics • the pain substantially limits daily activities • any underlying health condition has deteriorated.	Consensus-based recommendation

Pharmacological management of endometriosis using hormonal medical treatments

No.	Recommendation	Type of recommendation
48	Explain to people with suspected or confirmed endometriosis that hormonal treatment for endometriosis can reduce pain and has no permanent negative effect on subsequent fertility (other than delaying the time to fertility, which may be important depending on the person's age).	Evidence-based recommendation
49	Offer hormonal treatment (for example, the combined oral contraceptive pill or a progestogen as an oral form, a subcutaneous implant or IUD form[2]) to people with suspected, confirmed or recurrent endometriosis. The choice of hormonal treatment should be in a shared decision-making approach, recognising that no hormonal treatment has been demonstrated to be superior.	Evidence-based recommendation
50	If initial hormonal treatment for endometriosis is not effective, not tolerated or contraindicated, refer the person to a gynaecologist for investigation and treatment options, based on the person's preferences.	Evidence-based recommendation
51	As an adjunct to surgery for deep endometriosis involving the bowel, bladder or ureter, consider 3 months of gonadotrophin-releasing hormone agonists2 before surgery.	Consensus-based recommendation

[2] At the time of publication, not all combined oral contraceptive pills or progestogens have Therapeutic Good Administration (TGA) approval for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented.

Pharmacological management of adenomyosis using hormonal medical treatments

No.	Recommendation	Type of recommendation
52	Explain to people with suspected or confirmed adenomyosis that hormonal treatment for adenomyosis can reduce pain and heavy bleeding and has no permanent negative effect on subsequent fertility (other than delaying the time to fertility, which may be important, depending on the person's age).	Evidence-based recommendation
53	Offer hormonal treatment (for example, the combined oral contraceptive pill or a progestogen as an oral form, subcutaneous implant or IUD form[2]) to people with suspected, confirmed or recurrent adenomyosis. The choice of hormonal treatment should be in a shared decision-making approach, recognising that no hormonal treatment has been demonstrated to be superior.	Evidence-based recommendation
54	If initial hormonal treatment for adenomyosis is not effective, not tolerated or contraindicated, refer the person to a gynaecologist for investigation and treatment options based on the person's preferences.	Evidence-based recommendation

Alternatives to pharmacological and surgical management for endometriosis

No.	Recommendation	Type of recommendation
55	Advise people that the there is no evidence to support the use of Chinese herbal medicines or supplements for treating endometriosis, and that there are concerns relating to potential harms associated with their use.	Evidence-based recommendation
56	Advise people that there is limited low-quality evidence on the effectiveness of acupuncture for the management of endometriosis pain.	Evidence-based recommendation

Alternatives to pharmacological and surgical management for adenomyosis

No.	Recommendation	Type of recommendation
57	Advise people with adenomyosis who are considering using alternatives to pharmacological and surgical management to treat adenomyosis-associated pain that there is little to no evidence to support the use of alternatives.	Consensus-based recommendation

Surgical management of endometriosis

No.	Recommendation	Type of recommendation
58	Perform surgery for endometriosis laparoscopically unless there are contraindications.	Evidence-based recommendation
59	Discuss surgical management options with people 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.	Evidence-based recommendation
60	Consider excision rather than ablation to treat endometriomas, taking into account the person's desire for fertility, previous ovarian surgery and ovarian reserve.	Evidence-based recommendation
61	Deeply invasive endometriosis with side-wall disease, bowel or bladder involvement increases surgical complexity and may increase the risk of complications. Referral to one or more clinicians with appropriate skills to address this disease is advised.	EEWG Committee opinion

Surgical management of adenomyosis

No.	Recommendation	Type of recommendation
62	Advise people contemplating conservative excisional or ablative surgery for the treatment of adenomyosis that there is no evidence for or against excisional or ablative surgery in the treatment of adenomyosis.	Consensus-based recommendation

Combination of surgery and hormonal treatment for endometriosis

No.	Recommendation	Type of recommendation
63	After laparoscopic excision or ablation of endometriosis, consider hormonal treatment, to prolong the benefits of surgery and manage symptoms. The particular hormonal therapy chosen should consider person's preferences and clinical judgement.	Evidence-based recommendation

Combination of surgery plus hormonal treatment for treatment of adenomyosis

No.	Recommendation	Type of recommendation
64	Adenomyosis is a condition that is usually treated with either hormonal therapy or surgery (e.g. adenomyectomy or hysterectomy), rather than combined hormonal and surgical therapies. Depending on patient preference and clinical judgement, hormonal therapy may be an offered as a first-line treatment for adenomyosis. Surgical options are limited if fertility is to be preserved.	Consensus-based recommendation

Hysterectomy for the management of endometriosis

No.	Recommendation	Type of recommendation
65	Advise people contemplating a hysterectomy for the treatment of endometriosis that there is no evidence for or against the effectiveness of hysterectomy for endometriosis. If hysterectomy is indicated (for example, if the person has adenomyosis or heavy menstrual bleeding that has not responded to other treatments), all visible endometriotic lesions should be excised at the time of the hysterectomy.	Consensus-based recommendation
66	When hysterectomy is combined with surgical treatment of endometriosis, perform the hysterectomy (with or without oophorectomy) laparoscopically unless there are contraindications.	Evidence-based recommendation
67	For people with endometriosis who are 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 as hysterectomy • how a hysterectomy (with or without oophorectomy) could affect endometriosis symptoms • that hysterectomy should be combined with excision of all visible endometriotic lesions • that endometriosis may recur, with the possible need for further surgery • the possible benefits and risks of menopausal hormone therapy after hysterectomy with oophorectomy.	Consensus-based recommendation

Hysterectomy for the management of adenomyosis

No.	Recommendation	Type of recommendation
68	Advise people contemplating a hysterectomy for the treatment of adenomyosis that there is no evidence for or against the effectiveness of hysterectomy for adenomyosis-associated pain. Women who have heavy menstrual bleeding will have resolution of their heavy menstrual bleeding.	Consensus-based recommendation
69	For people with adenomyosis who are 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 as the hysterectomy • how a hysterectomy (with or without oophorectomy) could affect adenomyosis symptoms • that hysterectomy should be combined with excision of all visible adenomyotic and endometriosis lesions • that adenomyosis may recur, with the possible need for further surgery • the possible benefits and risks of menopausal hormone therapy after hysterectomy with oophorectomy.	Consensus-based recommendation

Management strategies to enhance fertility in people with endometriosis

No.	Recommendation	Type of recommendation
70	The management of endometriosis-related infertility should involve an interdisciplinary team that includes a specialist with a specific interest in fertility associated with endometriosis. This should include the recommended diagnostic fertility tests or preoperative tests, as well as other recommended fertility treatments, such as assisted reproduction.	EEWG Committee opinion
71	For people who are trying to conceive, discuss the benefits and risks of laparoscopic surgery as a treatment option (working with a specialist with an interest in fertility associated with endometriosis). Topics to discuss may include: • whether laparoscopic surgery may alter the chance of future pregnancy • the possible impact on ovarian reserve • the possible impact on fertility if complications arise • alternatives to surgery • other fertility factors • non-fertility related benefits, such as pain management.	Evidence-based recommendation
72	Offer excision or ablation of endometriosis because this improves the chance of expectant pregnancy. Offer laparoscopic ovarian cystectomy with excision of the cyst wall to people with endometriomas because this improves the chance of expectant pregnancy and reduces recurrence. Consider the person's ovarian reserve.	Evidence-based recommendation
73	Do not offer hormonal suppression treatments to people with endometriosis who are trying to conceive, because it does not improve expectant pregnancy rates.	Evidence-based recommendation

Follow-up of asymptomatic endometriosis

No.	Recommendation	Type of recommendation
74	Consider follow-up (with or without examination and pelvic imaging) for people with confirmed endometriosis, particularly those who choose not to have surgery, if they have: • deep endometriosis involving the bowel, bladder or ureter or • 1 or more endometrioma that are larger than 3 cm.	Consensus-based recommendation

Secondary prevention of endometriosis

No.	Recommendation	Type of recommendation
75	Prophylactic surgery is not recommended in the absence of symptoms given the lack of evidence and potential for surgical complications.	Consensus-based recommendation

Risk of cancer of the reproductive organs in people with endometriosis

No.	Recommendation	Type of recommendation
76	People may be concerned that endometriosis is associated with an increased risk of cancer of the reproductive organs. Be aware of these concerns, and that there is no conclusive evidence to support such an association; thus, additional surveillance is unnecessary.	EEWG Committee opinion