Resource impact summary report

Resource impact
Published: 16 April 2024

Last updated: 11 November 2024

www.nice.org.uk

The NICE guideline on endometriosis: diagnosis and management (NG73) originally published in 2017 and was partially updated in the areas of diagnosing endometriosis (November 2024) and surgical management if fertility is a priority (April 2024). The updates replace the relevant parts from the original guideline.

Diagnosing endometriosis (November 2024 update)

The guideline update sets out revised recommendations on diagnosing endometriosis. We expect that this update will lead to more secondary care referrals and investigations and advise that the resource impact is evaluated at a local level. The key changes are outlined below.

The updated guideline recommendation 1.5.2 states that GPs should offer a transvaginal ultrasound examination to all people with suspected endometriosis. The previous guideline's recommendation was to consider a transvaginal ultrasound examination in secondary care, if empirical treatments had failed. Experts on the committee agreed that these scans are already being used in current practice and so the recommendation should not have a significant resource impact, although there may be a need for additional training of sonographers to increase their competency to detect features associated with endometriosis. Conducting a transvaginal ultrasound scan at an earlier stage should identify alternative causes of pain, such as fibroids or malignancy, and this in turn could assist with the triaging of referrals to gynaecology, ensuring that people are given an appointment with the most appropriate clinic.

For illustration, the table below shows the potential capacity and financial impact of completing an additional 10,000 transvaginal ultrasound scans using a unit cost of £209* (fully absorbed cost) and assuming they would be conducted by a band 7 clinician and require a 30-minute appointment.

Table 1 showing the potential capacity impact and potential cost impact of completing an additional 10,000 transvaginal ultrasound scans

Number of scans	Cost of scans (£209* per scan)	Hours required (30 minutes per scan)	Cost of appointments (band 7 clinician midpoint of scale with oncosts)	Number of WTE jobs (based on 1,560 clinical hours worked)
10,000	£2.09 million	5,000	£0.2 million	3.2

* costs obtained from National Cost Collection data.

The updated guideline recommendation 1.5.5 states that women or people with symptoms of, or confirmed, endometriosis who meet the specified criteria should be referred to a gynaecology service for further investigation and management. The previous version of this guideline advised clinicians to consider referring women and people who fell into these groups. Experts on the committee think that the strengthening of this recommendation will bring about overall improvements to care together with earlier diagnosis and improved outcomes for a complex group who have failed to be effectively managed in primary care. They did concede however that endometriosis clinics generally lack capacity and there are existing lengthy wait times. The stronger recommendation is likely to exacerbate this capacity issue and additional system engagement confirmed this. Earlier diagnosis and treatment however should result in less damage to organs and structures from the disease, and therefore reduce subsequent treatment costs.

For illustration, the table below shows the potential capacity impact of an additional 10,000 referrals assuming they would be completed by a consultant and require a 20-minute outpatient appointment.

Table 2 showing the potential capacity impact of an additional 10,000 referrals to secondary care

Number referrals	Hours required (20 minutes per appointment)	Number of WTE jobs (based on 1,376 clinical consultant hours worked)	Number of additional clinics required (based on 4 hours per clinic)
10,000	3,333	2.42	833

The updated guideline recommendation 1.5.6 amends the criteria for referral to a specialist endometriosis service to include the presence of an endometrioma. Endometriomas are often associated with deep endometriosis or severe endometriosis, and management, particularly if fertility is a priority, can be complicated, so specialist services are the most appropriate treatment setting. The inclusion of endometriomas may increase the number of referrals to specialist endometriosis clinics.

Recommendation 1.5.7 states that young women or people (aged 17 and under) with suspected or confirmed endometriosis should be referred to a paediatric and adolescent gynaecology service or specialist endometriosis service (endometriosis centre) for further investigation and management. This compares to a consider recommendation that was in the previous version. This will likely lead to an increased number of referrals to these specialist services.

Recommendation 1.5.9 states that specialists in secondary care can consider using pelvic MRI or specialist transvaginal ultrasound to diagnose deep endometriosis and assess its extent. The previous guideline only referenced MRI as being an option.

This change may increase the use of specialist transvaginal ultrasound as an alternative to MRI to diagnose deep endometriosis. MRI scans are more costly than ultrasounds, but ultrasounds are only effective when conducted by healthcare professionals who have acquired skills in spotting endometriosis. Training and development programmes will likely be needed to bridge the skills gap in the current workforce.

Surgical management if fertility is a priority (April 2024 update)

The guideline update sets out recommendations for treating endometriosis when fertility is a priority.

We expect that the resource impact of this update:

- for any single guideline recommendation in England will be less than £1 million per year (or approximately £1,800 per 100,000 population, based on a population for England of 56.6 million people) **and**
- for implementing the whole guideline in England will be less than £5 million per year (or approximately £8,800 per 100,000 population, based on a population for England of 56.6 million people).

Only minor changes have been made to the existing recommendations, and these are not expected to have a significant resource impact to the NHS.

The updated guideline recommendation 1.11.2 now includes an option to offer laparoscopic drainage and ablation as an alternative to laparoscopic ovarian cystectomy to women or people with endometriomas.

This additional treatment option is not expected to cause a significant resource impact because both options are keyhole surgeries which merely utilise differing techniques. Procedure costs are similar. Theatre and recovery time will depend on the patient characteristics and the degree of endometriosis as opposed to the type of surgery selected. Treatment with laparoscopic drainage and ablation may lead to an increased ovarian reserve in comparison with laparoscopic ovarian cystectomy. This may reduce the requirement for future fertility treatment.

Services for people with endometriosis are commissioned by integrated care boards. Providers are NHS hospital trusts.