NICE National Institute for Health and Care Excellence

Endometriosis: diagnosis and management (NG73) – Update to recommendations on diagnosis of endometriosis

Draft for consultation

This guideline covers diagnosing and managing endometriosis. It aims to raise awareness of the symptoms of endometriosis, and to provide clear advice on what action to take when women with signs and symptoms first present in healthcare settings. It also provides advice on the range of treatments available.

These recommendations will update NICE guideline NG73 (published September 2017).

Who is it for?

- Healthcare professionals
- Commissioners
- Women with suspected or confirmed endometriosis, their families and carers.

What does it include?

- revised recommendations on diagnosing endometriosis
- rationale and impact information that explains why the committee made the 2024 recommendations and updates, and how they might affect practice and services. Full details of the evidence and the committee's discussion are included in evidence review A: diagnosing endometriosis

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence review, details of the committee and any declarations of interest.

Updated recommendations

We have reviewed the evidence on diagnosing endometriosis. You are invited to comment on the revised recommendations only. These are marked as **[2024].**

ID Number (please use to identify what comment relates to at consultation)	Existing recommendation in NG73	Proposed revised recommendation	Rationale for change	Impact of change
	1.3 Endometriosis symptoms and signs 1.3.1 Suspect endometriosis in women (including young women aged 17 and under) presenting with 1 or more of the following symptoms or signs:	NOT PART OF UPDATE – INCLUDED IN TABLE FOR CONTEXT ONLY.		

	• chronic 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.			
	No existing recommendation	1.3.2 Be aware that a family history of endometriosis in a first-degree relative increases the likelihood of endometriosis. **[2024]**	Based on their knowledge and experience the committee agreed that a family history of endometriosis should be considered when assessing a person with signs or symptoms suggesting endometriosis, as there was an increased likelihood of endometriosis in this situation.	This may increase the suspicion of endometriosis, which may lead to earlier diagnosis.

	1.3.3 Inform women with suspected or confirmed endometriosis that keeping a pain and symptom diary can aid discussions.	NOT PART OF UPDATE – INCLUDED IN TABLE FOR CONTEXT ONLY.		
	1.3.4 Offer an abdominal and pelvic examination to women 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.	NOT PART OF UPDATE – INCLUDED IN TABLE FOR CONTEXT ONLY		
	1.3.5 If a pelvic examination is not appropriate, offer an abdominal examination to exclude abdominal masses.	NOT PART OF UPDATE – INCLUDED IN TABLE FOR CONTEXT ONLY.		
1		**1.4 Initial pharmacological treatment for women with suspected endometriosis**	This new section has been created in the guideline to make the patient pathway clearer.	
2	**Analgesics** 1.8.1 For women with endometriosis-related pain,	**Analgesics** 1.4.1 For women with endometriosis-related pain,	The recommendation has not changed but position in guideline has been revised	No impact

	discuss the benefits and risks of analgesics, taking into account any comorbidities and the woman's preferences.	discuss the benefits and risks of analgesics, taking into account any comorbidities and the woman's preferences. **[2017]**	to make the patient pathway clearer.	
3	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.	1.4.2 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. **[2017]**	The recommendation has not changed but position in guideline has been revised to make the patient pathway clearer.	No impact
4	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.	1.4.3 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. **[2017]**	The recommendation has not changed but position in guideline has been revised to make the patient pathway clearer.	No impact
5	**Neuromodulators and neuropathic pain treatments** 1.8.4 For recommendations on using neuromodulators to treat neuropathic pain, see	**Neuromodulators and neuropathic pain treatments** 1.4.4 For recommendations on using neuromodulators to treat neuropathic pain, see	The recommendation has not changed but position in guideline has been revised to make the patient pathway clearer.	No impact

	the NICE guideline on neuropathic pain.	the NICE guideline on neuropathic pain. **[2017]**		
6	**Hormonal treatments** NICE has produced a patient decision aid on hormonal treatment for endometriosis.	**Hormonal treatments** NICE has produced a patient decision aid on hormonal treatment for endometriosis. **[2017]**	The recommendation has not changed but position in guideline has been revised to make the patient pathway clearer.	No impact
7	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.	1.4.5 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. **[2017]**	The recommendation has not changed but position in guideline has been revised to make the patient pathway clearer.	No impact
8	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	1.4.6 Offer hormonal treatment (for example, the combined oral contraceptive pill or a progestogen) to women with suspected, confirmed or recurrent endometriosis. **[2017]** In September 2017, this was off-label use for some combined oral contraceptive pills or progestogens. See NICE's	The recommendation has not changed but position in guideline has been revised to make the patient pathway clearer.	No impact

	information on prescribing medicines.	information on prescribing medicines. **[2017]**		
9	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.		This recommendation has been deleted as referral is now covered in the next section of the guideline (see recommendations 1.5.4, 1.5.5 and 1.5.6).	No impact
10	**1.4 Referral for women with suspected or confirmed endometriosis** **1.5 Diagnosing endometriosis**	**1.5 Diagnosis and referral for women with suspected or confirmed endometriosis**	The sections on referral and diagnosis have been merged and reordered to make the patient pathway clear.	No impact
		Additional investigations such as ultrasound and referral (if necessary) can be carried out in parallel with	This additional information has been added to emphasise that initial pharmacological treatment, a	Earlier investigation and referral for endometriosis is likely to lead to earlier treatment and reduce

		each other, and in conjunction with initial pharmacological treatment.	non-specialist ultrasound and referral do not need to happen sequentially and can happen in parallel so that the overall pathway of care is more timely.	serious disease and subsequent costs.
11	**Ultrasound** 1.5.2 Consider transvaginal ultrasound: • to investigate suspected endometriosis even if the pelvic and/or abdominal examination is normal • to identify endometriomas and deep endometriosis involving the bowel, bladder or ureter. **[2017]**	**Ultrasound** 1.5.1 GPs should offer transvaginal ultrasound to all women or people with suspected endometriosis, even if pelvic or abdominal examination is normal. The aim of this ultrasound is to: • identify endometriomas and deep endometriosis involving the bowel, bladder or ureter • identify or rule out other pathology which may be causing symptoms • guide management options and enable referral to an appropriate service (such as gynaecology, a specialist endometriosis service, or gastroenterology), depending on the ultrasound findings. See recommendations 1.5.4, 1.5.5 and 1.5.6. **[2024]**	The committee discussed that all women or people with suspected endometriosis should undergo an ultrasound examination as this would allow identification of deep endometriosis or endometriomas if present, may identify other pathology which could be leading to the symptoms (such as fibroids or malignancy), and would therefore help determine the need for a referral, and the most appropriate referral option. The strength of the recommendation has been changed to a strong ‘offer’ rather than a weaker ‘consider’ as the committee agreed that an ultrasound was part of the standard diagnostic work-up for women or people presenting with symptoms suggesting	This change to the recommendation reflects current best practice and therefore is unlikely to lead to a large increase in the use of transvaginal ultrasound in primary care. This early scan may replace the need for a transvaginal ultrasound after referral to gynaecology services for some women (particularly those who are referred and then seen without undue delay) and so is unlikely to increase the total number of transvaginal ultrasounds for diagnosis of endometriosis. This change is therefore not expected to lead to a large increase in resource use. However, earlier diagnosis of endometriosis (particularly endometriomas) is likely to lead to earlier treatment and

			endometriosis and that is was current good practice. The committee noted that additional new evidence had been identified showing that transvaginal ultrasound was, in the majority of studies, moderately to highly sensitive at detecting endometriosis, particularly when involving the ovaries. However, the committee were aware that these data were when the ultrasound was carried out by a specialist operator, and that ultrasounds carried out in a non-specialist setting may not achieve this degree of sensitivity However, the committee agreed that a non-specialist ultrasound was still a useful tool that would help identify deep endometriosis or endometrioma or other pathology. The committee agreed that failure to diagnose endometriosis was a common problem and that ultrasound should therefore	reduce serious disease and subsequent costs.

			be offered to all symptomatic women and people.	
12	1.5.3 If a transvaginal scan is not appropriate, consider a transabdominal ultrasound scan of the pelvis. **[2017]**	1.5.2 If a transvaginal scan is not appropriate, consider a transabdominal ultrasound scan of the pelvis. **[2017]**	No change	No impact
13	1.5.1 Do not exclude the possibility of endometriosis if the abdominal or pelvic examination, ultrasound or MRI are normal. If clinical suspicion remains or symptoms persist, consider referral for further assessment and investigation. **[2017]**	1.5.3 Do not exclude the possibility of endometriosis if the abdominal or pelvic examination and ultrasound are normal, and recognise that referral may still be necessary even with a normal scan. **[2017, amended 2024]**	As the recommendations have been reordered, the advice not to exclude a diagnosis of endometriosis with normal scan results now only applies to ultrasound scans. Normal MRI scans are now covered in a later recommendation.	No impact
14	1.4.1 Consider referring women to a gynaecology service (see the recommendation on gynaecology services) for an ultrasound or gynaecology opinion if: • they have severe, persistent or recurrent symptoms of endometriosis • they have pelvic signs of endometriosis or	1.5.4 Consider referring women or people to a gynaecology service (see the recommendation on gynaecology services) for a gynaecology opinion if: • they have severe, persistent or recurrent symptoms of endometriosis, **or** • they have pelvic signs of endometriosis, **or** • initial empirical treatment is not effective, is not tolerated or is	The committee agreed that women would usually have had an ultrasound before they were referred to a gynaecology service and therefore removed ultrasound from this recommendation.	No impact

	• initial management is not effective, not tolerated or is contraindicated. **[2017**]	contraindicated. **[2017, amended 2024]**		
15.	1.4.2 Refer women to a specialist endometriosis service (see the recommendation on specialist endometriosis services [endometriosis centre]) if they have suspected or confirmed: • deep endometriosis involving the bowel, bladder or ureter, or • endometriosis outside the pelvic cavity. **[2017]**	1.5.5 Refer women or people to a specialist endometriosis service (see the recommendation on specialist endometriosis services [endometriosis centre]) if they have suspected or confirmed: • endometrioma, **or** • deep endometriosis involving the bowel, bladder or ureter, **or** • endometriosis outside the pelvic cavity. **[2017]**	No change	No impact
16	1.4.3.Consider referring young women (aged 17 and under) with suspected or confirmed endometriosis to a paediatric and adolescent gynaecology service, gynaecology service or specialist endometriosis service (endometriosis centre), depending on local service provision. **[2017]**	1.5.6.Consider referring young women or people (aged 17 and under) with suspected or confirmed endometriosis to a paediatric and adolescent gynaecology service, gynaecology service or specialist endometriosis service (endometriosis centre), depending on local service provision. **[2017]**	No change	No impact
17	**Serum CA125** 1.5.4 Do not use serum CA125 to diagnose endometriosis. **[2017]**	**Serum CA125** 1.5.7 Do not use serum CA125 to diagnose endometriosis. **[2017]**	No change	No impact

18	1.5.5 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). **[2017]**	1.5.8 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). **[2017]**	No change	No impact
19.	**MRI** 1.5.6 Do not use pelvic MRI as the primary investigation to diagnose endometriosis in women with symptoms or signs suggestive of endometriosis. **[2017]**	**MRI** <Recommendation deleted>	MRI is not used as a primary investigation to diagnose endometriosis. All women or people would require an ultrasound scan first, so the committee deleted this recommendation.	No impact
20	1.5.7 Consider pelvic MRI to assess the extent of deep endometriosis involving the bowel, bladder or ureter. **[2017]**	1.5.9 Consider pelvic MRI or specialist transvaginal ultrasound to diagnose deep endometriosis and assess its extent. **[2024]**	The evidence for the use of transvaginal ultrasound for the diagnosis of deep endometriosis involving a number of locations (vaginal, rectosigmoid, rectovaginal, uterosacral ligaments, pouch of Douglas, bowel, bladder and ureters) showed that, in the majority of studies, it was moderately sensitive, although the committee	This may increase the use of specialist ultrasound as an alternative to MRI to diagnose deep endometriosis. As MRI is more expensive than ultrasound this may lead to cost-savings in the NHS.

			agreed this may depend on operator experience, and that sensitivity would be optimal with more experienced operators, who would be likely to be carrying out ultrasounds in gynaecology or specialist endometriosis services. There was also evidence from the majority of studies that MRI was moderately to highly sensitive at detecting deep endometriosis. Based on this the committee agreed that suspected deep endometriosis could be diagnosed and assessed by specialist ultrasound or MRI, and the choice of imaging technique would be a clinical decision and be based on available resources.	
21	1.5.8 Ensure that pelvic MRI scans are interpreted by a healthcare professional with specialist expertise in gynaecological imaging. **[2017]**	1.5.10 Ensure that pelvic MRI scans are planned and interpreted by a healthcare professional with specialist expertise in gynaecological imaging. **[2017, amended 2024]**	The committee agreed that the MRI scans should be planned as well as interpreted by someone with expertise in gynaecological imaging.	No impact
22	**Diagnostic laparoscopy**	**Diagnostic laparoscopy**	As this recommendation follows recommendations on	No impact

	Also refer to the section on surgical management and the section on surgical 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. **[2017]**	Also refer to the section on surgical management and the section on surgical management if fertility is a priority. 1.5.11 Consider laparoscopy to diagnose endometriosis in women or people with suspected endometriosis, even if the ultrasound or MRI imaging was normal. **[2017, amended 2024]**	ultrasound and MRI the committee confirmed that laparoscopy could be considered in symptomatic women or people even if the ultrasound or MRI were normal.	
23	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. **[2017]**	1.5.12 For women or people with suspected deep endometriosis consider a specialist pelvic ultrasound or MRI before an operative laparoscopy. **[2017, amended 2024]**	The committee agreed that ultrasound and MRI had both, in the majority of studies, shown at least moderate sensitivity for diagnosing deep endometriosis at a wide variety of sites, in addition to bowel, bladder and ureter, and so it was not necessary to list them all in the recommendation.	No impact
24.	1.5.11 During a diagnostic laparoscopy, a gynaecologist with training and skills in laparoscopic surgery for endometriosis should perform a systematic	1.5.13 During a diagnostic laparoscopy, a gynaecologist with training and skills in laparoscopic surgery for endometriosis should perform a systematic inspection of the pelvis and	The committee added, based on their knowledge and experience, the need to record the imaging results when carrying out a diagnostic laparoscopy.	No impact

	inspection of the pelvis. **[2017]**	record the findings with imaging. **[2017.amended 2024]**		
25	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. **[2017]**	1.5.14 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. **[2017]**	No change	No impact
26.	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. **[2017]**	1.5.15 If a full, systematic laparoscopy is performed and is normal, explain to the woman or person that it is unlikely that they have endometriosis, and offer alternative management of their symptoms. **[2017, amended 2024]**	The committee noted that even a normal laparoscopy could not rule out endometriosis fully, as there was a possibility of microscopic endometriosis causing the symptoms. The committee therefore amended this recommendation and clarified that management of symptoms was therefore the aim of treatment.	No impact