

# Endometriosis: diagnosis and management

Appendices D, F and H - J

*Main appendix document*

*Review protocol, identified studies, excluded studies, forest plots and GRADE tables*

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*Developed by the National Guideline Alliance, hosted  
by the Royal College of Obstetricians and  
Gynaecologist*



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# 1 Appendices

## 2 Appendix D: Review Protocols

### D.1 Specialist services

Item	Details
Area of the scope	Use of specialist services to deliver care
Review question in the scope	Using specialist services to deliver care What is the clinical and cost effectiveness of specialist endometriosis services?
Review question	What is the clinical and cost effectiveness of specialist endometriosis services?
Objective	The aim of this review is to determine the clinical and cost effectiveness of specialist endometriosis services?
Language	English
Study design	Systematic reviews of RCTs RCTs Comparative cohort studies Controlled before and after studies  In the absence of full text published RCTs, conference abstracts will be considered. Cross over RCTs will be considered where it is appropriate Non-comparative studies will be excluded.
Population and directness	Women with endometriosis of any stage or severity. Women with a suspected diagnosis of endometriosis (definition: suspected diagnosis based on the history of the patient, pelvic examination and other tests such as ultrasound, MRI and the CA-125 blood test) Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women) will not be considered Exclusions: <ul style="list-style-type: none"> <li>• women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>• Those suspected based solely on a CA-125 test with no other contributing factor, CA-125 should be used in combination with other evaluative measures.</li> <li>• Studies with mixed populations of women with pelvic pain of which less than 66% have a confirmed diagnosis of endometriosis</li> </ul>
Stratified, subgroup and adjusted analyses	Groups that will be reviewed and analysed separately: <ul style="list-style-type: none"> <li>• women who want to preserve fertility</li> </ul> Pre-specified sub-group analyses: <ul style="list-style-type: none"> <li>• Type of hormonal treatments</li> <li>• Types of pain cyclical vs non-cyclical period-like, sharp, dyschezia, painful intercourse, chronic pelvic pain, pain</li> <li>• Site of endometriosis (not specified, ovarian, superficial and deep infiltrating {bladder, peritoneal, recto vaginal})</li> </ul>

Item	Details
	<ul style="list-style-type: none"> <li>Type of specialist service</li> </ul> <p>Important confounders (when comparative observational studies are included for interventional reviews):</p> <ul style="list-style-type: none"> <li>Age</li> <li>Severity</li> <li>Prior interventions</li> </ul>
Intervention	<p>Specialist services</p> <p>Gynaecology services (Mild to moderate endometriosis)</p> <p>Specialist endometriosis centre (Severe endometriosis)</p> <ul style="list-style-type: none"> <li>Multi-disciplinary approach should have access to the following whenever the need arises: <ul style="list-style-type: none"> <li>Colo-rectal surgeon</li> <li>Urologist</li> <li>Pain management specialist</li> <li>Sub-fertility specialist</li> <li>Specialist endometriosis nurse</li> <li>Gynaecologist specialising in laparoscopic surgery</li> <li>Specialist nurses (specialty in gynaecology or fertility but not necessarily in endometriosis)</li> </ul> </li> </ul>
Comparison	<p>Specialist service A (one configuration) vs Specialist service B (another configuration) – i.e. any study comparing different types of specialist services</p> <p>Specialist services vs. GP only</p> <p>Specialist services vs. General gynaecology</p>
Outcomes	<ul style="list-style-type: none"> <li>Pain relief (measured either by visual analogue scale (VAS), other validated scales, or as a dichotomous outcome, for example improved or not improved)</li> <li>Quality of life (measured using a validated scale, for example the SF36)</li> <li>Effect on daily activities (measured as proportion of women who reported activity restriction)</li> <li>Absence from work or school (measured as proportion of women reporting absences from work or school, and also as hours or days of absence as a more selective measure)</li> <li>Unintended effects from treatment (incidence and duration of total side-effects, and type of side-effects)</li> <li>Number of women requiring more invasive treatment (for example laparoscopic surgery), and length of follow up</li> <li>Requirements for additional medication (measured as proportion of women requiring analgesics (not NSAIDs) additional to their assigned treatment)</li> <li>Participant satisfaction with treatment (measured as proportion of women who reported improvements and satisfaction with their treatment)</li> </ul>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <ul style="list-style-type: none"> <li>critical (up to 3 outcomes) – pain, quality of life and effect on daily activities</li> <li>important but not critical (up to 3 outcomes)</li> <li>of limited importance (1 outcome)</li> </ul>
Setting	Secondary and tertiary centres
Search strategy	<p>Sources to be searched: Medline, Medline In-Process, CENTRAL, CDSR, DARE, HTA, Embase</p> <p>Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate</p>

Item	Details
	Supplementary search techniques: No supplementary search techniques will be used. See appendix for full strategies
Review strategy	Appraisal of methodological quality: The methodological quality of each study should be assessed using quality checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs, CASP for cohort studies) and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE. Synthesis of data: Meta-analysis will be conducted where appropriate. Default MIDs will be used: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes to assess imprecision. When meta analysing continuous data final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed. If studies only report p-values, this information will be plotted in GRADE tables without an assessment of imprecision possible to be made.
Equalities	Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment
Notes/additional information	<a href="https://www.england.nhs.uk/wp-content/uploads/2014/04/e10-comp-gynaec-0414.pdf">https://www.england.nhs.uk/wp-content/uploads/2014/04/e10-comp-gynaec-0414.pdf</a>

## D.2 Timing: association between duration of symptoms before laparoscopy and treatment outcomes

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Item	Details
Area of the scope	Timing of interventions
Review question in the scope	Does early laparoscopy and treatment improve outcomes?
Review question	Is there an association between duration of symptoms before laparoscopy and /or treatment and treatment outcomes?
Objective	The aim of this review is to determine whether there is an association between duration of symptoms before laparoscopy and /or treatment and treatment outcomes?
Language	English
Study design	Systematic reviews RCTs Comparative cohort studies Case-control studies using multivariable adjustment  In the absence of full text published RCTs, conference abstracts will be considered. Cross over RCTs will be considered where it is appropriate
Population and directness	<ul style="list-style-type: none"> <li>Women with endometriosis of any stage or severity.</li> <li>Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women) will not be considered</li> <li>Women with a suspected diagnosis of endometriosis (definition: suspected diagnosis based on the history of the patient, pelvic examination and other tests such as ultrasound, MRI and the CA-125 blood test)</li> </ul> Exclusions:

Item	Details
	<ul style="list-style-type: none"> <li>women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>Those suspected based solely on a CA-125 test with no other contributing factor, CA-125 should be used in combination with other evaluative measures.</li> </ul>
Stratified, subgroup and adjusted analyses	<p>Groups that will be reviewed and analysed separately:</p> <ul style="list-style-type: none"> <li>women who want to preserve fertility</li> </ul> <p>Stratification:</p> <ul style="list-style-type: none"> <li>Type of treatment (surgical or medical)</li> <li>Age (adolescent vs adult)</li> <li>Severity</li> </ul> <p>Important confounders:</p> <ul style="list-style-type: none"> <li>Severity and type of pain</li> <li>Type of treatment</li> <li>Age (adolescent vs adult)</li> <li>Severity</li> <li>BMI</li> </ul>
Intervention	Duration of symptoms followed by early laparoscopy and treatment
Comparison	Duration of symptoms followed by later laparoscopy (at least 1 year later)
Outcomes	<ul style="list-style-type: none"> <li>Pain relief (measured either by visual analogue scale (VAS), other validated scales, or as a dichotomous outcome, for example improved or not improved)</li> <li>Quality of life (measured using a validated scale, for example the SF36)</li> <li>Effect on daily activities (measured as proportion of women who reported activity restriction)</li> <li>Participant satisfaction with treatment (measured as proportion of women who reported improvements and satisfaction with their treatment)</li> </ul>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <ul style="list-style-type: none"> <li>critical (up to 3 outcomes) – pain, quality of life and effect on daily activities</li> <li>important but not critical (up to 3 outcomes) - Participant satisfaction with treatment</li> </ul>
Setting	No particular setting specified.
Search strategy	<p>Sources to be searched: Medline, Medline In-Process, CENTRAL, CDSR, DARE, HTA, Embase</p> <p>Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate</p> <p>Supplementary search techniques: No supplementary search techniques will be used.</p> <p>See appendix for full strategies</p>
Review strategy	<p>Appraisal of methodological quality:</p> <p>The methodological quality of each study should be assessed using quality checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs, CASP for cohort and case control studies) and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE.</p> <p>Synthesis of data:</p> <p>Meta-analysis will be conducted where appropriate.</p> <p>Default MIDs will be used: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes to assess imprecision.</p> <p>When meta analysing continuous data final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed.</p>

Item	Details
	If studies only report p-values, this information will be plotted in GRADE tables without an assessment of imprecision possible to be made.
Equalities	Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment

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### D.3 Signs and symptoms of endometriosis (monitoring and referral)

3

Item	Details
Area of the scope	Symptoms and signs of endometriosis
Review question in the scope	Clinical manifestations of endometriosis <ul style="list-style-type: none"> <li>What are the symptoms and signs of endometriosis?</li> </ul>
Review question	Review question 1: What are the symptoms and signs of endometriosis?  Review question 2: How and when should women with endometriosis be monitored and referred for the following symptoms or condition progression and complications: <ul style="list-style-type: none"> <li>pelvic pain disrupting daily activities</li> <li>cyclical bowel pain</li> <li>cyclical voiding pain</li> <li></li> </ul>
Objective	Objective 1: To identify the signs and symptoms of endometriosis Objective 2: To identify how and when should women with endometriosis be monitored and referred for the following symptoms or condition progression and complications such as pelvic pain disrupting daily activities, cyclical bowel pain and cyclical voiding pain
Population and directness	Women and young women suspected of having endometriosis
Symptoms or signs to be considered	Signs and symptoms:  Signs <ul style="list-style-type: none"> <li>vaginal (visible Endometriosis, severe vaginismus)</li> <li>pelvic (palpable nodules in rectovaginal septum and uterosacral ligaments, fixed or tethered uterus and pelvic mass, tender adnexa, tenderness)</li> <li>rectal (palpable extrinsic pelvic mass)</li> <li>renal (loin tenderness, palpable mass)</li> <li>family history of Endometriosis</li> </ul> Symptoms <ul style="list-style-type: none"> <li>pelvic symptoms- pelvic pain, cyclical/non-cyclical</li> <li>uterus pain (dysmenorrhoea) and abnormal bleeding (prolonged and heavy and inter-menstrual bleeding)</li> <li>bowel (rectal bleeding, dyschezia, bloating, constipation and diarrhoea)</li> <li>bladder (bladder pain or irritability, blood in the urine)</li> <li>vaginal pain: painful sex (dyspareunia), pain when using tampons</li> <li>referred pain – back, leg, thigh, hip</li> <li>infertility</li> <li>fatigue</li> </ul>

Item	Details
	<ul style="list-style-type: none"> <li>psychological effects (isolation, depression/anxiety, low self-esteem, low mood, poor body image, loss of libido)</li> <li></li> </ul>
Comparator	<ul style="list-style-type: none"> <li>There may be groups that are compared who do or do not have a particular sign who are then followed up</li> </ul>
Stratified, subgroup and adjusted analyses	<p>Groups that will be reviewed and analysed separately:</p> <ul style="list-style-type: none"> <li>N/A</li> </ul> <p>In case of heterogeneity of study results we would investigate the following pre-specified sub-groups:</p> <ul style="list-style-type: none"> <li>Site of endometriosis</li> <li>Age</li> </ul> <p>If there is sufficient evidence from studies using adjusted multivariable analysis (uncontaminated by baseline differences) then evidence from studies using univariate analysis only will be excluded.</p> <p>Critical confounders:</p> <ul style="list-style-type: none"> <li>Age</li> <li>Hormonal contraception</li> </ul>
Reference standard	Future diagnosis of endometriosis
Outcomes	<p>Predictive value of sign or symptom</p> <p>Accuracy of sign or symptom if used in the diagnosis of endometriosis</p>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making: critical (up to 3 outcomes)</p> <ul style="list-style-type: none"> <li>Confirmed diagnosis of endometriosis at follow-up</li> <li>Severity of endometriosis</li> <li>Referral to diagnostic services</li> </ul>
Language	English
Study design	<p>Systematic reviews of RCTs</p> <p>RCTs</p> <p>Prospective and retrospective comparative cohort studies</p> <p>Prospective or retrospective comparative observational studies</p> <p>Cross sectional studies will not be considered</p> <p>Case series will only be included if no comparative studies are identified</p> <p>Consensus surveys will not be considered</p>
Setting	No particular setting specified.
Search strategy	<p>Sources to be searched: Medline, Medline In-Process, CENTRAL, CDSR, DARE, HTA, Embase</p> <p>Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate</p> <p>Supplementary search techniques: No supplementary search techniques will be used.</p> <p>See appendix for full strategies</p>
Review strategy	<p>Appraisal of methodological quality:</p> <p>The methodological quality of each study will be assessed using quality checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs, QUIPS for prognostic studies).</p> <p>Synthesis of data:</p>

Item	Details
	<p>Meta-analysis will be conducted where appropriate.</p> <p>Default MIDs will be used: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes.to assess imprecision.</p> <p>When meta analysing continuous data, final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed.</p>
Equalities	Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment

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## D.4 Information and support

Item	Details
Area in the scope	Information and support for women with endometriosis
Review question in the scope	What information and support do women with endometriosis and their families and carers need?
Review question for the guideline	What information and support do women with endometriosis and their families find helpful and what are the barriers and facilitators in the provision of these information and support needs?
Objective	<p>To discover what information and support makes a positive difference to women and their families when diagnosed with endometriosis, including women's reports of what information and/or support they would have liked.</p> <p>Tree objectives have been set up:</p> <ul style="list-style-type: none"> <li>• To explore the areas of information and support that women and their families find helpful.</li> <li>• To test the effectiveness of interventions or package of care to provide additional information and support needs compared to usual care</li> <li>• To see how they would like to receive this information or support</li> </ul>
Population and directness	<ul style="list-style-type: none"> <li>• Women with endometriosis of any stage or severity.</li> <li>• Women with a suspected diagnosis of endometriosis (definition: suspected diagnosis based on the history of the patient, pelvic examination and other tests such as ultrasound, MRI and the CA-125 blood test)</li> <li>• Family or partners of women with confirmed or suspected endometriosis</li> </ul> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• Studies with indirect populations (such as women with dysmenorrhoea, women with non-confirmed pelvic pain, or post-menopausal women)</li> <li>• women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>• Those suspected based solely on a CA-125 test with no other contributing factor, CA-125 should be used in combination with other evaluative measures.</li> <li>• Studies with mixed populations of women with pelvic pain where less than 66% of women have a diagnosis of endometriosis</li> </ul>
Intervention – information and support (quantitative)	<ul style="list-style-type: none"> <li>• Support groups</li> <li>• Volunteer supporters</li> <li>• Helplines</li> <li>• Methods of information provision (Tools to facilitate) <ul style="list-style-type: none"> <li>○ Verbal</li> <li>○ Written</li> <li>○ Online (and online networks)</li> <li>○ Apps</li> </ul> </li> </ul>

Item	Details
	<ul style="list-style-type: none"> <li>○ In groups (peer groups) online or face or face to face</li> <li>○ 1:1 advocacy support</li> <li>○ Online health forum</li> </ul>
Comparison	<p>Additional information and support with no comparator</p> <p>Additional information and support vs usual care</p>
Context and perspective (qualitative)	<p><b>Context</b></p> <p>Information content and type and support needs with regards to endometriosis for women confirmed or suspected of having the condition as well as their family, partner.</p> <p><b>Themes</b></p> <p>Themes will be identified from the literature, but expected themes are:</p> <ul style="list-style-type: none"> <li>● Methods of information provision (Tools to facilitate) <ul style="list-style-type: none"> <li>○ Verbal</li> <li>○ Written</li> <li>○ Online (and online networks)</li> <li>○ Apps</li> <li>○ In groups (peer groups) online or face or face to face</li> <li>○ 1:1 advocacy support</li> <li>○ Online health forum</li> </ul> </li> <li>● Choice and options (treatment related) <ul style="list-style-type: none"> <li>○ Information needs with regards to treatments for pain or fertility (pharmacological, surgical and non-pharmacological)</li> </ul> </li> <li>● Information content: <ul style="list-style-type: none"> <li>○ Provision of basic information: what is endometriosis, signs/symptoms, guidance for medical appointments and what to expect)</li> <li>○ Impact on relationships</li> <li>○ Support for husbands/partners and families</li> <li>○ Sexual health/psychosexual effects</li> <li>○ Support for adolescents with endometriosis</li> <li>○ Misconceptions</li> <li>○ Mental health</li> </ul> </li> </ul>
Outcomes (quantitative)	<ul style="list-style-type: none"> <li>● Health related quality of life</li> <li>● Psychological wellbeing outcomes (any including post-traumatic stress disorder, and anxiety)</li> <li>● Knowing choices available/able to make informed decisions including involvement in decision-making</li> <li>● Participant satisfaction with treatment (measured as proportion of women who reported improvements and satisfaction with their treatment)</li> </ul>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <p>critical (up to 3 outcomes):</p> <ul style="list-style-type: none"> <li>● Health related quality of life</li> <li>● Psychological wellbeing</li> <li>● Participant satisfaction</li> </ul> <p>important but not critical (up to 3 outcomes)</p> <ul style="list-style-type: none"> <li>● Improved decision making</li> </ul>
Setting	All settings



Item	Details
Stratified, subgroup and adjusted analyses	Groups that will be reviewed and analysed separately: pre-specified sub-group analyses: Young women
Language	English
Study design	Systematic reviews of RCTs or Systematic reviews of qualitative studies RCTs Comparative cohort studies Qualitative studies Cross sectional studies  In absence of full text published RCT and Conference abstracts are being considered. RCTs with <10 participants and observational studies with < 30 participants will not be considered
Search strategy	Sources to be searched: Medline, Medline In-Process, CENTRAL, CDSR, DARE, HTA, Embase Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate Supplementary search techniques: No supplementary search techniques will be used. See appendix for full strategies
Review strategy	Appraisal of methodological quality: State how this will be assessed, e.g. The methodological quality of each study should be assessed using checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs, CASP for cohort studies) and the quality of the evidence for an outcome (or a theme / review finding) across studies will be assessed using GRADE or a GRADE CERQual approach for qualitative research. Synthesis of data quantitative: State the method of analysis, e.g. meta-analysis will be conducted where appropriate. If comparative cohort studies are included, multivariable analysis evidence will be used wherever possible and only if no multivariable evidence is identified will univariate analysis be considered MIDs: default MIDs will be used: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes. Synthesis of qualitative data: Evidence will be summarised by theme and the quality of the themes will be assessed across studies using a process like GRADE but adapted for qualitative information GRADE-CERQual. A theme map may also be presented if there is sufficient information identified in the search.
Equalities	Women receiving information through an interpreter Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment
Notes/additional information	

## D.5 Risk of reproductive cancer

Item	Details
Area of the scope	How and when to monitor and refer for complications and disease progression.
Review question in the scope	How and when should women with endometriosis be monitored and referred for disease progression and complications, including: <ul style="list-style-type: none"> <li>• pain</li> <li>• bowel involvement</li> <li>• bladder and ureter involvement</li> <li>• cancer</li> </ul>
Review question	<ul style="list-style-type: none"> <li>• Do women with endometriosis have an increased risk of reproductive cancer and do they need to be monitored or referred accordingly?</li> </ul>
Objective	This review considers the clinical and cost-effectiveness of monitoring women with endometriosis for the progression of the reproductive cancer
Language	English
Study design	<p>Systematic reviews of RCTs RCTs Comparative cohort studies</p> <p>In the absence of full text published RCTs, conference abstracts will be considered. RCTs with &lt;10 participants and observational studies with &lt; 30 participants will not be considered</p>
Population and directness	<p>Women with endometriosis of any stage or severity. Women with a suspected diagnosis of endometriosis (definition: suspected diagnosis based on the history of the patient, pelvic examination and other tests such as ultrasound, MRI and the CA-125 blood test) Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women) will not be considered Exclusions:</p> <ul style="list-style-type: none"> <li>• women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>• Those suspected based solely on a CA-125 test with no other contributing factor. CA-125 should be used in combination with other evaluative measures.</li> </ul>
Stratified, subgroup and adjusted analyses	<p>Groups that will be reviewed and analysed separately:</p> <ul style="list-style-type: none"> <li>• women who want to preserve fertility</li> </ul> <p>Pre-specified sub-group analyses:</p> <ul style="list-style-type: none"> <li>• Type of hormonal treatments</li> <li>• Type of diagnosis of endometriosis</li> <li>• Types of pain cyclical vs non-cyclical period-like, sharp, dyschezia, painful intercourse, chronic pelvic pain, pain</li> <li>• Site of endometriosis (not specified, ovarian, superficial and deep infiltrating {bladder, peritoneal, recto vaginal})</li> </ul>
Intervention	<p>Monitoring regimen:</p> <ul style="list-style-type: none"> <li>• Different monitoring regimens (different test or tools)</li> <li>• Different intervals of monitoring</li> </ul> <p>Referral criteria:</p>

Item	Details
	<ul style="list-style-type: none"> <li>referral criteria (history {combination and severity of symptoms}, examination {visible vaginal Endometriosis, pelvic mass, pelvic nodule, inability to examine}, and investigation) for suspected or confirmed endometriosis from primary to secondary care</li> </ul>
Comparison	<p>Different frequency of monitoring regimen:</p> <p>Referrals compared to usual care without referral to specialist services</p>
Outcomes	<ul style="list-style-type: none"> <li>Pain relief (measured either by visual analogue scale (VAS), other validated scales, or as a dichotomous outcome, for example improved or not improved)</li> <li>Quality of life (measured using a validated scale, for example the SF36)</li> <li>Effect on daily activities (measured as proportion of women who reported activity restriction)</li> <li>Absence from work or school (measured as proportion of women reporting absences from work or school, and also as hours or days of absence as a more selective measure)</li> <li>Participant satisfaction with treatment (measured as proportion of women who reported improvements and satisfaction with their treatment)</li> </ul>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <ul style="list-style-type: none"> <li>critical (up to 3 outcomes) – pain, quality of life and effect on daily activities</li> <li>important but not critical (up to 3 outcomes)</li> </ul>
Setting	No particular setting specified.
Search strategy	<p>Sources to be searched: Medline, Medline In-Process, CENTRAL, CDSR, DARE, HTA, Embase</p> <p>Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate</p> <p>Supplementary search techniques: No supplementary search techniques will be used.</p> <p>See appendix for full strategies</p>
Review strategy	<p>Appraisal of methodological quality:</p> <p>The methodological quality of each study should be assessed using quality checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs, CASP for cohort studies) and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE.</p> <p>Synthesis of data:</p> <p>Meta-analysis will be conducted where appropriate.</p> <p>Default MIDAs will be used: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes to assess imprecision.</p> <p>When meta analysing continuous data final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed.</p> <p>If studies only report p-values, this information will be plotted in GRADE tables without an assessment of imprecision possible to be made.</p>
Equalities	Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment

## D.6 Use of diagnostic tests including imaging, biomarkers and surgical diagnosis

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Item	Details
Key area in the scope	Use of diagnostic tests including imaging, biomarkers and surgical diagnosis.
Review question in the scope	What is the accuracy of the following tests in diagnosing endometriosis:

Item	Details
	<ul style="list-style-type: none"> <li>• imaging</li> <li>• biomarkers</li> <li>• surgical diagnosis?</li> </ul>
Objective	To evaluate the accuracy of diagnostic tests for the diagnosis of endometriosis in women with suspected endometriosis.
Population	<p>Symptomatic and asymptomatic women with suspected endometriosis</p> <p>Symptomatic Dyspareunia (pain on intercourse), deep dyspareunia (pain on entry), dyschezia (pain on bowel actions), rectal bleeding, cyclical bleeding, dysmenorrhea, painful periods</p> <p>Cyclical/non-cyclical symptoms</p> <p>Asymptomatic</p> <ul style="list-style-type: none"> <li>• women who have an appendicitis removed (or any other abdominal surgery) with the finding of an endometrioma or endometriosis</li> <li>• Women who have a scan for other reasons with the finding of an endometrioma or endometriosis</li> <li>• women who have a ureteric obstruction</li> <li>• Women presenting with symptoms similar to IBS</li> <li>• Infertility investigations can discover endometriosis</li> </ul>
Subgroups and sensitivity analyses	<p>The following groups will be assessed separately:</p> <ul style="list-style-type: none"> <li>• subgroups of women with different presenting symptoms of endometriosis (subfertility, pelvic pain, ovarian mass, asymptomatic women)</li> <li>• deep endometriosis vs superficial endometriosis</li> <li>• Methodological changes in practice; scanning techniques and advances in equipment</li> </ul>
Index test: Severity assessment tools/clinical markers	<p>(1) Imaging (see subgroup above):</p> <p>Ultrasound (visual):</p> <ul style="list-style-type: none"> <li>• transabdominal</li> <li>• transvaginal</li> <li>• rectal scanning</li> </ul> <p>MRI:</p> <ul style="list-style-type: none"> <li>• pelvic MRI</li> </ul> <p>(2) Biomarkers:</p> <ul style="list-style-type: none"> <li>• biomarker cancer antigen 125 (CA-125, cut-off <math>\geq 35</math>U/ml)</li> <li>• biomarker Human epididymis protein 4 (HE- 4)</li> </ul> <p>(3) Biomarkers in endometrial tissues (the nerve fibre marker Protein Gene Product 9.5 (PGP 9.5))</p> <p>(4) Surgical diagnosis with or without histological confirmation:</p> <ul style="list-style-type: none"> <li>• combination of tests need to be considered, a clean scan is not always conclusive – an abnormal scan however can stand on its own.</li> </ul>

Item	Details
Reference standard or target condition/patient outcomes	Surgical visualisation with histological confirmation
Outcomes	<ul style="list-style-type: none"> <li>• sensitivity</li> <li>• specificity</li> </ul> For continuous outcomes: <ul style="list-style-type: none"> <li>• area under the Curve</li> </ul>
Importance of outcomes	Critical outcomes: <ul style="list-style-type: none"> <li>• sensitivity -</li> <li>• specificity</li> </ul> If there were any test-and-treat trials <ul style="list-style-type: none"> <li>• quality of life</li> </ul>
Study design	Systematic reviews Randomised controlled trials (test and treat trials) Cross sectional studies Cohort studies Case control studies will be excluded
Population size and directness	Studies with indirect populations will not be considered
Search strategy	Sources to be searched: Medline, Medline In-Process, CENTRAL, CDSR, DARE, HTA, Embase Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate Supplementary search techniques: No supplementary search techniques will be used. See appendix for full strategies
Review strategy	Appraisal of methodological quality: <ul style="list-style-type: none"> <li>• The methodological quality of each study should be assessed using quality checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs, QUADAS2 for diagnostic studies) and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE.</li> </ul> Synthesis of data: <ul style="list-style-type: none"> <li>• Meta-analysis of diagnostic test accuracy tests will be conducted where appropriate</li> </ul>
Equalities	Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment

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## D.7 Staging Systems

Item	Details
Area of the scope	Timing of interventions: Use of staging systems to guide treatment decisions.
Review question in the scope	What is the effectiveness of staging systems in guiding the treatment of endometriosis?
Review question	<ul style="list-style-type: none"> <li>• What is the effectiveness of using endometriosis-staging systems to guide treatment of endometriosis?</li> </ul>

Item	Details
Objective	To determine the effectiveness of using endometriosis-staging systems to guide treatment of endometriosis
Population and directness	<ul style="list-style-type: none"> <li>• Women with endometriosis of any stage or severity.</li> </ul> <p>These may also include women with a suspected diagnosis of endometriosis (definition: suspected diagnosis based on the history of the patient, pelvic examination and other tests such as ultrasound, MRI and the CA-125 blood test)</p> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women)</li> <li>• women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>• Those suspected based solely on a CA-125 test with no other contributing factor, CA-125 should be used in combination with other evaluative measures.</li> <li>• mixed populations of women with pelvic pain where less than 66% of women have a diagnosis of endometriosis</li> </ul>
Intervention	<p>Staging systems:</p> <ul style="list-style-type: none"> <li>• Revised American Society for Reproductive Medicine (rASRM) staging system</li> <li>• Revised American Fertility Society classification system (rAFS)</li> <li>• Enzian (for staging of deep infiltrating endometriosis only)</li> <li>• Enzian plus rASRM</li> <li>• Endometriosis Fertility Index EFI</li> <li>• Surgical staging</li> </ul> <p>Exclude:</p> <ul style="list-style-type: none"> <li>• Non-validated scales</li> </ul>
Comparison	Usual care (i.e. no staging system)
Outcomes	<p>Statistical outcomes</p> <ul style="list-style-type: none"> <li>• Accuracy measures (sensitivity / specificity) related to a particular cut-off and outcomes</li> <li>• Prognostic measures (staging as predictors of severity of endometriosis in relation to treatment and patient reported outcomes)</li> </ul> <p>Patient related outcomes – if reported:</p> <ul style="list-style-type: none"> <li>• Pain relief (measured either by visual analogue scale (VAS), other validated scales, or as a dichotomous outcome, for example improved or not improved)</li> <li>• Pregnancy rate / fertility</li> <li>• Quality of life (measured using a validated scale, for example the SF36)</li> <li>• Effect on daily activities (measured as proportion of women who reported activity restriction)</li> <li>• Absence from work or school (measured as proportion of women reporting absences from work or school, and also as hours or days of absence as a more selective measure)</li> <li>• Unintended effects from treatment (incidence and duration of total side-effects, and type of side-effects)</li> <li>• Number of women requiring more invasive treatment (for example laparoscopic surgery), and length of follow up</li> <li>• Requirements for additional medication (measured as proportion of women requiring analgesics additional to their assigned treatment)</li> <li>• Participant satisfaction with treatment (measured as proportion of women who reported improvements and satisfaction with their treatment)</li> </ul>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <ul style="list-style-type: none"> <li>• critical (up to 3 outcomes) – pain, quality of life and effect on daily activities</li> <li>• important but not critical (up to 3 outcomes)</li> </ul>

Item	Details
Stratified, subgroup and adjusted analyses	<p>Groups that will be reviewed and analysed separately: pre-specified sub-group analyses:</p> <ul style="list-style-type: none"> <li>• Age</li> <li>• Time since diagnosis</li> <li>• Types of pain cyclical vs non-cyclical period-like, sharp, dyschezia, painful intercourse, chronic pelvic pain</li> <li>• Site of endometriosis (not specified, ovarian, superficial and deep infiltrating {bladder, peritoneal, recto vaginal})</li> </ul>
Setting	All settings in which NHS care is provided
Study design	<p>Systematic reviews RCTs Comparative cohort studies Non-comparative cohort studies</p> <p>In the absence of full text published RCTs, conference abstracts will be considered.</p>
Language	English
Search strategy	<p>Sources to be searched: Medline, Medline In-Process, CENTRAL, CDSR, DARE, HTA, Embase</p> <p>Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate</p> <p>Supplementary search techniques: No supplementary search techniques will be used.</p> <p>See appendix for full strategies</p>
Review strategy	<p>Appraisal of methodological quality: The methodological quality of each study should be assessed using quality checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs, CASP for cohort and case control studies) and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE.</p> <p>Synthesis of data: Meta-analysis will be conducted where appropriate. Default MIDs will be used: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes to assess imprecision.</p> <p>When meta analysing continuous data final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed.</p> <p>If studies only report p-values, this information will be plotted in GRADE tables without an assessment of imprecision possible to be made.</p>
Equalities	Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment

1

## D.8 Pharmacological management – Analgesics

Item	Details
Area of the scope	Pharmacological and surgical treatments including analgesics, hormonal medical treatments, neuromodulators, ablation, excision and hysterectomy with or without oophorectomy
Review question in the scope	<p>Pharmacological and surgical treatments</p> <p>What is the effectiveness of the following treatments for endometriosis, including recurrent and asymptomatic endometriosis:</p>

Item	Details
	<ul style="list-style-type: none"> <li>• <b>analgesics</b></li> <li>• neuromodulators</li> <li>• hormonal medical treatments</li> <li>• ablation</li> <li>• excision</li> <li>• hysterectomy with or without oophorectomy?</li> </ul>
Review question	What is the effectiveness of analgesics for reducing pain in women with endometriosis, including recurrent and asymptomatic endometriosis?
Objective	The aim of this review is to determinethe effectiveness of analgesics for treating endometriosis, including recurrent and asymptomatic endometriosis
Language	English
Study design	<p>Systematic reviews of RCTs RCTs Comparative cohort studies</p> <p>In the absence of full text published RCT, conference abstracts will be considered. Cross over RCTs will be considered where it is appropriate</p>
Population and directness	<p>Women with endometriosis of any stage or severity. Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women) will not be considered</p> <ul style="list-style-type: none"> <li>• Women with suspected endometriosis (definition: suspected diagnosis based on the history of the patient, pelvic examination and other tests such as ultrasound, MRI and the CA-125 blood test)</li> </ul> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• women with chronic pelvic pain known to be due to causes other than endometriosis</li> </ul>
Stratified, subgroup and adjusted analyses	<p>Groups that will be reviewed and analysed separately: pre-specified sub-group analyses:</p> <ul style="list-style-type: none"> <li>• Type of non-steroidal anti-inflammatory drugs (NSAIDs)</li> <li>• Type of diagnosis of endometriosis (eg endometrioma)</li> </ul>
Intervention	<p>NSAIDs of any type and administered at any dose, frequency, treatment duration, or by any type of administration:</p> <p>Non-opioid analgesics:</p> <ul style="list-style-type: none"> <li>• paracetamol</li> </ul> <p>NSAIDs and COX-2 inhibitors:</p> <ul style="list-style-type: none"> <li>• diclofenac</li> <li>• ibuprofen</li> <li>• naproxen</li> <li>• celecoxib</li> <li>• mefenamic acid</li> <li>• etoricoxib</li> <li>• indomethacin</li> <li>• tolfenamic acid</li> <li>• aspirin (in doses greater than 600mg)</li> </ul> <p>Compound analgesics:</p> <ul style="list-style-type: none"> <li>• co-codamol</li> <li>• co-codaprin</li> <li>• co-dydramol</li> </ul>



Item	Details
	<p>Opioid analgesics:</p> <ul style="list-style-type: none"> <li>• codeine</li> <li>• dyhydrocodeine</li> <li>• tramadol</li> <li>• buprenorphine</li> </ul>
Comparison	<ul style="list-style-type: none"> <li>• analgesic vs no treatment / usual care</li> <li>• analgesic vs placebo</li> <li>• analgesic A vs Analgesic B</li> <li>• analgesic vs other pain management drug</li> </ul>
Outcomes	<ul style="list-style-type: none"> <li>• Pain relief (measured either by visual analogue scale (VAS), other validated scales, or as a dichotomous outcome, for example improved or not improved)</li> <li>• Quality of life (measured using a validated scale, for example the SF36)</li> <li>• Effect on daily activities (measured as proportion of women who reported activity restriction)</li> <li>• Absence from work or school (measured as proportion of women reporting absences from work or school, and also as hours or days of absence as a more selective measure)</li> <li>• Unintended effects from treatment (incidence and duration of total side-effects, and type of side-effects)</li> <li>• Number of women requiring more invasive treatment (for example laparoscopic surgery), and length of follow up</li> <li>• Requirements for additional medication (measured as proportion of women requiring analgesics (not NSAIDs) additional to their assigned treatment)</li> <li>• Participant satisfaction with treatment (measured as proportion of women who reported improvements and satisfaction with their treatment)</li> </ul>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <ul style="list-style-type: none"> <li>• critical (up to 3 outcomes) – pain, quality of life and effect on daily activities</li> <li>• important but not critical (up to 3 outcomes)</li> </ul>
Setting	No particular setting specified.
Search strategy	<p>Sources to be searched: Medline, Medline In-Process, CCTR, CDSR, DARE, HTA, Embase</p> <p>Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate. SR/RCT filter. Limit to 2008+</p> <p>Supplementary search techniques: No supplementary search techniques will be used.</p> <p>See appendix for full strategies</p>
Review strategy	<p>Appraisal of methodological quality:</p> <p>The methodological quality of each study should be assessed using quality checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs) and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE.</p> <p>Synthesis of data:</p> <p>Meta-analysis will be conducted where appropriate.</p> <p>Default MIDs will be used: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes.to assess imprecision.</p> <p>For Visual Analogue Scale (VAS) outcomes related to pain an MID of 1 cm (for a 10cm scale) will be used (Gerlinger 2010).</p> <p>When meta analysing continuous data final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed.</p> <p>If studies only report p-values, this information will be plotted in GRADE tables without an assessment of imprecision possible to be made.</p>

Item	Details
Equalities	Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment
Notes/additional information	

1

## D.9 Pharmacological management – Neuromodulators

Item	Details
Area of the scope	Pharmacological and surgical treatments including analgesics, hormonal medical treatments, neuromodulators, ablation, excision and hysterectomy with or without oophorectomy
Review question in the scope	Pharmacological and surgical treatments What is the effectiveness of the following treatments for endometriosis, including recurrent and asymptomatic endometriosis: <ul style="list-style-type: none"> <li>• analgesics</li> <li>• <b>neuromodulators</b></li> <li>• hormonal medical treatments</li> <li>• ablation</li> <li>• excision</li> <li>• hysterectomy with or without oophorectomy?</li> </ul>
Review question	What is the effectiveness of neuromodulators for treating endometriosis, including recurrent and asymptomatic endometriosis?
Objective	The aim of this review is to determine the effectiveness of neuromodulators for treating endometriosis, including recurrent and asymptomatic endometriosis.
Population and directness	<ul style="list-style-type: none"> <li>• Women with endometriosis of any stage or severity. These may also include suspected diagnoses Exclusions:</li> <li>• Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women)</li> <li>• women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>• Those suspected based solely on a CA-125 test with no other contributing factor, CA-125 should be used in combination with other evaluative measures.</li> <li>• mixed populations of women with pelvic pain where less than 66% of women have a diagnosis of endometriosis</li> </ul>
Intervention	<p>Neuromodulators (neuropathic analgesia ) of any type and administered at any dose, frequency, treatment duration, or by any type of administration:</p> <ul style="list-style-type: none"> <li>• Tricyclics ; Amitriptyline Nortriptyline,</li> <li>• Serotonin–norepinephrine reuptake inhibitors (SNRIs); Duloxetine, Mirtazapine, Venlafaxine</li> <li>• Local anaesthetics: lidocaine (topical and infusion)</li> <li>• Capsaicin patches</li> <li>• NMDA antagonist: Ketamine</li> <li>• Anticonvulsants: Gabapentin, Pregabalin, Tiagabine, Carbamazepine, Phenytoin, Valproate Topiramate</li> <li>• Nerve blocks</li> </ul> <p>Excluded intervention</p>

Item	Details
	<ul style="list-style-type: none"> <li>• Nerve ablation - Laparoscopic uterine nerve ablation (LUNA) is covered by a NICE Interventional Procedure Guideline (IPG) with the following recommendation: <i>The evidence on laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain suggests that it is not efficacious and therefore should not be used.</i></li> </ul>
Comparison	<ul style="list-style-type: none"> <li>• Neuromodulators vs no treatment / usual care</li> <li>• Neuromodulators vs placebo</li> <li>• Neuromodulators A vs Neuro-modulators B</li> <li>• Neuromodulators vs other pain management drug (see analgesics protocol)</li> <li>• Neuromodulators vs hormonal treatment</li> <li>• Neuromodulators vs surgical treatment</li> </ul>
Outcomes	<ul style="list-style-type: none"> <li>• Pain relief</li> <li>• Health related Quality of Life</li> <li>• Rate of success (Disease recurrence and subsequent reoperation rate)</li> <li>• Pregnancy rate/ fertility</li> <li>• Unintended effects from treatment (side effects and complications)</li> <li>• Participant satisfaction with treatment</li> <li>• Analgesic use</li> </ul> <p>Effect on daily activities (measured as proportion of women who reported activity restriction which could include; absence from work and school)</p>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <p>critical (up to 3 outcomes) –</p> <ul style="list-style-type: none"> <li>• pain relief,</li> <li>• health related quality of life,</li> <li>• adverse events</li> </ul> <p>important but not critical (up to 3 outcomes) –</p> <ul style="list-style-type: none"> <li>• number of women requiring more surgery</li> <li>• absence from work and other activities of daily living</li> <li>• fertility</li> <li>• analgesic use</li> </ul>
Stratified, subgroup and adjusted analyses	<p>Stratification:</p> <ul style="list-style-type: none"> <li>• Type / class of neuromodulator</li> </ul> <p>Subgroups:</p> <p>Population related:</p> <ul style="list-style-type: none"> <li>• Types of pain cyclical vs non-cyclical period-like, sharp, dyschezia, painful intercourse, chronic pelvic pain</li> <li>• Site of endometriosis (not specified, ovarian, superficial and deep infiltrating {bladder, peritoneal, recto vaginal})</li> </ul> <p>Treatment related:</p> <ul style="list-style-type: none"> <li>• Dosage</li> <li>• Route of administration</li> </ul>
Language	English
Study design	<p>Systematic reviews of RCTs</p> <p>RCTs</p> <p>Comparative cohort studies</p>

Item	Details
	In the absence of full text published RCTs, conference abstracts are being considered. Cross over RCTs will be considered where it is appropriate RCTs with <10 participants in each group and observational studies with < 30 participants will not be considered
Setting	No particular setting specified.
Search strategy	Sources to be searched: Medline, Medline In-Process, CENTRAL, CDSR, DARE, HTA, Embase Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate Supplementary search techniques: No supplementary search techniques will be used. See appendix for full strategies
Review strategy	Appraisal of methodological quality: The methodological quality of each study should be assessed using quality checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs, CASP for cohort studies) and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE. Synthesis of data: Meta-analysis will be conducted where appropriate. Default MIDs will be used: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes to assess imprecision. For Visual Analogue Scale (VAS) outcomes related to pain an MID of 1 cm (for a 10cm scale) will be used (Gerlinger 2010). When meta analysing continuous data final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed. If studies only report p-values, this information will be plotted in GRADE tables without an assessment of imprecision possible to be made.
Equalities	Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment
Notes/additional information	

1

## D.10 Pharmacological, non-pharmacological, surgical and combination management strategies

3

### D.10.1 Network meta-analysis for women presenting with pain as their primary concern

5

Item	Details
Review question	<b>What is the effectiveness of the following treatments for pain relief endometriosis, including recurrent and asymptomatic endometriosis:</b> <ul style="list-style-type: none"> <li>• Hormonal medical treatments</li> <li>• Surgery</li> <li>• Non-pharmacological treatments</li> <li>• Combinations of surgery plus hormonal treatments?</li> </ul>
Objective	The aim of this NMA is to determine the clinical efficacy of treatments in women with endometriosis.
Population	Women between menarche and menopause with endometriosis or suspected endometriosis of any stage or severity who are experiencing pain. Suspected

Item	Details
	<p>endometriosis may be based on the history of the patient, pelvic examination, and other tests such as ultrasound, MRI and the CA-125 blood test. Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women) will not be considered</p> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>• Use of hormonal therapies (excluding depot medroxyprogesterone) in the previous 1 month</li> <li>• Use of depot medroxyprogesterone in the previous 6 months</li> </ul> <p>Those suspected based solely on a CA-125 test with no other contributing factor, CA-125 should be used in combination with other evaluative measures.</p>
Stratified analyses	
Subgroup Analyses	<p>Networks will be examined separately if study populations for separate groups of treatments are substantially different:</p> <ul style="list-style-type: none"> <li>• Hormonal treatments</li> <li>• Surgical treatments</li> <li>• Non-pharmacological treatments</li> </ul> <p>Other subgroup analyses</p> <ul style="list-style-type: none"> <li>• Type of diagnosis of endometriosis (eg endometrioma)</li> <li>• Types of pain</li> </ul>
Covariates	<p>Covariates can sometimes be included to reduce heterogeneity instead of running subgroup analyses, where data is available. In order of importance (where data are available):</p> <ul style="list-style-type: none"> <li>• Type of disease (ovarian, peritoneal, deep)</li> <li>• Stage of endometriosis</li> <li>• Prior surgery within the last 6 months <ul style="list-style-type: none"> <li>○ Not including diagnostic surgery if separately defined by study</li> <li>○ Not including surgery immediately (within 4 weeks) prior (combined surgery + hormonal therapy)</li> </ul> </li> <li>• Bias (e.g. blinding)</li> <li>• Age</li> <li>• BMI</li> <li>• Associated heavy menstrual bleeding</li> </ul>
Interventions	<p><b>All interventions in the following classes (in bold) will be considered, provided doses are within ranges specified by the Committee (as below) or those within the BNF.</b></p> <p><b><u>Hormonal Medical Treatments</u></b></p> <p><b><i>Danazol/gestrinone</i></b></p> <p>Danazol</p> <ul style="list-style-type: none"> <li>• High dose (400-800mg/d)</li> <li>• Low dose (100-400mg/d)</li> </ul> <p>Gestrinone</p> <p><b><i>Oestrogens</i></b></p> <p>Oestradiol (oral – 1-2mg/d)</p> <p>Conjugated equine oestrogens (CEE) (oral – 0.3-1.25mg/d)</p>

Item	Details
	<p><b>Progestogens</b></p> <p>Lynestrenol  Norethindrone (norethisterone) (2.5mg/d)  Gestodene (i.m 5-10mg)  Desogestrel (oral – 75ug/d)  Medroxyprogesterone</p> <ul style="list-style-type: none"> <li>• Low dose oral (15-20mg/d)</li> <li>• High dose oral (20-30mg/d)</li> <li>• i.m (150mg/3m)</li> <li>• s.c. (104mg/3m)</li> </ul> <p>Levonorgestrel</p> <ul style="list-style-type: none"> <li>• Oral (30ug/d)</li> <li>• Mirena coil (20ug/d released over 5 years)</li> </ul> <p>Promegestone (s.c. – 68mg released over 3 years)  Dienogest (2mg/d) – <i>Not available in BNF but will be used to provide evidence of class efficacy</i></p> <p><b>GnRH agonists</b></p> <p>Nafarelin (nasal spray – 200ug/12h)  Leuprorelin acetate (depot – 3.75mg/m)  Goserelin (s.c – 3.6mg/m)  Triptorelin (dipherelin) (i.m – 3mg/m)  Buserelin (300ug/8h)</p> <p><b>Anti-androgens/Progestogens</b></p> <p>Cyproterone acetate (10-12.5mg/d) <i>(only in combination as COC)</i></p> <p><b>Aromatase inhibitors</b></p> <p>Anastrozole (oral – 1mg/d)  Letrozole (oral – 2.5mg/d)</p> <p><b>Selective oestrogen receptor modulators</b></p> <p>Raloxifene (60mg/d)</p> <p><b>Selective progestogen receptor modulators</b></p> <p>Tibolone (oral – 2.5mg/d)</p> <p><b><u>Surgical Treatments</u></b></p> <p><b><i>Excisional laparoscopic surgery</i></b>  Laser, diathermy, etc.</p> <p><b><i>Ablative laparoscopic surgery</i></b>  Laser, diathermy, etc.</p> <p><b><u>Non-Pharmacological Treatments</u></b></p> <p><b><i>Behavioural medicine (such as psychological and physiotherapy techniques)</i></b></p> <ul style="list-style-type: none"> <li>• Cognitive behavioural therapy</li> </ul>

Item	Details
	<ul style="list-style-type: none"> <li>• Mindfulness</li> <li>• Relaxation techniques</li> <li>• Pain management programmes –</li> <li>• Pain management physiotherapy</li> <li>• Pain management psychology</li> <li>• Expert patient programme</li> <li>• Exercise (for example yoga and pilates)</li> <li>• Hypnosis</li> <li>• Psychosexual therapy</li> <li>• Biofeedback</li> </ul> <p><b>Physical methods</b></p> <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• (TENS)</li> <li>• Manual and Physical therapy</li> <li>• Massage (e.g. shiatsu)</li> <li>• Osteopathy</li> <li>• Chiropractic treatment</li> <li>• Reflexology</li> </ul> <p><b>Other</b></p> <ul style="list-style-type: none"> <li>• Herbal medicine</li> <li>• Naturopathy</li> <li>• Homeopathic therapy</li> <li>• Nutrition (gluten free, dairy free, vegetarian, endo diet)</li> </ul>
Comparisons	<ul style="list-style-type: none"> <li>• All interventions listed above</li> <li>• Combinations of those interventions</li> <li>• Placebo</li> <li>• No treatment</li> </ul>
Outcomes	<p><u>Primary</u></p> <ul style="list-style-type: none"> <li>• Pain (measured by Biberoglu and Behrman scale or other scale with identical subscales) <ul style="list-style-type: none"> <li>◦ Separated into subscales if data for these are reported separately (non-menstrual pelvic pain, dyspareunia, dysmenorrhea, induration, pelvic tenderness)</li> </ul> </li> <li>• Pain measured by a Visual Analogue Scale (VAS)</li> <li>• Quality of life (measured using the SF-36)</li> <li>• Discontinuation of treatment due to adverse effects (surgical studies will not be included for this outcome)</li> </ul> <p>The latest time point from each study will be used, up to a maximum duration of 12 months (inclusive) for pain relief and QoL.</p> <p>For discontinuation, maximum duration will depend on whether relative effects change across different study follow-ups:</p> <ul style="list-style-type: none"> <li>• If no change then we will use a maximum of 12 months (inclusive) and model as OR – this assumes all discontinuation occurs within the first 3 months</li> <li>• If change is found then we will include all study durations and model discontinuation as a rate ratio or HR</li> </ul>

Item	Details
Study design	<p>Only RCTs will be considered for inclusion. Both periods of cross over RCTs will be considered if authors have used a suitable paired analysis and if they have tested for carryover effects or have used a suitable washout period.</p> <p>Exclusion criteria: studies with a duration of less than 3 months, studies with less than two relevant treatments (non-relevant treatments include non UK licensed drugs).</p>
Population size and directness	<p>Studies with mixed populations (e.g. mixture of patients with different (but specified) severities) will be considered under the following assumptions:</p> <ul style="list-style-type: none"> <li>• If more than 2/3 of the sample are within a particular pre-specified strata then we will code the study as including women with this characteristic. Otherwise we will label this characteristic as “mixed”.</li> <li>• Studies must have &gt;15 participants per treatment arm</li> </ul>
Review strategy	<p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Network meta-analysis will be conducted using Winbugs codes (TSU Bristol Unit)</li> <li>• We will use mean differences for reporting the results of continuous outcomes</li> <li>• We will use the ORs (95% cr.i.) for reporting the results of dichotomous outcomes</li> <li>• We will use rate ratios or HRs for reporting the results of rate outcomes.</li> <li>• We will impute SD (accounting for uncertainty in SD imputation) where it has not been reported and assess impact of this in a sensitivity analysis</li> <li>• We will not use MIDs as outputs will feed directly into HE model so MIDs will not be needed</li> </ul>
Model Structure	<ul style="list-style-type: none"> <li>• Treatments not included in the list of interventions will be included if they provide indirect evidence to the network via a closed loop of treatment effects.</li> <li>• Class effect model to allow borrowing of evidence from other treatments if network is too sparse. The following investigations into which class effect model fits the data best will be performed. <ul style="list-style-type: none"> <li>○ Treatments of the same class grouped by route of administration (e.g. orally administered GnRH analogues would be an individual class)</li> <li>○ Treatments of the same class grouped (e.g. GnRH analogues would be an individual class)</li> </ul> </li> <li>• We will test for exchangeability of within-class treatments to assess if a class model is appropriate</li> <li>• We will calculate a composite score of the Biberoglu and Behrman subscales, using a multivariate approach with known correlations between each scale</li> <li>• We will consider a multivariate NMA approach between Biberoglu and Behrman total (composite) score, VAS, and QoL scales and consider a multivariate approach</li> <li>• Adjusted for covariate(s) (severity as primary) <ul style="list-style-type: none"> <li>○ For multivariate this requires assuming correlations are same in different covariate subgroups (e.g. more/less severe)</li> </ul> </li> <li>• Use empirical priors (if available) where the ratio of studies to treatments is less than 3:1</li> </ul>
Assumptions	<ul style="list-style-type: none"> <li>• Standard NMA assumptions</li> <li>• Means are normally distributed (Central Limit Theorem)</li> <li>• If covariates are included we assume that there is no multiplicative effect of this with the different hormonal therapies (i.e. no interaction terms)</li> </ul>
Sensitivity Analyses	<ul style="list-style-type: none"> <li>• Treatment characteristics that have not been stratified/subgrouped (e.g. dose – high/low, if there is not enough data for subgroup analysis)</li> </ul>



Item	Details
	<ul style="list-style-type: none"> <li>• Using studies with mixed populations</li> <li>• Imputed SDs</li> <li>• Priors</li> </ul>

1

## D.102 Clinical pairwise review

Item	Details
Areas in the scope	<ul style="list-style-type: none"> <li>• Pharmacological and surgical treatments including analgesics, hormonal medical treatments, neuromodulators, ablation, excision and hysterectomy with or without oophorectomy.</li> <li>• Combining pharmacological and surgical treatments.</li> <li>• Non-pharmacological management specific to pain (for example acupuncture).</li> </ul>
Review question in the scope	<p><b>Pharmacological and surgical treatments</b> What is the effectiveness of the following treatments for endometriosis, including recurrent and asymptomatic endometriosis:</p> <ul style="list-style-type: none"> <li>• analgesics</li> <li>• neuromodulators</li> <li>• <b>hormonal medical treatments</b></li> <li>• <b>ablation</b></li> <li>• <b>excision</b></li> <li>• hysterectomy, with or without oophorectomy?</li> </ul> <p><b>Combinations of treatments</b> What is the effectiveness of pharmacological therapy before or after surgery compared with surgery alone?</p> <p><b>Non-pharmacological management specific to pain</b> What is the effectiveness of non-pharmacological therapies (for example acupuncture) for managing pain associated with endometriosis?</p>
Review question for the guideline	<p>What is the effectiveness of the following treatments for endometriosis, including recurrent and asymptomatic endometriosis:</p> <ul style="list-style-type: none"> <li>• Hormonal medical treatments</li> <li>• Ablation</li> <li>• Excision</li> <li>• Combinations of treatments (pharmacological therapy before or after surgery compared to surgery alone)</li> <li>• Non-pharmacological management specific to pain</li> </ul>
Objective	<p>The objective of these reviews was to identify effective treatment classes and interventions within hormonal medical treatment and non-pharmacological management of pain, effective surgical techniques and to establish whether and which hormonal medical treatment and surgery combinations are effective.</p>
Population and directness	<p>Inclusions:</p> <ul style="list-style-type: none"> <li>• women between menarche and menopause with endometriosis of any stage or severity.</li> <li>• women with a suspected diagnosis of endometriosis (definition: suspected diagnosis based on the history of the patient, pelvic examination and other tests such as ultrasound, MRI and the CA-125 blood test)</li> </ul> <p>Exclusions:</p>

Item	Details
	<ul style="list-style-type: none"> <li>• women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>• those suspected based solely on a CA-125 test with no other contributing factor (CA-125 should be used in combination with other evaluative measures)</li> </ul> <p>Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women) will not be considered.</p>
Intervention	<p><b>Hormonal medical treatments</b></p> <p>of any type and administered at any dose, frequency, treatment duration recommended in the BNF, or by any route of administration:</p> <ul style="list-style-type: none"> <li>• Combined oral contraceptive pill (patch, ring)</li> <li>• Progesterone only pill</li> <li>• Implant (Nexplanon / Implanon {not available in UK anymore})</li> <li>• Injection [Depo-Provera]</li> <li>• Levonorgestrel-releasing intrauterine system (LNG-IUS [mirena])</li> <li>• High dose progestogens (e.g medroxyprogesterone acetate)</li> <li>• Danazol</li> <li>• Gonadotrophin-releasing hormone analogues (GnRHa)</li> <li>• Antiprogestogens (mifepristone [RU 486])</li> <li>• Combined treatment (GnRH agonist with "add back" HRT/Tibolone)</li> <li>• Aromatase inhibitors (for example anastrozole, letrozole, exemestane)</li> <li>• Selective oestrogen receptor modulators (SERMs) (tamoxifen, raloxifene)</li> <li>• Selective progesterone receptor modulators (SPRMs) (ulipristal, mifepristone)</li> </ul> <p><b>Surgical interventions</b></p> <ul style="list-style-type: none"> <li>• Ablation</li> <li>• Excision</li> <li>• General techniques <ul style="list-style-type: none"> <li>○ Robotic</li> <li>○ Laparoscopic</li> <li>○ Open excision</li> <li>○ Total peritoneal excision</li> </ul> </li> <li>• Specific techniques <ul style="list-style-type: none"> <li>○ laser</li> <li>○ diathermy</li> <li>○ bi-polar and mono polar</li> <li>○ ultrasonic energy or a combination i.e. ultrasonic with bi-polar)</li> </ul> </li> <li>• These may also include: <ul style="list-style-type: none"> <li>○ Ovarian cystectomy</li> <li>○ Drainage of endometriosis</li> </ul> </li> <li>• Exclude: helium coagulation {refer to IPG, no sufficient evidence to use in normal practice}</li> </ul> <p><b>Combinations of treatments</b></p> <ul style="list-style-type: none"> <li>• Any hormonal medical treatment administered before, after or both before + after any surgical treatment</li> </ul> <p><b>Non-pharmacological management specific to pain</b></p> <ul style="list-style-type: none"> <li>• Behavioural medicine (such as psychological and physiotherapy techniques)</li> </ul>

Item	Details
	<ul style="list-style-type: none"> <li>○ Cognitive behavioural therapy</li> <li>○ Mindfulness</li> <li>○ Relaxation techniques</li> <li>○ Pain management programmes -</li> <li>○ Pain management physiotherapy</li> <li>○ Pain management psychology</li> <li>○ Expert patient programme</li> <li>○ Exercise (for example yoga and pilates)</li> <li>○ Hypnosis</li> <li>○ Psychosexual therapy</li> <li>○ Biofeedback</li> <li>● Physical methods <ul style="list-style-type: none"> <li>○ Acupuncture</li> <li>○ (TENS)</li> <li>○ Manual and Physical therapy</li> <li>○ Massage (e.g. shiatsu)</li> <li>○ Osteopathy</li> <li>○ Chiropractic treatment</li> <li>○ Reflexology</li> </ul> </li> <li>● Other <ul style="list-style-type: none"> <li>○ Herbal medicine</li> <li>○ Naturopathy</li> <li>○ Homeopathic therapy</li> <li>○ Nutrition (gluten free, dairy free, vegetarian, endo diet)</li> </ul> </li> </ul>
Comparison	<p><b>For hormonal medical treatments:</b></p> <ul style="list-style-type: none"> <li>● Hormonal medical treatment vs no treatment, usual care or placebo</li> <li>● Hormonal medical treatment A vs Hormonal medical treatment B</li> <li>● Hormonal medical treatment vs other medical treatment</li> <li>● Hormonal medical treatment vs. surgery</li> <li>● Hormonal medical treatment vs. combinations of hormonal medical and surgical treatment</li> </ul> <p><b>For surgical interventions:</b></p> <ul style="list-style-type: none"> <li>● Surgery compared to diagnostic laparoscopy</li> <li>● Ablation vs excision</li> </ul> <p><b>For combinations of treatments</b></p> <ul style="list-style-type: none"> <li>● Hormonal medical treatment before surgery vs no treatment/placebo</li> <li>● Hormonal medical treatment after surgery vs no treatment/placebo</li> <li>● Hormonal medical treatment before vs after surgery</li> <li>● Hormonal medical treatment before and after surgery vs no treatment/usual care</li> </ul> <p><b>For non-pharmacological management specific to pain:</b></p> <ul style="list-style-type: none"> <li>● Non-pharmacological management vs no treatment, usual care or placebo</li> <li>● Non-pharmacological management A vs non-pharmacological management B</li> <li>● Non-pharmacological management vs pharmacological treatment (hormonal medical treatment, analgesics and neuromodulators)</li> <li>● Non-pharmacological management vs surgical interventions</li> </ul>

Item	Details
	<p><b>For NMA outcomes:</b></p> <ul style="list-style-type: none"> <li>• All interventions specified in this protocol</li> </ul>
Outcomes	<ul style="list-style-type: none"> <li>• Pain relief</li> <li>• Health related Quality of Life</li> <li>• Rate of success (Disease recurrence and subsequent reoperation rate)</li> <li>• Adverse events (specifically withdrawal due to adverse events)</li> <li>• Surgical complications</li> <li>• Participant satisfaction with treatment</li> <li>• Effect on daily activities (measured as proportion of women who reported activity restriction which could include; absence from work and school)</li> </ul> <p>Additional outcomes for non-pharmacological treatments:</p> <ul style="list-style-type: none"> <li>• Reduction in size and extent of endometrial cysts</li> <li>• Adherence to treatment programme</li> </ul>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <p>Critical</p> <ul style="list-style-type: none"> <li>• Pain relief</li> <li>• Health related Quality of Life</li> <li>• Adverse events (specifically withdrawal due to adverse events)</li> <li>• Adherence to treatment programme (for non-pharmacological treatments)</li> </ul> <p>Important</p> <ul style="list-style-type: none"> <li>• Rate of success (Disease recurrence and subsequent reoperation rate)</li> <li>• Participant satisfaction with treatment</li> <li>• Effect on daily activities (measured as proportion of women who reported activity restriction which could include; absence from work and school)</li> <li>• Reduction in size and extent of endometrial cysts (for non-pharmacological treatments)</li> </ul>
Setting	No particular setting specified
Stratified, subgroup and adjusted analyses	<p>The following groups of interventions will be reviewed, analysed and presented separately. However, for NMA outcomes, interventions will be included in the same network provided study populations are considered to be sufficiently similar:</p> <ul style="list-style-type: none"> <li>• Hormonal medical treatments</li> <li>• Surgical interventions</li> <li>• Combinations of treatments (hormonal medical treatment before or after surgery compared to surgery alone)</li> <li>• Non-pharmacological management specific to pain</li> </ul> <p>Pre-specified subgroup analyses:</p> <ul style="list-style-type: none"> <li>• Type of diagnosis of endometriosis</li> <li>• Types of pain <ul style="list-style-type: none"> <li>○ cyclical vs non-cyclical</li> <li>○ period-like, sharp, dyschezia, painful intercourse, chronic pelvic pain</li> </ul> </li> <li>• Site of endometriosis (not specified, ovarian, superficial and deep infiltrating {bladder, peritoneal, recto vaginal})</li> <li>• Bowel involvement (shave/skinning, disk, bowel resection)</li> </ul>

Item	Details
	<ul style="list-style-type: none"> <li>• Route of administration</li> </ul>
Language	English
Study design	<ul style="list-style-type: none"> <li>• Systematic reviews of RCTs</li> <li>• RCTs</li> <li>• In absence of full text published RCTs, conference abstracts will be considered.</li> <li>• Cross over RCTs will be considered where it is appropriate</li> <li>• Studies with &gt;66% women with endometriosis will be included. If the analysis has been performed for the women with endometriosis separately then only this data will be extracted.</li> <li>• RCTs with &lt;10 participants in each arm will not be included</li> </ul>
Search strategy	See appendix for full strategies
Review strategy	<p><b>Appraisal of methodological quality:</b></p> <ul style="list-style-type: none"> <li>• The methodological quality of each study should be assessed using quality checklists and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE.</li> </ul> <p><b>Synthesis of data:</b></p> <ul style="list-style-type: none"> <li>• Network meta-analysis will be conducted where data are available for the following outcomes (see NMA protocol): <ul style="list-style-type: none"> <li>○ Pain relief (Biberoglu and Behrman scale, Visual Analogue Scale)</li> <li>○ Withdrawal due to adverse events</li> <li>○ Quality of life (SF-36 scale)</li> </ul> </li> <li>• Pairwise meta-analysis will be conducted where appropriate for all other outcomes</li> <li>• Default MIDs will be used: 0.80 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes to assess imprecision.</li> <li>• For Visual Analogue Scale (VAS) outcomes related to pain an MID of 1 cm (for a 10cm scale) will be used (Gerlinger 2010).</li> <li>• When meta-analysing continuous data final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed.</li> <li>• If studies only report p-values, this information will be plotted in GRADE tables without an assessment of imprecision possible to be made.</li> </ul>
Equalities	None noted

1

## D.11 Surgical management - Hysterectomy with or without oophorectomy

3

Item	Details
Area in the scope	Pharmacological and surgical treatments including analgesics, hormonal medical treatments, neuromodulators, ablation, excision and hysterectomy with or without oophorectomy.
Review question in the scope	<p>Pharmacological and surgical treatments</p> <p>What is the effectiveness of the following treatments for endometriosis, including recurrent and asymptomatic endometriosis:</p> <ul style="list-style-type: none"> <li>• analgesics</li> <li>• neuromodulators</li> </ul>

Item	Details
	<ul style="list-style-type: none"> <li>• hormonal medical treatments</li> <li>• ablation</li> <li>• excision</li> <li>• <b>hysterectomy with or without oophorectomy?</b></li> </ul>
Review question	What is the effectiveness of hysterectomy with or without oophorectomy, including recurrent and asymptomatic endometriosis, in managing endometriosis?
Objective	The aim of this review is to determine the effectiveness of hysterectomy with or without oophorectomy, including recurrent and asymptomatic endometriosis, in managing endometriosis
Language	English
Study design	<p>Systematic reviews of RCTs</p> <p>RCTs</p> <p>Prospective and retrospective comparative cohort studies (only if RCTs are unavailable or limited data to inform decision making)</p> <p>In the absence of full text published RCTs, conference abstracts will be considered.</p>
Population and directness	Women with endometriosis of any stage and severity. Studies with indirect populations will not be considered.
Stratified, subgroup and adjusted analyses	<p>Stratification, e.g.</p> <p>Groups that will be reviewed and analysed separately:</p> <p>Pre-specified sub-group analyses, e.g. In the presence of heterogeneity, the following subgroups will be considered for sensitivity analysis:</p> <ul style="list-style-type: none"> <li>• women with or without cyclic pain</li> <li>• women with a combination of adenomyosis and endometriosis</li> <li>• hysterectomy with or without excision of endometriosis</li> <li>• laparoscopy vs laparotomy</li> </ul> <p>Important confounders (when comparative observational studies are included for interventional reviews):</p> <ul style="list-style-type: none"> <li>• age</li> <li>• severity of the condition</li> </ul>
Intervention	hysterectomy without oophorectomy
Comparison	Hysterectomy, with oophorectomy
Outcomes	<ul style="list-style-type: none"> <li>• Health related Quality of Life</li> <li>• Rate of success (Disease recurrence and subsequent reoperation rate)</li> <li>• Pain relief</li> <li>• Effect on daily activities</li> <li>• Adverse events</li> <li>• Participant satisfaction with treatment</li> </ul>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <ul style="list-style-type: none"> <li>• critical (up to 3 outcomes) – pain relief, health related quality of life, adverse events</li> <li>• important but not critical (up to 3 outcomes) – number of women requiring more surgery, effect on daily activities including absence from work</li> </ul>
Setting	Tertiary care

Item	Details
Search strategy	Sources to be searched: Medline, Medline In-Process, CENTRAL, CDSR, DARE, HTA, Embase Limits (e.g. date, study design): Limit to English language and human-only studies where appropriate Supplementary search techniques: No supplementary search techniques will be used. See appendix for full strategies
Review strategy	Appraisal of methodological quality: The methodological quality of each study should be assessed using quality checklists (eg AMSTAR for systematic reviews, Cochrane RoB tool for RCTs, CASP for cohort studies) and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE. Synthesis of data: Meta-analysis will be conducted where appropriate. Default MIDs will be used: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes to assess imprecision. When meta analysing continuous data final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed. If studies only report p-values, this information will be plotted in GRADE tables without an assessment of imprecision possible to be made.
Equalities	Adolescents are noted as a specific subgroup requiring consideration in the equalities impact assessment

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## D.12 Pharmacological, non-pharmacological, surgical and combination management strategies – if fertility is a priority

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### D.1251 Network meta-analysis for women presenting with subfertility as primary concern

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Item	Details
Review question	<b>What is the effectiveness of the following ovulation suppression treatments or surgery (or combinations of these) or non-pharmacological treatments for improving spontaneous pregnancy rates in endometriosis, including recurrent and asymptomatic endometriosis:</b> <ul style="list-style-type: none"> <li>• Hormonal medical treatments</li> <li>• Surgery</li> <li>• Non-pharmacological therapies</li> <li>• Combinations of surgery plus hormonal treatments?</li> </ul>
Objective	The aim of this NMA is to determine the clinical efficacy of ovulation suppression treatments, surgery and non-pharmacological therapies to improve fertility in women with endometriosis.
Population	Subfertile women desiring pregnancy, between menarche and menopause with endometriosis or suspected endometriosis (based on the history of the patient, pelvic examination, and other tests such as ultrasound, MRI and the CA-125 blood test) of any stage or severity. Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women) will not be considered. Infertility defined as failure to conceive after $\geq 12$ months unprotected intercourse

Item	Details
	<p>Exclusions:</p> <ul style="list-style-type: none"> <li>• women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>• Use of hormonal therapies (excluding depot medroxyprogesterone) in the previous 1 month</li> <li>• Use of depot medroxyprogesterone in the previous 6 months</li> <li>• Women receiving other fertility treatments as covered by NICE guidance on fertility (e.g. IVF, clomiphene citrate)</li> </ul> <p>Those suspected based solely on a CA-125 test with no other contributing factor, CA-125 should be used in combination with other evaluative measures.</p>
Stratified analyses	
Subgroup Analyses	<p>Networks will be examined separately if study populations for separate groups of treatments are substantially different:</p> <ul style="list-style-type: none"> <li>• Hormonal treatments</li> <li>• Surgical treatments</li> <li>• Non-pharmacological treatments</li> </ul>
Covariates	<p>Covariates can sometimes be included to reduce heterogeneity instead of running subgroup analyses, where data is available. In order of importance:</p> <ul style="list-style-type: none"> <li>• Stage of endometriosis</li> <li>• Prior surgery within the last 6 months <ul style="list-style-type: none"> <li>○ Not including diagnostic surgery if separately defined by study</li> <li>○ Not including surgery immediately (within 4 weeks) prior (combined surgery + hormonal therapy)</li> </ul> </li> </ul>
Interventions	<p><b>All interventions in the following classes (in bold) will be considered, provided doses are within ranges specified by the Committee (as below) or those within the BNF.</b></p> <p><b><u>Hormonal Medical Treatments</u></b></p> <p><b><i>Danazol/gestrinone</i></b>  Danazol</p> <ul style="list-style-type: none"> <li>• High dose (400-800mg/d)</li> <li>• Low dose (100-400mg/d)</li> </ul> Gestrinone <p><b><i>Oestrogens</i></b>  Oestradiol (oral – 1-2mg/d)  Conjugated equine oestrogens (CEE) (oral – 0.3-1.25mg/d)</p> <p><b><i>Progestogens</i></b>  Lynestrenol  Norethindrone (norethisterone) (2.5mg/d)  Gestodene (i.m 5-10mg)  Desogestrel (oral – 75ug/d)  Medroxyprogesterone</p> <ul style="list-style-type: none"> <li>• Low dose oral (15-20mg/d)</li> <li>• High dose oral (20-30mg/d)</li> <li>• i.m (150mg/3m)</li> <li>• s.c. (104mg/3m)</li> </ul> Levonorgestrel



Item	Details
	<ul style="list-style-type: none"> <li>• Oral (30ug/d)</li> <li>• Mirena coil (20ug/d released over 5 years)</li> </ul> <p>Promegestone (s.c. – 68mg released over 3 years)</p> <p>Dienogest (2mg/d) – <i>Not available in BNF but will be used to provide evidence of class efficacy</i></p> <p><b>GnRH agonists</b></p> <p>Nafarelin (nasal spray – 200ug/12h)</p> <p>Leuprorelin acetate (depot – 3.75mg/m)</p> <p>Goserelin (s.c – 3.6mg/m)</p> <p>Triptorelin (dipherelin) (i.m – 3mg/m)</p> <p>Buserelin (300ug/8h)</p> <p><b>Anti-androgens/Progestogens</b></p> <p>Cyproterone acetate (10-12.5mg/d) (<i>only in combination as COC</i>)</p> <p><b>Aromatase inhibitors</b></p> <p>Anastrozole (oral – 1mg/d)</p> <p>Letrozole (oral – 2.5mg/d)</p> <p><b>Selective oestrogen receptor modulators</b></p> <p>Raloxifene (60mg/d)</p> <p><b>Selective progestogen receptor modulators</b></p> <p>Tibolone (oral – 2.5mg/d)</p> <p><b><u>Surgical Treatments</u></b></p> <p><b>Excisional laparoscopic surgery</b></p> <p>Laser, diathermy, etc.</p> <p><b>Ablative laparoscopic surgery</b></p> <p>Laser, diathermy, etc.</p> <p><b><u>Non-Pharmacological Treatments</u></b></p> <p><b>Behavioural medicine</b> (<i>such as psychological and physiotherapy techniques</i>)</p> <ul style="list-style-type: none"> <li>• Cognitive behavioural therapy</li> <li>• Mindfulness</li> <li>• Relaxation techniques</li> <li>• Pain management programmes –</li> <li>• Pain management physiotherapy</li> <li>• Pain management psychology</li> <li>• Expert patient programme</li> <li>• Exercise (for example yoga and pilates)</li> <li>• Hypnosis</li> <li>• Psychosexual therapy</li> <li>• Biofeedback</li> </ul>

Item	Details
	<p><b>Physical methods</b></p> <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• (TENS)</li> <li>• Manual and Physical therapy</li> <li>• Massage (e.g. shiatsu)</li> <li>• Osteopathy</li> <li>• Chiropractic treatment</li> <li>• Reflexology</li> </ul> <p><b>Other</b></p> <ul style="list-style-type: none"> <li>• Herbal medicine</li> <li>• Naturopathy</li> <li>• Homeopathic therapy</li> <li>• Nutrition (gluten free, dairy free, vegetarian, endo diet)</li> </ul>
Comparisons	<ul style="list-style-type: none"> <li>• All interventions listed above</li> <li>• Combinations of those interventions</li> <li>• Placebo</li> <li>• No treatment</li> </ul>
Outcomes	<p><u>Primary</u></p> <ul style="list-style-type: none"> <li>• Spontaneous pregnancy</li> </ul> <p>The latest time point from each study will be used, up to a maximum duration of 24 months (inclusive). Results will be examined to assess if there is a relationship between study-follow-up and clinical pregnancy.</p>
Study design	<p>Only RCTS will be considered for inclusion. For crossover trials, only data from the first period of the study will be included.</p> <p>Exclusion criteria: studies with a duration of less than 3 months, studies with less than two relevant treatments.</p>
Population size and directness	<p>Studies with mixed populations (e.g. prior surgery) will be considered under the following assumptions:</p> <ul style="list-style-type: none"> <li>• If more than 2/3 of the sample are within a particular pre-specified strata then we will code the study as including women with this characteristic. Otherwise we will label this characteristic as “mixed”.</li> <li>• Studies must have &gt;10 participants in each arm</li> </ul>
Search strategy	See separate document
Review strategy	<p>Synthesis of data</p> <ul style="list-style-type: none"> <li>• Network meta-analysis will be conducted using Winbugs codes (TSU Bristol Unit)</li> <li>• We will use the ORs (95% cr.i.) for reporting the results of dichotomous outcomes</li> <li>• We will use rate ratios or HRs for reporting the results of rate outcomes.</li> <li>• We will not use MIDs as outputs will feed directly into HE model so MIDs will not be needed</li> </ul>
Model Structure	<ul style="list-style-type: none"> <li>• Class effect model to allow borrowing of evidence from other treatments if network is too sparse. The following investigations into which class effect model fits the data best will be performed. <ul style="list-style-type: none"> <li>○ Treatments of the same class grouped by route of administration (e.g. orally administered GnRH analogues would be an individual class)</li> <li>○ Treatments of the same class grouped (e.g. GnRH analogues would be an individual class)</li> </ul> </li> </ul>

Item	Details
	<ul style="list-style-type: none"> <li>• We will test for exchangeability of within-class treatments to assess if a class model is appropriate</li> <li>• Adjusted for prior surgery</li> <li>• Use empirical priors (if available) where the ratio of studies to treatments is less than 3:1</li> </ul>
Assumptions	<ul style="list-style-type: none"> <li>• Standard NMA assumptions</li> <li>• We assume that there is no multiplicative effect of prior surgery with the different treatments (i.e. no interaction terms)</li> </ul>
Sensitivity Analyses	<ul style="list-style-type: none"> <li>• Treatment characteristics that have not been stratified/subgrouped (e.g. dose – high/low, if there is not enough data for subgroup analysis)</li> <li>• Using studies with mixed populations</li> <li>• Imputed SDs</li> <li>• Priors</li> </ul>

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## D.122 Clinical pairwise review

Item	Details
Area in the scope	<ul style="list-style-type: none"> <li>• Pharmacological and surgical treatments including analgesics, hormonal medical treatments, neuromodulators, ablation, excision and hysterectomy with or without oophorectomy.</li> <li>• Combining pharmacological and surgical treatments.</li> <li>• Non-pharmacological management specific to pain (for example acupuncture).</li> </ul>
Review question in the scope	<p><b>Pharmacological and surgical treatments</b> What is the effectiveness of the following treatments for endometriosis, including recurrent and asymptomatic endometriosis:</p> <ul style="list-style-type: none"> <li>• analgesics</li> <li>• neuromodulators</li> <li>• hormonal medical treatments</li> <li>• ablation</li> <li>• excision</li> <li>• hysterectomy, with or without oophorectomy?</li> </ul> <p><b>Combinations of treatments</b> What is the effectiveness of pharmacological therapy before or after surgery compared with surgery alone?</p> <p><b>Non-pharmacological management specific to pain</b> What is the effectiveness of non-pharmacological therapies (for example acupuncture) for managing pain associated with endometriosis?</p>
Review question for the guideline	<p>What is the effectiveness of the following treatments for improving fertility in endometriosis, including recurrent and asymptomatic endometriosis:</p> <ul style="list-style-type: none"> <li>• Hormonal medical treatments</li> <li>• Ablation</li> <li>• Excision</li> <li>• Combinations of treatments (pharmacological therapy before or after surgery compared to surgery alone)</li> <li>• Non-pharmacological management specific to pain</li> </ul>

Item	Details
Objective	<p>The objective of these reviews was to identify treatment classes and interventions within hormonal medical treatment and non-pharmacological management of pain, surgical techniques and combinations of hormonal medical treatment and surgery which are effective in improving fertility.</p>
Population and directness	<p>Inclusions:</p> <ul style="list-style-type: none"> <li>• subfertile women between menarche and menopause with endometriosis of any stage or severity. (Subfertility definition: failure to conceive after <math>\geq 12</math> months of unprotected intercourse)</li> <li>• women with a suspected diagnosis of endometriosis (definition: suspected diagnosis based on the history of the patient, pelvic examination and other tests such as ultrasound, MRI and the CA-125 blood test)</li> </ul> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• women with chronic pelvic pain which was known to be due to causes other than endometriosis</li> <li>• those suspected based solely on a CA-125 test with no other contributing factor (CA-125 should be used in combination with other evaluative measures)</li> <li>• women receiving additional fertility treatments (e.g. IVF, clomiphene citrate)</li> </ul> <p>Studies with indirect populations (such as women with dysmenorrhea, women with non-confirmed pelvic pain, or post-menopausal women) will not be considered.</p>
Intervention	<p><b>Hormonal medical treatments - Ovulation suppression</b> of any type and administered at any dose, frequency, treatment duration recommended in the BNF, or by any route of administration:</p> <ul style="list-style-type: none"> <li>• Combined oral contraceptive pill (patch, ring)</li> <li>• Progesterone only pill</li> <li>• Implant (Nexplanon / Implanon {not available in UK anymore})</li> <li>• Injection [Depo-Provera]</li> <li>• Levonorgestrel-releasing intrauterine system (LNG-IUS [mirena])</li> <li>• Progestogens (high dose- put all classes together for e.g medroxyprogesterone acetate)</li> <li>• Danazol</li> <li>• Gonadotrophin-releasing hormone analogues (GnRHa)</li> <li>• Antiprogestogens (mifepristone [RU 486])</li> <li>• Combined treatment (GnRH agonist with "add back" HRT/Tibolone)</li> <li>• Aromatase inhibitors (for example anastrozole, letrozole, exemestane)</li> <li>• Selective oestrogen receptor modulators (SERMs) (tamoxifen, raloxifene)</li> <li>• Selective progesterone receptor modulators (SPRMs) (ulipristal, mifepristone)</li> </ul> <p><b>Surgical interventions</b></p> <ul style="list-style-type: none"> <li>• Ablation</li> <li>• Excision</li> <li>• General techniques <ul style="list-style-type: none"> <li>○ Robotic</li> <li>○ Laparoscopic</li> <li>○ Open excision</li> <li>○ Total peritoneal excision</li> </ul> </li> </ul>

Item	Details
	<ul style="list-style-type: none"> <li>• Specific techniques               <ul style="list-style-type: none"> <li>○ laser</li> <li>○ diathermy</li> <li>○ bi-polar and mono polar</li> <li>○ ultrasonic energy or a combination i.e. ultrasonic with bi-polar)</li> </ul> </li> <li>• These may also include:               <ul style="list-style-type: none"> <li>○ Ovarian cystectomy</li> <li>○ Drainage of endometriosis</li> </ul> </li> <li>• Exclude: helium coagulation {refer to IPG, no sufficient evidence to use in normal practice}</li> </ul> <p><b>Combinations of treatments</b></p> <ul style="list-style-type: none"> <li>• Any hormonal medical treatment administered before, after or both before + after any surgical treatment</li> </ul> <p><b>Non-pharmacological management specific to pain</b></p> <ul style="list-style-type: none"> <li>• Behavioural medicine (such as psychological and physiotherapy techniques)               <ul style="list-style-type: none"> <li>○ Cognitive behavioural therapy</li> <li>○ Mindfulness</li> <li>○ Relaxation techniques</li> <li>○ Pain management programmes -</li> <li>○ Pain management physiotherapy</li> <li>○ Pain management psychology</li> <li>○ Expert patient programme</li> <li>○ Exercise (for example yoga and pilates)</li> <li>○ Hypnosis</li> <li>○ Psychosexual therapy</li> <li>○ Biofeedback</li> </ul> </li> <li>• Physical methods               <ul style="list-style-type: none"> <li>○ Acupuncture</li> <li>○ (TENS)</li> <li>○ Manual and Physical therapy</li> <li>○ Massage (e.g. shiatsu)</li> <li>○ Osteopathy</li> <li>○ Chiropractic treatment</li> <li>○ Reflexology</li> </ul> </li> <li>• Other               <ul style="list-style-type: none"> <li>○ Herbal medicine</li> <li>○ Naturopathy</li> <li>○ Homeopathic therapy</li> <li>○ Nutrition (gluten free, dairy free, vegetarian, endo diet)</li> </ul> </li> </ul>
Comparison	<p><b>For hormonal medical treatments:</b></p> <ul style="list-style-type: none"> <li>• Hormonal medical treatment vs no treatment, usual care or placebo</li> <li>• Hormonal medical treatment A vs Hormonal medical treatment B</li> <li>• Hormonal medical treatment vs other medical treatment</li> <li>• Hormonal medical treatment vs. surgery</li> <li>• Hormonal medical treatment vs. combinations of hormonal medical and surgical treatment</li> </ul> <p><b>For surgical interventions:</b></p>

Item	Details
	<ul style="list-style-type: none"> <li>• Surgery compared to diagnostic laparoscopy</li> <li>• Ablation vs excision</li> </ul> <p><b>For combinations of treatments</b></p> <ul style="list-style-type: none"> <li>• Hormonal medical treatment before surgery vs no treatment/placebo</li> <li>• Hormonal medical treatment after surgery vs no treatment/placebo</li> <li>• Hormonal medical treatment before vs after surgery</li> <li>• Hormonal medical treatment before and after surgery vs no treatment/usual care</li> </ul> <p><b>For non-pharmacological management specific to pain:</b></p> <ul style="list-style-type: none"> <li>• Non-pharmacological management vs no treatment, usual care or placebo</li> <li>• Non-pharmacological management A vs non-pharmacological management B</li> <li>• Non-pharmacological management vs pharmacological treatment (hormonal medical treatment, analgesics and neuromodulators)</li> <li>• Non-pharmacological management vs surgical interventions</li> </ul> <p><b>For NMA outcomes:</b> All interventions specified in this protocol</p>
Outcomes	<ul style="list-style-type: none"> <li>• Live birth</li> <li>• Clinical pregnancy</li> <li>• Miscarriage</li> </ul>
Importance of outcomes	<p>Preliminary classification of the outcomes for decision making:</p> <p><b>Critical</b></p> <ul style="list-style-type: none"> <li>• Live birth</li> <li>• Clinical pregnancy</li> <li>• Miscarriage</li> </ul>
Setting	No particular setting specified
Stratified, subgroup and adjusted analyses	<p>The following groups of interventions will be reviewed, analysed and presented separately. However, for NMA outcomes, interventions will be included in the same network provided study populations are considered to be sufficiently similar:</p> <ul style="list-style-type: none"> <li>• Hormonal medical treatments</li> <li>• Surgical interventions</li> <li>• Combinations of treatments (pharmacological therapy before or after surgery compared to surgery alone)</li> <li>• Non-pharmacological management specific to pain</li> </ul> <p>Pre-specified subgroup analyses:</p> <ul style="list-style-type: none"> <li>• Type of diagnosis of endometriosis</li> <li>• Site of endometriosis (not specified, ovarian, superficial and deep infiltrating {bladder, peritoneal, recto vaginal})</li> <li>• Bowel involvement (shave/skinning, disk, bowel resection)</li> <li>• Route of administration</li> </ul>
Language	English

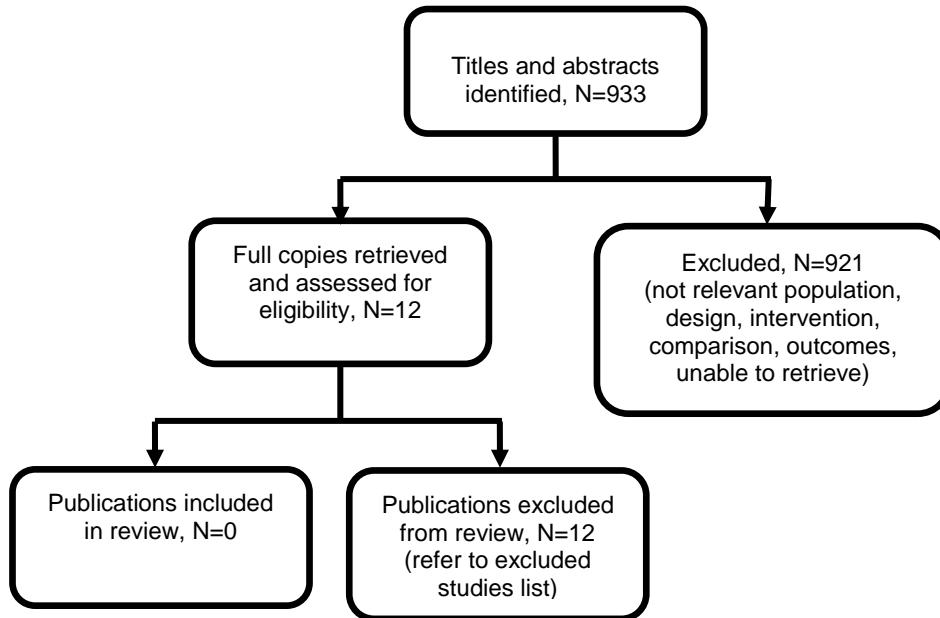
Item	Details
Study design	<ul style="list-style-type: none"> <li>• Systematic reviews of RCTs</li> <li>• RCTs</li> <li>• In absence of full text published RCT and Conference abstracts are being considered.</li> <li>• Cross over RCTs will be considered where it is appropriate</li> <li>• Studies with &gt;66% women with endometriosis will be included. If the analysis has been performed for the women with endometriosis separately then only this data will be extracted.</li> <li>• RCTs with &lt;10 participants in each arm will not be included</li> </ul>
Search strategy	See appendix for full strategies
Review strategy	<p><b>Appraisal of methodological quality:</b></p> <ul style="list-style-type: none"> <li>• The methodological quality of each study should be assessed using quality checklists and the quality of the evidence for an outcome (i.e. across studies) will be assessed using GRADE.</li> </ul> <p><b>Synthesis of data:</b></p> <ul style="list-style-type: none"> <li>• Network meta-analysis will be conducted where data are available for the following outcomes (see NMA protocol): <ul style="list-style-type: none"> <li>○ Clinical pregnancy</li> </ul> </li> <li>• Pairwise meta-analysis will be conducted where appropriate for all other outcomes</li> <li>• Default MIDs will be used: 0.80 and 1.25 for dichotomous outcomes; 0.5 times SD for continuous outcomes to assess imprecision. For Visual Analogue Scale (VAS) outcomes related to pain an MID of 1 cm (for a 10cm scale) will be used (Gerlinger 2010).</li> <li>• When meta-analysing continuous data final and change scores will be pooled and if any study reports both, the method used in the majority of studies will be analysed.</li> <li>• If studies only report p-values, this information will be plotted in GRADE tables without an assessment of imprecision possible to be made.</li> </ul> <p>10% of search results will be double sifted.</p>
Equalities	None noted

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# 1 Appendix F: Summary of identified studies

## F.1 Specialist services

3 Figure 1: Flow diagram of clinical article selection for specialist services review



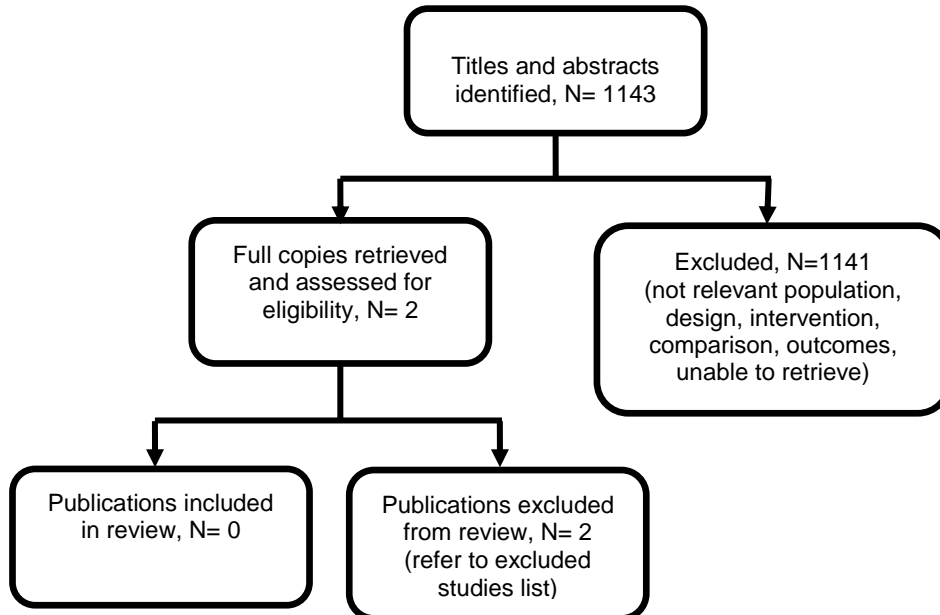
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## F.2 Timing of interventions: association between duration of symptoms before laparoscopy and treatment outcomes

3 **Figure 2: Flow diagram of clinical article selection for timing of interventions review**



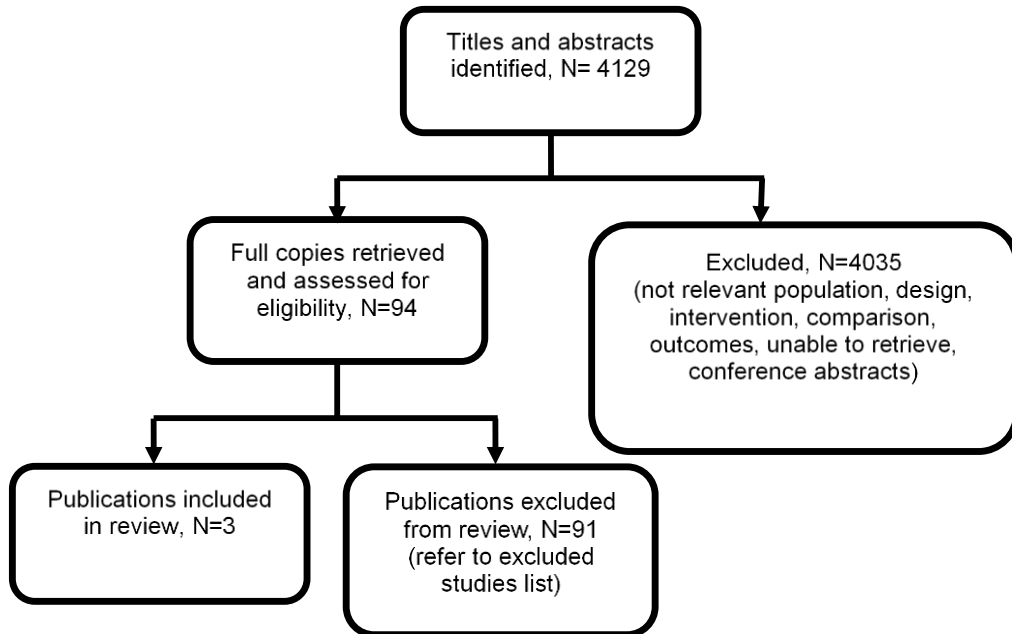
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### F.3 Signs and symptoms of endometriosis (monitoring and referral)

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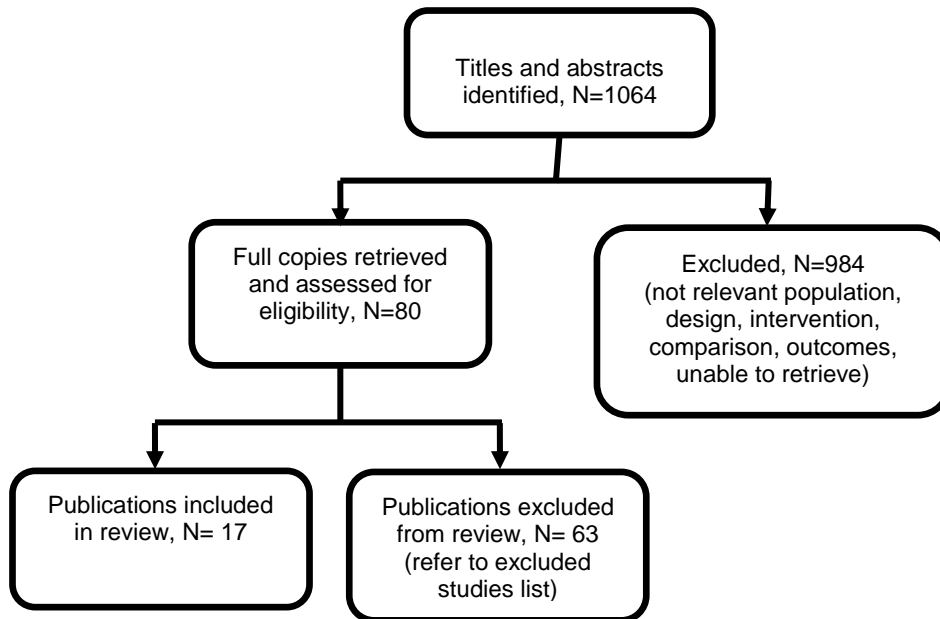
Figure 3: Flow diagram of clinical article selection for signs and symptoms of endometriosis review



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## F.4 Information and support

2 **Figure 4: Flow diagram of clinical article selection for information and support review**

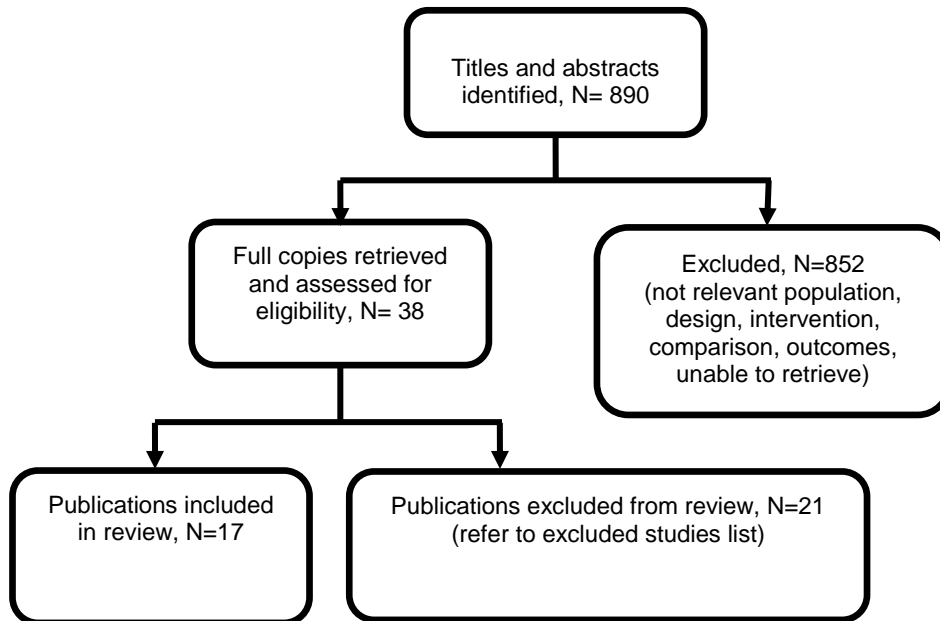


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## F.5 Risk of reproductive cancer

2 **Figure 5: Flow diagram of clinical article selection for the risk of reproductive cancer**  
3 **review**

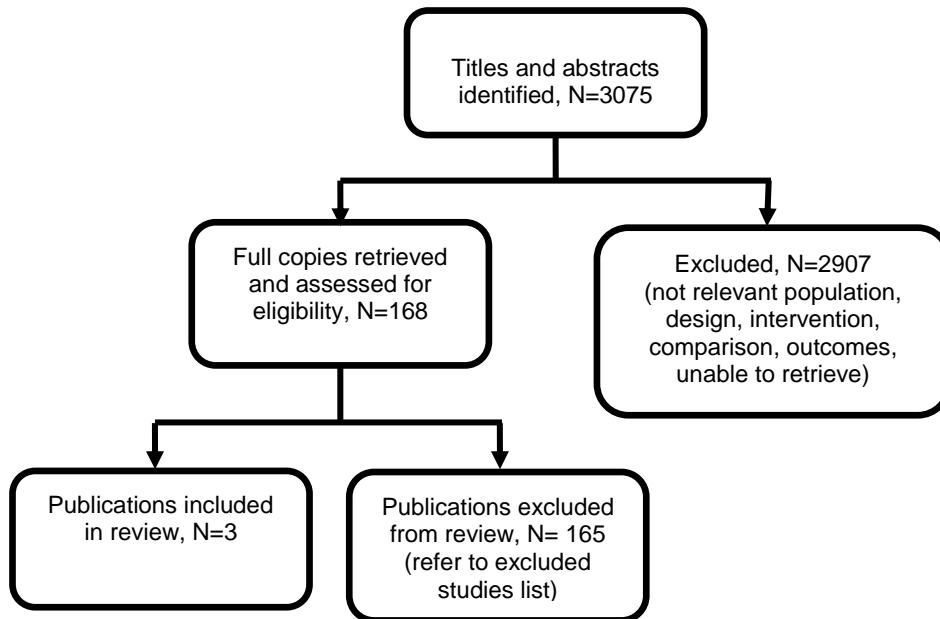


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## F.6 Diagnosis – Ultrasound

2 Figure 6: Flow diagram of clinical article selection for ultrasound review

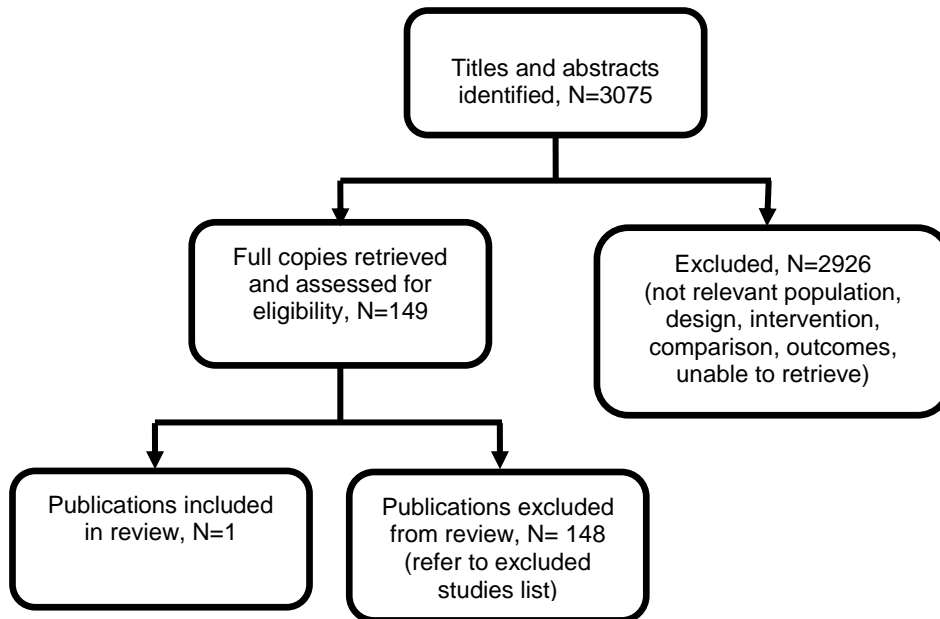


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## F.7 Diagnosis – Biomarkers: CA-125

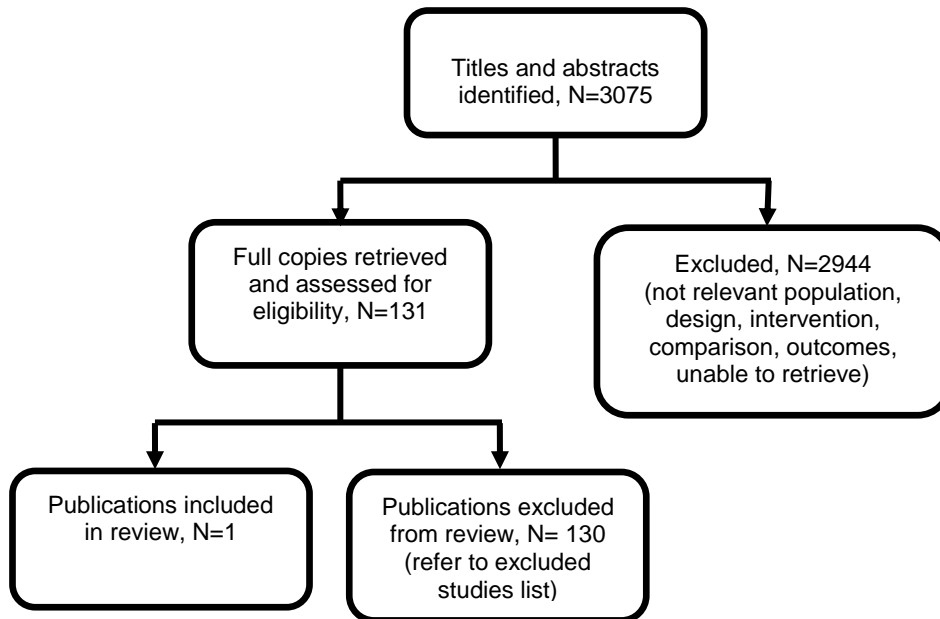
2 Figure 7: Flow diagram of clinical article selection for CA-125 review



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## F.8 Diagnosis – Biomarkers: HE-4

2 Figure 8: Flow diagram of clinical article selection for HE-4 review

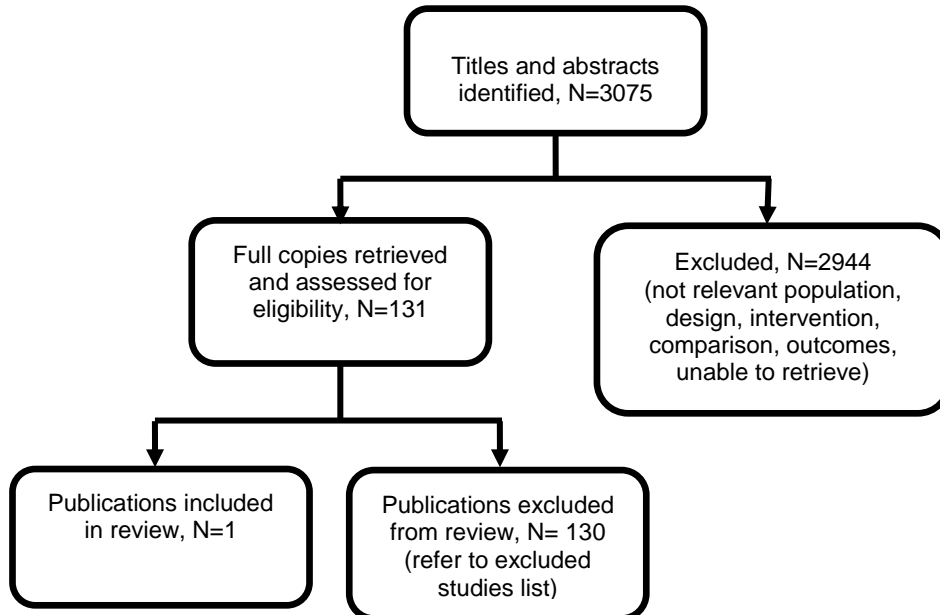


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## F.9 Diagnosis – Biomarkers: Nerve fibre marker Protein Gene Product 9.5 (PGP 9.5)

3 Figure 9: Flow diagram of clinical article selection for PGP 9.5 review



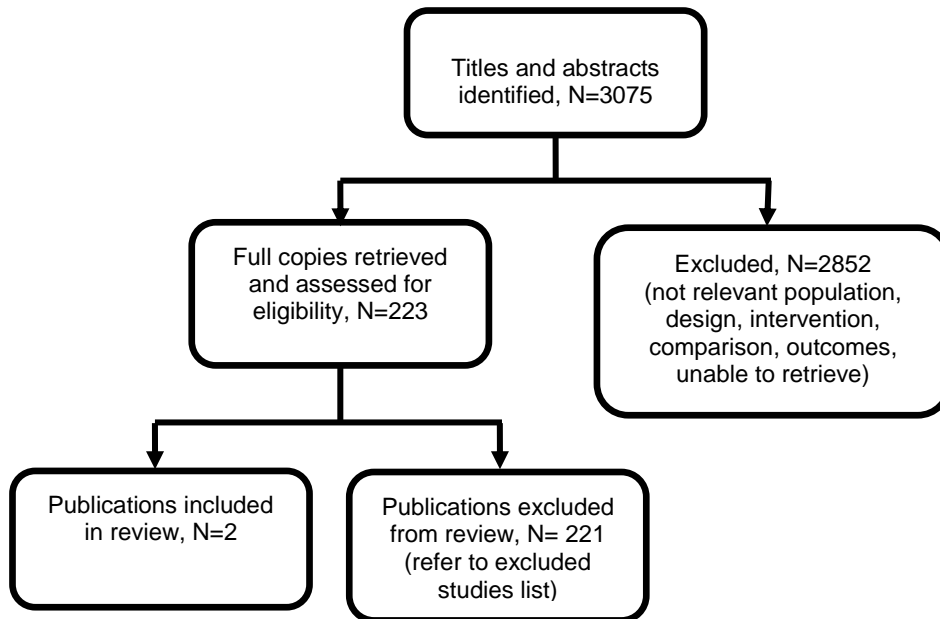
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## F.10 Diagnosis – MRI

2 **Figure 10:** Flow diagram of clinical article selection for MRI review



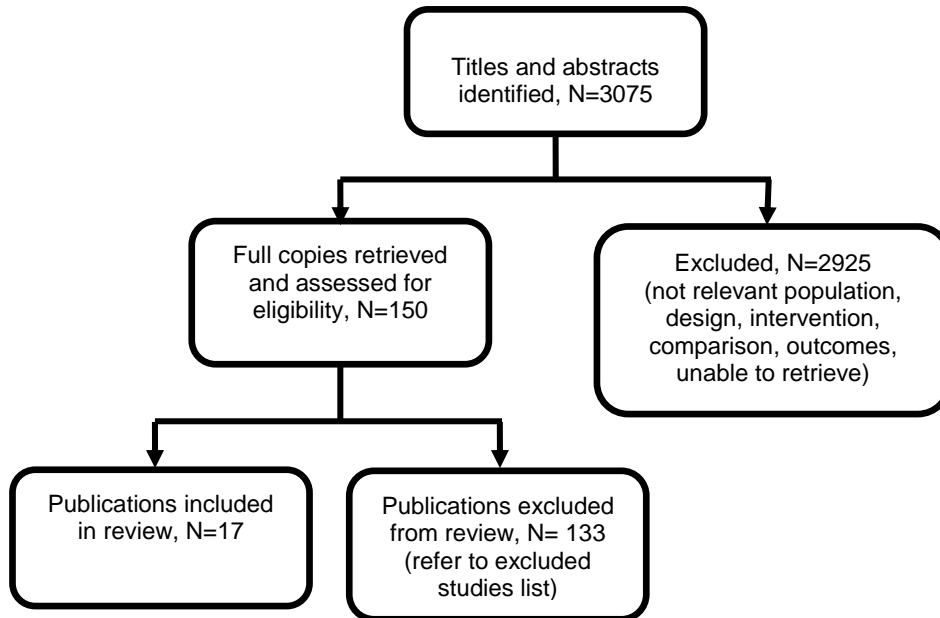
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## F.11 Diagnosis – Surgical diagnosis with or without histological confirmation

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3 **Figure 11: Flow diagram of clinical article selection for surgical diagnosis with or**  
4 **without histological confirmation review**

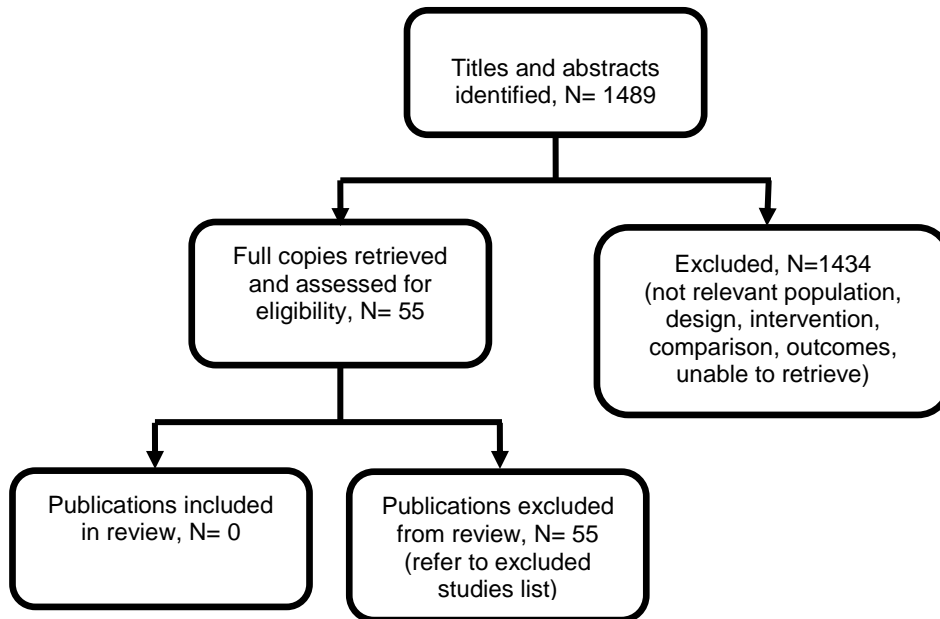


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## F.12 Staging Systems

2 **Figure 12: Flow diagram of clinical article selection for endometriosis-staging**  
3 **systems review**

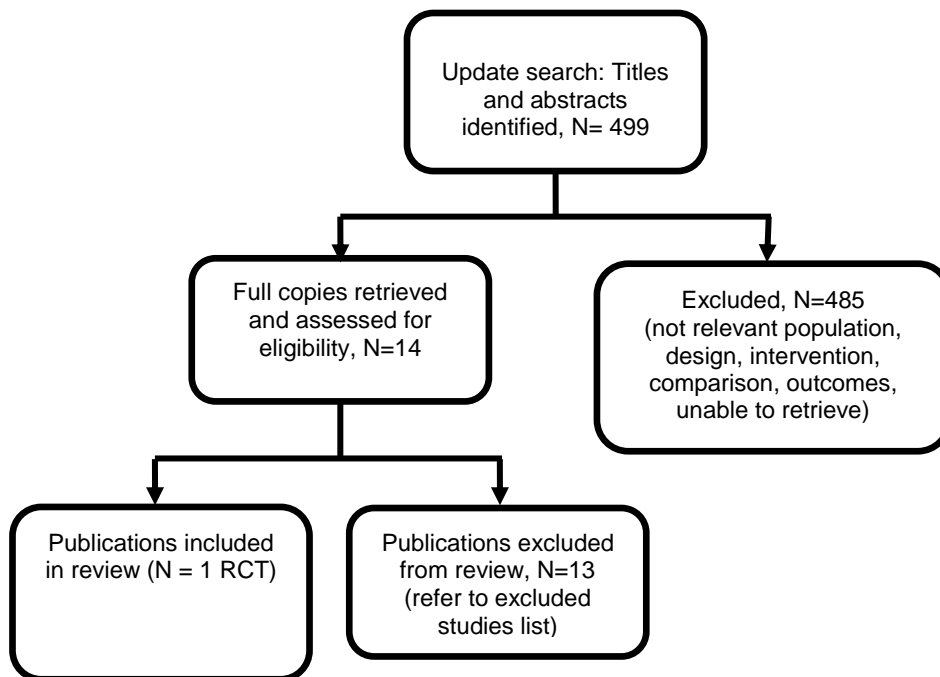


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## F.13 Pharmacological management – Analgesics

2 **Figure 13:** Flow diagram of clinical article selection for analgesics review

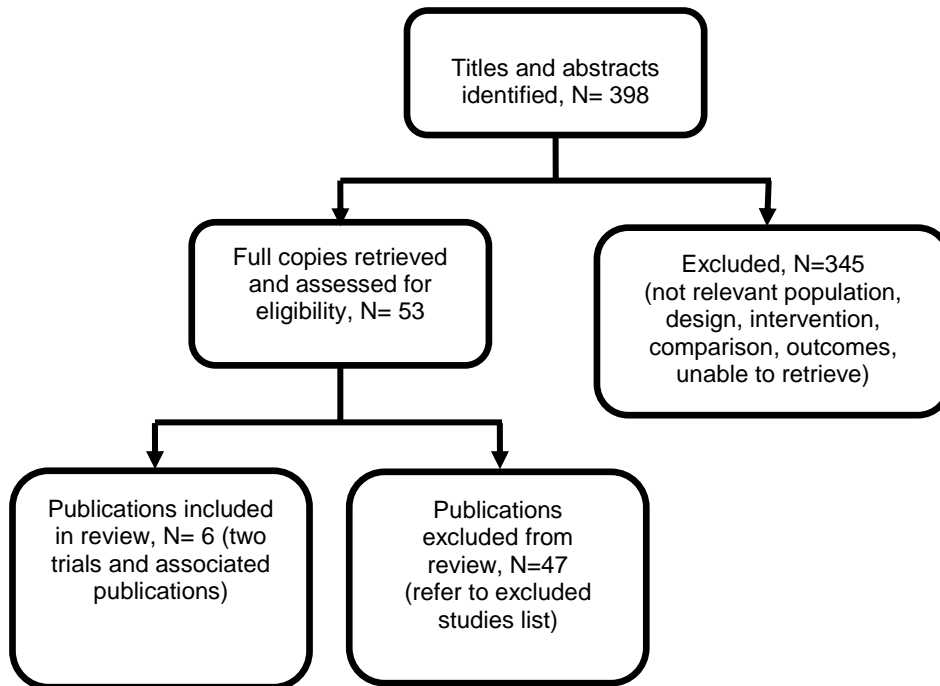


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## F.14 Pharmacological management – Neuromodulators

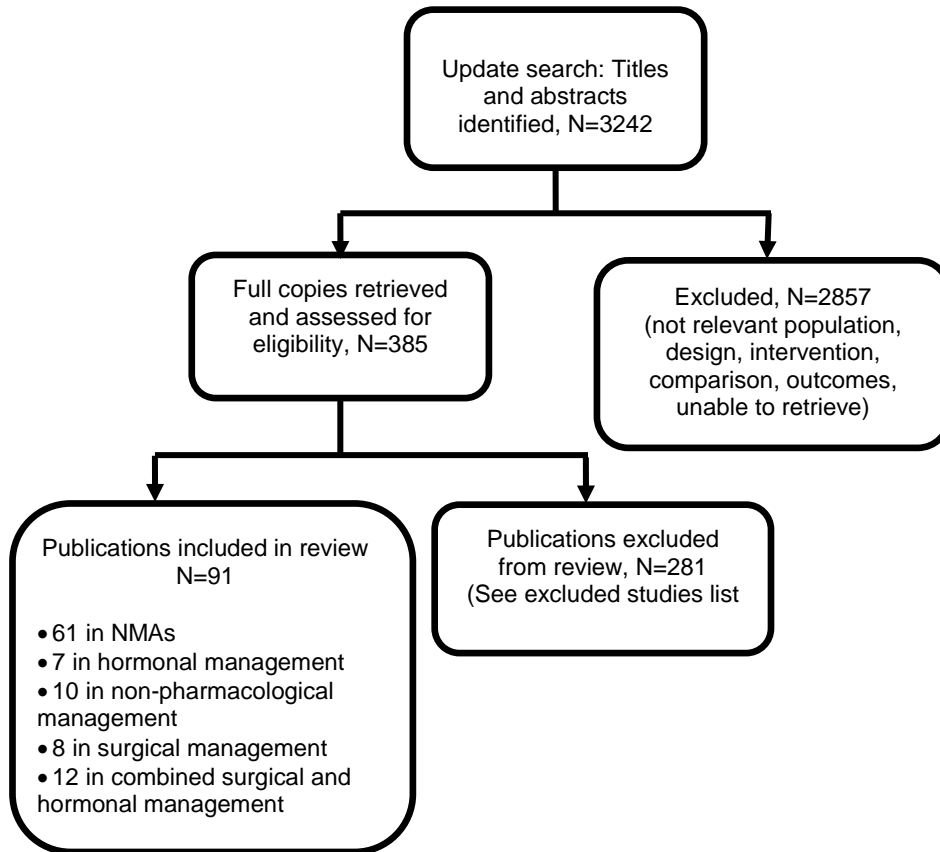
2 **Figure 14:** Flow diagram of clinical article selection for neuromodulators review



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**F.15** Pharmacological, non-pharmacological, surgical and combination management strategies (NMA and pairwise comparisons, and fertility (NMA))

**Figure 15:** Flow diagram of clinical article selection for pharmacological, non-pharmacological, surgical and combination management strategies review including NMA

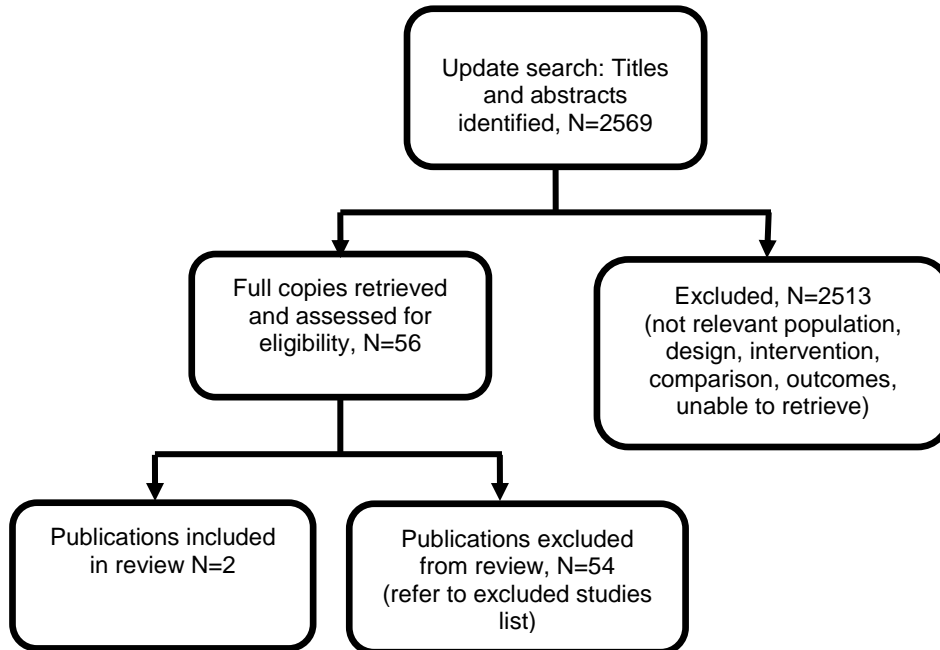


*Note:* Numbers of included studies for separate reviews do not add up to total number included as some studies were included in both NMAs and pairwise reviews

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## F.16 Hysterectomy with or without oophorectomy

2 **Figure 16:** Flow diagram of clinical article selection for hysterectomy with or  
3 without oophorectomy review

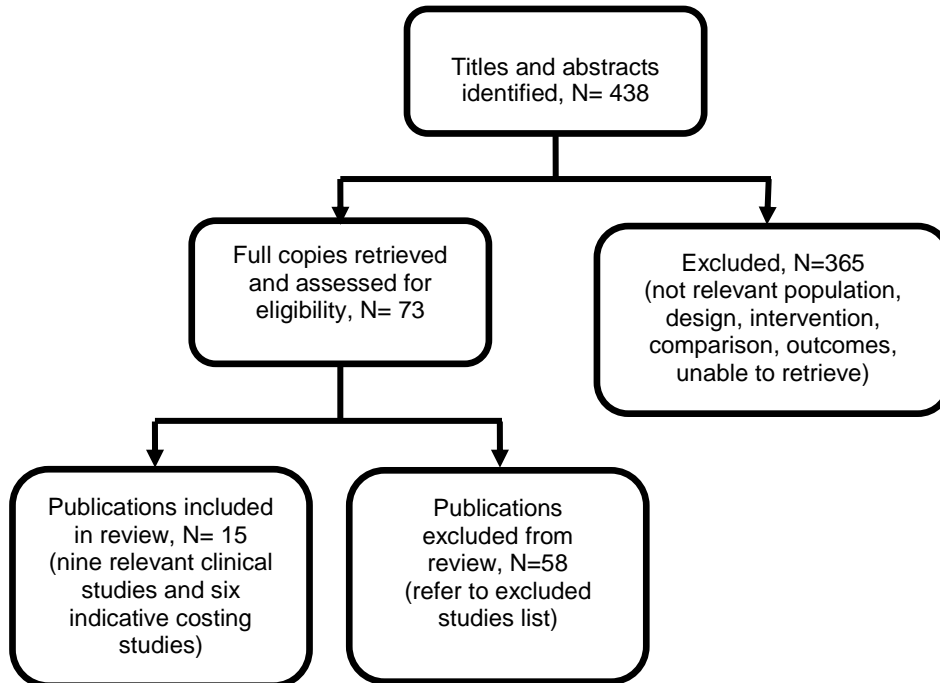


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## F.17 Management strategies to improve spontaneous pregnancy rates

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## F.18 Economic evidence



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# 1 Appendix H: Excluded studies

## H.1 Specialist services

Reference	Reason for exclusion
Bruen, L., Shacaluga, A., Penketh, R., Nurse-led self-referral service for women with endometriosis and pelvic pain, <i>Gynecological Surgery</i> , 8, S124, 2011	Insufficient information about services and comparison group. No publication identified.
Cambitzi, J., Nagaratnam, M., Endometriosis-associated pain syndrome: a nurse-led approach, <i>British Journal of Pain</i> , 7, 31-8, 2013	Narrative review
Dakkak, R., Rosenow, G., Von Kleinsorgen, C., Thiel-Moder, U., Papadopolous, T., Kruger, K., Liehr, M. R., Adam, U., Ebert, A. D., Establishment of endometriosis centers of excellence: Facts, problems and fiction, <i>Archives of Gynecology and Obstetrics</i> , 282, S176, 2010	Not enough information about data provided to analyse further
D'Hooghe, T., Hummelshoj, L., Multi-disciplinary centres/networks of excellence for endometriosis management and research: a proposal, <i>Human Reproduction</i> , 21, 2743-8, 2006	Narrative review
Ebert, A. D., Rosenow, G., Kruger, K., Liehr, R. M., Adam, U., Braunig, P., Haselmann, J., Freitag, A., Papadopolous, T., Von Kleinsorgen, C., Development of centres of excellence for endometriosis - The Berlin experiences, <i>Molecular Human Reproduction</i> , 24, i54-i55, 2009	Insufficient information regarding service, no comparator service
Ebert, A. D., Ulrich, U., Keckstein, J., Muller, M., Schindler, A. E., Sillem, M., Tinneberg, H. R., De Wilde, R. L., Schweppe, K. W., Endometriosis Research, Foundation, the European Endometriosis, League, Implementation of certified endometriosis centers: 5-year experience in German-speaking Europe, <i>Gynecologic &amp; Obstetric Investigation</i> , 76, 4-9, 2013	Narrative review
Greco, C. D., Management of adolescent chronic pelvic pain from endometriosis: a pain center perspective, <i>Journal of Pediatric &amp; Adolescent Gynecology</i> , 16, S17-9, 2003	Narrative review
Hogg, S., Vyas, S., Endometriosis, <i>Obstetrics, Gynaecology and Reproductive Medicine</i> , 25, 133-141, 2015	Narrative review
Lasmar, R. B., Lasmar, B. P., Keller Celeste, R., Larbig, A., De Wilde, R. L., Validation of a score to guide endometriosis therapy for the non-specialized gynecologist, <i>International Journal of Gynecology and Obstetrics</i> , 131, 78-81, 2015	The intervention is a tool, not a specialist service
Marqueta, L., Munoz, L., Tejerizo, A., Lopez, G., Lorenzo, E., Munoz, J. L., Jimenez, J. S., Multidisciplinary approach in the management of deep infiltrating endometriosis. 5 years follow up, <i>Journal of Minimally Invasive Gynecology</i> , 1), S126, 2012	No comparator group; insufficient information regarding service.
Metzger, D.A., Treating endometriosis pain: A multidisciplinary approach, <i>Seminars in Reproductive Endocrinology</i> , 15, 245-250, 1997	Narrative review
Moura, A. P. C., Nogueira, L. A. A., Demystifying the exam for the detection of deep endometriosis-5 step approach for non-specialists, <i>Ultrasound in Medicine and Biology</i> , 1), S36, 2013	Intervention was ultrasonography, not specialist service.

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## H.2 Timing of interventions: association between duration of symptoms before laparoscopy and treatment outcomes

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Reference	Reason for exclusion
Abbott, J., Hawe, J., Hunter, D., Holmes, M., Finn, P., Garry, R., Laparoscopic excision of endometriosis: a randomized, placebo-controlled trial, <i>Fertility &amp; Sterility</i> , 82, 878-84, 2004	There was no information regarding duration of symptoms of the women included in the study
Jia,S.Z., Leng,J.H., Shi,J.H., Sun,P.R., Lang,J.H., Health-related quality of life in women with endometriosis: A systematic review, <i>Journal of Ovarian Research</i> , 5, -, 2012	The topic of the systematic review does not include duration of symptoms associated with laparoscopy

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## H.3 Signs and symptoms of endometriosis (monitoring and referral)

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Study	Reason for Exclusion
Adamson, G. D., Diagnosis and clinical presentation of endometriosis, <i>American Journal of Obstetrics &amp; Gynecology</i> , 162, 568-9, 1990	A narrative paper; an opinion
Anonymous, Risk factors for pelvic endometriosis in women with pelvic pain or infertility. Gruppo Italiano per lo Studio dell' endometriosi, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 83, 195-9, 1999	Analysis does not look at any of the protocol's listed factors; no comparison between pelvic pain and infertility, just trends in each group
Apostolopoulos, N. V., Alexandraki, K. I., Gorry, A., Coker, A., Association between chronic pelvic pain symptoms and the presence of endometriosis, <i>Archives of gynecology and obstetrics</i> , 293, 439-445, 2016	No adjustment
Bai, S. W., Cho, H. J., Kim, J. Y., Jeong, K. A., Kim, S. K., Cho, D. J., Song, C. H., Park, K. H., Endometriosis in an adolescent population: the severance hospital in Korean experience, <i>Yonsei Medical Journal</i> , 43, 48-52, 2002	No adjusted analysis, just descriptive
Ballard, K. D., Seaman, H. E., De Vries, C. S., Wright, J. T., Can symptomatology help in the diagnosis of endometriosis? Findings from a national case-control study - Part 1, <i>BJOG: An International Journal of Obstetrics and Gynaecology</i> , 115, 1382-1391, 2008	Diagnosed not suspected endometriosis
Ballard, K., Lane, H., Hudelist, G., Banerjee, S., Wright, J., Can specific pain symptoms help in the diagnosis of endometriosis? A cohort study of women with chronic pelvic pain, <i>Fertility &amp; Sterility</i> , 94, 20-7, 2010	No adjusted analysis; pain intensity and not "cyclical/non-cyclical" pain as in protocol
Barcellos, M. B., Lasmar, B., Lasmar, R., Agreement between the preoperative findings and the operative diagnosis in patients with deep endometriosis, <i>Archives of Gynecology &amp; Obstetrics Arch Gynecol Obstet</i> , 293, 845-50, 2016	Not relevant to the PICO question

Study	Reason for Exclusion
Becker, C., Diagnosis and management of endometriosis, <i>Prescriber</i> , 26, 17-21, 2015	A narrative review
Bell, J. S., Endometriosis. Will identifying risk factors enable an early diagnosis?, <i>Australian Family Physician</i> , 30, 649-53, 2001	Narrative review
Brown, Julie, Kives, Sari, Akhtar, Muhammad, Progestagens and anti-progestagens for pain associated with endometriosis, <i>Cochrane Database of Systematic Reviews</i> , 2012	No investigation of sign and symptoms
Buck Louis, G. M., Backonja, U., Schliep, K. C., Sun, L., Peterson, C. M., Chen, Z., Women's Reproductive History Before the Diagnosis of Incident Endometriosis, <i>Journal of Women's Health</i> , 25, 1021-1029, 2016	No investigation of signs/symptoms
Carneiro, M. M., Filogonio, I. D. D. S., Costa, L. M. P., De Avila, I., Ferreira, M. C., Accuracy of clinical signs and symptoms in the diagnosis of endometriosis, <i>Journal of Endometriosis</i> , 2, 63-70, 2010	A narrative review/opinion
Chapron, C., Borghese, B., Streuli, I., de Ziegler, D., Markers of adult endometriosis detectable in adolescence, <i>Journal of Pediatric &amp; Adolescent Gynecology</i> , 24, S7-12, 2011	A clinical narrative paper about management of endometriosis
Cheewadhanaraks, S., Peeyananjarassri, K., Dhanaworavibul, K., Liabsuetrakul, T., Positive predictive value of clinical diagnosis of endometriosis, <i>Journal of the Medical Association of Thailand</i> , 87, 740-4, 2004	The study was not a prognostic study design
Farland, L. V., Tamimi, R. M., Eliassen, A. H., Spiegelman, D., Collins, L. C., Schnitt, S. J., Missmer, S. A., A prospective study of endometriosis and risk of benign breast disease, <i>Breast Cancer Research &amp; Treatment</i> , 159, 545-52, 2016	Not relevant to the PICO question
Forman, R. G., Robinson, J. N., Mehta, Z., Barlow, D. H., Patient history as a simple predictor of pelvic pathology in subfertile women, <i>Human Reproduction</i> , 8, 53-5, 1993	Not entirely clear if RR is adjusted
Fraser, I. A., Recognising, understanding and managing endometriosis, <i>Medicine Today</i> , 9, 31-41, 2008	Narrative review
Fraser, I. S., Recognising, understanding and managing endometriosis, <i>Journal of Human Reproductive Sciences</i> , 1, 56-64, 2008	A narrative review
French, L., Dysmenorrhea in adolescents: diagnosis and treatment, <i>Paediatric Drugs</i> , 10, 1-7, 2008	Narrative review
Galle, P. C., Clinical presentation and diagnosis of endometriosis, <i>Obstetrics &amp; Gynecology Clinics of North America</i> , 16, 29-42, 1989	A narrative paper
Garad, R., Vancaillie, T. G., Farrell, E., Pelvic pain: a diagnosis in itself, <i>Australian Nursing &amp; Midwifery Journal</i> , 21, 36-9, 2013	A narrative review
Garry, R., Diagnosis of endometriosis and pelvic pain, <i>Fertility and sterility</i> , 86, 1307-1309, 2006	A narrative paper, an opinion

Study	Reason for Exclusion
Garry, R., The endometriosis syndromes: A clinical classification in the presence of aetiological confusion and therapeutic anarchy, <i>Human Reproduction</i> , 19, 760-768, 2004	A clinical paper
Ghazi, N., Arjmand, M., Akbari, Z., Mellati, A. O., Saheb-Kashaf, H., Zamani, Z., (1)H NMR-based metabolomics approaches as non-invasive tools for diagnosis of endometriosis, <i>International Journal of Reproductive BiomedicineInt</i> , 14, 1-8, 2016	No multivariate regression analysis
Griffiths, A. N., Koutsouridou, R. N., Penketh, R. J., Predicting the presence of rectovaginal endometriosis from the clinical history: a retrospective observational study, <i>Journal of Obstetrics &amp; Gynaecology</i> , 27, 493-5, 2007	No adjustment
Gruppo Italiano per lo Studio, dell'Endometriosi, Relationship between stage, site and morphological characteristics of pelvic endometriosis and pain, <i>Human Reproduction</i> , 16, 2668-71, 2001	A cross-sectional study
Gungor, T., Kanat-Pektas, M., Ozat, M., Zayifoglu Karaca, M., A systematic review: endometriosis presenting with ascites, <i>Archives of Gynecology &amp; Obstetrics</i> , 283, 513-8, 2011	Diagnosed endometriosis
Gupta, Devashana, Hull, Louise M., Fraser, Ian, Miller, Laura, Bossuyt, M. M. Patrick, Johnson, Neil, Nisenblat, Vicki, Endometrial biomarkers for the non-invasive diagnosis of endometriosis, <i>Cochrane Database of Systematic Reviews</i> , 2016	Not relevant to the PICO question
Halis, G., Mechsner, S., Ebert, A. D., The diagnosis and treatment of deep infiltrating endometriosis, <i>Deutsches Arzteblatt International</i> , 107, 446-55; quiz 456, 2010	A narrative review
Harrison, B. T., Mittal, K., Morphologic features suggestive of endometriosis in nondiagnostic peritoneal biopsies, <i>International Journal of Gynecological Pathology</i> , 34, 507-516, 2015	A study of morphologic and immunohistochemical features to improve diagnosis of endometriosis
Hassa, H., Tanir, H. M., Uray, M., Symptom distribution among infertile and fertile endometriosis cases with different stages and localisations, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 119, 82-6, 2005	A cross-sectional study
Hickey, M., Ballard, K., Farquhar, C., Endometriosis, <i>BMJ</i> , 348, g1752, 2014	Clinical (descriptive) review
Hickey, M., Balen, A., Menstrual disorders in adolescence: Investigation and management, <i>Human Reproduction Update</i> , 9, 493-504, 2003	A descriptive clinical paper, an opinion
Hurd, W. W., Criteria that indicate endometriosis is the cause of chronic pelvic pain, <i>Obstetrics and gynecology</i> , 92, 1029-1032, 1998	A clinical opinion
Hurd, W. W., Rothenberg, J. M., Schilder, J. M., Hurteau, J. A., Rogers, R. E., Chronic pelvic pain and endometriosis, <i>Contemporary Reviews</i>	A clinical narrative paper, an opinion

Study	Reason for Exclusion
in Obstetrics and Gynaecology, 11, 289-295, 1999	
Hwang, S. M., Lee, C. W., Lee, B. S., Park, J. H., Clinical features of thoracic endometriosis: A single center analysis, Obstetrics & Gynecology Science, 58, 223-31, 2015	Thoracic endometriosis
Jansen, R. P., Endometriosis symptoms and the limitations of pathology-based classification of severity, International Journal of Gynaecology & Obstetrics, 40 Suppl, S3-7, 1993	A descriptive study, an opinion
Jones, G. T., Psychosocial Vulnerability and Early Life Adversity as Risk Factors for Central Sensitivity Syndromes, Current Rheumatology Reviews, 12, 140-53, 2016	Not relevant to the PICO question
Joseph, J., Sahn, S. A., Thoracic endometriosis syndrome: New observations from an analysis of 110 cases, American Journal of Medicine, 100, 164-170, 1996	Thoracic endometriosis
Khetan, N., Torkington, J., Watkin, A., Jamison, M. H., Humphreys, W. V., Endometriosis: presentation to general surgeons, Annals of the Royal College of Surgeons of England, 81, 255-9, 1999	Pathologically confirmed and not suspected endometriosis
Kirkegaard, K., Sundvall, L., Erlandsen, M., Hindkjaer, J. J., Knudsen, U. B., Ingerslev, H. J., Timing of human preimplantation embryonic development is confounded by embryo origin, Human ReproductionHum Reprod, 31, 324-331, 2015	No endometriosis
Klein, S., D'Hooghe, T., Meuleman, C., Dirksen, C., Dunselman, G., Simoens, S., What is the societal burden of endometriosis-associated symptoms? a prospective Belgian study, Reproductive Biomedicine Online, 28, 116-24, 2014	A cost-off-illness study
Kumar, V., Khan, M., Vilos, G. A., Sharma, V., Revisiting the association between endometriosis and bipolar disorder, Journal of Obstetrics & Gynaecology Canada: JOGC, 33, 1141-5, 2011	Not the review question; a cross-sectional study
Kuohung, W., Jones, G. L., Vitonis, A. F., Cramer, D. W., Kennedy, S. H., Thomas, D., Hornstein, M. D., Characteristics of patients with endometriosis in the United States and the United Kingdom, Fertility & Sterility, 78, 767-72, 2002	Confirmed and not suspected endometriosis
Laufer, M. R., Sanfilippo, J., Rose, G., Adolescent endometriosis: diagnosis and treatment approaches, Journal of Pediatric & Adolescent Gynecology, 16, S3-11, 2003	A narrative paper; an opinion about diagnosis and treatment of endometriosis
Lemaire, G. S., More than just menstrual cramps: symptoms and uncertainty among women with endometriosis, JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing, 33, 71-9, 2004	A cross-sectional study

Study	Reason for Exclusion
Liu, Emily, Nisenblat, Vicki, Farquhar, Cindy, Fraser, Ian, Bossuyt, M. M. Patrick, Johnson, Neil, Hull, Louise M., Urinary biomarkers for the non-invasive diagnosis of endometriosis, Cochrane Database of Systematic Reviews, 2015	Not relevant to the PICO question
Liu, X., Guo, S. W., Dysmenorrhea: risk factors in women with endometriosis, Women's health, 4, 399-411, 2008	Not a systematic review management of disease
Lorenatto, C., Petta, C. A., Navarro, M. J., Bahamondes, L., Matos, A., Depression in women with endometriosis with and without chronic pelvic pain, Acta Obstetrica et Gynecologica Scandinavica, 85, 88-92, 2006	Not suspected endometriosis; a cross-sectional study
Lu, Donghao, Song, Huan, Li, Yalun, Clarke, Jane, Shi, Gang, Pentoxifylline for endometriosis, Cochrane Database of Systematic Reviews, -, 2012	Not relevant to the PICO question
Luciano, D.E., Luciano, A.A., Management of endometriosis-related pain: An update, Women's health, 7, 585-590, 2011	Narrative review
Luscombe, G. M., Markham, R., Judio, M., Grigoriu, A., Fraser, I. S., Abdominal bloating: an under-recognized endometriosis symptom, Journal of Obstetrics & Gynaecology Canada: JOGC, 31, 1159-71, 2009	Women with diagnosed and not suspected endometriosis
Mahmood, T. A., Templeton, A., Pathophysiology of mild endometriosis: review of literature, Human Reproduction, 5, 765-84, 1990	A narrative review
Majak, P., Langebrekke, A., Hagen, O. M., Qvigstad, E., Catamenial pneumothorax, clinical manifestations: A multidisciplinary challenge, Pneumologia i Alergologia Polska, 79, 347-350, 2011	Pleural endometriosis (not in the protocol); n=9 -> case reports?
Majmudar, T., Abdel-Rahman, H., Pelvic mass - diagnosis and management, Obstetrics, Gynaecology and Reproductive Medicine, 18, 193-198, 2008	A clinical narrative paper
Manta, L., Suci, N., Constantin, A., Toader, O., Popa, F., Focal adenomyosis (intramural endometriotic cyst) in a very young patient - differential diagnosis with uterine fibromatosis, Journal of Medicine & Life, 9, 180-2, 2016	Not relevant to the PICO question
Maroun, P., Cooper, M. J., Reid, G. D., Keirse, M. J., Relevance of gastrointestinal symptoms in endometriosis, Australian & New Zealand Journal of Obstetrics & Gynaecology, 49, 411-4, 2009	No adjusted analysis, just a descriptive analysis
Matorras, R., Rodriguez, F., Pijoan, J. I., Soto, E., Perez, C., Ramon, O., Rodriguez-Escudero, F., Are there any clinical signs and symptoms that are related to endometriosis in infertile women?, American Journal of Obstetrics & Gynecology, 174, 620-3, 1996	Analysis adjusted for the total number of infertile patients; Not the confounder of interest

Study	Reason for Exclusion
Menakaya, U., Lu, C., Infante, F., Lam, A., Condous, G., Relating historical variables at first presentation with operative findings at laparoscopy for endometriosis, Australian & New Zealand Journal of Obstetrics & Gynaecology, 54, 480-6, 2014	Not adjusted
Mishra, V. V., Gaddagi, R. A., Aggarwal, R., Choudhary, S., Sharma, U., Patel, U., Prevalence; Characteristics and Management of Endometriosis Amongst Infertile Women: A One Year Retrospective Study, Journal of Clinical and Diagnostic Research JCDR, 9, QC01-3, 2015	Not adjusted
Murphy, A. A., Clinical aspects of endometriosis, Annals of the New York Academy of Sciences, 955, 1-10, 2002	Narrative review
Muse, K., Clinical manifestations and classification of endometriosis, Clinical Obstetrics & Gynecology, 31, 813-22, 1988	A clinical narrative paper, an opinion
Nisenblat, Vicki, Bossuyt, M. M. Patrick, Farquhar, Cindy, Johnson, Neil, Hull, Louise M., Imaging modalities for the non-invasive diagnosis of endometriosis, Cochrane Database of Systematic Reviews, 2016	Not relevant to the PICO question
Nisenblat, Vicki, Bossuyt, M. M. Patrick, Shaikh, Rabia, Farquhar, Cindy, Jordan, Vanessa, Scheffers, Carola S., Mol, Willem Ben, Johnson, Neil, Hull, Louise M., Blood biomarkers for the non-invasive diagnosis of endometriosis, Cochrane Database of Systematic Reviews, 2016	Not relevant to the PICO question
Nisenblat, Vicki, Prentice, Lucy, Bossuyt, M. M. Patrick, Farquhar, Cindy, Hull, Louise M., Johnson, Neil, Combination of the non-invasive tests for the diagnosis of endometriosis, Cochrane Database of Systematic Reviews, 2016	Not relevant to the PICO question
Osayande, A. S., Mehulic, S., Diagnosis and initial management of dysmenorrhea, American Family Physician, 89, 341-346, 2014	A narrative review
Pagliardini, L., Vigano, P., Molgora, M., Persico, P., Salonia, A., Vailati, S. H., Paffoni, A., Somigliana, E., Papaleo, E., Candiani, M., High Prevalence of Vitamin D Deficiency in Infertile Women Referring for Assisted Reproduction, Nutrients, 7, 9972-84, 2015	No study design
Petta, C. A., Matos, A. M., Bahamondes, L., Faundes, D., Current practice in the management of symptoms of endometriosis: a survey of Brazilian gynecologists, Revista Da Associacao Medica Brasileira, 53, 525-9, 2007	A cross-sectional study
Pope, C. J., Sharma, V., Sharma, S., Mazmanian, D., A Systematic Review of the Association Between Psychiatric Disturbances and Endometriosis, Journal of Obstetrics & Gynaecology Canada: JOGC, 37, 1006-15, 2015	Not relevant to the PICO question

Study	Reason for Exclusion
Porpora, M. G., Koninckx, P. R., Piazze, J., Natili, M., Colagrande, S., Cosmi, E. V., Correlation between endometriosis and pelvic pain, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 6, 429-434, 1999	Biopsy proven and not suspected endometriosis
Ripps, B. A., Martin, D. C., Focal pelvic tenderness, pelvic pain and dysmenorrhea in endometriosis, <i>Journal of Reproductive Medicine</i> , 36, 470-2, 1991	No adjusted analysis, just a descriptive analysis
Signorile, P. G., Baldi, A., New evidence in endometriosis, <i>International Journal of Biochemistry &amp; Cell Biology</i> , 60, 19-22, 2015	Pathogenesis of endometriosis
Skoog, S. M., Foxx-Orenstein, A. E., Levy, M. J., Rajan, E., Session, D. R., Intestinal endometriosis: the great masquerader, <i>Current Gastroenterology Reports</i> , 6, 405-9, 2004	A case study of 2 patients
Smorgick, N., Marsh, C. A., As-Sanie, S., Smith, Y. R., Quint, E. H., Prevalence of pain syndromes, mood conditions, and asthma in adolescents and young women with endometriosis, <i>Journal of Pediatric &amp; Adolescent Gynecology</i> , 26, 171-5, 2013	Women with diagnosed endometriosis; not suspected
Steed, H., Chapman, W., Laframboise, S., Endometriosis-associated ovarian cancer: a clinicopathologic review, <i>Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC</i> , 26, 709-715, 2004	nNt relevant to the PICO question
Steenberg, C. K., Tanbo, T. G., Qvigstad, E., Endometriosis in adolescence: predictive markers and management, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 92, 491-5, 2013	A narrative paper; an opinion
Stovner, L. J., Aegidius, K., Linde, M., Endometriosis and headache, <i>Current Pain &amp; Headache Reports</i> , 15, 415-9, 2011	A narrative review
Tan-Kim, J., Menefee, S. A., Reinsch, C. S., O'Day, C. H., Bebchuk, J., Kennedy, J. S., Whitcomb, E. L., Laparoscopic Hysterectomy and Urinary Tract Injury: Experience in a Health Maintenance Organization, <i>Journal of Minimally Invasive Gynecology</i> , 22, 1278-86, 2015	Not relevant to the PICO question
Tervila, L., Marttila, P., Headache as a symptom of endometriosis externa, <i>Annales Chirurgiae et Gynaecologiae Fenniae</i> , 64, 239-41, 1975	Not suspected endometriosis
Tietjen, G. E., Conway, A., Utley, C., Gunning, W. T., Herial, N. A., Migraine is associated with menorrhagia and endometriosis, <i>Headache</i> , 46, 422-428, 2006	Women with a migraine and not suspected endometriosis
Toor, K., Wessels, J. M., Agarwal, S. K., Leyland, N., Foster, W. G., Clinical markers of endometriosis: have we been too quick to judge?, <i>Medical Hypotheses</i> , 82, 493-501, 2014	Systematic review reports on biomarkers for correlation of endometriosis, not prognostic factors
Vercellini, P., Bracco, B., Mosconi, P., Roberto, A., Alberico, D., Dhouha, D., Somigliana, E., Norethindrone acetate or dienogest for the treatment of symptomatic endometriosis: a	Not relevant to the PICO question



Study	Reason for Exclusion
before and after study, Fertility & Sterility/Fertil Steril, 105, 734-43.e3, 2016	
Vercellini, P., De Giorgi, O., Aimi, G., Panazza, S., Uglietti, A., Crosignani, P. G., Menstrual characteristics in women with and without endometriosis, Obstetrics & Gynecology, 90, 264-8, 1997	No adjusted analysis, just a descriptive analysis
Vercellini, P., Giudice, L. C., Evers, J. L., Abrao, M. S., Reducing low-value care in endometriosis between limited evidence and unresolved issues: a proposal, Human Reproduction, 30, 1996-2004, 2015	Not relevant to the PICO question
Waller, K. G., Shaw, R. W., Risk factors for endometriosis: Menstrual and life-style characteristics, Medical Principles and Practice, 7, 127-133, 1998	Confirmed and not suspected endometriosis
Wilson, A. L., Endometriosis. A common cause of infertility and pelvic pain, JAAPA, 16, 20-3, 2003	A narrative paper; an opinion
Yeungr, P., Bazinet, C., Gavard, J. A., Development of a symptom-based, Screening tool for early-stage endometriosis in patients with chronic pelvic pain, Journal of Endometriosis and Pelvic Pain Disorders, 6, 174-189, 2014	The authors report combining variables in the analysis to gain statistical significance
Zannoni, L., Forno, S. D., Paradisi, R., Seracchioli, R., Endometriosis in Adolescence: Practical Rules for an Earlier Diagnosis, Pediatric Annals, 45, e332-5, 2016	No study design
Zannoni, L., Giorgi, M., Spagnolo, E., Montanari, G., Villa, G., Seracchioli, R., Dysmenorrhea, absenteeism from school, and symptoms suspicious for endometriosis in adolescents, Journal of Pediatric & Adolescent Gynecology, 27, 258-65, 2014	Cross-sectional study design
Zondervan, K. T., Sivananthan, S., Nnoaham, K. E., Hummelshoj, L., Jenkinson, C., Webster, P., Kennedy, S. H., Susceptibility and risk factors for developing endometriosis: A diagnostic aid, International Journal of Gynecology and Obstetrics, 107, S92, 2009	Unavailable
Zondervan, K. T., Yudkin, P. L., Vessey, M. P., Dawes, M. G., Barlow, D. H., Kennedy, S. H., Patterns of diagnosis and referral in women consulting for chronic pelvic pain in UK primary care, British Journal of Obstetrics & Gynaecology, 106, 1156-61, 1999	Incidence of chronic pelvic pain

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## H.4 Information and support

Study	Reason for Exclusion
American Academy of Family Physicians, Information from your family doctor. Endometriosis:	Leaflet on endometriosis

Study	Reason for Exclusion
what you should know, American Family Physician, 74, 601-2, 2006	
Anonymous,, Patient information. Endometriosis: what it is and how it is treated.[Original report in Cleve Clin J Med. 2002 Aug;69(8):647-53; PMID: 12184473], Cleveland Clinic Journal of Medicine, 69, 654, 2002	Leaflet on endometriosis
Anonymous,, Endometriosis resources, Nursing, 45, 68, 2015	Tools for health care professionals to give/explain information on endometriosis to women
Aragao, L. C., Liberman, D., Guerra, C. G., Sessa, F. V., Rodrigues, M. A., Costa, M. F., Crispi, C. P., Fonseca, M. F., Quality of life and deep infiltrating endometriosis: Worries about epidemiological quantitative studies using short form 36 and endometriosis health profile 30, Journal of Minimally Invasive Gynecology, 1), S98-S99, 2012	Conference abstract, the abstract refers to the problems of studies using SF36 and EHP30 tools
Ballweg, M. L., Campbell, P. F., Psychosocial aspects of teen endo, Journal of Pediatric & Adolescent Gynecology, 16, S13-5, 2003	Information already in included studies
Ballweg, ML, Endometriosis: the patient's perspective, Infertility and Reproductive Medicine Clinics of North America, 3, 747-761, 1992	Information already included from other studies
Barlow, D., Today's treatments: how do you choose?, International Journal of Gynaecology & Obstetrics, 64 Suppl 1, S15-21, 1999	Narrative
Barlow, J. H., Wright, C. C., Turner, A. P., Bancroft, G. V., A 12-month follow-up study of self-management training for people with chronic disease: are changes maintained over time?, British Journal of Health Psychology, 10, 589-99, 2005	Study did not fit the protocol criteria
Bauer, E., Widschwendter, P., Stuck, D., Gundelach, T., Wulff, C., Janni, W., Hancke, K., Endometriosis Health Profile scores and their association with surgical diagnosis in premenopausal women, Journal of Endometriosis, 5, S31-S32, 2013	Conference abstract
Brandes, I., Cluster analysis of endometriosis patients in an outpatient education programme, Archives of Gynecology and Obstetrics, 282, S174, 2010	Conference abstract refers to the development and implementation of an outpatient intervention
Brown, Kristina Schelbert, Dyspareunia due to endometriosis: A qualitative study of its effect on the couple relationship, Dissertation Abstracts International: Section B: The Sciences and Engineering, 68, 3387, 2007	Themes covered in the study already in other included studies
Campbell, P. F., Relieving endometriosis pain: why is it so tough?, Obstetrics & Gynecology Clinics of North America, 30, 209-20, 2003	No information on participants, narrative
Charnock, D., Shepperd, S., Needham, G., Gann, R., DISCERN: an instrument for judging the quality of written consumer health information on treatment choices, Journal of Epidemiology & Community Health, 53, 105-11, 1999	Validation tool not specific to endometriosis
Christian, A., The relationship between women's symptoms of endometriosis and self-esteem, Journal of obstetric, gynecologic, and neonatal nursing : JOGNN / NAACOG, 22, 370-376, 1993	Interventions not of interest

Study	Reason for Exclusion
Culley, L., Law, C., Hudson, N., Denny, E., Mitchell, H., Baumgarten, M., Raine-Fenning, N., The social and psychological impact of endometriosis on women's lives: a critical narrative review, Human Reproduction Update, 19, 625-39, 2013	Systematic review, individual studies checked for inclusion according to protocol
Culley, L., Nudson, N., Law, C., Denny, E., Mitchell, H., Baumgarten, M., Raine-Fenning, N., Pain management decisions amongst couples living with endometriosis, Journal of Endometriosis, 5, S21-S22, 2013	Conference abstract
Dancet, E. A. F., Apers, S., Kremer, J. A. M., Nelen, W. L. D. M., Sermeus, W., D'Hooghe, T. M., The patient-centeredness of endometriosis care and targets for improvement: A systematic review, Gynecologic and obstetric investigation, 78, 69-80, 2014	Systematic review, individual studies checked for inclusion according to protocol
Deal, L. S., Williams, V. S., DiBenedetti, D. B., Fehnel, S. E., Development and psychometric evaluation of the Endometriosis Treatment Satisfaction Questionnaire, Quality of Life Research, 19, 899-905, 2010	Account of the development of a questionnaire
Denny, E., 'You are one of the unlucky ones™': Delay in the diagnosis of endometriosis, Diversity in Health and Social Care, 1, 39-44, 2004	No available full text
Denny, E., Khan, K. S., Systematic reviews of qualitative evidence: what are the experiences of women with endometriosis?, Journal of Obstetrics & Gynaecology, 26, 501-6, 2006	Systematic review, individual studies checked for inclusion according to protocol
Denny, E., Mann, C. H., Endometriosis and the primary care consultation, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 139, 111-5, 2008	Themes in the study are covered by other included studies
Di Donato, N., Montanari, G., Benfenati, A., Leonardi, D., Bertoldo, V., Monti, G., Casadio, P., La Marca, A., Seracchioli, R., The impact of socioeconomic and anamnestic characteristics on quality of life and sexual function in women with endometriosis, Journal of Endometriosis and Pelvic Pain Disorders, 5, 159-165, 2013	No study design
Duffy, O., Iversen, L., Hannaford, P.C., The menopause 'It's somewhere between a taboo and a joke'. A focus group study, Climacteric, 14, 497-505, 2011	Topic out of scope
Dunselman, G., Vermeulen, N., Nap, A., The ESHRE's endometriosis app, based on ESHRE's 2013 guideline on the management of women with endometriosis, Human Reproduction, 29, i11-i12, 2014	Not information and support, this is a conference abstract referring to an application developed by ESHRE
Facchin, F., Barbara, G., Saita, E., Mosconi, P., Roberto, A., Fedele, L., Vercellini, P., Impact of endometriosis on quality of life and mental health: pelvic pain makes the difference, Journal of Psychosomatic Obstetrics & Gynecology, 36, 135-41, 2015	Study did not fit the protocol criteria
Fourquet, J., Gao, X., Zavala, D., Orengo, J. C., Abac, S., Ruiz, A., Laboy, J., Flores, I., Patients'	Survey, not information and support

Study	Reason for Exclusion
report on how endometriosis affects health, work, and daily life, <i>Fertility &amp; Sterility</i> , 93, 2424-8, 2010	
Fritzer, N., Haas, D., Oppelt, P., Renner, S., Hornung, D., Wolfler, M., Ulrich, U., Fischerlehner, G., Sillem, M., Hudelist, G., More than just bad sex: sexual dysfunction and distress in patients with endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 169, 392-6, 2013	Topic not of interest
Gherghe, M., Robert, H., David, Y., Christopher, H., The predictive value of endometriosis related information on the internet, <i>Gynecological Surgery</i> , 10, S37, 2013	Conference abstract, looks at the diagnostic value of websites to provide key information about endometriosis
Gould, D., Endometriosis, <i>Nursing Standard</i> , 17, 47-53; quiz 54-5, 2003	Leaflet that provides information on endometriosis for nurses
Haas, D., Wurm, P., Schimetta, W., Schabetsberger, K., Shamiyeh, A., Oppelt, P., Binder, H., Endometriosis patients in the postmenopausal period: pre- and postmenopausal factors influencing postmenopausal health, <i>BioMed Research International</i> , 2014, 746705, 2014	Population was postmenopausal women
Halpern, Vera, Lopez, Laureen M., Grimes, David A., Stockton, Laurie L., Gallo, Maria F., Strategies to improve adherence and acceptability of hormonal methods of contraception, <i>Cochrane Database of Systematic Reviews</i> , -, 2013	The systematic review investigates the role of client-provider interventions for women's adherence to hormonal treatment
Hirsh, K. W., Ladipo, O. A., Bhal, P. S., Shaw, R. W., The management of endometriosis: a survey of patients' aspirations, <i>Journal of Obstetrics &amp; Gynaecology</i> , 21, 500-3, 2001	Study focuses on the patients aspiration about a specialist endometriosis clinic
Hudson, N., Culley, L., Law, C., Denny, E., Mitchell, H., Baumgarten, M., Raine-Fenning, N., Improving the well being of couples living with endometriosis, <i>Human Reproduction</i> , 28, i281, 2013	Conference abstract, theme covered by other included studies
Hudson, N., Culley, L., Mitchell, H., Law, C., Denny, E., Raine-Fenning, N., Men living with endometriosis: Perceptions and experiences of male partners of women with the condition, <i>Human Reproduction</i> , 30, i35, 2015	Information from this study has been included from another conference abstract
Jacox, Cynthia Marlaine, Coping styles and psychological distress in women with endometriosis, <i>Dissertation Abstracts International: Section B: The Sciences and Engineering</i> , 56, 6394, 1996	Research abstract, original paper not found
Jones, K. P., Emotional aspects of endometriosis: a physician's perspective, <i>Clinical Obstetrics &amp; Gynecology</i> , 31, 874-82, 1988	Narrative
Karavadra, B., Simpson, P., Mullins, E., Prosser-Snellings, E., Morris, E., A mixed qualitative and quantitative analysis on the impact of endometriosis on women in the UK; a silent disease?, <i>BJOG: An International Journal of Obstetrics and Gynaecology</i> , 123, 56, 2016	Conference abstract
Kennedy, S., What is important to the patient with endometriosis?, <i>British Journal of Clinical Practice. Supplement</i> , 72, 8-10; discussion 11-3, 1991	No available full text

Study	Reason for Exclusion
Kilaru, A. S., Paciotti, B., Ha, Y., Ranard, B., Griffis, H., Merchant, R., What do patients say about emergency departments in online reviews?, <i>Annals of Emergency Medicine</i> , 1), S135, 2014	Topic not of interest
Kundu, S., Wildgrube, J., Schippert, C., Hillemanns, P., Brandes, I., Supporting and inhibiting factors when coping with endometriosis from the patients' perspective, <i>Geburtshilfe und Frauenheilkunde</i> , 75, 462-469, 2015	No available full text
Manderson, L., Warren, N., Markovic, M., Circuit breaking: pathways of treatment seeking for women with endometriosis in Australia, <i>Qualitative Health Research</i> , 18, 522-34, 2008	Themes in study covered by other included studies
Pope, C. J., Sharma, V., Sharma, S., Mazmanian, D., A Systematic Review of the Association Between Psychiatric Disturbances and Endometriosis, <i>Journal of Obstetrics &amp; Gynaecology Canada: JOGC</i> , 37, 1006-15, 2015	Study did not fit the protocol criteria
Quilliam, S., Endometriosis: the bloggers' tales, <i>Journal of Family Planning &amp; Reproductive Health Care</i> , 40, 142-4, 2014	Narrative review
Roman, H., Loisel, C., Resch, B., Tuech, J. J., Hochain, P., Leroi, A. M., Marpeau, L., Delayed functional outcomes associated with surgical management of deep rectovaginal endometriosis with rectal involvement: giving patients an informed choice, <i>Human Reproduction</i> , 25, 890-9, 2010	Outcomes not in protocol
Sahin, S., Beji, N. K., Assessment of quality of life of women with endometriosis, <i>Human Reproduction</i> , 27, 2012	Validation of EHP30 questionnaire into Turkish to assess QOL of women with endometriosis
Schenken, R. S., Delayed diagnosis of endometriosis, <i>Fertility and sterility</i> , 86, 1305-1306, 2006	Commentary on Ballard 2006 study
Sepulcri Rde, P., do Amaral, V. F., Depressive symptoms, anxiety, and quality of life in women with pelvic endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 142, 53-6, 2009	The study did not fit the protocol (no interventions)
Seyhan, A., Ata, B., Uncu, G., The Impact of Endometriosis and Its Treatment on Ovarian Reserve, <i>Seminars in Reproductive Medicine</i> , 33, 422-8, 2015	Study did not fit the protocol criteria
Shadbolt, N. A., Parker, M. A., Orthia, L. A., Communicating endometriosis with young women to decrease diagnosis time, <i>Health Promotion Journal of Australia</i> , 24, 151-4, 2013	Survey looked at women's knowledge of endometriosis rather than what they would find useful in terms of information and support
Shah, D. K., Moravek, M. B., Vahratian, A., Dalton, V. K., Lebovic, D. I., Public perceptions of endometriosis: perspectives from both genders, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 89, 646-50, 2010	Survey about endometriosis, not qualitative format
Soliman, A. M., Gooch, K. L., Winkel, C. A., Quality of life (QOL) in endometriosis patients and its correlation with symptomatic burden: A cross sectional survey among us women, <i>Endocrine Reviews. Conference: 96th Annual Meeting and Expo of the Endocrine Society, ENDO</i> , 35, 2014	Conference abstract

Study	Reason for Exclusion
Suchard, M. A., Hadfield, R., Elliott, T., Kennedy, S., Beyond providing information: the Internet as a research tool in reproductive medicine, <i>Human Reproduction</i> , 13, 6-7, 1998	Response of women to a website developed at Oxford University
Toye, F., Seers, K., Barker, K., A meta-ethnography of patients' experiences of chronic pelvic pain: struggling to construct chronic pelvic pain as 'real', <i>Journal of Advanced Nursing</i> , 70, 2713-27, 2014	Systematic review, individual studies already checked for inclusion according to protocol
Tripoli, T. M., Sato, H., Sartori, M. G., de Araujo, F. F., Girao, M. J., Schor, E., Evaluation of quality of life and sexual satisfaction in women suffering from chronic pelvic pain with or without endometriosis, <i>Journal of Sexual Medicine</i> , 8, 497-503, 2011	Study uses a questionnaire to look at quality of life and sexual satisfaction in women with endometriosis, not information and support
Turnbull, H., Mukhopadhyay, S., Morris, E., The effect of endometriosis on quality of life in patients with a diagnosis in their younger reproductive years, <i>International Journal of Gynecology and Obstetrics</i> , 107, S631, 2009	This was a response of women to a website developed by Oxford University
van de Burgt, T. J., Kluivers, K. B., Hendriks, J. C., Responsiveness of the Dutch Endometriosis Health Profile-30 (EHP-30) questionnaire, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 168, 92-4, 2013	Background information
Wang, C. Y., Coping with endometriosis, <i>Lancet</i> , 364, 1800, 2004	Personal account of a woman with endometriosis
Weinstein, K., The emotional aspects of endometriosis: what the patient expects from her doctor, <i>Clinical Obstetrics &amp; Gynecology</i> , 31, 866-73, 1988	Narrative review
Whitney, M. L., Importance of lay organizations for coping with endometriosis, <i>Journal of Reproductive Medicine</i> , 43, 331-4, 1998	Information already covered in included studies
Wingfield, M. B., Wood, C., Henderson, L. S., Wood, R. M., Treatment of endometriosis involving a self-help group positively affects patients' perception of care, <i>Journal of Psychosomatic Obstetrics &amp; Gynecology</i> , 18, 255-8, 1997	Target population not endometriosis
Wright, C. C., Barlow, J. H., Turner, A. P., Bancroft, G. V., Self-management training for people with chronic disease: an exploratory study, <i>British Journal of Health Psychology</i> , 8, 465-76, 2003	Only 10% of participants had endometriosis
Young-Lewis, L., Silverman, J., Endometriosis. Supportive care is essential, <i>Advance for Nurse Practitioners</i> , 9, 24-6, 29-30, 2001	No available full text
Yuzpe, A. A., Oral contraception: Trends over time, <i>Journal of Reproductive Medicine for the Obstetrician and Gynecologist</i> , 47, 967-973, 2002	Narrative review, not qualitative study

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## H.5 Risk of reproductive cancer

Reference	Reason for exclusion
Aure, J. C., Hoeg, K., Kolstad, P., Carcinoma of the ovary and endometriosis, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 50, 63-7, 1971	All have cancer
Borgfeldt, C., Andolf, E., Cancer risk after hospital discharge diagnosis of benign ovarian cysts and endometriosis, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 83, 395-400, 2004	Case control study
Bounous, V. E., Ferrero, A., Fuso, L., Ravarino, N., Ceccaroni, M., Menato, G., Biglia, N., Endometriosis-associated Ovarian Cancer: A Distinct Clinical Entity?, <i>Anticancer Research</i> , 36, 3445-9, 2016	Not adjusted or stratified for any of the confounders specified in the protocol
Devereux, W. P., Endometriosis: Long-Term Observation, with Particular Reference to Incidence of Pregnancy, <i>Obstetrics &amp; Gynecology</i> , 22, 444-50, 1963	Doesn't look at reproductive cancer prevalence.
Dinkelspiel, H. E., Matrai, C., Pauk, S., Pierre-Louis, A., Chiu, Y. L., Gupta, D., Caputo, T., Ellenson, L. H., Holcomb, K., Does the Presence of Endometriosis Affect Prognosis of Ovarian Cancer?, <i>Cancer Investigation</i> , 34, 148-54, 2016	Case-control study
Frick, H. C., 2nd, Munnell, E. W., Richart, R. M., Berger, A. P., Lawry, M. F., Carcinoma of the endometrium, <i>American Journal of Obstetrics &amp; Gynecology</i> , 115, 663-76, 1973	All have cancer
Gemmill, J. A., Stratton, P., Cleary, S. D., Ballweg, M. L., Sinaii, N., Cancers, infections, and endocrine diseases in women with endometriosis, <i>Fertility &amp; Sterility</i> , 94, 1627-31, 2010	Cross sectional study. All have endometriosis
Heidemann, L. N., Hartwell, D., Heidemann, C. H., Jochumsen, K. M., The relation between endometriosis and ovarian cancer - A review, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 93, 20-31, 2014	Does not meet protocol. Includes case control and cross sectional studies. Used as a check list.
Hollander, D., History of endometriosis places women at high risk of ovarian cancer, but pill use remains protective, <i>Perspectives on Sexual and Reproductive Health</i> , 37, 52, 2005	Summary of results from an excluded study (pooled case control)
Kim, H. S., Kim, T. H., Chung, H. H., Song, Y. S., Risk and prognosis of ovarian cancer in women with endometriosis: a meta-analysis, <i>British Journal of Cancer</i> , 110, 1878-90, 2014	Does not meet protocol inclusion criteria. Includes case control. Used as a check list.
Kontoravdis, A., Augoulea, A., Lambrinouadaki, I., Christodoulakos, G., Tzortziotis, D., Grammatikakis, I., Kontoravdis, N., Creatsas, G., Ovarian endometriosis associated with ovarian cancer and endometrial-endocervical polyps, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 33, 294-8, 2007	Cross sectional study, no comparator
Kvaskoff, M., Mu, F., Terry, K. L., Harris, H. R., Poole, E. M., Farland, L., Missmer, S. A., Endometriosis: a high-risk population for major chronic diseases?, <i>Human Reproduction Update</i> , 21, 500-16, 2015	Does not match protocol. Unclear inclusion/exclusion criteria. All study types are included.
Matalliotakis, I. M., Cakmak, H., Krasonikolakis, G. D., Dermitzaki, D., Fragouli, Y., Vlastos, G., Arici, A., Endometriosis related to family history of malignancies in the Yale series, <i>Surgical Oncology</i> , 19, 33-7, 2010	Only looks at family history of cancer

Reference	Reason for exclusion
Ness, R., Pearce, C., Stram, D., Berchuck, A., Pike, M., Pharoah, P., LIFETIME RISK OF OVARIAN CANCER BASED ON ENDOMETRIOSIS AND OTHER RISK FACTORS: IGCS-0014 06. Ovarian Cancer, International Journal of Gynecological Cancer, 25 Suppl 1, 50, 2015	Case control meta-analysis
Nishida, M., Watanabe, K., Sato, N., Ichikawa, Y., Malignant transformation of ovarian endometriosis, Gynecologic & Obstetric Investigation, 50 Suppl 1, 18-25, 2000	Cross sectional study, no comparator
Nomellini, R. S., Ferreira, F. A., Borges, R. C., Adad, S. J., Murta, E. F., Frequency of endometriosis and adenomyosis in patients with leiomyomas, gynecologic premalignant, and malignant neoplasias, Clinical & Experimental Obstetrics & Gynecology, 40, 40-4, 2013	All have cancer
Olson, J. E., Cerhan, J. R., Janney, C. A., Anderson, K. E., Vachon, C. M., Sellers, T. A., Postmenopausal cancer risk after self-reported endometriosis diagnosis in the Iowa Women's Health Study, Cancer, 94, 1612-1618, 2002	Post-menopausal women population. Self-reported endo dx.
Szubert, M., Suzin, J., Obirek, K., Sochacka, A., Loszakiewicz, M., Clear cell ovarian cancer and endometriosis: Is there a relationship?, Przegląd Menopauzalny, 15, 85-89, 2016	Descriptive data
Yoshikawa, H., Jimbo, H., Okada, S., Matsumoto, K., Onda, T., Yasugi, T., Taketani, Y., Prevalence of endometriosis in ovarian cancer, Gynecologic and Obstetric Investigation, 50, 11-17, 2000	No methods listed. Not a Systematic Review. Looks at % of ovarian cancer have endometriosis.
Zafrakas, M., Grimbizis, G., Timologou, A., Tarlatzis, B. C., Endometriosis and ovarian cancer risk: a systematic review of epidemiological studies, Frontiers in Surgery, 1, 14, 2014	Does not meet protocol. Includes case control and cross sectional studies. Used as a check list.
Zanetta, G. M., Webb, M. J., Li, H., Keeney, G. L., Hyperestrogenism: A relevant risk factor for the development of cancer from endometriosis, Gynecologic Oncology, 79, 18-22, 2000	Wrong population comparison. Unable to calculate prevalence.

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## H.6 Diagnosis – Ultrasound

Study	Reason for Exclusion
Abrao, M. S., Goncalves, M. O., Dias, J. A., Jr., Podgaec, S., Chamie, L. P., Blasbalg, R., Comparison between clinical examination, transvaginal sonography and magnetic resonance imaging for the diagnosis of deep endometriosis, Human Reproduction, 22, 3092-7, 2007	Included as one of the studies in the Nisenblat 2016 review
Abrao, M. S., Podgaec, S., Filho, B. M., Ramos, L. O., Pinotti, J. A., de Oliveira, R. M., The use of biochemical markers in the diagnosis of pelvic endometriosis, Human Reproduction, 12, 2523-7, 1997	Case-control stud



Study	Reason for Exclusion
Abrao, M. S., Podgaec, S., Pinotti, J. A., de Oliveira, R. M., Tumor markers in endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 66, 19-22, 1999	Case-control study
Acimovic, M., Vidakovic, S., Milic, N., Jeremic, K., Markovic, M., Milosevic-Djeric, A., Lazovic-Radonjic, G., Survivin and Vegf as Novel Biomarkers in Diagnosis of Endometriosis, <i>Journal of Medical Biochemistry</i> , 35, 63-68, 2016	No laparoscopy/ laparotomy and no histological confirmation
Alcazar, J. L., Laparte, C., Jurado, M., Lopez-Garcia, G., The role of transvaginal ultrasonography combined with color velocity imaging and pulsed Doppler in the diagnosis of endometrioma, <i>Fertility &amp; Sterility</i> , 67, 487-91, 1997	Postmenopausal women, analysis included number of lesions, not number of participants
Aleem, F., Pennisi, J., Zeitoun, K., Predanic, M., The role of color Doppler in diagnosis of endometriomas, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 5, 51-4, 1995	The aim of this study is to describe vascular appearance in endometriomas. No outcome of interest.
Anaf, V., El Nakadi, I., De Moor, V., Coppens, E., Zalcman, M., Noel, J. C., Anatomic significance of a positive barium enema in deep infiltrating endometriosis of the large bowel, <i>World Journal of Surgery</i> , 33, 822-7, 2009	All patients had surgery and DCBE
Balasch, J., Creus, M., Fabregues, F., Carmona, F., Ordi, J., Martinez-Roman, S., Vanrell, J. A., Visible and non-visible endometriosis at laparoscopy in fertile and infertile women and in patients with chronic pelvic pain: a prospective study, <i>Human Reproduction</i> , 11, 387-91, 1996	Not a diagnostic study
Balleyguier, C., Roupert, M., Nguyen, T., Kinkel, K., Helenon, O., Chapron, C., Ureteral endometriosis: the role of magnetic resonance imaging, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 11, 530-6, 2004	No outcome of interest. Moreover, only 6 patients were included.
Barcellos, M. B., Lasmar, B., Lasmar, R., Agreement between the preoperative findings and the operative diagnosis in patients with deep endometriosis, <i>Archives of Gynecology &amp; Obstetrics</i> Arch Gynecol Obstet, 293, 845-50, 2016	Lesion-level analysis
Bazot, M., Detchev, R., Cortez, A., Amouyal, P., Uzan, S., Darai, E., Transvaginal sonography and rectal endoscopic sonography for the assessment of pelvic endometriosis: a preliminary comparison, <i>Human Reproduction</i> , 18, 1686-92, 2003	Population overlap with Bazot 2009
Bazot, M., Gasner, A., Ballester, M., Darai, E., Value of thin-section oblique axial T2-weighted magnetic resonance images to assess uterosacral ligament endometriosis, <i>Human Reproduction</i> , 26, 346-53, 2011	Retrospective study; one MRI technique compared to conventional technique
Bazot, M., Gasner, A., Lafont, C., Ballester, M., Darai, E., Deep pelvic endometriosis: limited additional diagnostic value of postcontrast in comparison with conventional MR images,	Retrospective study; comparison of post-contrast MRI versus conventional MRI

Study	Reason for Exclusion
European Journal of Radiology, 80, e331-9, 2011	
Bazot, M., Lafont, C., Rouzier, R., Roseau, G., Thomassin-Naggara, I., Darai, E., Diagnostic accuracy of physical examination, transvaginal sonography, rectal endoscopic sonography, and magnetic resonance imaging to diagnose deep infiltrating endometriosis, Fertility & Sterility, 92, 1825-33, 2009	Included as one of the studies in the Nisenblat 2016 review
Bazot, M., Malzy, P., Cortez, A., Roseau, G., Amouyal, P., Darai, E., Accuracy of transvaginal sonography and rectal endoscopic sonography in the diagnosis of deep infiltrating endometriosis, Ultrasound in Obstetrics & Gynecology, 30, 994-1001, 2007	Population overlap with Bazot 2009
Bazot, M., Stivalet, A., Darai, E., Coudray, C., Thomassin-Naggara, I., Poncelet, E., Comparison of 3D and 2D FSE T2-weighted MRI in the diagnosis of deep pelvic endometriosis: preliminary results, Clinical Radiology, 68, 47-54, 2013	Included in MRI review
Bazot, M., Thomassin, I., Hourani, R., Cortez, A., Darai, E., Diagnostic accuracy of transvaginal sonography for deep pelvic endometriosis, Ultrasound in Obstetrics & Gynecology, 24, 180-5, 2004	Population overlap with Bazot 2009
Bedaiwy, M. A., Falcone, T., Laboratory testing for endometriosis, Clinica Chimica Acta, 340, 41-56, 2004	Narrative review
Bedaiwy, M. A., Falcone, T., Sharma, R. K., Goldberg, J. M., Attaran, M., Nelson, D. R., Agarwal, A., Prediction of endometriosis with serum and peritoneal fluid markers: a prospective controlled trial, Human Reproduction, 17, 426-31, 2002	Biomarkers not of interest
Belghiti, J., Thomassin-Naggara, I., Zacharopoulou, C., Zilberman, S., Jarboui, L., Bazot, M., Ballester, M., Darai, E., Contribution of Computed Tomography Enema and Magnetic Resonance Imaging to Diagnose Multifocal and Multicentric Bowel Lesions in Patients With Colorectal Endometriosis, Journal of Minimally Invasive Gynecology, 22, 776-84, 2015	Lesion-level analysis
Belli, P., De Gaetano, A. M., Mirk, P., Specca, S., Valentini, A. L., Uterine adenomyosis and tubal endometriosis: diagnostic imaging, Rays, 23, 693-701, 1998	Narrative review
Benacerraf, B. R., Finkler, N. J., Wojciechowski, C., Knapp, R. C., Sonographic accuracy in the diagnosis of ovarian masses, Journal of Reproductive Medicine for the Obstetrician and Gynecologist, 35, 491-495, 1990	No outcome of interest
Benacerraf, B. R., Groszmann, Y., Sonography should be the first imaging examination done to evaluate patients with suspected endometriosis, Journal of Ultrasound in Medicine, 31, 651-3, 2012	Narrative review

Study	Reason for Exclusion
Bergamini, V., Ghezzi, F., Scarperi, S., Raffaelli, R., Cromi, A., Franchi, M., Preoperative assessment of intestinal endometriosis: A comparison of transvaginal sonography with water-contrast in the rectum, transrectal sonography, and barium enema, <i>Abdominal Imaging</i> , 35, 732-6, 2010	Included as one of the studies in the Nisenblat 2016 review
Boog, G., Penot, P., Momber, A., Ultrasound as a diagnostic aid in endometriosis, <i>Contributions to Gynecology &amp; Obstetrics</i> , 16, 119-24, 1987	Retrospective study
Bordin, L., Fiore, C., Dona, G., Andrisani, A., Ambrosini, G., Faggian, D., Plebani, M., Clari, G., Armanini, D., Evaluation of erythrocyte band 3 phosphotyrosine level, glutathione content, CA-125, and human epididymal secretory protein E4 as combined parameters in endometriosis, <i>Fertility &amp; Sterility</i> , 94, 1616-21, 2010	All the patients have proven endometriosis
Carbognin, G., Girardi, V., Pinali, L., Raffaelli, R., Bergamini, V., Pozzi Mucelli, R., Assessment of pelvic endometriosis: correlation of US and MRI with laparoscopic findings, <i>Radiologia Medica</i> , 111, 687-701, 2006	Analysis included number of lesions, not number of participants
Chapron, C., Vieira, M., Chopin, N., Balleyguier, C., Barakat, H., Dumontier, I., Roseau, G., Fauconnier, A., Foulot, H., Dousset, B., Accuracy of rectal endoscopic ultrasonography and magnetic resonance imaging in the diagnosis of rectal involvement for patients presenting with deeply infiltrating endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 24, 175-9, 2004	Not initial diagnosis; retrospective study
Cheng, Y. M., Wang, S. T., Chou, C. Y., Serum CA-125 in preoperative patients at high risk for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 99, 375-80, 2002	CA-125 has been used for identifying high risk woman not as a diagnostic tool.
Cho, S., Cho, H., Nam, A., Kim, H. Y., Choi, Y. S., Park, K. H., Cho, D. J., Lee, B. S., Neutrophil-to-lymphocyte ratio as an adjunct to CA-125 for the diagnosis of endometriosis, <i>Fertility &amp; Sterility</i> , 90, 2073-9, 2008	It is a case-control study
Chung, M. K., Chung, R. R., Gordon, D., Jennings, C., The evil twins of chronic pelvic pain syndrome: endometriosis and interstitial cystitis, <i>JSLs : Journal of the Society of Laparoendoscopic Surgeons / Society of Laparoendoscopic Surgeons</i> , 6, 311-314, 2002	No outcome of interest
Cohen, L. S., Valle, R. F., Sabbagha, R. E., A comparison of preoperative ultrasound images of surgically proven endometriomas scanned by both transabdominal and transvaginal techniques, <i>Journal of Gynecologic Surgery</i> , 11, 27-32, 1995	All the patients have surgically confirmed endometriosis.
Cohen, M. R., Laparoscopy in the diagnosis and management of endometriosis, <i>Journal of Reproductive Medicine</i> , 27, 240-2, 1982	No outcome of interest

Study	Reason for Exclusion
Colacurci, N., Fortunato, N., De Franciscis, P., Fratta, M., Cioffi, M., Zarcone, R., Cardone, A., Serum and peritoneal CA-125 levels as diagnostic test for endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 66, 41-3, 1996	Case-control study
Coleman, B. G., Arger, P. H., Mulhern, C. B., Jr., Endometriosis: clinical and ultrasonic correlation, <i>AJR. American Journal of Roentgenology</i> , 132, 747-9, 1979	All patients were recruited in this study, had surgically proven endometriosis
Corwin, M. T., Gerscovich, E. O., Lamba, R., Wilson, M., McGahan, J. P., Differentiation of ovarian endometriomas from hemorrhagic cysts at MR imaging: utility of the T2 dark spot sign, <i>Radiology</i> , 271, 126-32, 2014	Using a diagnostic test to diagnose endometriosis has not been addressed in this study. It is about a sign in MRI to distinguish between Endometrioma and haemorrhagic cysts
Daniilidis, A., Giannoulis, H., Tantanasis, T., Papathanasiou, K., Loufopoulos, A., Tzafettas, J., Diagnostic laparoscopy, infertility, and endometriosis - 5 Years experience, <i>Gynecological Surgery</i> , 5, 231-234, 2008	Outcomes not of interest
de Kroon, C. D., van der Sandt, H. A., van Houwelingen, J. C., Jansen, F. W., Sonographic assessment of non-malignant ovarian cysts: does sonohistology exist?, <i>Human Reproduction</i> , 19, 2138-43, 2004	Postmenopausal women included in the analysis
Dechaud, H., Ali Ahmed, S. A., Aligier, N., Vergnes, C., Hedon, B., Does transvaginal hydrolaparoscopy render standard diagnostic laparoscopy obsolete for unexplained infertility investigation?, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 94, 97-102, 2001	Transvaginal hydro laparoscopy compared with conventional laparoscopy; no data for outcomes
Delpy, R., Barthet, M., Gasmi, M., Berdah, S., Shojai, R., Desjeux, A., Boubli, L., Grimaud, J. C., Value of endorectal ultrasonography for diagnosing rectovaginal septal endometriosis infiltrating the rectum, <i>Endoscopy</i> , 37, 357-61, 2005	Not able to calculate 2 by 2 table
Dessole, S., Farina, M., Rubattu, G., Cosmi, E., Ambrosini, G., Nardelli, G. B., Sonovaginography is a new technique for assessing rectovaginal endometriosis, <i>Fertility &amp; Sterility</i> , 79, 1023-7, 2003	Included as one of the studies in the Nisenblat 2016 review
do Amaral, V. F., Ferriani, R. A., de Sa, M. F. S., Nogueira, A. A., Silva, J. C. R., de Sa Rosa e Silva, A. C. J., de Moura, M. D., Positive correlation between serum and peritoneal fluid CA-125 levels in women with pelvic endometriosis, <i>Sao Paulo Medical Journal</i> , 124, 223-227, 2006	It is a case-control study
Dogan, M. M., Ugur, M., Soysal, S. K., Soysal, M. E., Ekici, E., Gokmen, O., Transvaginal sonographic diagnosis of ovarian endometrioma, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 52, 145-9, 1996	Analysis included lesions, not number of participants
Doniec, J. M., Kahlke, V., Peetz, F., Schniewind, B., Mundhenke, C., Lohnert, M. S., Kremer, B.,	Some of the population have confirmed endometriosis and some suspected

Study	Reason for Exclusion
Rectal endometriosis: high sensitivity and specificity of endorectal ultrasound with an impact for the operative management, <i>Diseases of the Colon &amp; Rectum</i> , 46, 1667-73, 2003	
Dunselman, G. A. J., Vermeulen, N., Becker, C., Calhaz-Jorge, C., D'Hooghe, T., De Bie, B., Heikinheimo, O., Horne, A. W., Kiesel, L., Nap, A., Prentice, A., Saridogan, E., Soriano, D., Nelen, W., ESHRE guideline: Management of women with endometriosis, <i>Human Reproduction</i> , 29, 400-412, 2014	The individual studies in this publication have been checked for inclusion in the review
El Maati, A. A. A., Ibrahim, E. A. G., Mokhtar, F. Z., A two-stage imaging protocol for evaluating women presenting with acute pelvic pain, <i>Egyptian Journal of Radiology and Nuclear Medicine</i> , 44, 923-936, 2013	The population is women with acute pelvic pain, not suspected endometriosis
Ellett, L., Readman, E., Newman, M., McIlwaine, K., Villegas, R., Jagasia, N., Maher, P., Are endometrial nerve fibres unique to endometriosis? A prospective case-control study of endometrial biopsy as a diagnostic test for endometriosis in women with pelvic pain, <i>Human Reproduction</i> , 30, 2808-15, 2015	Case-control study
Eskenazi, B., Warner, M., Bonsignore, L., Olive, D., Samuels, S., Vercellini, P., Validation study of nonsurgical diagnosis of endometriosis, <i>Fertility &amp; Sterility</i> , 76, 929-35, 2001	Included as one of the studies in the Nisenblat 2016 review
Exacoustos, C., Luciano, D., Corbett, B., De Felice, G., Di Felicianantonio, M., Luciano, A., Zupi, E., The uterine junctional zone: a 3-dimensional ultrasound study of patients with endometriosis, <i>American Journal of Obstetrics &amp; Gynecology</i> , 209, 248.e1-7, 2013	In the study, the relation between thickness of uterine junctional zone and endometriosis has been evaluated. It has not been used as a diagnostic tool.
Exacoustos, C., Malzoni, M., Di Giovanni, A., Lazzeri, L., Tosti, C., Petraglia, F., Zupi, E., Ultrasound mapping system for the surgical management of deep infiltrating endometriosis, <i>Fertility &amp; Sterility</i> , 102, 143-150.e2, 2014	Only women with positive index test underwent surgery)
Fedele, L., Bianchi, S., Portuese, A., Borruto, F., Dorta, M., Transrectal ultrasonography in the assessment of rectovaginal endometriosis, <i>Obstetrics &amp; Gynecology</i> , 91, 444-8, 1998	Included as one of the studies in the Nisenblat 2016 review
Federici, D., Muggiasca, M. L., Conti, M., Diagnostic value of laparoscopic evaluation of women with chronic pelvic pain: Our experience and a review of the literature, <i>VALEUR DIAGNOSTIQUE DE L'EXPLORATION LAPAROSCOPIQUE DES FEMMES SOUFFRANT DE DOULEURS PELVIENNES CHRONIQUES: EXPERIENCE PERSONNELLE ET REVUE DE LA LITTERATURE</i> , <i>Acta Endoscopica</i> , 22, 177-186, 1992	Narrative review
Felding, C., Mikkelsen, A. L., Peen, U., Laparoscopy and ultrasound in patients with chronic pelvic pain, <i>Journal of Obstetrics and Gynaecology</i> , 10, 419-422, 1990	No outcome of interest

Study	Reason for Exclusion
Ferrero, S., Biscaldi, E., Morotti, M., Venturini, P. L., Remorgida, V., Rollandi, G. A., Valenzano Menada, M., Multidetector computerized tomography enteroclysis vs. rectal water contrast transvaginal ultrasonography in determining the presence and extent of bowel endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 37, 603-13, 2011	Included as one of the studies in the Nisenblat 2016 review
Fiaschetti, V., Crusco, S., Meschini, A., Cama, V., Di Vito, L., Marziali, M., Piccione, E., Calabria, F., Simonetti, G., Deeply infiltrating endometriosis: evaluation of retro-cervical space on MRI after vaginal opacification, <i>European Journal of Radiology</i> , 81, 3638-45, 2012	Analysis included lesions, not number of participants
Foda, A. A., Aal, I. A. A., Role of some biomarkers in chronic pelvic pain for early detection of endometriosis in infertile women, <i>Middle East Fertility Society Journal</i> , 17, 187-194, 2012	Case-control study
Fratelli, N., Scioscia, M., Bassi, E., Musola, M., Minelli, L., Trivella, G., Transvaginal sonography for preoperative assessment of deep endometriosis, <i>Journal of Clinical Ultrasound</i> , 41, 69-75, 2013	Data for TVS was collected retrospectively
Friedman, H., Vogelzang, R. L., Mendelson, E. B., Neiman, H. L., Cohen, M., Endometriosis detection by US with laparoscopic correlation, <i>Radiology</i> , 157, 217-20, 1985	No data on outcomes
Ghezzi, F., Raio, L., Cromi, A., Duwe, D. G., Beretta, P., Buttarelli, M., Mueller, M. D., "Kissing ovaries": a sonographic sign of moderate to severe endometriosis, <i>Fertility &amp; Sterility</i> , 83, 143-7, 2005	Included as one of the studies in the Nisenblat 2016 review
Goncalves, M. O., Podgaec, S., Dias, J. A., Jr., Gonzalez, M., Abrao, M. S., Transvaginal ultrasonography with bowel preparation is able to predict the number of lesions and rectosigmoid layers affected in cases of deep endometriosis, defining surgical strategy, <i>Human Reproduction</i> , 25, 665-71, 2010	Included as one of the studies in the Nisenblat 2016 review
Gougoutas, C. A., Siegelman, E. S., Hunt, J., Outwater, E. K., Pelvic endometriosis: various manifestations and MR imaging findings, <i>AJR. American Journal of Roentgenology</i> , 175, 353-8, 2000	Narrative review
Grasso, R. F., Di Giacomo, V., Sedati, P., Sizzi, O., Florio, G., Faiella, E., Rossetti, A., Del Vescovo, R., Zobel, B. B., Diagnosis of deep infiltrating endometriosis: accuracy of magnetic resonance imaging and transvaginal 3D ultrasonography, <i>Abdominal Imaging</i> , 35, 716-25, 2010	Included as one of the studies in the Nisenblat 2016 review
Guerriero, S., Ajossa, S., Gerada, M., D'Aquila, M., Piras, B., Melis, G. B., "Tenderness-guided" transvaginal ultrasonography: a new method for the detection of deep endometriosis in patients	Included as one of the studies in the Nisenblat 2016 review

Study	Reason for Exclusion
with chronic pelvic pain, <i>Fertility &amp; Sterility</i> , 88, 1293-7, 2007	
Guerriero, S., Ajossa, S., Gerada, M., Virgilio, B., Angioni, S., Melis, G. B., Diagnostic value of transvaginal 'tenderness-guided' ultrasonography for the prediction of location of deep endometriosis, <i>Human Reproduction</i> , 23, 2452-7, 2008	Included as one of the studies in the Nisenblat 2016 review
Guerriero, S., Ajossa, S., Mais, V., Risalvato, A., Lai, M. P., Melis, G. B., The diagnosis of endometriomas using colour Doppler energy imaging, <i>Human Reproduction</i> , 13, 1691-5, 1998	Analysis included lesions only, not number of participants
Guerriero, S., Ajossa, S., Minguez, J. A., Jurado, M., Mais, V., Melis, G. B., Alcazar, J. L., Accuracy of transvaginal ultrasound for diagnosis of deep endometriosis in uterosacral ligaments, rectovaginal septum, vagina and bladder: systematic review and meta-analysis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 46, 534-45, 2015	Single studies were assessed according to inclusion criteria and, if relevant, included
Guerriero, S., Ajossa, S., Paoletti, A. M., Mais, V., Angiolucci, M., Melis, G. B., Tumor markers and transvaginal ultrasonography in the diagnosis of endometrioma, <i>Obstetrics &amp; Gynecology</i> , 88, 403-7, 1996	Included as one of the studies in the Nisenblat 2016 review
Guerriero, S., Mais, V., Ajossa, S., Paoletti, A. M., Angiolucci, M., Labate, F., Melis, G. B., The role of endovaginal ultrasound in differentiating endometriomas from other ovarian cysts, <i>Clinical &amp; Experimental Obstetrics &amp; Gynecology</i> , 22, 20-2, 1995	Analysis included number of lesions, not number of participants
Guerriero, S., Mais, V., Ajossa, S., Paoletti, A. M., Angiolucci, M., Melis, G. B., Transvaginal ultrasonography combined with CA-125 plasma levels in the diagnosis of endometrioma, <i>Fertility &amp; Sterility</i> , 65, 293-8, 1996	Included as one of the studies in the Nisenblat 2016 review
Guerriero, S., Mallarini, G., Ajossa, S., Risalvato, A., Satta, R., Mais, V., Angiolucci, M., Melis, G. B., Transvaginal ultrasound and computed tomography combined with clinical parameters and CA-125 determinations in the differential diagnosis of persistent ovarian cysts in premenopausal women, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 9, 339-43, 1997	Analysis included number of lesions, not number of participants
Guerriero, S., Saba, L., Ajossa, S., Peddes, C., Angiolucci, M., Perniciano, M., Melis, G. B., Alcazar, J. L., Three-dimensional ultrasonography in the diagnosis of deep endometriosis, <i>Human Reproduction</i> , 29, 1189-98, 2014	Included as one of the studies in the Nisenblat 2016 review
Güven, M. A., Bese, T., Demirkiran, F., Comparison of hydrosoneography and transvaginal ultrasonography in the detection of intracavitary pathologies in women with abnormal uterine bleeding, <i>International Journal of Gynecological Cancer</i> , 14, 57-63, 2004	The study population are women with history of abnormal uterine bleeding not women suspected to endometriosis.

Study	Reason for Exclusion
Harada, T., Kubota, T., Aso, T., Usefulness of CA19-9 versus CA125 for the diagnosis of endometriosis, <i>Fertility and Sterility</i> , 78, 733-739, 2002	Case-control study
Holland, T. K., Cutner, A., Saridogan, E., Mavrellos, D., Pateman, K., Jurkovic, D., Ultrasound mapping of pelvic endometriosis: does the location and number of lesions affect the diagnostic accuracy? A multicentre diagnostic accuracy study, <i>BMC Women's Health</i> , 13, 43, 2013	Analysis included number of lesions, not number of participants
Holland, T.K., Yazbek, J., Cutner, A., Saridogan, E., Hoo, W.L., Jurkovic, D., Value of transvaginal ultrasound in assessing severity of pelvic endometriosis, <i>Ultrasound in Obstetrics and Gynecology</i> , 36, 241-248, 2010	Included as one of the studies in the Nisenblat 2016 review
Howard, F. M., El-Minawi, A. M., Sanchez, R. A., Conscious pain mapping by laparoscopy in women with chronic pelvic pain, <i>Obstetrics &amp; Gynecology</i> , 96, 934-9, 2000	The study investigated conscious pain mapping using laparoscopy
Hudelist, G., Ballard, K., English, J., Wright, J., Banerjee, S., Mastoroudes, H., Thomas, A., Singer, C. F., Keckstein, J., Transvaginal sonography vs. clinical examination in the preoperative diagnosis of deep infiltrating endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 37, 480-7, 2011	Included as one of the studies in the Nisenblat 2016 review
Hudelist, G., English, J., Thomas, A. E., Tinelli, A., Singer, C. F., Keckstein, J., Diagnostic accuracy of transvaginal ultrasound for non-invasive diagnosis of bowel endometriosis: systematic review and meta-analysis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 37, 257-63, 2011	Individual studies checked for inclusion/exclusion
Hudelist, G., Fritzer, N., Staettner, S., Tammaa, A., Tinelli, A., Sparic, R., Keckstein, J., Uterine sliding sign: a simple sonographic predictor for presence of deep infiltrating endometriosis of the rectum, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 41, 692-5, 2013	Included as one of the studies in the Nisenblat 2016 review
Hudelist, G., Oberwinkler, K. H., Singer, C. F., Tuttlies, F., Rauter, G., Ritter, O., Keckstein, J., Combination of transvaginal sonography and clinical examination for preoperative diagnosis of pelvic endometriosis, <i>Human Reproduction</i> , 24, 1018-24, 2009	No separate data for imaging test
Hudelist, G., Tuttlies, F., Rauter, G., Pucher, S., Keckstein, J., Can transvaginal sonography predict infiltration depth in patients with deep infiltrating endometriosis of the rectum?, <i>Human Reproduction</i> , 24, 1012-7, 2009	Focus of study was on the depth of invasion of endometriotic lesions
Ikeda, F., Bernardini, M. A., Vanni, D., Vasconcelos, A., Pinotti, J. A., Abrao, M. S., A comparison of microlaparoscopy under sedation, microlaparoscopy under general anesthesia and conventional laparoscopy for diagnosis and	The effectiveness of using a diagnostic tool for diagnosis of endometriosis has not been addressed.



Study	Reason for Exclusion
treatment of pelvic endometriosis in early stages, <i>Fertility and sterility</i> , 77, S21, 2002	
Jain, K. A., Friedman, D. L., Pettinger, T. W., Alagappan, R., Jeffrey, R. B., Jr., Sommer, F. G., Adnexal masses: comparison of specificity of endovaginal US and pelvic MR imaging, <i>Radiology</i> , 186, 697-704, 1993	Not enough data to calculate sensitivity and specificity for 2x2 table
Johnson, W. K., Ott, D. J., Chen, M. Y. M., Fayez, J. A., Gelfand, D. W., Efficacy of hysterosalpingography in evaluating endometriosis, <i>Abdominal Imaging</i> , 19, 278-280, 1994	The study evaluated the effectiveness of hysterosalpingography and laparoscopy-retrospective study
Kafali, H., Artuc, H., Demir, N., Use of CA125 fluctuation during the menstrual cycle as a tool in the clinical diagnosis of endometriosis; a preliminary report, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 116, 85-8, 2004	It is a case-control study
Kang, S. B., Chung, H. H., Lee, H. P., Lee, J. Y., Chang, Y. S., Impact of diagnostic laparoscopy on the management of chronic pelvic pain, <i>Surgical Endoscopy</i> , 21, 916-9, 2007	there was no comparison between laparoscopy and another test
Karabacak, O., Tiras, M. B., Taner, M. Z., Guner, H., Yildiz, A., Yildirim, M., Small diameter versus conventional laparoscopy: a prospective, self-controlled study, <i>Human Reproduction</i> , 12, 2399-401, 1997	Comparison of two types of laparoscopy
Kitawaki, J., Ishihara, H., Koshiba, H., Kiyomizu, M., Teramoto, M., Kitaoka, Y., Honjo, H., Usefulness and limits of CA-125 in diagnosis of endometriosis without associated ovarian endometriomas.[Erratum appears in <i>Hum Reprod.</i> 2007 Feb;22(2):627], <i>Human Reproduction</i> , 20, 1999-2003, 2005	Women enrolled in the study were already diagnosed with endometriosis, adenomyosis and/or leiomyomas
Kruger, K., Behrendt, K., Niedobitek-Kreuter, G., Koltermann, K., Ebert, A. D., Location-dependent value of pelvic MRI in the preoperative diagnosis of endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 169, 93-8, 2013	Pelvic MRI retrospectively assessed with histology
Kurjak, A., Kupesic, S., Scoring system for prediction of ovarian endometriosis based on transvaginal color and pulsed Doppler sonography, <i>Fertility &amp; Sterility</i> , 62, 81-8, 1994	Postmenopausal women were included in the analysis, analysis included number of lesions, not number of participants
Leon, M., Vaccaro, H., Alcazar, J. L., Martinez, J., Gutierrez, J., Amor, F., Iturra, A., Sovino, H., Extended transvaginal sonography in deep infiltrating endometriosis: use of bowel preparation and an acoustic window with intravaginal gel: preliminary results, <i>Journal of Ultrasound in Medicine</i> , 33, 315-21, 2014	Included as one of the studies in the Nisenblat 2016 review
Leslie, C., Ma, T., McElhinney, B., Leake, R., Stewart, C. J., Is the detection of endometrial nerve fibers useful in the diagnosis of endometriosis?, <i>International Journal of Gynecological Pathology</i> , 32, 149-55, 2013	No outcome of interest

Study	Reason for Exclusion
Li, G., Yu, Z., Li, K., The value of FS, NLR, and CA-125 in the diagnosis of endometriosis, <i>International journal of clinical and experimental medicine</i> , 9, 7309-7313, 2016	Not the population of interest
Macer, M. L., Mathur, M., Spektor, M., Gysler, S., Staib, L., Kodaman, P., McCarthy, S., Utility of magnetic resonance imaging in the evaluation of intraoperatively confirmed pelvic adhesions, <i>Journal of Computer Assisted Tomography</i> , 39, 896-900, 2015	Not the population of interest
Maiorana, A., Incandela, D., Giambanco, L., Alio, W., Alio, L., Ultrasound diagnosis of pelvic endometriosis, <i>Journal of Endometriosis</i> , 3, 105-119, 2011	A narrative review, no QUADAS2 assessment
Mais, V., Guerriero, S., Ajossa, S., Angiolucci, M., Paoletti, A. M., Melis, G. B., The efficiency of transvaginal ultrasonography in the diagnosis of endometrioma, <i>Fertility &amp; Sterility</i> , 60, 776-80, 1993	Analysis include number of lesions, not number of participants
Malik, E., Berg, C., Meyhofer-Malik, A., Buchweitz, O., Moubayed, P., Diedrich, K., Fluorescence diagnosis of endometriosis using 5-aminolevulinic acid, <i>Surgical Endoscopy</i> , 14, 452-5, 2000	The test is not of interest
Manganaro, L., Fierro, F., Tomei, A., Irimia, D., Lodise, P., Sergi, M. E., Vinci, V., Sollazzo, P., Porpora, M. G., Delfini, R., Vittori, G., Marini, M., Feasibility of 3.0T pelvic MR imaging in the evaluation of endometriosis, <i>European Journal of Radiology</i> , 81, 1381-7, 2012	Women in the study already had a diagnosis of endometriosis by transvaginal ultrasound
Mangler, M., Medrano, N., Bartley, J., Mechsner, S., Speiser, D., Schneider, A., Kohler, C., Value of diagnostic procedures in rectovaginal endometriosis, <i>Australian &amp; New Zealand Journal of Obstetrics &amp; Gynaecology</i> , 53, 389-94, 2013	Included as one of the studies in the Nisenblat 2016 review
Marasinghe, J. P., Senanayake, H., Saravanabhava, N., Arambepola, C., Condous, G., Greenwood, P., History, pelvic examination findings and mobility of ovaries as a sonographic marker to detect pelvic adhesions with fixed ovaries, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 40, 785-90, 2014	TVS was used as a marker of ovarian mobility
Mathlouthi, N., Ayed, B. B., Dhoub, M., Chaabene, K., Trabelsi, K., Amouri, H., Guerhazi, M., Confrontation ultrasonography-CA125-histology in the management of ovarian cysts: A prospective study about 77 cases, <i>Tunisie Medicale</i> , 89, 686-692, 2011	Full-text in French
McBride, N., Newman, R. L., Diagnostic laparoscopy, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 15, 556-8, 1978	No outcome of interest
McKinnon, B., Mueller, M. D., Nirgianakis, K., Bersinger, N. A., Comparison of ovarian cancer markers in endometriosis favours HE4 over CA125, <i>Molecular Medicine Reports</i> , 12, 5179-84, 2015	No data reported to calculate sensitivity

Study	Reason for Exclusion
Melega, C., Marchesini, F. P., Bellettini, L., Biscontin, S., Flamigni, C., Diagnostic value of laparoscopy in endometriosis and infertility, <i>Journal of Reproductive Medicine</i> , 29, 597-600, 1984	No outcome of interest
Melis, G. B., Ajossa, S., Guerriero, S., Paoletti, A. M., Angiolucci, M., Piras, B., Caffiero, A., Mais, V., Epidemiology and diagnosis of endometriosis, <i>Annals of the New York Academy of Sciences</i> , 734, 352-7, 1994	Analysis included number of endometriomas, not number of participants
Menada, M. V., Remorgida, V., Abbamonte, L. H., Fulcheri, E., Ragni, N., Ferrero, S., Transvaginal ultrasonography combined with water-contrast in the rectum in the diagnosis of rectovaginal endometriosis infiltrating the bowel, <i>Fertility &amp; Sterility</i> , 89, 699-700, 2008	Population overlap with Menada 2008 (401661)
Mezzi, G., Ferrari, S., Arcidiacono, P. G., Di Puppo, F., Candiani, M., Testoni, P. A., Endoscopic rectal ultrasound and elastosonography are useful in flow chart for the diagnosis of deep pelvic endometriosis with rectal involvement, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 37, 586-90, 2011	No comparison with surgery
Mikami, M., Tanabe, K., Matsuo, K., Miyazaki, Y., Miyazawa, M., Hayashi, M., Asai, S., Ikeda, M., Shida, M., Hirasawa, T., Kojima, N., Sho, R., Iijima, S., Fully-sialylated alpha-chain of complement 4-binding protein: Diagnostic utility for ovarian clear cell carcinoma, <i>Gynecologic Oncology</i> , 139, 520-528, 2015	Not the population of interest
Millischer, A. E., Salomon, L. J., Santulli, P., Borghese, B., Dousset, B., Chapron, C., Fusion imaging for evaluation of deep infiltrating endometriosis: feasibility and preliminary results, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 46, 109-17, 2015	No data on surgical diagnosis
Miyagi, E., Maruyama, Y., Mogami, T., Numazaki, R., Ikeda, A., Yamamoto, H., Hirahara, F., Comparison of plasma amino acid profile-based index and CA125 in the diagnosis of epithelial ovarian cancers and borderline malignant tumors, <i>International Journal of Clinical Oncology</i> , 1-8, 2016	Not the population of interest
Moore, J., Copley, S., Morris, J., Lindsell, D., Golding, S., Kennedy, S., A systematic review of the accuracy of ultrasound in the diagnosis of endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 20, 630-4, 2002	Individual studies assessed for inclusion/exclusion
Ota, H., Maki, M., Evaluation of autoantibody and CA125 in the diagnosis of endometriosis or adenomyosis, <i>Medical Science Research</i> , 18, 309-310, 1990	All the participants had known condition.
Othman, E. E. D. R., Hornung, D., Al-Hendy, A., Biomarkers of endometriosis, <i>Expert Opinion on Medical Diagnostics</i> , 2, 741-752, 2008	Narrative review
Pascual, M. A., Guerriero, S., Hereter, L., Barri-Soldevila, P., Ajossa, S., Graupera, B.,	Included as one of the studies in the Nisenblat 2016 review

Study	Reason for Exclusion
Rodriguez, I., Diagnosis of endometriosis of the rectovaginal septum using introital three-dimensional ultrasonography, <i>Fertility &amp; Sterility</i> , 94, 2761-5, 2010	
Pascual, M. A., Tresserra, F., Lopez-Marin, L., Ubeda, A., Grases, P. J., Dexeus, S., Role of color Doppler ultrasonography in the diagnosis of endometriotic cyst, <i>Journal of Ultrasound in Medicine</i> , 19, 695-9, 2000	Lesion-level analysis
Pastorfide, G., Fong, Y. F., Use of narrowband imaging for the detection of endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 22, 535, 2015	No outcome of interest
Patel, M. D., Feldstein, V. A., Chen, D. C., Lipson, S. D., Filly, R. A., Endometriomas: diagnostic performance of US.[Erratum appears in <i>Radiology</i> 1999 Dec;213(3):930], <i>Radiology</i> , 210, 739-45, 1999	Retrospective review of sonograms by two sonologists
Patel, M. D., Feldstein, V. A., Filly, R. A., The likelihood ratio of sonographic findings for the diagnosis of hemorrhagic ovarian cysts, <i>Journal of Ultrasound in Medicine</i> , 24, 607-14; quiz 615, 2005	It is about diagnosis of haemorrhagic ovarian cyst not endometrioma
Philip, C. A., Bisch, C., Coulon, A., de Saint-Hilaire, P., Rudigoz, R. C., Dubernard, G., Correlation between three-dimensional rectosonography and magnetic resonance imaging in the diagnosis of rectosigmoid endometriosis: a preliminary study on the first fifty cases, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 187, 35-40, 2015	MRI was the reference test
Piessens, S., Healey, M., Maher, P., Tsaltas, J., Rombauts, L., Can anyone screen for deep infiltrating endometriosis with transvaginal ultrasound?, <i>Australian &amp; New Zealand Journal of Obstetrics &amp; Gynaecology</i> , 54, 462-8, 2014	Included as one of the studies in the Nisenblat 2016 review
Piketty, M., Chopin, N., Dousset, B., Millischer-Bellaische, A. E., Roseau, G., Leconte, M., Borghese, B., Chapron, C., Preoperative work-up for patients with deeply infiltrating endometriosis: transvaginal ultrasonography must definitely be the first-line imaging examination, <i>Human Reproduction</i> , 24, 602-7, 2009	Included as one of the studies in the Nisenblat 2016 review
Preutthipan, S., Hesla, J.S., A comparative study between pelvic ultrasonography and laparoscopy in the detection of pelvic pathology in the initial workup of subfertile women, <i>Journal of the Medical Association of Thailand</i> , 78, 596-599, 1995	No separated data for endometriosis
Redwine, D. B., Ovarian endometriosis: A marker for more extensive pelvic and intestinal disease, <i>Fertility and Sterility</i> , 72, 310-315, 1999	All the patients have endometriosis
Reid, S., Lu, C., Casikar, I., Reid, G., Abbott, J., Cario, G., Chou, D., Kowalski, D., Cooper, M., Condous, G., Prediction of pouch of Douglas	Included as one of the studies in the Nisenblat 2016 review

Study	Reason for Exclusion
obliteration in women with suspected endometriosis using a new real-time dynamic transvaginal ultrasound technique: the sliding sign, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 41, 685-91, 2013	
Reid, S., Lu, C., Hardy, N., Casikar, I., Reid, G., Cario, G., Chou, D., Almashat, D., Condous, G., Office gel sonovaginography for the prediction of posterior deep infiltrating endometriosis: a multicenter prospective observational study, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 44, 710-8, 2014	Included as one of the studies in the Nisenblat 2016 review
Ribeiro, H. S., Ribeiro, P. A., Rossini, L., Rodrigues, F. C., Donadio, N., Aoki, T., Double-contrast barium enema and transrectal endoscopic ultrasonography in the diagnosis of intestinal deeply infiltrating endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 15, 315-20, 2008	Included as one of the studies in the Nisenblat 2016 review
Rosa, E. Silva A. C., Rosa, E. Silva J. C., Ferriani, R. A., Serum CA-125 in the diagnosis of endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 96, 206-7, 2007	Retrospective study. Women included in the study already had a diagnosis of endometriosis prior to CA-125 serum collection
Saba, L., Guerriero, S., Sulcis, R., Ajossa, S., Melis, G., Mallarini, G., Agreement and reproducibility in identification of endometriosis using magnetic resonance imaging, <i>Acta Radiologica</i> , 51, 573-80, 2010	No outcome of interest
Saba, L., Guerriero, S., Sulcis, R., Pilloni, M., Ajossa, S., Melis, G., Mallarini, G., MRI and "tenderness guided" transvaginal ultrasonography in the diagnosis of recto-sigmoid endometriosis, <i>Journal of Magnetic Resonance Imaging</i> , 35, 352-60, 2012	Only women with positive index test underwent surgery
Saba, L., Guerriero, S., Sulis, R., Pilloni, M., Ajossa, S., Melis, G., Mallarini, G., Learning curve in the detection of ovarian and deep endometriosis by using Magnetic Resonance: comparison with surgical results, <i>European Journal of Radiology</i> , 79, 237-44, 2011	The aim of the study was to determine whether diagnostic accuracy is correlated to radiologist expertise
Saccardi, C., Cosmi, E., Borghero, A., Tregnaghi, A., Dessole, S., Litta, P., Comparison between transvaginal sonography, saline contrast sonovaginography and magnetic resonance imaging in the diagnosis of posterior deep infiltrating endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 40, 464-9, 2012	Only women with positive index test underwent surgery
Said, T. H., Azzam, A. Z., Prediction of endometriosis by transvaginal ultrasound in reproductive-age women with normal ovarian size, <i>Middle East Fertility Society Journal</i> , 19, 197-207, 2014	Included as one of the studies in the Nisenblat 2016 review
Savelli, L., Manuzzi, L., Coe, M., Mabrouk, M., Di Donato, N., Venturoli, S., Seracchioli, R., Comparison of transvaginal sonography and double-contrast barium enema for diagnosing deep infiltrating endometriosis of the posterior	Included as one of the studies in the Nisenblat 2016 review

Study	Reason for Exclusion
compartment, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 38, 466-71, 2011	
Savelli, L., Manuzzi, L., Pollastri, P., Mabrouk, M., Seracchioli, R., Venturoli, S., Diagnostic accuracy and potential limitations of transvaginal sonography for bladder endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 34, 595-600, 2009	Retrospective analysis
Scardapane, A., Bettocchi, S., Lorusso, F., Stabile Ianora, A. A., Vimercati, A., Ceci, O., Lasciarrea, M., Angelelli, G., Diagnosis of colorectal endometriosis: contribution of contrast enhanced MR-colonography, <i>European Radiology</i> , 21, 1553-63, 2011	Comparison of MRI between two radiologists
Scardapane, A., Lorusso, F., Scioscia, M., Ferrante, A., Stabile Ianora, A. A., Angelelli, G., Standard high-resolution pelvic MRI vs. low-resolution pelvic MRI in the evaluation of deep infiltrating endometriosis, <i>European Radiology</i> , 24, 2590-6, 2014	Comparison of MRI carried out by two different radiologists
Schenken, R. S., Improving the diagnosis of endometriosis in adolescents, <i>Sexuality, Reproduction and Menopause</i> , 6, 4-8, 2008	Narrative review
Seeber, B., Sammel, M. D., Fan, X., Gerton, G. L., Shaunik, A., Chittams, J., Barnhart, K. T., Panel of markers can accurately predict endometriosis in a subset of patients, <i>Fertility &amp; Sterility</i> , 89, 1073-81, 2008	It is a case-control study
Shen, A., Xu, S., Ma, Y., Guo, H., Li, C., Yang, C., Zou, S., Diagnostic value of serum CA125, CA19-9 and CA15-3 in endometriosis: A meta-analysis, <i>Journal of International Medical Research</i> , 43, 599-609, 2015	It is about association of biomarkers and stage of endometriosis. No outcome of interest.
Sokalska, A., Timmerman, D., Testa, A. C., Van Holsbeke, C., Lissoni, A. A., Leone, F. P., Jurkovic, D., Valentin, L., Diagnostic accuracy of transvaginal ultrasound examination for assigning a specific diagnosis to adnexal masses, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 34, 462-70, 2009	Women in the study had postmenopausal status
Somigliana, E., Vigano, P., Candiani, M., Felicetta, I., Di Blasio, A. M., Vignali, M., Use of serum-soluble intercellular adhesion molecule-1 as a new marker of endometriosis, <i>Fertility &amp; Sterility</i> , 77, 1028-31, 2002	Women included in the study already had laparoscopy prior to CA-125 serum collection
Somigliana, E., Vigano, P., Tirelli, A. S., Felicetta, I., Torresani, E., Vignali, M., Di Blasio, A. M., Use of the concomitant serum dosage of CA 125, CA 19-9 and interleukin-6 to detect the presence of endometriosis. Results from a series of reproductive age women undergoing laparoscopic surgery for benign gynaecological conditions, <i>Human Reproduction</i> , 19, 1871-6, 2004	Case-control study
Spencer, J. A., Weston, M. J., Imaging in endometriosis, <i>Imaging</i> , 15, 63-71, 2003	Narrative review

Study	Reason for Exclusion
Szubert, M., Suzin, J., Wierzbowski, T., Kowalczyk-Amico, K., CA-125 concentration in serum and peritoneal fluid in patients with endometriosis - preliminary results, Archives of Medical Science, 8, 504-8, 2012	Case-control study
Takahashi, K., Nagata, H., Kitao, M., CA-125 in the menstrual blood is an effective marker for diagnosing early stage endometriosis: A preliminary report, Japanese Journal of Fertility and Sterility, 36, 356-359, 1991	Ultrasound was used to confirm ovulatory day only
Takeuchi, M., Matsuzaki, K., Nishitani, H., Susceptibility-weighted MRI of endometrioma: preliminary results, AJR. American Journal of Roentgenology, 191, 1366-70, 2008	No outcome of interest
Theodoridis, T. D., Zepiridis, L., Mikos, T., Grimbizis, G. F., Dinas, K., Athanasiadis, A., Bontis, J. N., Comparison of diagnostic accuracy of transvaginal ultrasound with laparoscopy in the management of patients with adnexal masses, Archives of Gynecology & Obstetrics, 280, 767-73, 2009	Analysis included lesions, not number of participants
Tirlapur, S. A., Daniels, J. P., Khan, K. S., Medal trial collaboration, Chronic pelvic pain: how does noninvasive imaging compare with diagnostic laparoscopy?, Current Opinion in Obstetrics & Gynecology, 27, 445-8, 2015	This systematic review has not only focused on patients with suspected endometriosis. It is more general about pelvic pain and diagnostic tools
Tumedei, U., Ciardelli, V., Paltrinieri, F., Kuria, M. S., Amadori, A., Stefanetti, M., Gori, G., Transvaginal ultrasound in the diagnosis of endometrial abnormalities, Tumori, 87, S15, 2001	It has focused on endometrial abnormalities not endometriosis
Ubaldi, F., Wisanto, A., Camus, M., Tournaye, H., Clasen, K., Devroey, P., The role of transvaginal ultrasonography in the detection of pelvic pathologies in the infertility workup, Human Reproduction, 13, 330-3, 1998	Included as one of the studies in the Nisenblat 2016 review
Valenzano Menada, M., Remorgida, V., Abbamonte, L. H., Nicoletti, A., Ragni, N., Ferrero, S., Does transvaginal ultrasonography combined with water-contrast in the rectum aid in the diagnosis of rectovaginal endometriosis infiltrating the bowel?, Human Reproduction, 23, 1069-75, 2008	Included as one of the studies in the Nisenblat 2016 review
Van den Bosch, T., Vandendael, A., Van Schoubroeck, D., Wranz, P. A. B., Lombard, C. J., Combining vaginal ultrasonography and office endometrial sampling in the diagnosis of endometrial disease in postmenopausal women, Obstetrics and Gynecology, 85, 349-352, 1995	It is not about endometriosis, it has addressed endometrial diseases
Van Holsbeke, C., Van Calster, B., Guerriero, S., Savelli, L., Leone, F., Fischerova, D., Czekierdowski, A., Fruscio, R., Veldman, J., Van de Putte, G., Testa, A. C., Bourne, T., Valentin, L., Timmerman, D., Imaging in gynaecology: How good are we in identifying endometriomas?, Facts Views & Vision in Obgyn, 1, 7-17, 2009	Population overlap with Van Holsbeke 2010

Study	Reason for Exclusion
Van Holsbeke, C., Van Calster, B., Guerriero, S., Savelli, L., Paladini, D., Lissoni, A. A., Czekierdowski, A., Fischerova, D., Zhang, J., Mestdagh, G., Testa, A. C., Bourne, T., Valentin, L., Timmerman, D., Endometriomas: their ultrasound characteristics, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 35, 730-40, 2010	Retrospective analysis included postmenopausal women
Vimercati, A., Achillarre, M. T., Scardapane, A., Lorusso, F., Ceci, O., Mangiatordi, G., Angelelli, G., Van Herendael, B., Selvaggi, L., Bettocchi, S., Accuracy of transvaginal sonography and contrast-enhanced magnetic resonance-colonography for the presurgical staging of deep infiltrating endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 40, 592-603, 2012	Analysis included lesions, not number of participants
Volpi, E., De Grandis, T., Zuccaro, G., La Vista, A., Sisoni, P., Role of transvaginal sonography in the detection of endometriomata, <i>Journal of Clinical Ultrasound</i> , 23, 163-7, 1995	Retrospective study
Vrachnis, N., Sifakis, S., Samoli, E., Kappou, D., Pavlakis, K., Iliodromiti, Z., Botsis, D., Three-dimensional ultrasound and three-dimensional power Doppler improve the preoperative evaluation of complex benign ovarian lesions, <i>Clinical &amp; Experimental Obstetrics &amp; Gynecology</i> , 39, 474-8, 2012	No outcome of interest
Walsh, J. W., Taylor, K. J., Wasson, J. F., Schwartz, P. E., Rosenfield, A. T., Gray-scale ultrasound in 204 proved gynecologic masses: accuracy and specific diagnostic criteria, <i>Radiology</i> , 130, 391-7, 1979	No outcome of interest
Wang, L., Liu, H. Y., Shi, H. H., Lang, J. H., Sun, W., Urine peptide patterns for non-invasive diagnosis of endometriosis: a preliminary prospective study, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 177, 23-8, 2014	Biomarker not of interest
Weerakiet, S., Wongkularb, A., Rochanawutanon, M., Rojanasakul, A., Transvaginal ultrasonography combined with pelvic examination in the diagnosis of ovarian endometrioma, <i>Journal of the Medical Association of Thailand</i> , 83, 523-8, 2000	Retrospective study
Wessels, J. M., Kay, V. R., Leyland, N. A., Agarwal, S. K., Foster, W. G., Assessing brain-derived neurotrophic factor as a novel clinical marker of endometriosis, <i>Fertility &amp; Sterility</i> , 105, 119-128.e5, 2016	Not the test of interest
Wolfler, M. M., Nagele, F., Kolbus, A., Seidl, S., Schneider, B., Huber, J. C., Tschugguel, W., A predictive model for endometriosis, <i>Human Reproduction</i> , 20, 1702-8, 2005	Biomarker not of interest
Yamashita, Y., Torashima, M., Hatanaka, Y., Harada, M., Higashida, Y., Takahashi, M., Mizutani, H., Tashiro, H., Iwamasa, J., Miyazaki, K., et al., Adnexal masses: accuracy of characterization with transvaginal US and	Review of MRI and TVUS by five radiologists



Study	Reason for Exclusion
precontrast and postcontrast MR imaging, Radiology, 194, 557-65, 1995	
Yazbek, J., Helmy, S., Ben-Nagi, J., Holland, T., Sawyer, E., Jurkovic, D., Value of preoperative ultrasound examination in the selection of women with adnexal masses for laparoscopic surgery, Ultrasound in Obstetrics and Gynecology, 30, 883-888, 2007	The preoperative sonography has not been used to diagnose endometriosis.
Zapardiel, I., Gorostidi, M., Ravaggi, A., Allende, M. T., Silveira, M., Abehsera, D., MacUks, R., Utility Serum Marker HE4 for the Differential Diagnosis between Endometriosis and Adnexal Malignancy, International Journal of Gynecological Cancer, 26, 52-55, 2016	No data on surgical diagnosis

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## H.7 Diagnosis – Biomarkers: CA-125

Study	Reason for Exclusion
Abrao, M. S., Podgaec, S., Filho, B. M., Ramos, L. O., Pinotti, J. A., de Oliveira, R. M., The use of biochemical markers in the diagnosis of pelvic endometriosis, Human Reproduction, 12, 2523-7, 1997	Case-control study
Abrao, M. S., Podgaec, S., Pinotti, J. A., de Oliveira, R. M., Tumor markers in endometriosis, International Journal of Gynaecology & Obstetrics, 66, 19-22, 1999	Case-control study
Abu-Musa, A., Takahashi, K., Nagata, H., Yamasaki, H., Mizoguchi, S., Kitao, M., CA-125 in menstrual discharge in patients with chronic pelvic pain, International Journal of Gynaecology & Obstetrics, 37, 111-4, 1992	The level of CA-125 in menstrual discharge has been assessed
Acimovic, M., Vidakovic, S., Milic, N., Jeremic, K., Markovic, M., Milosevic-Djeric, A., Lazovic-Radonjic, G., Survivin and Vegf as Novel Biomarkers in Diagnosis of Endometriosis, Journal of Medical Biochemistry, 35, 63-68, 2016	No laparoscopy/ laparotomy and no histological confirmation
Adamy, L. V., Fanchenko, N. D., Alexeyeva, M. L., Andreyeva Ye, N., Novikov Ye, A., Jahan, I., Hormonal and immunologic methods in the diagnosis and treatment of patients with benign ovarian tumors and endometriotic cysts, International Journal of Fertility, 38, 92-8, 1993	Not able to calculate 2x2 table
Aleem, F., Pennisi, J., Zeitoun, K., Predanic, M., The role of color Doppler in diagnosis of endometriomas, Ultrasound in Obstetrics & Gynecology, 5, 51-4, 1995	The aim of this study is to describe vascular appearance in endometriomas. No outcome of interest.
Anaf, V., El Nakadi, I., De Moor, V., Coppens, E., Zalcman, M., Noel, J. C., Anatomic significance of a positive barium enema in deep infiltrating endometriosis of the large bowel, World Journal of Surgery, 33, 822-7, 2009	All patients had surgery and DCBE

Study	Reason for Exclusion
Bagan, P., Berna, P., Assouad, J., Hupertan, V., Le Pimpec Barthes, F., Riquet, M., Value of cancer antigen 125 for diagnosis of pleural endometriosis in females with recurrent pneumothorax, <i>European Respiratory Journal</i> , 31, 140-2, 2008	The control group are males
Balasch, J., Creus, M., Fabregues, F., Carmona, F., Ordi, J., Martinez-Roman, S., Vanrell, J. A., Visible and non-visible endometriosis at laparoscopy in fertile and infertile women and in patients with chronic pelvic pain: a prospective study, <i>Human Reproduction</i> , 11, 387-91, 1996	Not a diagnostic study
Balleyguier, C., Roupret, M., Nguyen, T., Kinkel, K., Helenon, O., Chapron, C., Ureteral endometriosis: the role of magnetic resonance imaging, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 11, 530-6, 2004	No outcome of interest. Moreover, only 6 patients were included
Barbati, A., Cosmi, E. V., Spaziani, R., Ventura, R., Montanino, G., Serum and peritoneal fluid CA-125 levels in patients with endometriosis, <i>Fertility &amp; Sterility</i> , 61, 438-42, 1994	Included as one of the studies in the Nisenblat 2016 review
Barbieri, R. L., Niloff, J. M., Bast, R. C., Jr., Scaetzel, E., Kistner, R. W., Knapp, R. C., Elevated serum concentrations of CA-125 in patients with advanced endometriosis, <i>Fertility &amp; Sterility</i> , 45, 630-4, 1986	Postmenopausal women included
Barcellos, M. B., Lasmar, B., Lasmar, R., Agreement between the preoperative findings and the operative diagnosis in patients with deep endometriosis, <i>Archives of Gynecology &amp; ObstetricsArch Gynecol Obstet</i> , 293, 845-50, 2016	Lesion-level analysis
Bazot, M., Gasner, A., Ballester, M., Darai, E., Value of thin-section oblique axial T2-weighted magnetic resonance images to assess uterosacral ligament endometriosis, <i>Human Reproduction</i> , 26, 346-53, 2011	Retrospective study; one MRI technique compared to conventional technique
Bazot, M., Gasner, A., Lafont, C., Ballester, M., Darai, E., Deep pelvic endometriosis: limited additional diagnostic value of postcontrast in comparison with conventional MR images, <i>European Journal of Radiology</i> , 80, e331-9, 2011	Retrospective study; comparison of post-contrast MRI versus conventional MRI
Bedaiwy, M. A., Falcone, T., Laboratory testing for endometriosis, <i>Clinica Chimica Acta</i> , 340, 41-56, 2004	Narrative review
Bedaiwy, M. A., Falcone, T., Sharma, R. K., Goldberg, J. M., Attaran, M., Nelson, D. R., Agarwal, A., Prediction of endometriosis with serum and peritoneal fluid markers: a prospective controlled trial, <i>Human Reproduction</i> , 17, 426-31, 2002	Biomarkers not of interest
Belli, P., De Gaetano, A. M., Mirk, P., Specca, S., Valentini, A. L., Uterine adenomyosis and tubal endometriosis: diagnostic imaging, <i>Rays</i> , 23, 693-701, 1998	Narrative review

Study	Reason for Exclusion
Benacerraf, B. R., Finkler, N. J., Wojciechowski, C., Knapp, R. C., Sonographic accuracy in the diagnosis of ovarian masses, <i>Journal of Reproductive Medicine for the Obstetrician and Gynecologist</i> , 35, 491-495, 1990	No outcome of interest
Benacerraf, B. R., Groszmann, Y., Sonography should be the first imaging examination done to evaluate patients with suspected endometriosis, <i>Journal of Ultrasound in Medicine</i> , 31, 651-3, 2012	Narrative review
Bilibio, J. P., Souza, C. A., Rodini, G. P., Andreoli, C. G., Genro, V. K., de Conto, E., Cunha-Filho, J. S., Serum prolactin and CA-125 levels as biomarkers of peritoneal endometriosis, <i>Gynecologic &amp; Obstetric Investigation</i> , 78, 45-52, 2014	Included as one of the studies in the Nisenblat 2016 review
Bordin, L., Fiore, C., Dona, G., Andrisani, A., Ambrosini, G., Faggian, D., Plebani, M., Clari, G., Armanini, D., Evaluation of erythrocyte band 3 phosphotyrosine level, glutathione content, CA-125, and human epididymal secretory protein E4 as combined parameters in endometriosis, <i>Fertility &amp; Sterility</i> , 94, 1616-21, 2010	All the patients have proven endometriosis.
Chen, F. P., Soong, Y. K., Lee, N., Lo, S. K., The use of serum CA-125 as a marker for endometriosis in patients with dysmenorrhea for monitoring therapy and for recurrence of endometriosis, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 77, 665-70, 1998	Included as one of the studies in the Nisenblat 2016 review
Cheng, Y. M., Wang, S. T., Chou, C. Y., Serum CA-125 in preoperative patients at high risk for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 99, 375-80, 2002	CA-125 has been used for identifying high risk woman not as a diagnostic tool.
Cho, S., Cho, H., Nam, A., Kim, H. Y., Choi, Y. S., Park, K. H., Cho, D. J., Lee, B. S., Neutrophil-to-lymphocyte ratio as an adjunct to CA-125 for the diagnosis of endometriosis, <i>Fertility &amp; Sterility</i> , 90, 2073-9, 2008	It is a case-control study
Chudecka-Glaz, A., Cymbaluk-Ploska, A., Luterek-Puszyńska, K., Menkiszak, J., Diagnostic usefulness of the Risk of Ovarian Malignancy Algorithm using the electrochemiluminescence immunoassay for HE4 and the chemiluminescence microparticle immunoassay for CA125, <i>Oncology Letters</i> , 12, 3101-3114, 2016	Women with no suspected endometriosis
Chung, M. K., Chung, R. R., Gordon, D., Jennings, C., The evil twins of chronic pelvic pain syndrome: endometriosis and interstitial cystitis, <i>JSLs : Journal of the Society of Laparoendoscopic Surgeons / Society of Laparoendoscopic Surgeons</i> , 6, 311-314, 2002	No outcome of interest
Cohen, L. S., Valle, R. F., Sabbagha, R. E., A comparison of preoperative ultrasound images of surgically proven endometriomas scanned by both transabdominal and transvaginal	All the patients have surgically confirmed endometriosis

Study	Reason for Exclusion
techniques, Journal of Gynecologic Surgery, 11, 27-32, 1995	
Cohen, M. R., Laparoscopy in the diagnosis and management of endometriosis, Journal of Reproductive Medicine, 27, 240-2, 1982	No outcome of interest
Colacurci, N., Fortunato, N., De Franciscis, P., Cardone, A., Relevance of CA-125 in the evaluation of endometriosis, Clinical & Experimental Obstetrics & Gynecology, 23, 150-4, 1996	Included as one of the studies in the Nisenblat 2016 review
Colacurci, N., Fortunato, N., De Franciscis, P., Fratta, M., Cioffi, M., Zarccone, R., Cardone, A., Serum and peritoneal CA-125 levels as diagnostic test for endometriosis, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 66, 41-3, 1996	Unable to calculate 2x2 table
Coleman, B. G., Arger, P. H., Mulhern, C. B., Jr., Endometriosis: clinical and ultrasonic correlation, AJR. American Journal of Roentgenology, 132, 747-9, 1979	All patients were recruited in this study, had surgically proven endometriosis
Corwin, M. T., Gerscovich, E. O., Lamba, R., Wilson, M., McGahan, J. P., Differentiation of ovarian endometriomas from hemorrhagic cysts at MR imaging: utility of the T2 dark spot sign, Radiology, 271, 126-32, 2014	Using a diagnostic test to diagnose endometriosis has not been addressed in this study. It is about a sign in MRI to distinguish between Endometrioma and haemorrhagic cysts.
Daher, R. M. F., Rosa, E. Silva J. C., Poli-Neto, O. B., Candido-Dos-reis, F. J., Nogueira, A. A., Diagnosis of endometriosis in women with chronic pelvic pain, Clinical and Experimental Obstetrics and Gynecology, 43, 512-515, 2016	No data for the CA-125 cut-off of $\geq 35$ U/ml
Daniilidis, A., Giannoulis, H., Tantanasis, T., Papathanasiou, K., Loufopoulos, A., Tzafettas, J., Diagnostic laparoscopy, infertility, and endometriosis - 5 Years experience, Gynecological Surgery, 5, 231-234, 2008	Outcomes not of interest
Dechaud, H., Ali Ahmed, S. A., Aligier, N., Vergnes, C., Hedon, B., Does transvaginal hydrolaparoscopy render standard diagnostic laparoscopy obsolete for unexplained infertility investigation?, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 94, 97-102, 2001	Transvaginal hydrolaparoscopy compared with conventional laparoscopy; no data for outcomes
do Amaral, V. F., Ferriani, R. A., de Sa, M. F. S., Nogueira, A. A., Silva, J. C. R., de Sa Rosa e Silva, A. C. J., de Moura, M. D., Positive correlation between serum and peritoneal fluid CA-125 levels in women with pelvic endometriosis, Sao Paulo Medical Journal, 124, 223-227, 2006	No data for the CA-125 cut-off of $\geq 35$ U/ml
Dunselman, G. A. J., Vermeulen, N., Becker, C., Calhaz-Jorge, C., D'Hooghe, T., De Bie, B., Heikinheimo, O., Horne, A. W., Kiesel, L., Nap, A., Prentice, A., Saridogan, E., Soriano, D., Nelen, W., ESHRE guideline: Management of women with endometriosis, Human Reproduction, 29, 400-412, 2014	The individual studies in this publication have been checked for inclusion in the review

Study	Reason for Exclusion
El Maati, A. A. A., Ibrahim, E. A. G., Mokhtar, F. Z., A two-stage imaging protocol for evaluating women presenting with acute pelvic pain, Egyptian Journal of Radiology and Nuclear Medicine, 44, 923-936, 2013	The population is women with acute pelvic pain, not suspected endometriosis
Elgafor El Sharkwy, I. A., Combination of non-invasive and semi-invasive tests for diagnosis of minimal to mild endometriosis, Archives of gynecology and obstetrics, 288, 793-7, 2013	The diagnostic test (IL-6 combined with nerve fibres) which has been used in this study is not matched with the protocol.
Ellett, L., Readman, E., Newman, M., McIlwaine, K., Villegas, R., Jagasia, N., Maher, P., Are endometrial nerve fibres unique to endometriosis? A prospective case-control study of endometrial biopsy as a diagnostic test for endometriosis in women with pelvic pain, Human Reproduction, 30, 2808-15, 2015	Case-control study
Exacoustos, C., Luciano, D., Corbett, B., De Felice, G., Di Feliciano, M., Luciano, A., Zupi, E., The uterine junctional zone: a 3-dimensional ultrasound study of patients with endometriosis, American Journal of Obstetrics & Gynecology, 209, 248.e1-7, 2013	In the study, the relation between thickness of uterine junctional zone and endometriosis has been evaluated. It has not been used as a diagnostic tool.
Faccioli, N., Manfredi, R., Mainardi, P., Dalla Chiara, E., Spoto, E., Minelli, L., Mucelli, R. P., Barium enema evaluation of colonic involvement in endometriosis, AJR. American Journal of Roentgenology, 190, 1050-4, 2008	The diagnostic test (Barium enema) which has been used in this study is not matched with the protocol.
Fedele, L., Arcaini, L., Vercellini, P., Marchini, M., Baglioni, A., Bianchi, S., Serum Ca-125 concentrations in endometriosis, Acta Europaea Fertilitatis, 20, 137-9, 1989	Included as one of the studies in the Nisenblat 2016 review
Federici, D., Muggiasca, M. L., Conti, M., Diagnostic value of laparoscopic evaluation of women with chronic pelvic pain: Our experience and a review of the literature, VALEUR DIAGNOSTIQUE DE L'EXPLORATION LAPAROSCOPIQUE DES FEMMES SOUFFRANT DE DOULEURS PELVIENNES CHRONIQUES: EXPERIENCE PERSONNELLE ET REVUE DE LA LITTERATURE, Acta Endoscopica, 22, 177-186, 1992	Narrative review
Felding, C., Mikkelsen, A. L., Peen, U., Laparoscopy and ultrasound in patients with chronic pelvic pain, Journal of Obstetrics and Gynaecology, 10, 419-422, 1990	No outcome of interest
Fisk, N. M., Tan, C. E., CA 125 in peritoneal fluid and serum of patients with endometriosis, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 29, 153-8, 1988	Case-control study
Florio, P., Reis, F. M., Torres, P. B., Calonaci, F., Abrao, M. S., Nascimento, L. L., Franchini, M., Cianferoni, L., Petraglia, F., High serum follistatin levels in women with ovarian endometriosis, Human Reproduction, 24, 2600-6, 2009	No data for the CA-125 cut-off of $\geq 35$ U/ml
Foda, A. A., Aal, I. A. A., Role of some biomarkers in chronic pelvic pain for early	Case-control study

Study	Reason for Exclusion
detection of endometriosis in infertile women, Middle East Fertility Society Journal, 17, 187-194, 2012	
Fratelli, N., Scioscia, M., Bassi, E., Musola, M., Minelli, L., Trivella, G., Transvaginal sonography for preoperative assessment of deep endometriosis, Journal of Clinical Ultrasound, 41, 69-75, 2013	Data for TVS was collected retrospectively
Friedman, H., Vogelzang, R. L., Mendelson, E. B., Neiman, H. L., Cohen, M., Endometriosis detection by US with laparoscopic correlation, Radiology, 157, 217-20, 1985	No data on outcomes
Gagne, D., Rivard, M., Page, M., Lepine, M., Platon, C., Shazand, K., Hugo, P., Gosselin, D., Development of a nonsurgical diagnostic tool for endometriosis based on the detection of endometrial leukocyte subsets and serum CA-125 levels, Fertility & Sterility, 80, 876-85, 2003	Included as one of the studies in the Nisenblat 2016 review
Gougoutas, C. A., Siegelman, E. S., Hunt, J., Outwater, E. K., Pelvic endometriosis: various manifestations and MR imaging findings, AJR. American Journal of Roentgenology, 175, 353-8, 2000	Narrative review
Guerriero, S., Mais, V., Ajossa, S., Paoletti, A. M., Angiolucci, M., Melis, G. B., Transvaginal ultrasonography combined with CA-125 plasma levels in the diagnosis of endometrioma, Fertility & Sterility, 65, 293-8, 1996	Included as one of the studies in the Nisenblat 2016 review
Guerriero, S., Mallarini, G., Ajossa, S., Risalvato, A., Satta, R., Mais, V., Angiolucci, M., Melis, G. B., Transvaginal ultrasound and computed tomography combined with clinical parameters and CA-125 determinations in the differential diagnosis of persistent ovarian cysts in premenopausal women, Ultrasound in Obstetrics & Gynecology, 9, 339-43, 1997	The cut-off which has been used in this study is 25 U/ml
Gurgan, T., Kisinisci, H., Yarali, H., Aksu, T., Zeyneloglu, H., Develioglu, O., Serum and peritoneal fluid CA-125 levels in early stage endometriosis, Gynecologic & Obstetric Investigation, 30, 105-8, 1990	The cut-off for CA-125 is 16 U/ml
Guen, M. A., Bese, T., Demirkiran, F., Comparison of hydrosoneography and transvaginal ultrasonography in the detection of intracavitary pathologies in women with abnormal uterine bleeding, International Journal of Gynecological Cancer, 14, 57-63, 2004	The study population are women with history of abnormal uterine bleeding not women suspected to endometriosis.
Harada, T., Kubota, T., Aso, T., Usefulness of CA19-9 versus CA125 for the diagnosis of endometriosis, Fertility and Sterility, 78, 733-739, 2002	Included as one of the studies in the Nisenblat 2016 review
Hirsch, M., Duffy, J. M. N., Davis, C. J., Plana, Nieves M., Khan, K. S., the International Collaboration to Harmonise, Outcomes, Measures for, Endometriosis, Diagnostic accuracy of cancer antigen 125 for endometriosis: a systematic review and meta-	Single studies were assessed according to inclusion criteria and, if relevant, included

Study	Reason for Exclusion
analysis, BJOG: An International Journal of Obstetrics & Gynaecology	
Hompes, P. G., Koninckx, P. R., Kennedy, S., van Kamp, G. F., Verstraeten, R. A., Cornillie, F., Serum CA-125 concentrations during midfollicular phase, a clinically useful and reproducible marker in diagnosis of advanced endometriosis, <i>Clinical Chemistry</i> , 42, 1871-4, 1996	No outcome of interest has been reported.
Hornstein, M. D., Harlow, B. L., Thomas, P. P., Check, J. H., Use of a new CA 125 assay in the diagnosis of endometriosis, <i>Human Reproduction</i> , 10, 932-4, 1995	Included as one of the studies in the Nisenblat 2016 review
Howard, F. M., El-Minawi, A. M., Sanchez, R. A., Conscious pain mapping by laparoscopy in women with chronic pelvic pain, <i>Obstetrics &amp; Gynecology</i> , 96, 934-9, 2000	The study investigated conscious pain mapping using laparoscopy
Ikeda, F., Bernardini, M. A., Vanni, D., Vasconcelos, A., Pinotti, J. A., Abrao, M. S., A comparison of microlaparoscopy under sedation, microlaparoscopy under general anesthesia and conventional laparoscopy for diagnosis and treatment of pelvic endometriosis in early stages, <i>Fertility and sterility</i> , 77, S21, 2002	The effectiveness of using a diagnostic tool for diagnosis of endometriosis has not been addressed.
Ismail, M. A., Rotmensch, J., Mercer, L. J., Block, B. S., Salti, G. I., Holt, J. A., CA-125 in peritoneal fluid from patients with nonmalignant gynecologic disorders, <i>Journal of Reproductive Medicine</i> , 39, 510-2, 1994	The women without any symptom who went through laparoscopic sterilization have been considered as control group.
Johnson, W. K., Ott, D. J., Chen, M. Y. M., Fayez, J. A., Gelfand, D. W., Efficacy of hysterosalpingography in evaluating endometriosis, <i>Abdominal Imaging</i> , 19, 278-280, 1994	The study evaluated the effectiveness of hysterosalpingography and laparoscopy-retrospective study
Kafali, H., Artuc, H., Demir, N., Use of CA125 fluctuation during the menstrual cycle as a tool in the clinical diagnosis of endometriosis; a preliminary report, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 116, 85-8, 2004	It is a case-control study
Kang, S. B., Chung, H. H., Lee, H. P., Lee, J. Y., Chang, Y. S., Impact of diagnostic laparoscopy on the management of chronic pelvic pain, <i>Surgical Endoscopy</i> , 21, 916-9, 2007	there was no comparison between laparoscopy and another test
Karabacak, O., Tiras, M. B., Taner, M. Z., Guner, H., Yildiz, A., Yildirim, M., Small diameter versus conventional laparoscopy: a prospective, self-controlled study, <i>Human Reproduction</i> , 12, 2399-401, 1997	Comparison of two types of laparoscopy
Kitawaki, J., Ishihara, H., Koshiba, H., Kiyomizu, M., Teramoto, M., Kitaoka, Y., Honjo, H., Usefulness and limits of CA-125 in diagnosis of endometriosis without associated ovarian endometriomas.[Erratum appears in <i>Hum Reprod.</i> 2007 Feb;22(2):627], <i>Human Reproduction</i> , 20, 1999-2003, 2005	No data for the CA-125 cut-off of $\geq 35$ U/ml

Study	Reason for Exclusion
Koninckx, P. R., Meuleman, C., Oosterlynck, D., Cornillie, F. J., Diagnosis of deep endometriosis by clinical examination during menstruation and plasma CA-125 concentration, <i>Fertility &amp; Sterility</i> , 65, 280-7, 1996	Included as one of the studies in the Nisenblat 2016 review
Koninckx, P. R., Riittinen, L., Seppala, M., Cornillie, F. J., CA-125 and placental protein 14 concentrations in plasma and peritoneal fluid of women with deeply infiltrating pelvic endometriosis, <i>Fertility &amp; Sterility</i> , 57, 523-30, 1992	Wrong data and result have been reported
Kruger, K., Behrendt, K., Niedobitek-Kreuter, G., Koltermann, K., Ebert, A. D., Location-dependent value of pelvic MRI in the preoperative diagnosis of endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 169, 93-8, 2013	Pelvic MRI retrospectively assessed with histology
Kruitwagen, R. F., Thomas, C., Poels, L. G., Koster, A. M., Willemsen, W. N., Rolland, R., High CA-125 concentrations in peritoneal fluid of normal cyclic women with various infertility-related factors as demonstrated with two-step immunoradiometric assay, <i>Fertility &amp; Sterility</i> , 56, 863-9, 1991	The outcome of interest has not been reported.
Lanzone, A., Marana, R., Muscatello, R., Fulghesu, A. M., Dell'Acqua, S., Caruso, A., Mancuso, S., Serum CA-125 levels in the diagnosis and management of endometriosis, <i>Journal of Reproductive Medicine</i> , 36, 603-7, 1991	Included as one of the studies in the Nisenblat 2016 review
Leslie, C., Ma, T., McElhinney, B., Leake, R., Stewart, C. J., Is the detection of endometrial nerve fibers useful in the diagnosis of endometriosis?, <i>International Journal of Gynecological Pathology</i> , 32, 149-55, 2013	No outcome of interest
Li, G., Yu, Z., Li, K., The value of FS, NLR, and CA-125 in the diagnosis of endometriosis, <i>International journal of clinical and experimental medicine</i> , 9, 7309-7313, 2016	Not the population of interest
Macer, M. L., Mathur, M., Spektor, M., Gysler, S., Staib, L., Kodaman, P., McCarthy, S., Utility of magnetic resonance imaging in the evaluation of intraoperatively confirmed pelvic adhesions, <i>Journal of Computer Assisted Tomography</i> , 39, 896-900, 2015	Not the population of interest
Maiorana, A., Cicerone, C., Niceta, M., Alio, L., Evaluation of serum CA 125 levels in patients with pelvic pain related to endometriosis, <i>International Journal of Biological Markers</i> , 22, 200-2, 2007	Included as one of the studies in the Nisenblat 2016 review
Malik, E., Berg, C., Meyhofer-Malik, A., Buchweitz, O., Moubayed, P., Diedrich, K., Fluorescence diagnosis of endometriosis using 5-aminolevulinic acid, <i>Surgical Endoscopy</i> , 14, 452-5, 2000	The test is not of interest
Manganaro, L., Fierro, F., Tomei, A., Irimia, D., Lodise, P., Sergi, M. E., Vinci, V., Sollazzo, P.,	Women in the study already had a diagnosis of endometriosis by transvaginal ultrasound



Study	Reason for Exclusion
Porpora, M. G., Delfini, R., Vittori, G., Marini, M., Feasibility of 3.0T pelvic MR imaging in the evaluation of endometriosis, <i>European Journal of Radiology</i> , 81, 1381-7, 2012	
Martinez, S., Garrido, N., Coperias, J. L., Pardo, F., Desco, J., Garcia-Velasco, J. A., Simon, C., Pellicer, A., Serum interleukin-6 levels are elevated in women with minimal-mild endometriosis, <i>Human Reproduction</i> , 22, 836-42, 2007	Included as one of the studies in the Nisenblat 2016 review
Mathlouthi, N., Ayed, B. B., Dhoubi, M., Chaabene, K., Trabelsi, K., Amouri, H., Guermazi, M., Confrontation ultrasonography-CA125-histology in the management of ovarian cysts: A prospective study about 77 cases, <i>Tunisie Medicale</i> , 89, 686-692, 2011	Full-text in French
May, K. E., Conduit-Hulbert, S. A., Villar, J., Kirtley, S., Kennedy, S. H., Becker, C. M., Peripheral biomarkers of endometriosis: a systematic review, <i>Human Reproduction Update</i> , 16, 651-74, 2010	This systematic review includes papers also regarding other biomarkers. The full texts of individual related studies were retrieved and reviewed.
May, K. E., Villar, J., Kirtley, S., Kennedy, S. H., Becker, C. M., Endometrial alterations in endometriosis: a systematic review of putative biomarkers, <i>Human Reproduction Update</i> , 17, 637-53, 2011	Single studies were assessed for inclusion and, if relevant, included
McBride, N., Newman, R. L., Diagnostic laparoscopy, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 15, 556-8, 1978	No outcome of interest
McKinnon, B., Mueller, M. D., Nirgianakis, K., Bersinger, N. A., Comparison of ovarian cancer markers in endometriosis favours HE4 over CA125, <i>Molecular Medicine Reports</i> , 12, 5179-84, 2015	No data reported to calculate sensitivity
Medl, M., Ogris, E., Peters-Engl, C., Mierau, M., Buxbaum, P., Leodolter, S., Serum levels of the tumour-associated trypsin inhibitor in patients with endometriosis, <i>British Journal of Obstetrics &amp; Gynaecology</i> , 104, 78-81, 1997	Wrong data and result have been reported
Melega, C., Marchesini, F. P., Bellettini, L., Biscontin, S., Flamigni, C., Diagnostic value of laparoscopy in endometriosis and infertility, <i>Journal of Reproductive Medicine</i> , 29, 597-600, 1984	No outcome of interest
Mezzi, G., Ferrari, S., Arcidiacono, P. G., Di Puppo, F., Candiani, M., Testoni, P. A., Endoscopic rectal ultrasound and elastosonography are useful in flow chart for the diagnosis of deep pelvic endometriosis with rectal involvement, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 37, 586-90, 2011	There was no comparison with surgery
Mikami, M., Tanabe, K., Matsuo, K., Miyazaki, Y., Miyazawa, M., Hayashi, M., Asai, S., Ikeda, M., Shida, M., Hirasawa, T., Kojima, N., Sho, R., Iijima, S., Fully-sialylated alpha-chain of complement 4-binding protein: Diagnostic utility	Not the population of interest

Study	Reason for Exclusion
for ovarian clear cell carcinoma, <i>Gynecologic Oncology</i> , 139, 520-528, 2015	
Millischer, A. E., Salomon, L. J., Santulli, P., Borghese, B., Dousset, B., Chapron, C., Fusion imaging for evaluation of deep infiltrating endometriosis: feasibility and preliminary results, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 46, 109-17, 2015	No data on surgical diagnosis
Miyagi, E., Maruyama, Y., Mogami, T., Numazaki, R., Ikeda, A., Yamamoto, H., Hirahara, F., Comparison of plasma amino acid profile-based index and CA125 in the diagnosis of epithelial ovarian cancers and borderline malignant tumors, <i>International Journal of Clinical Oncology</i> , 1-8, 2016	Not the population of interest
Mohamed, M. L., El Behery, M. M., Mansour, S. A., Comparative study between VEGF-A and CA-125 in diagnosis and follow-up of advanced endometriosis after conservative laparoscopic surgery, <i>Archives of Gynecology &amp; Obstetrics</i> , 287, 77-82, 2013	Included as one of the studies in the Nisenblat 2016 review
Mol, B. W., Bayram, N., Lijmer, J. G., Wiegerinck, M. A., Bongers, M. Y., van der Veen, F., Bossuyt, P. M., The performance of CA-125 measurement in the detection of endometriosis: a meta-analysis, <i>Fertility &amp; Sterility</i> , 70, 1101-8, 1998	All the studies included in this systematic review could not be included in our systematic review. The full-texts of all individual studies were retrieved and reviewed and related studies were included in our review.
Molo, M. W., Kelly, M., Radwanska, E., Binor, Z., Preoperative serum CA-125 and CA-72 in predicting endometriosis in infertility patients, <i>Journal of Reproductive Medicine</i> , 39, 964-6, 1994	Included as one of the studies in the Nisenblat 2016 review
Moloney, M. D., Thornton, J. G., Cooper, E. H., Serum CA 125 antigen levels and disease severity in patients with endometriosis, <i>Obstetrics &amp; Gynecology</i> , 73, 767-9, 1989	Women had laparoscopically confirmed endometriosis and then CA-125 level has been evaluated.
Moretuzzo, R. W., DiLauro, S., Jenison, E., Chen, S. L., Reindollar, R. H., McDonough, P. G., Serum and peritoneal lavage fluid CA-125 levels in endometriosis, <i>Fertility &amp; Sterility</i> , 50, 430-3, 1988	No outcome of interest
Muscatello, R., Cucinelli, F., Fulghesu, A., Lanzone, A., Caruso, A., Mancuso, S., Multiple serum marker assay in the diagnosis of endometriosis, <i>Gynecological Endocrinology</i> , 6, 265-9, 1992	Included as one of the studies in the Nisenblat 2016 review
O'Shaughnessy, A., Check, J. H., Nowroozi, K., Lurie, D., CA 125 levels measured in different phases of the menstrual cycle in screening for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 81, 99-103, 1993	Wrong data and result have been reported.
Ota, H., Maki, M., Evaluation of autoantibody and CA125 in the diagnosis of endometriosis or adenomyosis, <i>Medical Science Research</i> , 18, 309-310, 1990	All the participants had known condition

Study	Reason for Exclusion
Othman, E. E. D. R., Hornung, D., Al-Hendy, A., Biomarkers of endometriosis, Expert Opinion on Medical Diagnostics, 2, 741-752, 2008	Narrative review
Ozaksit, G., Caglar, T., Cicek, N., Kuscu, E., Batioglu, S., Gokmen, O., Serum CA 125 levels before, during and after treatment for endometriosis, International Journal of Gynaecology & Obstetrics, 50, 269-73, 1995	Women had a confirmed diagnosis of endometriosis prior to CA-125 test
Paiva, P., Lappas, M., Barker, G., Healey, M., Using symptom scores, lifestyle measures and biochemical markers to create a test for endometriosis, Journal of Endometriosis and Pelvic Pain Disorders, 6, 135-143, 2014	No outcome of interest
Panidis, D., Vlassis, G., Matalliotakis, J., Skiadopoulou, S., Kalogeropoulos, A., Serum levels of the oncofetal antigens CA-125, CA 19-9 and CA 15-3 in patients with endometriosis, Journal of Endocrinological Investigation, 11, 801-804, 1988	All women who involved in the study have proven endometriosis
Pastorfide, G., Fong, Y. F., Use of narrowband imaging for the detection of endometriosis, Journal of Minimally Invasive Gynecology, 22, 535, 2015	No outcome of interest
Patel, M. D., Feldstein, V. A., Chen, D. C., Lipson, S. D., Filly, R. A., Endometriomas: diagnostic performance of US.[Erratum appears in Radiology 1999 Dec;213(3):930], Radiology, 210, 739-45, 1999	Retrospective review of sonograms by two sonologists
Patel, M. D., Feldstein, V. A., Filly, R. A., The likelihood ratio of sonographic findings for the diagnosis of hemorrhagic ovarian cysts, Journal of Ultrasound in Medicine, 24, 607-14; quiz 615, 2005	It is about diagnosis of haemorrhagic ovarian cyst not endometrioma
Patton, P. E., Field, C. S., Harms, R. W., Coulam, C. B., CA-125 levels in endometriosis, Fertility & Sterility, 45, 770-3, 1986	Included as one of the studies in the Nisenblat 2016 review
Philip, C. A., Bisch, C., Coulon, A., de Saint-Hilaire, P., Rudigoz, R. C., Dubernard, G., Correlation between three-dimensional rectosonography and magnetic resonance imaging in the diagnosis of rectosigmoid endometriosis: a preliminary study on the first fifty cases, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 187, 35-40, 2015	MRI was the reference test
Piessens, S., Healey, M., Maher, P., Tsaltas, J., Rombauts, L., Can anyone screen for deep infiltrating endometriosis with transvaginal ultrasound?, Australian & New Zealand Journal of Obstetrics & Gynaecology, 54, 462-8, 2014	Women included in the study had the ultrasound test after diagnosis of endometriosis by surgery
Pittaway, D. E., Douglas, J. W., Serum CA-125 in women with endometriosis and chronic pelvic pain, Fertility & Sterility, 51, 68-70, 1989	The cut-off for CA-125 is 16 U/ml
Pittaway, D. E., Fayez, J. A., The use of CA-125 in the diagnosis and management of	No separate data for endometriosis

Study	Reason for Exclusion
endometriosis, <i>Fertility &amp; Sterility</i> , 46, 790-5, 1986	
Ramos, I. M. L., Podgaec, S., Abrao, M. S., de Oliveira, R., Baracat, E. C., Evaluation of CA-125 and soluble CD-23 in patients with pelvic endometriosis: A case-control study, <i>Revista Da Associacao Medica Brasileira</i> , 58, 26-32, 2012	Not able to calculate 2x2 table
Randall, G. W., Gantt, P. A., Poe-Zeigler, R. L., Bergmann, C. A., Noel, M. E., Strawbridge, W. R., Richardson-Cox, B., Hereford, J. R., Reiff, R. H., Serum antiendometrial antibodies and diagnosis of endometriosis, <i>American Journal of Reproductive Immunology</i> , 58, 374-82, 2007	The diagnostic test which has been used in this study is not matched with the protocol
Redwine, D. B., Ovarian endometriosis: A marker for more extensive pelvic and intestinal disease, <i>Fertility and Sterility</i> , 72, 310-315, 1999	All the patients have endometriosis
Reid, S., Lu, C., Casikar, I., Reid, G., Abbott, J., Cario, G., Chou, D., Kowalski, D., Cooper, M., Condous, G., Prediction of pouch of Douglas obliteration in women with suspected endometriosis using a new real-time dynamic transvaginal ultrasound technique: the sliding sign, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 41, 685-91, 2013	It has focused on the pouch of Douglas obliteration not only endometriosis
Rosa, E. Silva A. C., Rosa, E. Silva J. C., Ferriani, R. A., Serum CA-125 in the diagnosis of endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 96, 206-7, 2007	Retrospective study. Women included in the study already had a diagnosis of endometriosis prior to CA-125 serum collection
Saba, L., Guerriero, S., Sulcis, R., Ajossa, S., Melis, G., Mallarini, G., Agreement and reproducibility in identification of endometriosis using magnetic resonance imaging, <i>Acta Radiologica</i> , 51, 573-80, 2010	No outcome of interest.
Saba, L., Guerriero, S., Sulis, R., Pilloni, M., Ajossa, S., Melis, G., Mallarini, G., Learning curve in the detection of ovarian and deep endometriosis by using Magnetic Resonance: comparison with surgical results, <i>European Journal of Radiology</i> , 79, 237-44, 2011	The aim of the study was to determine whether diagnostic accuracy is correlated to radiologist expertise
Salehpour, S., Sene, A. A., Mehrjerdi, E. K., Akhoond, M. R., The correlation between serum and peritoneal fluid CA125 level in women with pelvic endometriosis, <i>International Journal of Fertility and Sterility</i> , 3, 29-34, 2009	No data for the CA-125 cut-off $\geq 35$ U/ml
Santulli, P., Streuli, I., Melonio, I., Marcellin, L., M'Baye, M., Bititi, A., Borghese, B., Lafay Pillet, M. C., Chapron, C., Increased serum cancer antigen-125 is a marker for severity of deep endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 22, 275-84, 2015	No data for the CA-125 cut-off of $\geq 35$ U/ml
Scardapane, A., Bettocchi, S., Lorusso, F., Stabile Ianora, A. A., Vimercati, A., Ceci, O., Lasciarrea, M., Angelelli, G., Diagnosis of colorectal endometriosis: contribution of contrast enhanced MR-colonography, <i>European Radiology</i> , 21, 1553-63, 2011	Comparison of MRI between two radiologists

Study	Reason for Exclusion
Scardapane, A., Lorusso, F., Scioscia, M., Ferrante, A., Stabile Ianora, A. A., Angelelli, G., Standard high-resolution pelvic MRI vs. low-resolution pelvic MRI in the evaluation of deep infiltrating endometriosis, <i>European Radiology</i> , 24, 2590-6, 2014	Comparison of MRI carried out by two different radiologists
Schenken, R. S., Improving the diagnosis of endometriosis in adolescents, <i>Sexuality, Reproduction and Menopause</i> , 6, 4-8, 2008	Narrative review
Seeber, B., Sammel, M. D., Fan, X., Gerton, G. L., Shaunik, A., Chittams, J., Barnhart, K. T., Panel of markers can accurately predict endometriosis in a subset of patients, <i>Fertility &amp; Sterility</i> , 89, 1073-81, 2008	It is a case-control study
Shen, A., Xu, S., Ma, Y., Guo, H., Li, C., Yang, C., Zou, S., Diagnostic value of serum CA125, CA19-9 and CA15-3 in endometriosis: A meta-analysis, <i>Journal of International Medical Research</i> , 43, 599-609, 2015	It is about association of biomarkers and stage of endometriosis. No outcome of interest.
Somigliana, E., Vigano, P., Candiani, M., Felicetta, I., Di Blasio, A. M., Vignali, M., Use of serum-soluble intercellular adhesion molecule-1 as a new marker of endometriosis, <i>Fertility &amp; Sterility</i> , 77, 1028-31, 2002	Women included in the study already had laparoscopy prior to CA-125 serum collection
Somigliana, E., Vigano, P., Tirelli, A. S., Felicetta, I., Torresani, E., Vignali, M., Di Blasio, A. M., Use of the concomitant serum dosage of CA 125, CA 19-9 and interleukin-6 to detect the presence of endometriosis. Results from a series of reproductive age women undergoing laparoscopic surgery for benign gynaecological conditions, <i>Human Reproduction</i> , 19, 1871-6, 2004	Included as one of the studies in the Nisenblat 2016 review
Spencer, J. A., Weston, M. J., Imaging in endometriosis, <i>Imaging</i> , 15, 63-71, 2003	Narrative review
Stowell, S. B., Wiley, C. M., Perez-Reyes, N., Powers, C. N., Cytologic diagnosis of peritoneal fluids. Applicability to the laparoscopic diagnosis of endometriosis, <i>Acta Cytologica</i> , 41, 817-22, 1997	The diagnostic test in this study is not matched with the protocol.
Szubert, M., Suzin, J., Wierzbowski, T., Kowalczyk-Amico, K., CA-125 concentration in serum and peritoneal fluid in patients with endometriosis - preliminary results, <i>Archives of Medical Science</i> , 8, 504-8, 2012	Case-control study
Takahashi, K., Nagata, H., Kitao, M., CA-125 in the menstrual blood is an effective marker for diagnosing early stage endometriosis: A preliminary report, <i>Japanese Journal of Fertility and Sterility</i> , 36, 356-359, 1991	Ultrasound was used to confirm ovulatory day only
Takahashi, K., Nagata, H., Musa, A. A., Shibukawa, T., Yamasaki, H., Kitao, M., Clinical usefulness of CA-125 levels in the menstrual discharge in patients with endometriosis, <i>Fertility &amp; Sterility</i> , 54, 360-2, 1990	The level of CA-125 has been assessed in the menstrual discharge

Study	Reason for Exclusion
Takeuchi, M., Matsuzaki, K., Nishitani, H., Susceptibility-weighted MRI of endometrioma: preliminary results, <i>AJR. American Journal of Roentgenology</i> , 191, 1366-70, 2008	No outcome of interest
Tirlapur, S. A., Daniels, J. P., Khan, K. S., Medal trial collaboration, Chronic pelvic pain: how does noninvasive imaging compare with diagnostic laparoscopy?, <i>Current Opinion in Obstetrics &amp; Gynecology</i> , 27, 445-8, 2015	This systematic review has not only focused on patients with suspected endometriosis. It is more general about pelvic pain and diagnostic tools.
Tumedei, U., Ciardelli, V., Paltrinieri, F., Kuria, M. S., Amadori, A., Stefanetti, M., Gori, G., Transvaginal ultrasound in the diagnosis of endometrial abnormalities, <i>Tumori</i> , 87, S15, 2001	It has focused on endometrial abnormalities not endometriosis
Van den Bosch, T., Vandendael, A., Van Schoubroeck, D., Wranz, P. A. B., Lombard, C. J., Combining vaginal ultrasonography and office endometrial sampling in the diagnosis of endometrial disease in postmenopausal women, <i>Obstetrics and Gynecology</i> , 85, 349-352, 1995	It is not about endometriosis, it has addressed endometrial diseases
Vercellini, P., Oldani, S., Felicetta, I., Bramante, T., Rognoni, M. T., Crosignani, P. G., The value of cyst puncture in the differential diagnosis of benign ovarian tumours, <i>Human Reproduction</i> , 10, 1465-9, 1995	Post-menopausal women included
Vrachnis, N., Sifakis, S., Samoli, E., Kappou, D., Pavlakis, K., Iliodromiti, Z., Botsis, D., Three-dimensional ultrasound and three-dimensional power Doppler improve the preoperative evaluation of complex benign ovarian lesions, <i>Clinical &amp; Experimental Obstetrics &amp; Gynecology</i> , 39, 474-8, 2012	No outcome of interest
Walsh, J. W., Taylor, K. J., Wasson, J. F., Schwartz, P. E., Rosenfield, A. T., Gray-scale ultrasound in 204 proved gynecologic masses: accuracy and specific diagnostic criteria, <i>Radiology</i> , 130, 391-7, 1979	No outcome of interest
Wang, L., Liu, H. Y., Shi, H. H., Lang, J. H., Sun, W., Urine peptide patterns for non-invasive diagnosis of endometriosis: a preliminary prospective study, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 177, 23-8, 2014	Biomarker not of interest
Wessels, J. M., Kay, V. R., Leyland, N. A., Agarwal, S. K., Foster, W. G., Assessing brain-derived neurotrophic factor as a novel clinical marker of endometriosis, <i>Fertility &amp; Sterility</i> , 105, 119-128.e5, 2016	Not the test of interest
Wild, R. A., Hirisave, V., Bianco, A., Podczaski, E. S., Demers, L. M., Endometrial antibodies versus CA-125 for the detection of endometriosis, <i>Fertility &amp; Sterility</i> , 55, 90-4, 1991	The cut-off for CA-125 is 16 U/ml
Wolfler, M. M., Nagele, F., Kolbus, A., Seidl, S., Schneider, B., Huber, J. C., Tschugguel, W., A predictive model for endometriosis, <i>Human Reproduction</i> , 20, 1702-8, 2005	Biomarker not of interest

Study	Reason for Exclusion
Yamashita, Y., Torashima, M., Hatanaka, Y., Harada, M., Higashida, Y., Takahashi, M., Mizutani, H., Tashiro, H., Iwamasa, J., Miyazaki, K., et al., Adnexal masses: accuracy of characterization with transvaginal US and precontrast and postcontrast MR imaging, <i>Radiology</i> , 194, 557-65, 1995	Review of MRI and TVUS by five radiologists
Yazbek, J., Helmy, S., Ben-Nagi, J., Holland, T., Sawyer, E., Jurkovic, D., Value of preoperative ultrasound examination in the selection of women with adnexal masses for laparoscopic surgery, <i>Ultrasound in Obstetrics and Gynecology</i> , 30, 883-888, 2007	The preoperative sonography has not been used to diagnose endometriosis
Zapardiel, I., Gorostidi, M., Ravaggi, A., Allende, M. T., Silveira, M., Abehsera, D., MacUks, R., Utility Serum Marker HE4 for the Differential Diagnosis between Endometriosis and Adnexal Malignancy, <i>International Journal of Gynecological Cancer</i> , 26, 52-55, 2016	No data on surgical diagnosis
Zhang, Y., Qiao, C., Li, L., Zhao, X., Li, Y., Serum HE4 is more suitable as a biomarker than CA125 in Chinese women with benign gynecologic disorders, <i>African Health Sciences</i> , 14, 913-8, 2014	No data to calculate the full 2x2 table

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## H.8 Diagnosis – Biomarkers: HE-4

Study	Reason for Exclusion
Abrao, M. S., Goncalves, M. O., Dias, J. A., Jr., Podgaec, S., Chamie, L. P., Blasbalg, R., Comparison between clinical examination, transvaginal sonography and magnetic resonance imaging for the diagnosis of deep endometriosis, <i>Human Reproduction</i> , 22, 3092-7, 2007	Test not of interest
Abrao, M. S., Podgaec, S., Filho, B. M., Ramos, L. O., Pinotti, J. A., de Oliveira, R. M., The use of biochemical markers in the diagnosis of pelvic endometriosis, <i>Human Reproduction</i> , 12, 2523-7, 1997	Case-control study
Abrao, M. S., Podgaec, S., Pinotti, J. A., de Oliveira, R. M., Tumor markers in endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 66, 19-22, 1999	Case-control study
Abu-Musa, A., Takahashi, K., Nagata, H., Yamasaki, H., Mizoguchi, S., Kitao, M., CA-125 in menstrual discharge in patients with chronic pelvic pain, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 37, 111-4, 1992	The level of CA-125 in menstrual discharge has been assessed
Acimovic, M., Vidakovic, S., Milic, N., Jeremic, K., Markovic, M., Milosevic-Djeric, A., Lazovic-Radonjic, G., Survivin and Vegf as Novel Biomarkers in Diagnosis of Endometriosis,	No laparoscopy/ laparotomy and no histological confirmation

Study	Reason for Exclusion
Journal of Medical Biochemistry, 35, 63-68, 2016	
Alcazar, J. L., Laparte, C., Jurado, M., Lopez-Garcia, G., The role of transvaginal ultrasonography combined with color velocity imaging and pulsed Doppler in the diagnosis of endometrioma, Fertility & Sterility, 67, 487-91, 1997	Test not of interest
Aleem, F., Pennisi, J., Zeitoun, K., Predanic, M., The role of color Doppler in diagnosis of endometriomas, Ultrasound in Obstetrics & Gynecology, 5, 51-4, 1995	The aim of this study is to describe vascular appearance in endometriomas. No outcome of interest.
Al-Jefout, M., Dezarnaulds, G., Cooper, M., Tokushige, N., Luscombe, G. M., Markham, R., Fraser, I. S., Diagnosis of endometriosis by detection of nerve fibres in an endometrial biopsy: a double blind study, Human Reproduction (Oxford, England), 24, 3019-24, 2009	Not a test that is routinely carried out
Anaf, V., El Nakadi, I., De Moor, V., Coppens, E., Zalcman, M., Noel, J. C., Anatomic significance of a positive barium enema in deep infiltrating endometriosis of the large bowel, World Journal of Surgery, 33, 822-7, 2009	All patients had surgery and DCBE
Arrive, L., Hricak, H., Martin, M. C., Pelvic endometriosis: MR imaging, Radiology, 171, 687-92, 1989	Test not of interest
Bagan, P., Berna, P., Assouad, J., Hupertan, V., Le Pimpec Barthes, F., Riquet, M., Value of cancer antigen 125 for diagnosis of pleural endometriosis in females with recurrent pneumothorax, European Respiratory Journal, 31, 140-2, 2008	The control group are males
Balasch, J., Creus, M., Fabregues, F., Carmona, F., Ordi, J., Martinez-Roman, S., Vanrell, J. A., Visible and non-visible endometriosis at laparoscopy in fertile and infertile women and in patients with chronic pelvic pain: a prospective study, Human Reproduction, 11, 387-91, 1996	Not a diagnostic study
Balleyguier, C., Roupert, M., Nguyen, T., Kinkel, K., Helenon, O., Chapron, C., Ureteral endometriosis: the role of magnetic resonance imaging, Journal of the American Association of Gynecologic Laparoscopists, 11, 530-6, 2004	No outcome of interest. Moreover, only 6 patients were included
Barcellos, M. B., Lasmar, B., Lasmar, R., Agreement between the preoperative findings and the operative diagnosis in patients with deep endometriosis, Archives of Gynecology & ObstetricsArch Gynecol Obstet, 293, 845-50, 2016	Lesion-level analysis
Bazot, M., Gasner, A., Ballester, M., Darai, E., Value of thin-section oblique axial T2-weighted magnetic resonance images to assess uterosacral ligament endometriosis, Human Reproduction, 26, 346-53, 2011	Retrospective study; one MRI technique compared to conventional technique



Study	Reason for Exclusion
Bazot, M., Gasner, A., Lafont, C., Ballester, M., Darai, E., Deep pelvic endometriosis: limited additional diagnostic value of postcontrast in comparison with conventional MR images, <i>European Journal of Radiology</i> , 80, e331-9, 2011	Retrospective study; comparison of post-contrast MRI versus conventional MRI
Bedaiwy, M. A., Falcone, T., Laboratory testing for endometriosis, <i>Clinica Chimica Acta</i> , 340, 41-56, 2004	Narrative review
Bedaiwy, M. A., Falcone, T., Sharma, R. K., Goldberg, J. M., Attaran, M., Nelson, D. R., Agarwal, A., Prediction of endometriosis with serum and peritoneal fluid markers: a prospective controlled trial, <i>Human Reproduction</i> , 17, 426-31, 2002	Biomarkers not of interest
Belghiti, J., Thomassin-Naggara, I., Zacharopoulou, C., Zilberman, S., Jarboui, L., Bazot, M., Ballester, M., Darai, E., Contribution of Computed Tomography Enema and Magnetic Resonance Imaging to Diagnose Multifocal and Multicentric Bowel Lesions in Patients With Colorectal Endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 22, 776-84, 2015	Lesion-level analysis
Belli, P., De Gaetano, A. M., Mirk, P., Specca, S., Valentini, A. L., Uterine adenomyosis and tubal endometriosis: diagnostic imaging, <i>Rays</i> , 23, 693-701, 1998	Narrative review
Benacerraf, B. R., Finkler, N. J., Wojciechowski, C., Knapp, R. C., Sonographic accuracy in the diagnosis of ovarian masses, <i>Journal of Reproductive Medicine for the Obstetrician and Gynecologist</i> , 35, 491-495, 1990	No outcome of interest
Benacerraf, B. R., Groszmann, Y., Sonography should be the first imaging examination done to evaluate patients with suspected endometriosis, <i>Journal of Ultrasound in Medicine</i> , 31, 651-3, 2012	Narrative review
Bordin, L., Fiore, C., Dona, G., Andrisani, A., Ambrosini, G., Faggian, D., Plebani, M., Clari, G., Armanini, D., Evaluation of erythrocyte band 3 phosphotyrosine level, glutathione content, CA-125, and human epididymal secretory protein E4 as combined parameters in endometriosis, <i>Fertility &amp; Sterility</i> , 94, 1616-21, 2010	All the patients have proven endometriosis
Cheng, Y. M., Wang, S. T., Chou, C. Y., Serum CA-125 in preoperative patients at high risk for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 99, 375-80, 2002	CA-125 has been used for identifying high risk woman not as a diagnostic tool.
Cho, S., Cho, H., Nam, A., Kim, H. Y., Choi, Y. S., Park, K. H., Cho, D. J., Lee, B. S., Neutrophil-to-lymphocyte ratio as an adjunct to CA-125 for the diagnosis of endometriosis, <i>Fertility &amp; Sterility</i> , 90, 2073-9, 2008	It is a case-control study
Chudecka-Glaz, A., Cymbaluk-Ploska, A., Luterek-Puszynska, K., Menkiszak, J., Diagnostic usefulness of the Risk of Ovarian	Women with no suspected endometriosis

Study	Reason for Exclusion
Malignancy Algorithm using the electrochemiluminescence immunoassay for HE4 and the chemiluminescence microparticle immunoassay for CA125, <i>Oncology Letters</i> , 12, 3101-3114, 2016	
Chung, M. K., Chung, R. R., Gordon, D., Jennings, C., The evil twins of chronic pelvic pain syndrome: endometriosis and interstitial cystitis, <i>JSLs : Journal of the Society of Laparoendoscopic Surgeons / Society of Laparoendoscopic Surgeons</i> , 6, 311-314, 2002	No outcome of interest
Cicinelli, E., Resta, L., Nicoletti, R., Tartagni, M., Marinaccio, M., Bulletti, C., Colafoglio, G., Detection of chronic endometritis at fluid hysteroscopy, <i>Journal of Minimally Invasive Gynecology</i> , 12, 514-518, 2005	Comparison not of interest
Cohen, L. S., Valle, R. F., Sabbagha, R. E., A comparison of preoperative ultrasound images of surgically proven endometriomas scanned by both transabdominal and transvaginal techniques, <i>Journal of Gynecologic Surgery</i> , 11, 27-32, 1995	All the patients have surgically confirmed endometriosis
Cohen, M. R., Laparoscopy in the diagnosis and management of endometriosis, <i>Journal of Reproductive Medicine</i> , 27, 240-2, 1982	No outcome of interest
Colacurci, N., Fortunato, N., De Franciscis, P., Fratta, M., Cioffi, M., Zarcone, R., Cardone, A., Serum and peritoneal CA-125 levels as diagnostic test for endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 66, 41-3, 1996	Case-control study
Coleman, B. G., Arger, P. H., Mulhern, C. B., Jr., Endometriosis: clinical and ultrasonic correlation, <i>AJR. American Journal of Roentgenology</i> , 132, 747-9, 1979	All patients were recruited in this study, had surgically proven endometriosis
Corwin, M. T., Gerscovich, E. O., Lamba, R., Wilson, M., McGahan, J. P., Differentiation of ovarian endometriomas from hemorrhagic cysts at MR imaging: utility of the T2 dark spot sign, <i>Radiology</i> , 271, 126-32, 2014	Using a diagnostic test to diagnose endometriosis has not been addressed in this study. It is about a sign in MRI to distinguish between Endometrioma and haemorrhagic cysts.
Daniilidis, A., Giannoulis, H., Tantanasis, T., Papathanasiou, K., Loufopoulos, A., Tzafettas, J., Diagnostic laparoscopy, infertility, and endometriosis - 5 Years experience, <i>Gynecological Surgery</i> , 5, 231-234, 2008	Outcomes not of interest
Dechaud, H., Ali Ahmed, S. A., Aligier, N., Vergnes, C., Hedon, B., Does transvaginal hydrolaparoscopy render standard diagnostic laparoscopy obsolete for unexplained infertility investigation?, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 94, 97-102, 2001	Transvaginal hydrolaparoscopy compared with conventional laparoscopy; no data for outcomes
do Amaral, V. F., Ferriani, R. A., de Sa, M. F. S., Nogueira, A. A., Silva, J. C. R., de Sa Rosa e Silva, A. C. J., de Moura, M. D., Positive correlation between serum and peritoneal fluid CA-125 levels in women with pelvic	It is a case-control study

Study	Reason for Exclusion
endometriosis, Sao Paulo Medical Journal, 124, 223-227, 2006	
Dunselman, G. A. J., Vermeulen, N., Becker, C., Calhaz-Jorge, C., D'Hooghe, T., De Bie, B., Heikinheimo, O., Horne, A. W., Kiesel, L., Nap, A., Prentice, A., Saridogan, E., Soriano, D., Nelen, W., ESHRE guideline: Management of women with endometriosis, Human Reproduction, 29, 400-412, 2014	The individual studies in this publication have been checked for inclusion in the review
El Maati, A. A. A., Ibrahim, E. A. G., Mokhtar, F. Z., A two-stage imaging protocol for evaluating women presenting with acute pelvic pain, Egyptian Journal of Radiology and Nuclear Medicine, 44, 923-936, 2013	The population is women with acute pelvic pain, not suspected endometriosis
Elgafor El Sharkwy, I. A., Combination of non-invasive and semi-invasive tests for diagnosis of minimal to mild endometriosis, Archives of gynecology and obstetrics, 288, 793-7, 2013	The diagnostic test (IL-6 combined with nerve fibers) which has been used in this study is not matched with the protocol.
Ellett, L., Readman, E., Newman, M., McIlwaine, K., Villegas, R., Jagasia, N., Maher, P., Are endometrial nerve fibres unique to endometriosis? A prospective case-control study of endometrial biopsy as a diagnostic test for endometriosis in women with pelvic pain, Human Reproduction, 30, 2808-15, 2015	Case-control study
Exacoustos, C., Luciano, D., Corbett, B., De Felice, G., Di Felicianantonio, M., Luciano, A., Zupi, E., The uterine junctional zone: a 3-dimensional ultrasound study of patients with endometriosis, American Journal of Obstetrics & Gynecology, 209, 248.e1-7, 2013	In the study, the relation between thickness of uterine junctional zone and endometriosis has been evaluated. It has not been used as a diagnostic tool.
Faccioli, N., Manfredi, R., Mainardi, P., Dalla Chiara, E., Spoto, E., Minelli, L., Mucelli, R. P., Barium enema evaluation of colonic involvement in endometriosis, AJR. American Journal of Roentgenology, 190, 1050-4, 2008	The diagnostic test (Barium enema) which has been used in this study is not matched with the protocol.
Federici, D., Muggiasca, M. L., Conti, M., Diagnostic value of laparoscopic evaluation of women with chronic pelvic pain: Our experience and a review of the literature, VALEUR DIAGNOSTIQUE DE L'EXPLORATION LAPAROSCOPIQUE DES FEMMES SOUFFRANT DE DOULEURS PELVIENNES CHRONIQUES: EXPERIENCE PERSONNELLE ET REVUE DE LA LITTERATURE, Acta Endoscopica, 22, 177-186, 1992	Narrative review
Felding, C., Mikkelsen, A. L., Peen, U., Laparoscopy and ultrasound in patients with chronic pelvic pain, Journal of Obstetrics and Gynaecology, 10, 419-422, 1990	No outcome of interest
Fisk, N. M., Tan, C. E., CA 125 in peritoneal fluid and serum of patients with endometriosis, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 29, 153-8, 1988	Case-control study
Foda, A. A., Aal, I. A. A., Role of some biomarkers in chronic pelvic pain for early detection of endometriosis in infertile women,	Case-control study

Study	Reason for Exclusion
Middle East Fertility Society Journal, 17, 187-194, 2012	
Fratelli, N., Scioscia, M., Bassi, E., Musola, M., Minelli, L., Trivella, G., Transvaginal sonography for preoperative assessment of deep endometriosis, Journal of Clinical Ultrasound, 41, 69-75, 2013	Data for TVS was collected retrospectively
Friedman, H., Vogelzang, R. L., Mendelson, E. B., Neiman, H. L., Cohen, M., Endometriosis detection by US with laparoscopic correlation, Radiology, 157, 217-20, 1985	No data on outcomes
Gougoutas, C. A., Siegelman, E. S., Hunt, J., Outwater, E. K., Pelvic endometriosis: various manifestations and MR imaging findings, AJR. American Journal of Roentgenology, 175, 353-8, 2000	Narrative review
Gurgan, T., Kisinisci, H., Yarali, H., Aksu, T., Zeyneloglu, H., Develioglu, O., Serum and peritoneal fluid CA-125 levels in early stage endometriosis, Gynecologic & Obstetric Investigation, 30, 105-8, 1990	The cut-off for CA-125 is 16 U/ml
Güven, M. A., Bese, T., Demirkiran, F., Comparison of hydrosoneography and transvaginal ultrasonography in the detection of intracavitary pathologies in women with abnormal uterine bleeding, International Journal of Gynecological Cancer, 14, 57-63, 2004	The study population are women with history of abnormal uterine bleeding not women suspected to endometriosis.
Harada, T., Kubota, T., Aso, T., Usefulness of CA19-9 versus CA125 for the diagnosis of endometriosis, Fertility and Sterility, 78, 733-739, 2002	Case-control study
Hompes, P. G., Koninckx, P. R., Kennedy, S., van Kamp, G. F., Verstraeten, R. A., Cornillie, F., Serum CA-125 concentrations during midfollicular phase, a clinically useful and reproducible marker in diagnosis of advanced endometriosis, Clinical Chemistry, 42, 1871-4, 1996	No outcome of interest has been reported
Hornstein, M. D., Harlow, B. L., Thomas, P. P., Check, J. H., Use of a new CA 125 assay in the diagnosis of endometriosis, Human Reproduction, 10, 932-4, 1995	The reported result has adjusted for prevalence of endometriosis in the community. This data is not useful for our systematic review.
Howard, F. M., El-Minawi, A. M., Sanchez, R. A., Conscious pain mapping by laparoscopy in women with chronic pelvic pain, Obstetrics & Gynecology, 96, 934-9, 2000	The study investigated conscious pain mapping using laparoscopy
Ikeda, F., Bernardini, M. A., Vanni, D., Vasconcelos, A., Pinotti, J. A., Abrao, M. S., A comparison of microlaparoscopy under sedation, microlaparoscopy under general anesthesia and conventional laparoscopy for diagnosis and treatment of pelvic endometriosis in early stages, Fertility and sterility, 77, S21, 2002	The effectiveness of using a diagnostic tool for diagnosis of endometriosis has not been addressed.
Ismail, M. A., Rotmensch, J., Mercer, L. J., Block, B. S., Salti, G. I., Holt, J. A., CA-125 in peritoneal fluid from patients with nonmalignant	The women without any symptom who went through laparoscopic sterilization have been considered as control group.

Study	Reason for Exclusion
gynecologic disorders, Journal of Reproductive Medicine, 39, 510-2, 1994	
Johnson, W. K., Ott, D. J., Chen, M. Y. M., Fayez, J. A., Gelfand, D. W., Efficacy of hysterosalpingography in evaluating endometriosis, Abdominal Imaging, 19, 278-280, 1994	The study evaluated the effectiveness of hysterosalpingography and laparoscopy-retrospective study
Kafali, H., Artuc, H., Demir, N., Use of CA125 fluctuation during the menstrual cycle as a tool in the clinical diagnosis of endometriosis; a preliminary report, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 116, 85-8, 2004	It is a case-control study
Kang, S. B., Chung, H. H., Lee, H. P., Lee, J. Y., Chang, Y. S., Impact of diagnostic laparoscopy on the management of chronic pelvic pain, Surgical Endoscopy, 21, 916-9, 2007	there was no comparison between laparoscopy and another test
Karabacak, O., Tiras, M. B., Taner, M. Z., Guner, H., Yildiz, A., Yildirim, M., Small diameter versus conventional laparoscopy: a prospective, self-controlled study, Human Reproduction, 12, 2399-401, 1997	Comparison of two types of laparoscopy
Kitawaki, J., Ishihara, H., Koshiba, H., Kiyomizu, M., Teramoto, M., Kitaoka, Y., Honjo, H., Usefulness and limits of CA-125 in diagnosis of endometriosis without associated ovarian endometriomas.[Erratum appears in Hum Reprod. 2007 Feb;22(2):627], Human Reproduction, 20, 1999-2003, 2005	Women enrolled in the study were already diagnosed with endometriosis, adenomyosis and/or leiomyomas
Koninckx, P. R., Riittinen, L., Seppala, M., Cornillie, F. J., CA-125 and placental protein 14 concentrations in plasma and peritoneal fluid of women with deeply infiltrating pelvic endometriosis, Fertility & Sterility, 57, 523-30, 1992	Wrong data and result have been reported.
Kruger, K., Behrendt, K., Niedobitek-Kreuter, G., Koltermann, K., Ebert, A. D., Location-dependent value of pelvic MRI in the preoperative diagnosis of endometriosis, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 169, 93-8, 2013	Pelvic MRI retrospectively assessed with histology
Kruitwagen, R. F., Thomas, C., Poels, L. G., Koster, A. M., Willemsen, W. N., Rolland, R., High CA-125 concentrations in peritoneal fluid of normal cyclic women with various infertility-related factors as demonstrated with two-step immunoradiometric assay, Fertility & Sterility, 56, 863-9, 1991	The outcome of interest has not been reported
Leslie, C., Ma, T., McElhinney, B., Leake, R., Stewart, C. J., Is the detection of endometrial nerve fibers useful in the diagnosis of endometriosis?, International Journal of Gynecological Pathology, 32, 149-55, 2013	Included as one of the studies in Gupta et al. 2016 review
Li, G., Yu, Z., Li, K., The value of FS, NLR, and CA-125 in the diagnosis of endometriosis, International journal of clinical and experimental medicine, 9, 7309-7313, 2016	Not the population of interest

Study	Reason for Exclusion
Macer, M. L., Mathur, M., Spektor, M., Gysler, S., Staib, L., Kodaman, P., McCarthy, S., Utility of magnetic resonance imaging in the evaluation of intraoperatively confirmed pelvic adhesions, <i>Journal of Computer Assisted Tomography</i> , 39, 896-900, 2015	Not the population of interest
Malik, E., Berg, C., Meyhofer-Malik, A., Buchweitz, O., Moubayed, P., Diedrich, K., Fluorescence diagnosis of endometriosis using 5-aminolevulinic acid, <i>Surgical Endoscopy</i> , 14, 452-5, 2000	The test is not of interest
Manganaro, L., Fierro, F., Tomei, A., Irimia, D., Lodise, P., Sergi, M. E., Vinci, V., Sollazzo, P., Porpora, M. G., Delfini, R., Vittori, G., Marini, M., Feasibility of 3.0T pelvic MR imaging in the evaluation of endometriosis, <i>European Journal of Radiology</i> , 81, 1381-7, 2012	Women in the study already had a diagnosis of endometriosis by transvaginal ultrasound
Martinez, S., Garrido, N., Coperias, J. L., Pardo, F., Desco, J., Garcia-Velasco, J. A., Simon, C., Pellicer, A., Serum interleukin-6 levels are elevated in women with minimal-mild endometriosis, <i>Human Reproduction</i> , 22, 836-42, 2007	It is a case-control study
Mathlouthi, N., Ayed, B. B., Dhouib, M., Chaabene, K., Trabelsi, K., Amouri, H., Guermazi, M., Confrontation ultrasonography-CA125-histology in the management of ovarian cysts: A prospective study about 77 cases, <i>Tunisie Medicale</i> , 89, 686-692, 2011	Full-text in French
May, K. E., Conduit-Hulbert, S. A., Villar, J., Kirtley, S., Kennedy, S. H., Becker, C. M., Peripheral biomarkers of endometriosis: a systematic review, <i>Human Reproduction Update</i> , 16, 651-74, 2010	This systematic review includes papers also regarding other biomarkers. The full texts of individual related studies were retrieved and reviewed.
May, K. E., Villar, J., Kirtley, S., Kennedy, S. H., Becker, C. M., Endometrial alterations in endometriosis: a systematic review of putative biomarkers, <i>Human Reproduction Update</i> , 17, 637-53, 2011	Single studies from the review were assessed for inclusion
McBride, N., Newman, R. L., Diagnostic laparoscopy, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 15, 556-8, 1978	No outcome of interest
McKinnon, B., Mueller, M. D., Nirgianakis, K., Bersinger, N. A., Comparison of ovarian cancer markers in endometriosis favours HE4 over CA125, <i>Molecular Medicine Reports</i> , 12, 5179-84, 2015	No data reported to calculate sensitivity
Medl, M., Ogris, E., Peters-Engl, C., Mierau, M., Buxbaum, P., Leodolter, S., Serum levels of the tumour-associated trypsin inhibitor in patients with endometriosis, <i>British Journal of Obstetrics &amp; Gynaecology</i> , 104, 78-81, 1997	Wrong data and result have been reported
Melega, C., Marchesini, F. P., Bellettini, L., Biscontin, S., Flamigni, C., Diagnostic value of laparoscopy in endometriosis and infertility, <i>Journal of Reproductive Medicine</i> , 29, 597-600, 1984	No outcome of interest

Study	Reason for Exclusion
Mezzi, G., Ferrari, S., Arcidiacono, P. G., Di Puppo, F., Candiani, M., Testoni, P. A., Endoscopic rectal ultrasound and elastosonography are useful in flow chart for the diagnosis of deep pelvic endometriosis with rectal involvement, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 37, 586-90, 2011	There was no comparison with surgery
Mikami, M., Tanabe, K., Matsuo, K., Miyazaki, Y., Miyazawa, M., Hayashi, M., Asai, S., Ikeda, M., Shida, M., Hirasawa, T., Kojima, N., Sho, R., Iijima, S., Fully-sialylated alpha-chain of complement 4-binding protein: Diagnostic utility for ovarian clear cell carcinoma, <i>Gynecologic Oncology</i> , 139, 520-528, 2015	Not the population of interest
Millischer, A. E., Salomon, L. J., Santulli, P., Borghese, B., Dousset, B., Chapron, C., Fusion imaging for evaluation of deep infiltrating endometriosis: feasibility and preliminary results, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 46, 109-17, 2015	No data on surgical diagnosis
Miyagi, E., Maruyama, Y., Mogami, T., Numazaki, R., Ikeda, A., Yamamoto, H., Hirahara, F., Comparison of plasma amino acid profile-based index and CA125 in the diagnosis of epithelial ovarian cancers and borderline malignant tumors, <i>International Journal of Clinical Oncology</i> , 1-8, 2016	Not the population of interest
Mol, B. W., Bayram, N., Lijmer, J. G., Wiegerinck, M. A., Bongers, M. Y., van der Veen, F., Bossuyt, P. M., The performance of CA-125 measurement in the detection of endometriosis: a meta-analysis, <i>Fertility &amp; Sterility</i> , 70, 1101-8, 1998	All the studies included in this systematic review could not be included in our systematic review. The full-texts of all individual studies were retrieved and reviewed and related studies were included in our review.
Moloney, M. D., Thornton, J. G., Cooper, E. H., Serum CA 125 antigen levels and disease severity in patients with endometriosis, <i>Obstetrics &amp; Gynecology</i> , 73, 767-9, 1989	Women had laparoscopically confirmed endometriosis and then CA-125 level has been evaluated.
Moretuzzo, R. W., DiLauro, S., Jenison, E., Chen, S. L., Reindollar, R. H., McDonough, P. G., Serum and peritoneal lavage fluid CA-125 levels in endometriosis, <i>Fertility &amp; Sterility</i> , 50, 430-3, 1988	No outcome of interest
O'Shaughnessy, A., Check, J. H., Nowroozi, K., Lurie, D., CA 125 levels measured in different phases of the menstrual cycle in screening for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 81, 99-103, 1993	Wrong data and result have been reported
Ota, H., Maki, M., Evaluation of autoantibody and CA125 in the diagnosis of endometriosis or adenomyosis, <i>Medical Science Research</i> , 18, 309-310, 1990	All the participants had known condition
Othman, E. E. D. R., Hornung, D., Al-Hendy, A., Biomarkers of endometriosis, <i>Expert Opinion on Medical Diagnostics</i> , 2, 741-752, 2008	Narrative review
Ozaksit, G., Caglar, T., Cicek, N., Kuscu, E., Batioglu, S., Gokmen, O., Serum CA 125 levels before, during and after treatment for	Women had a confirmed diagnosis of endometriosis prior to CA-125 test

Study	Reason for Exclusion
endometriosis, International Journal of Gynaecology & Obstetrics, 50, 269-73, 1995	
Paiva, P., Lappas, M., Barker, G., Healey, M., Using symptom scores, lifestyle measures and biochemical markers to create a test for endometriosis, Journal of Endometriosis and Pelvic Pain Disorders, 6, 135-143, 2014	No outcome of interest
Panidis, D., Vlassis, G., Matalliotakis, J., Skiadopoulou, S., Kalogeropoulos, A., Serum levels of the oncofetal antigens CA-125, CA 19-9 and CA 15-3 in patients with endometriosis, Journal of Endocrinological Investigation, 11, 801-804, 1988	All women who involved in the study have proven endometriosis
Pastorfide, G., Fong, Y. F., Use of narrowband imaging for the detection of endometriosis, Journal of Minimally Invasive Gynecology, 22, 535, 2015	No outcome of interest
Patel, M. D., Feldstein, V. A., Chen, D. C., Lipson, S. D., Filly, R. A., Endometriomas: diagnostic performance of US.[Erratum appears in Radiology 1999 Dec;213(3):930], Radiology, 210, 739-45, 1999	Retrospective review of sonograms by two sonologists
Patel, M. D., Feldstein, V. A., Filly, R. A., The likelihood ratio of sonographic findings for the diagnosis of hemorrhagic ovarian cysts, Journal of Ultrasound in Medicine, 24, 607-14; quiz 615, 2005	It is about diagnosis of haemorrhagic ovarian cyst not endometrioma
Patton, P. E., Field, C. S., Harms, R. W., Coulam, C. B., CA-125 levels in endometriosis, Fertility & Sterility, 45, 770-3, 1986	Women who come for elective sterilization have been also included in this study, while they are not suspected for endometriosis.
Philip, C. A., Bisch, C., Coulon, A., de Saint-Hilaire, P., Rudigoz, R. C., Dubernard, G., Correlation between three-dimensional rectosonography and magnetic resonance imaging in the diagnosis of rectosigmoid endometriosis: a preliminary study on the first fifty cases, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 187, 35-40, 2015	MRI was the reference test
Piessens, S., Healey, M., Maher, P., Tsaltas, J., Rombauts, L., Can anyone screen for deep infiltrating endometriosis with transvaginal ultrasound?, Australian & New Zealand Journal of Obstetrics & Gynaecology, 54, 462-8, 2014	Women included in the study had the ultrasound test after diagnosis of endometriosis by surgery
Pittaway, D. E., Douglas, J. W., Serum CA-125 in women with endometriosis and chronic pelvic pain, Fertility & Sterility, 51, 68-70, 1989	The cut-off for CA-125 is 16 U/ml
Polisseni, F., Bambirra, E. A., Camargos, A. F., Detection of chronic endometritis by diagnostic hysteroscopy in asymptomatic infertile patients, Gynecologic & Obstetric Investigation, 55, 205-10, 2003	Comparison not of interest
Randall, G. W., Gantt, P. A., Poe-Zeigler, R. L., Bergmann, C. A., Noel, M. E., Strawbridge, W. R., Richardson-Cox, B., Hereford, J. R., Reiff, R. H., Serum antiendometrial antibodies and	The diagnostic test which has been used in this study is not matched with the protocol



Study	Reason for Exclusion
diagnosis of endometriosis, American Journal of Reproductive Immunology, 58, 374-82, 2007	
Redwine, D. B., Ovarian endometriosis: A marker for more extensive pelvic and intestinal disease, Fertility and Sterility, 72, 310-315, 1999	All the patients have endometriosis
Reid, S., Lu, C., Casikar, I., Reid, G., Abbott, J., Cario, G., Chou, D., Kowalski, D., Cooper, M., Condous, G., Prediction of pouch of Douglas obliteration in women with suspected endometriosis using a new real-time dynamic transvaginal ultrasound technique: the sliding sign, Ultrasound in Obstetrics & Gynecology, 41, 685-91, 2013	It has focused on the pouch of Douglas obliteration not only endometriosis
Rosa, E. Silva A. C., Rosa, E. Silva J. C., Ferriani, R. A., Serum CA-125 in the diagnosis of endometriosis, International Journal of Gynaecology & Obstetrics, 96, 206-7, 2007	Retrospective study. Women included in the study already had a diagnosis of endometriosis prior to CA-125 serum collection
Saba, L., Guerriero, S., Sulcis, R., Ajossa, S., Melis, G., Mallarini, G., Agreement and reproducibility in identification of endometriosis using magnetic resonance imaging, Acta Radiologica, 51, 573-80, 2010	No outcome of interest.
Saba, L., Guerriero, S., Sulis, R., Pilloni, M., Ajossa, S., Melis, G., Mallarini, G., Learning curve in the detection of ovarian and deep endometriosis by using Magnetic Resonance: comparison with surgical results, European Journal of Radiology, 79, 237-44, 2011	The aim of the study was to determine whether diagnostic accuracy is correlated to radiologist expertise
Scardapane, A., Bettocchi, S., Lorusso, F., Stabile Ianora, A. A., Vimercati, A., Ceci, O., Lasciarrea, M., Angelelli, G., Diagnosis of colorectal endometriosis: contribution of contrast enhanced MR-colonography, European Radiology, 21, 1553-63, 2011	Comparison of MRI between two radiologists
Scardapane, A., Lorusso, F., Scioscia, M., Ferrante, A., Stabile Ianora, A. A., Angelelli, G., Standard high-resolution pelvic MRI vs. low-resolution pelvic MRI in the evaluation of deep infiltrating endometriosis, European Radiology, 24, 2590-6, 2014	Comparison of MRI carried out by two different radiologists
Schenken, R. S., Improving the diagnosis of endometriosis in adolescents, Sexuality, Reproduction and Menopause, 6, 4-8, 2008	Narrative review
Seeber, B., Sammel, M. D., Fan, X., Gerton, G. L., Shaunik, A., Chittams, J., Barnhart, K. T., Panel of markers can accurately predict endometriosis in a subset of patients, Fertility & Sterility, 89, 1073-81, 2008	It is a case-control study
Shen, A., Xu, S., Ma, Y., Guo, H., Li, C., Yang, C., Zou, S., Diagnostic value of serum CA125, CA19-9 and CA15-3 in endometriosis: A meta-analysis, Journal of International Medical Research, 43, 599-609, 2015	It is about association of biomarkers and stage of endometriosis. No outcome of interest.
Somigliana, E., Vigano, P., Candiani, M., Felicetta, I., Di Blasio, A. M., Vignali, M., Use of serum-soluble intercellular adhesion molecule-1	Women included in the study already had laparoscopy prior to CA-125 serum collection

Study	Reason for Exclusion
as a new marker of endometriosis, <i>Fertility &amp; Sterility</i> , 77, 1028-31, 2002	
Somigliana, E., Vigano, P., Tirelli, A. S., Felicetta, I., Torresani, E., Vignali, M., Di Blasio, A. M., Use of the concomitant serum dosage of CA 125, CA 19-9 and interleukin-6 to detect the presence of endometriosis. Results from a series of reproductive age women undergoing laparoscopic surgery for benign gynaecological conditions, <i>Human Reproduction</i> , 19, 1871-6, 2004	Case-control study
Spencer, J. A., Weston, M. J., Imaging in endometriosis, <i>Imaging</i> , 15, 63-71, 2003	Narrative review
Stowell, S. B., Wiley, C. M., Perez-Reyes, N., Powers, C. N., Cytologic diagnosis of peritoneal fluids. Applicability to the laparoscopic diagnosis of endometriosis, <i>Acta Cytologica</i> , 41, 817-22, 1997	The diagnostic test in this study is not matched with the protocol
Szubert, M., Suzin, J., Wierzbowski, T., Kowalczyk-Amico, K., CA-125 concentration in serum and peritoneal fluid in patients with endometriosis - preliminary results, <i>Archives of Medical Science</i> , 8, 504-8, 2012	Case-control study
Takahashi, K., Nagata, H., Kitao, M., CA-125 in the menstrual blood is an effective marker for diagnosing early stage endometriosis: A preliminary report, <i>Japanese Journal of Fertility and Sterility</i> , 36, 356-359, 1991	Ultrasound was used to confirm ovulatory day only
Takahashi, K., Nagata, H., Musa, A. A., Shibukawa, T., Yamasaki, H., Kitao, M., Clinical usefulness of CA-125 levels in the menstrual discharge in patients with endometriosis, <i>Fertility &amp; Sterility</i> , 54, 360-2, 1990	The level of CA-125 has been assessed in the menstrual discharge
Takeuchi, M., Matsuzaki, K., Nishitani, H., Susceptibility-weighted MRI of endometrioma: preliminary results, <i>AJR. American Journal of Roentgenology</i> , 191, 1366-70, 2008	No outcome of interest
Tirlapur, S. A., Daniels, J. P., Khan, K. S., Medal trial collaboration, Chronic pelvic pain: how does noninvasive imaging compare with diagnostic laparoscopy?, <i>Current Opinion in Obstetrics &amp; Gynecology</i> , 27, 445-8, 2015	This systematic review has not only focused on patients with suspected endometriosis. It is more general about pelvic pain and diagnostic tools.
Tumedei, U., Ciardelli, V., Paltrinieri, F., Kuria, M. S., Amadori, A., Stefanetti, M., Gori, G., Transvaginal ultrasound in the diagnosis of endometrial abnormalities, <i>Tumori</i> , 87, S15, 2001	It has focused on endometrial abnormalities not endometriosis
Van den Bosch, T., Vandendael, A., Van Schoubroeck, D., Wranz, P. A. B., Lombard, C. J., Combining vaginal ultrasonography and office endometrial sampling in the diagnosis of endometrial disease in postmenopausal women, <i>Obstetrics and Gynecology</i> , 85, 349-352, 1995	It is not about endometriosis, it has addressed endometrial diseases
Vrachnis, N., Sifakis, S., Samoli, E., Kappou, D., Pavlakis, K., Iliodromiti, Z., Botsis, D., Three-dimensional ultrasound and three-dimensional power Doppler improve the preoperative	No outcome of interest

Study	Reason for Exclusion
evaluation of complex benign ovarian lesions, <i>Clinical &amp; Experimental Obstetrics &amp; Gynecology</i> , 39, 474-8, 2012	
Walsh, J. W., Taylor, K. J., Wasson, J. F., Schwartz, P. E., Rosenfield, A. T., Gray-scale ultrasound in 204 proved gynecologic masses: accuracy and specific diagnostic criteria, <i>Radiology</i> , 130, 391-7, 1979	No outcome of interest
Wang, L., Liu, H. Y., Shi, H. H., Lang, J. H., Sun, W., Urine peptide patterns for non-invasive diagnosis of endometriosis: a preliminary prospective study, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 177, 23-8, 2014	Biomarker not of interest
Wessels, J. M., Kay, V. R., Leyland, N. A., Agarwal, S. K., Foster, W. G., Assessing brain-derived neurotrophic factor as a novel clinical marker of endometriosis, <i>Fertility &amp; Sterility</i> , 105, 119-128.e5, 2016	Not the test of interest
Wild, R. A., Hirisave, V., Bianco, A., Podczaski, E. S., Demers, L. M., Endometrial antibodies versus CA-125 for the detection of endometriosis, <i>Fertility &amp; Sterility</i> , 55, 90-4, 1991	The cut-off for CA-125 is 16 U/ml
Wolfler, M. M., Nagele, F., Kolbus, A., Seidl, S., Schneider, B., Huber, J. C., Tschugguel, W., A predictive model for endometriosis, <i>Human Reproduction</i> , 20, 1702-8, 2005	Biomarker not of interest
Yamashita, Y., Torashima, M., Hatanaka, Y., Harada, M., Higashida, Y., Takahashi, M., Mizutani, H., Tashiro, H., Iwamasa, J., Miyazaki, K., et al., Adnexal masses: accuracy of characterization with transvaginal US and precontrast and postcontrast MR imaging, <i>Radiology</i> , 194, 557-65, 1995	Review of MRI and TVUS by five radiologists
Yazbek, J., Helmy, S., Ben-Nagi, J., Holland, T., Sawyer, E., Jurkovic, D., Value of preoperative ultrasound examination in the selection of women with adnexal masses for laparoscopic surgery, <i>Ultrasound in Obstetrics and Gynecology</i> , 30, 883-888, 2007	The preoperative sonography has not been used to diagnose endometriosis
Zapardiel, I., Gorostidi, M., Ravaggi, A., Allende, M. T., Silveira, M., Abehsera, D., MacUks, R., Utility Serum Marker HE4 for the Differential Diagnosis between Endometriosis and Adnexal Malignancy, <i>International Journal of Gynecological Cancer</i> , 26, 52-55, 2016	No data on surgical diagnosis
Zhang Y, Qiao C, Li L, Zhao X, Li Y. Serum HE4 is more suitable as a biomarker than CA125 in Chinese women with benign gynecologic disorders. <i>Afr Health Sci</i> , 14(4):913-8, 2014	Included in the nerve fibres question

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## H.9 Diagnosis – Biomarkers: Nerve fibre marker Protein Gene Product 9.5 (PGP 9.5)

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Study	Reason for Exclusion
Abrao, M. S., Goncalves, M. O., Dias, J. A., Jr., Podgaec, S., Chamie, L. P., Blasbalg, R., Comparison between clinical examination, transvaginal sonography and magnetic resonance imaging for the diagnosis of deep endometriosis, <i>Human Reproduction</i> , 22, 3092-7, 2007	Test not of interest
Abrao, M. S., Podgaec, S., Filho, B. M., Ramos, L. O., Pinotti, J. A., de Oliveira, R. M., The use of biochemical markers in the diagnosis of pelvic endometriosis, <i>Human Reproduction</i> , 12, 2523-7, 1997	Case-control study
Abrao, M. S., Podgaec, S., Pinotti, J. A., de Oliveira, R. M., Tumor markers in endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 66, 19-22, 1999	Case-control study
Abu-Musa, A., Takahashi, K., Nagata, H., Yamasaki, H., Mizoguchi, S., Kitao, M., CA-125 in menstrual discharge in patients with chronic pelvic pain, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 37, 111-4, 1992	The level of CA-125 in menstrual discharge has been assessed
Acimovic, M., Vidakovic, S., Milic, N., Jeremic, K., Markovic, M., Milosevic-Djeric, A., Lazovic-Radonjic, G., Survivin and Vegf as Novel Biomarkers in Diagnosis of Endometriosis, <i>Journal of Medical Biochemistry</i> , 35, 63-68, 2016	No laparoscopy/ laparotomy and no histological confirmation
Alcazar, J. L., Laparte, C., Jurado, M., Lopez-Garcia, G., The role of transvaginal ultrasonography combined with color velocity imaging and pulsed Doppler in the diagnosis of endometrioma, <i>Fertility &amp; Sterility</i> , 67, 487-91, 1997	Test not of interest
Aleem, F., Pennisi, J., Zeitoun, K., Predanic, M., The role of color Doppler in diagnosis of endometriomas, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 5, 51-4, 1995	The aim of this study is to describe vascular appearance in endometriomas. No outcome of interest.
Al-Jefout, M., Dezarnaulds, G., Cooper, M., Tokushige, N., Luscombe, G. M., Markham, R., Fraser, I. S., Diagnosis of endometriosis by detection of nerve fibres in an endometrial biopsy: a double blind study, <i>Human Reproduction (Oxford, England)</i> , 24, 3019-24, 2009	Not a test that is routinely carried out
Anaf, V., El Nakadi, I., De Moor, V., Coppens, E., Zalcman, M., Noel, J. C., Anatomic significance of a positive barium enema in deep infiltrating endometriosis of the large bowel, <i>World Journal of Surgery</i> , 33, 822-7, 2009	All patients had surgery and DCBE
Arrive, L., Hricak, H., Martin, M. C., Pelvic endometriosis: MR imaging, <i>Radiology</i> , 171, 687-92, 1989	Test not of interest
Bagan, P., Berna, P., Assouad, J., Hupertan, V., Le Pimpec Barthes, F., Riquet, M., Value of	The control group are males

Study	Reason for Exclusion
cancer antigen 125 for diagnosis of pleural endometriosis in females with recurrent pneumothorax, <i>European Respiratory Journal</i> , 31, 140-2, 2008	
Balasch, J., Creus, M., Fabregues, F., Carmona, F., Ordi, J., Martinez-Roman, S., Vanrell, J. A., Visible and non-visible endometriosis at laparoscopy in fertile and infertile women and in patients with chronic pelvic pain: a prospective study, <i>Human Reproduction</i> , 11, 387-91, 1996	Not a diagnostic study
Balleyguier, C., Roupret, M., Nguyen, T., Kinkel, K., Helenon, O., Chapron, C., Ureteral endometriosis: the role of magnetic resonance imaging, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 11, 530-6, 2004	No outcome of interest. Moreover, only 6 patients were included
Barcellos, M. B., Lasmar, B., Lasmar, R., Agreement between the preoperative findings and the operative diagnosis in patients with deep endometriosis, <i>Archives of Gynecology &amp; Obstetrics</i> Arch Gynecol Obstet, 293, 845-50, 2016	Lesion-level analysis
Bazot, M., Gasner, A., Ballester, M., Darai, E., Value of thin-section oblique axial T2-weighted magnetic resonance images to assess uterosacral ligament endometriosis, <i>Human Reproduction</i> , 26, 346-53, 2011	Retrospective study; one MRI technique compared to conventional technique
Bazot, M., Gasner, A., Lafont, C., Ballester, M., Darai, E., Deep pelvic endometriosis: limited additional diagnostic value of postcontrast in comparison with conventional MR images, <i>European Journal of Radiology</i> , 80, e331-9, 2011	Retrospective study; comparison of post-contrast MRI versus conventional MRI
Bedaiwy, M. A., Falcone, T., Laboratory testing for endometriosis, <i>Clinica Chimica Acta</i> , 340, 41-56, 2004	Narrative review
Bedaiwy, M. A., Falcone, T., Sharma, R. K., Goldberg, J. M., Attaran, M., Nelson, D. R., Agarwal, A., Prediction of endometriosis with serum and peritoneal fluid markers: a prospective controlled trial, <i>Human Reproduction</i> , 17, 426-31, 2002	Biomarkers not of interest
Belghiti, J., Thomassin-Naggara, I., Zacharopoulou, C., Zilberman, S., Jarboui, L., Bazot, M., Ballester, M., Darai, E., Contribution of Computed Tomography Enema and Magnetic Resonance Imaging to Diagnose Multifocal and Multicentric Bowel Lesions in Patients With Colorectal Endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 22, 776-84, 2015	Lesion-level analysis
Belli, P., De Gaetano, A. M., Mirk, P., Specca, S., Valentini, A. L., Uterine adenomyosis and tubal endometriosis: diagnostic imaging, <i>Rays</i> , 23, 693-701, 1998	Narrative review
Benacerraf, B. R., Finkler, N. J., Wojciechowski, C., Knapp, R. C., Sonographic accuracy in the diagnosis of ovarian masses, <i>Journal of</i>	No outcome of interest

Study	Reason for Exclusion
Reproductive Medicine for the Obstetrician and Gynecologist, 35, 491-495, 1990	
Benacerraf, B. R., Groszmann, Y., Sonography should be the first imaging examination done to evaluate patients with suspected endometriosis, Journal of Ultrasound in Medicine, 31, 651-3, 2012	Narrative review
Bordin, L., Fiore, C., Dona, G., Andrisani, A., Ambrosini, G., Faggian, D., Plebani, M., Clari, G., Armanini, D., Evaluation of erythrocyte band 3 phosphotyrosine level, glutathione content, CA-125, and human epididymal secretory protein E4 as combined parameters in endometriosis, Fertility & Sterility, 94, 1616-21, 2010	All the patients have proven endometriosis
Cheng, Y. M., Wang, S. T., Chou, C. Y., Serum CA-125 in preoperative patients at high risk for endometriosis, Obstetrics & Gynecology, 99, 375-80, 2002	CA-125 has been used for identifying high risk woman not as a diagnostic tool
Cho, S., Cho, H., Nam, A., Kim, H. Y., Choi, Y. S., Park, K. H., Cho, D. J., Lee, B. S., Neutrophil-to-lymphocyte ratio as an adjunct to CA-125 for the diagnosis of endometriosis, Fertility & Sterility, 90, 2073-9, 2008	It is a case control-study
Chudecka-Glaz, A., Cymbaluk-Ploska, A., Luterek-Puszynska, K., Menkiszak, J., Diagnostic usefulness of the Risk of Ovarian Malignancy Algorithm using the electrochemiluminescence immunoassay for HE4 and the chemiluminescence microparticle immunoassay for CA125, Oncology Letters, 12, 3101-3114, 2016	Women with no suspected endometriosis
Chung, M. K., Chung, R. R., Gordon, D., Jennings, C., The evil twins of chronic pelvic pain syndrome: endometriosis and interstitial cystitis, JSLS : Journal of the Society of Laparoendoscopic Surgeons / Society of Laparoendoscopic Surgeons, 6, 311-314, 2002	No outcome of interest
Cicinelli, E., Resta, L., Nicoletti, R., Tartagni, M., Marinaccio, M., Bulletti, C., Colafiglio, G., Detection of chronic endometritis at fluid hysteroscopy, Journal of Minimally Invasive Gynecology, 12, 514-518, 2005	Comparison not of interest
Cohen, L. S., Valle, R. F., Sabbagha, R. E., A comparison of preoperative ultrasound images of surgically proven endometriomas scanned by both transabdominal and transvaginal techniques, Journal of Gynecologic Surgery, 11, 27-32, 1995	All the patients have surgically confirmed endometriosis.
Cohen, M. R., Laparoscopy in the diagnosis and management of endometriosis, Journal of Reproductive Medicine, 27, 240-2, 1982	No outcome of interest
Colacurci, N., Fortunato, N., De Franciscis, P., Fratta, M., Cioffi, M., Zarcone, R., Cardone, A., Serum and peritoneal CA-125 levels as diagnostic test for endometriosis, European	Case-control study

Study	Reason for Exclusion
Journal of Obstetrics, Gynecology, & Reproductive Biology, 66, 41-3, 1996	
Coleman, B. G., Arger, P. H., Mulhern, C. B., Jr., Endometriosis: clinical and ultrasonic correlation, AJR. American Journal of Roentgenology, 132, 747-9, 1979	All patients were recruited in this study, had surgically proven endometriosis
Corwin, M. T., Gerscovich, E. O., Lamba, R., Wilson, M., McGahan, J. P., Differentiation of ovarian endometriomas from hemorrhagic cysts at MR imaging: utility of the T2 dark spot sign, Radiology, 271, 126-32, 2014	Using a diagnostic test to diagnose endometriosis has not been addressed in this study. It is about a sign in MRI to distinguish between Endometrioma and haemorrhagic cysts.
Daniilidis, A., Giannoulis, H., Tantanasis, T., Papathanasiou, K., Loufopoulos, A., Tzafettas, J., Diagnostic laparoscopy, infertility, and endometriosis - 5 Years experience, Gynecological Surgery, 5, 231-234, 2008	Outcomes not of interest
Dechaud, H., Ali Ahmed, S. A., Aligier, N., Vergnes, C., Hedon, B., Does transvaginal hydrolaparoscopy render standard diagnostic laparoscopy obsolete for unexplained infertility investigation?, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 94, 97-102, 2001	Transvaginal hydrolaparoscopy compared with conventional laparoscopy; no data for outcomes
do Amaral, V. F., Ferriani, R. A., de Sa, M. F. S., Nogueira, A. A., Silva, J. C. R., de Sa Rosa e Silva, A. C. J., de Moura, M. D., Positive correlation between serum and peritoneal fluid CA-125 levels in women with pelvic endometriosis, Sao Paulo Medical Journal, 124, 223-227, 2006	It is a case-control study
Dunselman, G. A. J., Vermeulen, N., Becker, C., Calhaz-Jorge, C., D'Hooghe, T., De Bie, B., Heikinheimo, O., Horne, A. W., Kiesel, L., Nap, A., Prentice, A., Saridogan, E., Soriano, D., Nelen, W., ESHRE guideline: Management of women with endometriosis, Human Reproduction, 29, 400-412, 2014	The individual studies in this publication have been checked for inclusion in the review
El Maati, A. A. A., Ibrahim, E. A. G., Mokhtar, F. Z., A two-stage imaging protocol for evaluating women presenting with acute pelvic pain, Egyptian Journal of Radiology and Nuclear Medicine, 44, 923-936, 2013	The population is women with acute pelvic pain, not suspected endometriosis
Elgafor El Sharkwy, I. A., Combination of non-invasive and semi-invasive tests for diagnosis of minimal to mild endometriosis, Archives of gynecology and obstetrics, 288, 793-7, 2013	The diagnostic test (IL-6 combined with nerve fibers) which has been used in this study is not matched with the protocol
Ellett, L., Readman, E., Newman, M., McIlwaine, K., Villegas, R., Jagasia, N., Maher, P., Are endometrial nerve fibres unique to endometriosis? A prospective case-control study of endometrial biopsy as a diagnostic test for endometriosis in women with pelvic pain, Human Reproduction, 30, 2808-15, 2015	Case-control study
Exacoustos, C., Luciano, D., Corbett, B., De Felice, G., Di Felicianantonio, M., Luciano, A., Zupi, E., The uterine junctional zone: a 3-dimensional ultrasound study of patients with	In the study, the relation between thickness of uterine junctional zone and endometriosis has been evaluated. It has not been used as a diagnostic tool.

Study	Reason for Exclusion
endometriosis, American Journal of Obstetrics & Gynecology, 209, 248.e1-7, 2013	
Faccioli, N., Manfredi, R., Mainardi, P., Dalla Chiara, E., Spoto, E., Minelli, L., Mucelli, R. P., Barium enema evaluation of colonic involvement in endometriosis, AJR. American Journal of Roentgenology, 190, 1050-4, 2008	The diagnostic test (Barium enema) which has been used in this study is not matched with the protocol.
Federici, D., Muggiasca, M. L., Conti, M., Diagnostic value of laparoscopic evaluation of women with chronic pelvic pain: Our experience and a review of the literature, VALEUR DIAGNOSTIQUE DE L'EXPLORATION LAPAROSCOPIQUE DES FEMMES SOUFFRANT DE DOULEURS PELVIENNES CHRONIQUES: EXPERIENCE PERSONNELLE ET REVUE DE LA LITTERATURE, Acta Endoscopica, 22, 177-186, 1992	Narrative review
Felding, C., Mikkelsen, A. L., Peen, U., Laparoscopy and ultrasound in patients with chronic pelvic pain, Journal of Obstetrics and Gynaecology, 10, 419-422, 1990	No outcome of interest.
Fisk, N. M., Tan, C. E., CA 125 in peritoneal fluid and serum of patients with endometriosis, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 29, 153-8, 1988	Case-control study
Foda, A. A., Aal, I. A. A., Role of some biomarkers in chronic pelvic pain for early detection of endometriosis in infertile women, Middle East Fertility Society Journal, 17, 187-194, 2012	Case-control study
Fratelli, N., Scioscia, M., Bassi, E., Musola, M., Minelli, L., Trivella, G., Transvaginal sonography for preoperative assessment of deep endometriosis, Journal of Clinical Ultrasound, 41, 69-75, 2013	Data for TVS was collected retrospectively
Friedman, H., Vogelzang, R. L., Mendelson, E. B., Neiman, H. L., Cohen, M., Endometriosis detection by US with laparoscopic correlation, Radiology, 157, 217-20, 1985	No data on outcomes
Gougoutas, C. A., Siegelman, E. S., Hunt, J., Outwater, E. K., Pelvic endometriosis: various manifestations and MR imaging findings, AJR. American Journal of Roentgenology, 175, 353-8, 2000	Narrative review
Gurgan, T., Kisinisci, H., Yarali, H., Aksu, T., Zeyneloglu, H., Develioglu, O., Serum and peritoneal fluid CA-125 levels in early stage endometriosis, Gynecologic & Obstetric Investigation, 30, 105-8, 1990	The cut-off for CA-125 is 16 U/ml
Güven, M. A., Bese, T., Demirkiran, F., Comparison of hydrosoneography and transvaginal ultrasonography in the detection of intracavitary pathologies in women with abnormal uterine bleeding, International Journal of Gynecological Cancer, 14, 57-63, 2004	The study population are women with history of abnormal uterine bleeding not women suspected to endometriosis.
Harada, T., Kubota, T., Aso, T., Usefulness of CA19-9 versus CA125 for the diagnosis of	Case-control study



Study	Reason for Exclusion
endometriosis, <i>Fertility and Sterility</i> , 78, 733-739, 2002	
Hompes, P. G., Koninckx, P. R., Kennedy, S., van Kamp, G. F., Verstraeten, R. A., Cornillie, F., Serum CA-125 concentrations during midfollicular phase, a clinically useful and reproducible marker in diagnosis of advanced endometriosis, <i>Clinical Chemistry</i> , 42, 1871-4, 1996	No outcome of interest has been reported
Hornstein, M. D., Harlow, B. L., Thomas, P. P., Check, J. H., Use of a new CA 125 assay in the diagnosis of endometriosis, <i>Human Reproduction</i> , 10, 932-4, 1995	The reported result has adjusted for prevalence of endometriosis in the community. This data is not useful for our systematic review
Howard, F. M., El-Minawi, A. M., Sanchez, R. A., Conscious pain mapping by laparoscopy in women with chronic pelvic pain, <i>Obstetrics &amp; Gynecology</i> , 96, 934-9, 2000	The study investigated conscious pain mapping using laparoscopy
Ikeda, F., Bernardini, M. A., Vanni, D., Vasconcelos, A., Pinotti, J. A., Abrao, M. S., A comparison of microlaparoscopy under sedation, microlaparoscopy under general anesthesia and conventional laparoscopy for diagnosis and treatment of pelvic endometriosis in early stages, <i>Fertility and sterility</i> , 77, S21, 2002	The effectiveness of using a diagnostic tool for diagnosis of endometriosis has not been addressed.
Ismail, M. A., Rotmensch, J., Mercer, L. J., Block, B. S., Salti, G. I., Holt, J. A., CA-125 in peritoneal fluid from patients with nonmalignant gynecologic disorders, <i>Journal of Reproductive Medicine</i> , 39, 510-2, 1994	The women without any symptom who went through laparoscopic sterilization have been considered as control group
Johnson, W. K., Ott, D. J., Chen, M. Y. M., Fayez, J. A., Gelfand, D. W., Efficacy of hysterosalpingography in evaluating endometriosis, <i>Abdominal Imaging</i> , 19, 278-280, 1994	The study evaluated the effectiveness of hysterosalpingography and laparoscopy-retrospective study
Kafali, H., Artuc, H., Demir, N., Use of CA125 fluctuation during the menstrual cycle as a tool in the clinical diagnosis of endometriosis; a preliminary report, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 116, 85-8, 2004	It is a case-control study
Kang, S. B., Chung, H. H., Lee, H. P., Lee, J. Y., Chang, Y. S., Impact of diagnostic laparoscopy on the management of chronic pelvic pain, <i>Surgical Endoscopy</i> , 21, 916-9, 2007	there was no comparison between laparoscopy and another test
Karabacak, O., Tiras, M. B., Taner, M. Z., Guner, H., Yildiz, A., Yildirim, M., Small diameter versus conventional laparoscopy: a prospective, self-controlled study, <i>Human Reproduction</i> , 12, 2399-401, 1997	Comparison of two types of laparoscopy
Kitawaki, J., Ishihara, H., Koshiba, H., Kiyomizu, M., Teramoto, M., Kitaoka, Y., Honjo, H., Usefulness and limits of CA-125 in diagnosis of endometriosis without associated ovarian endometriomas.[Erratum appears in <i>Hum Reprod.</i> 2007 Feb;22(2):627], <i>Human Reproduction</i> , 20, 1999-2003, 2005	Women enrolled in the study were already diagnosed with endometriosis, adenomyosis and/or leiomyomas

Study	Reason for Exclusion
Koninckx, P. R., Riittinen, L., Seppala, M., Cornillie, F. J., CA-125 and placental protein 14 concentrations in plasma and peritoneal fluid of women with deeply infiltrating pelvic endometriosis, <i>Fertility &amp; Sterility</i> , 57, 523-30, 1992	Wrong data and result have been reported.
Kruger, K., Behrendt, K., Niedobitek-Kreuter, G., Koltermann, K., Ebert, A. D., Location-dependent value of pelvic MRI in the preoperative diagnosis of endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 169, 93-8, 2013	Pelvic MRI retrospectively assessed with histology
Kruitwagen, R. F., Thomas, C., Poels, L. G., Koster, A. M., Willemsen, W. N., Rolland, R., High CA-125 concentrations in peritoneal fluid of normal cyclic women with various infertility-related factors as demonstrated with two-step immunoradiometric assay, <i>Fertility &amp; Sterility</i> , 56, 863-9, 1991	The outcome of interest has not been reported.
Leslie, C., Ma, T., McElhinney, B., Leake, R., Stewart, C. J., Is the detection of endometrial nerve fibers useful in the diagnosis of endometriosis?, <i>International Journal of Gynecological Pathology</i> , 32, 149-55, 2013	Included as one of the studies in Gupta et al. 2016 review
Li, G., Yu, Z., Li, K., The value of FS, NLR, and CA-125 in the diagnosis of endometriosis, <i>International journal of clinical and experimental medicine</i> , 9, 7309-7313, 2016	Not the population of interest
Macer, M. L., Mathur, M., Spektor, M., Gysler, S., Staib, L., Kodaman, P., McCarthy, S., Utility of magnetic resonance imaging in the evaluation of intraoperatively confirmed pelvic adhesions, <i>Journal of Computer Assisted Tomography</i> , 39, 896-900, 2015	Not the population of interest
Malik, E., Berg, C., Meyhofer-Malik, A., Buchweitz, O., Moubayed, P., Diedrich, K., Fluorescence diagnosis of endometriosis using 5-aminolevulinic acid, <i>Surgical Endoscopy</i> , 14, 452-5, 2000	The test is not of interest
Manganaro, L., Fierro, F., Tomei, A., Irimia, D., Lodise, P., Sergi, M. E., Vinci, V., Sollazzo, P., Porpora, M. G., Delfini, R., Vittori, G., Marini, M., Feasibility of 3.0T pelvic MR imaging in the evaluation of endometriosis, <i>European Journal of Radiology</i> , 81, 1381-7, 2012	Women in the study already had a diagnosis of endometriosis by transvaginal ultrasound
Martinez, S., Garrido, N., Coperias, J. L., Pardo, F., Desco, J., Garcia-Velasco, J. A., Simon, C., Pellicer, A., Serum interleukin-6 levels are elevated in women with minimal-mild endometriosis, <i>Human Reproduction</i> , 22, 836-42, 2007	It is a case-control study
Mathlouthi, N., Ayed, B. B., Dhouib, M., Chaabene, K., Trabelsi, K., Amouri, H., Guerhazi, M., Confrontation ultrasonography-CA125-histology in the management of ovarian cysts: A prospective study about 77 cases, <i>Tunisie Medicale</i> , 89, 686-692, 2011	Full-text in French

Study	Reason for Exclusion
May, K. E., Conduit-Hulbert, S. A., Villar, J., Kirtley, S., Kennedy, S. H., Becker, C. M., Peripheral biomarkers of endometriosis: a systematic review, <i>Human Reproduction Update</i> , 16, 651-74, 2010	This systematic review includes papers also regarding other biomarkers. The full texts of individual related studies were retrieved and reviewed.
May, K. E., Villar, J., Kirtley, S., Kennedy, S. H., Becker, C. M., Endometrial alterations in endometriosis: a systematic review of putative biomarkers, <i>Human Reproduction Update</i> , 17, 637-53, 2011	Single studies from the review were assessed for inclusion
McBride, N., Newman, R. L., Diagnostic laparoscopy, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 15, 556-8, 1978	No outcome of interest
McKinnon, B., Mueller, M. D., Nirgianakis, K., Bersinger, N. A., Comparison of ovarian cancer markers in endometriosis favours HE4 over CA125, <i>Molecular Medicine Reports</i> , 12, 5179-84, 2015	No data reported to calculate sensitivity
Medl, M., Ogris, E., Peters-Engl, C., Mierau, M., Buxbaum, P., Leodolter, S., Serum levels of the tumour-associated trypsin inhibitor in patients with endometriosis, <i>British Journal of Obstetrics &amp; Gynaecology</i> , 104, 78-81, 1997	Wrong data and result have been reported.
Melega, C., Marchesini, F. P., Bellettini, L., Biscontin, S., Flamigni, C., Diagnostic value of laparoscopy in endometriosis and infertility, <i>Journal of Reproductive Medicine</i> , 29, 597-600, 1984	No outcome of interest
Mezzi, G., Ferrari, S., Arcidiacono, P. G., Di Puppo, F., Candiani, M., Testoni, P. A., Endoscopic rectal ultrasound and elastosonography are useful in flow chart for the diagnosis of deep pelvic endometriosis with rectal involvement, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 37, 586-90, 2011	There was no comparison with surgery
Mikami, M., Tanabe, K., Matsuo, K., Miyazaki, Y., Miyazawa, M., Hayashi, M., Asai, S., Ikeda, M., Shida, M., Hirasawa, T., Kojima, N., Sho, R., Iijima, S., Fully-sialylated alpha-chain of complement 4-binding protein: Diagnostic utility for ovarian clear cell carcinoma, <i>Gynecologic Oncology</i> , 139, 520-528, 2015	Not the population of interest
Millischer, A. E., Salomon, L. J., Santulli, P., Borghese, B., Dousset, B., Chapron, C., Fusion imaging for evaluation of deep infiltrating endometriosis: feasibility and preliminary results, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 46, 109-17, 2015	No data on surgical diagnosis
Miyagi, E., Maruyama, Y., Mogami, T., Numazaki, R., Ikeda, A., Yamamoto, H., Hirahara, F., Comparison of plasma amino acid profile-based index and CA125 in the diagnosis of epithelial ovarian cancers and borderline malignant tumors, <i>International Journal of Clinical Oncology</i> , 1-8, 2016	Not the population of interest
Mol, B. W., Bayram, N., Lijmer, J. G., Wiegerinck, M. A., Bongers, M. Y., van der	All the studies included in this systematic review could not be included in our systematic

Study	Reason for Exclusion
Veen, F., Bossuyt, P. M., The performance of CA-125 measurement in the detection of endometriosis: a meta-analysis, <i>Fertility &amp; Sterility</i> , 70, 1101-8, 1998	reviewThe full-texts of all individual studies were retrieved and reviewed and related studies were included in our review
Moloney, M. D., Thornton, J. G., Cooper, E. H., Serum CA 125 antigen levels and disease severity in patients with endometriosis, <i>Obstetrics &amp; Gynecology</i> , 73, 767-9, 1989	Women had laparoscopically confirmed endometriosis and then CA-125 level has been evaluated
Moretuzzo, R. W., DiLauro, S., Jenison, E., Chen, S. L., Reindollar, R. H., McDonough, P. G., Serum and peritoneal lavage fluid CA-125 levels in endometriosis, <i>Fertility &amp; Sterility</i> , 50, 430-3, 1988	No outcome of interest
O'Shaughnessy, A., Check, J. H., Nowroozi, K., Lurie, D., CA 125 levels measured in different phases of the menstrual cycle in screening for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 81, 99-103, 1993	Wrong data and result have been reported
Ota, H., Maki, M., Evaluation of autoantibody and CA125 in the diagnosis of endometriosis or adenomyosis, <i>Medical Science Research</i> , 18, 309-310, 1990	All the participants had known condition
Othman, E. E. D. R., Hornung, D., Al-Hendy, A., Biomarkers of endometriosis, <i>Expert Opinion on Medical Diagnostics</i> , 2, 741-752, 2008	Narrative review
Ozaksit, G., Caglar, T., Cicek, N., Kuscu, E., Batioglu, S., Gokmen, O., Serum CA 125 levels before, during and after treatment for endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 50, 269-73, 1995	Women had a confirmed diagnosis of endometriosis prior to CA-125 test
Paiva, P., Lappas, M., Barker, G., Healey, M., Using symptom scores, lifestyle measures and biochemical markers to create a test for endometriosis, <i>Journal of Endometriosis and Pelvic Pain Disorders</i> , 6, 135-143, 2014	No outcome of interest
Panidis, D., Vlassis, G., Matalliotakis, J., Skiadopoulou, S., Kalogeropoulos, A., Serum levels of the oncofetal antigens CA-125, CA 19-9 and CA 15-3 in patients with endometriosis, <i>Journal of Endocrinological Investigation</i> , 11, 801-804, 1988	All women who involved in the study have proven endometriosis
Pastorfide, G., Fong, Y. F., Use of narrowband imaging for the detection of endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 22, 535, 2015	No outcome of interest
Patel, M. D., Feldstein, V. A., Chen, D. C., Lipson, S. D., Filly, R. A., Endometriomas: diagnostic performance of US.[Erratum appears in <i>Radiology</i> 1999 Dec;213(3):930], <i>Radiology</i> , 210, 739-45, 1999	Retrospective review of sonograms by two sonologists
Patel, M. D., Feldstein, V. A., Filly, R. A., The likelihood ratio of sonographic findings for the diagnosis of hemorrhagic ovarian cysts, <i>Journal of Ultrasound in Medicine</i> , 24, 607-14; quiz 615, 2005	It is about diagnosis of haemorrhagic ovarian cyst not endometrioma

Study	Reason for Exclusion
Patton, P. E., Field, C. S., Harms, R. W., Coulam, C. B., CA-125 levels in endometriosis, <i>Fertility &amp; Sterility</i> , 45, 770-3, 1986	Women who come for elective sterilization have been also included in this study, while they are not suspected for endometriosis
Philip, C. A., Bisch, C., Coulon, A., de Saint-Hilaire, P., Rudigoz, R. C., Dubernard, G., Correlation between three-dimensional rectosonography and magnetic resonance imaging in the diagnosis of rectosigmoid endometriosis: a preliminary study on the first fifty cases, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 187, 35-40, 2015	MRI was the reference test
Piessens, S., Healey, M., Maher, P., Tsalas, J., Rombauts, L., Can anyone screen for deep infiltrating endometriosis with transvaginal ultrasound?, <i>Australian &amp; New Zealand Journal of Obstetrics &amp; Gynaecology</i> , 54, 462-8, 2014	Women included in the study had the ultrasound test after diagnosis of endometriosis by surgery
Pittaway, D. E., Douglas, J. W., Serum CA-125 in women with endometriosis and chronic pelvic pain, <i>Fertility &amp; Sterility</i> , 51, 68-70, 1989	The cut-off for CA-125 is 16 U/ml
Polisseni, F., Bambirra, E. A., Camargos, A. F., Detection of chronic endometritis by diagnostic hysteroscopy in asymptomatic infertile patients, <i>Gynecologic &amp; Obstetric Investigation</i> , 55, 205-10, 2003	Comparison not of interest
Randall, G. W., Gantt, P. A., Poe-Zeigler, R. L., Bergmann, C. A., Noel, M. E., Strawbridge, W. R., Richardson-Cox, B., Hereford, J. R., Reiff, R. H., Serum antiendometrial antibodies and diagnosis of endometriosis, <i>American Journal of Reproductive Immunology</i> , 58, 374-82, 2007	The diagnostic test which has been used in this study is not matched with the protocol
Redwine, D. B., Ovarian endometriosis: A marker for more extensive pelvic and intestinal disease, <i>Fertility and Sterility</i> , 72, 310-315, 1999	All the patients have endometriosis
Reid, S., Lu, C., Casikar, I., Reid, G., Abbott, J., Cario, G., Chou, D., Kowalski, D., Cooper, M., Condous, G., Prediction of pouch of Douglas obliteration in women with suspected endometriosis using a new real-time dynamic transvaginal ultrasound technique: the sliding sign, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 41, 685-91, 2013	It has focused on the pouch of Douglas obliteration not only endometriosis
Rosa, E. Silva A. C., Rosa, E. Silva J. C., Ferriani, R. A., Serum CA-125 in the diagnosis of endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 96, 206-7, 2007	Retrospective study. Women included in the study already had a diagnosis of endometriosis prior to serum CA-125 collection
Saba, L., Guerriero, S., Sulcis, R., Ajossa, S., Melis, G., Mallarini, G., Agreement and reproducibility in identification of endometriosis using magnetic resonance imaging, <i>Acta Radiologica</i> , 51, 573-80, 2010	No outcome of interest
Saba, L., Guerriero, S., Sulis, R., Pilloni, M., Ajossa, S., Melis, G., Mallarini, G., Learning curve in the detection of ovarian and deep endometriosis by using Magnetic Resonance: comparison with surgical results, <i>European Journal of Radiology</i> , 79, 237-44, 2011	The aim of the study was to determine whether diagnostic accuracy is correlated to radiologist expertise

Study	Reason for Exclusion
Scardapane, A., Bettocchi, S., Lorusso, F., Stabile Ianora, A. A., Vimercati, A., Ceci, O., Lasciarrea, M., Angelelli, G., Diagnosis of colorectal endometriosis: contribution of contrast enhanced MR-colonography, <i>European Radiology</i> , 21, 1553-63, 2011	Comparison of MRI between two radiologists
Scardapane, A., Lorusso, F., Scioscia, M., Ferrante, A., Stabile Ianora, A. A., Angelelli, G., Standard high-resolution pelvic MRI vs. low-resolution pelvic MRI in the evaluation of deep infiltrating endometriosis, <i>European Radiology</i> , 24, 2590-6, 2014	Comparison of MRI carried out by two different radiologists
Schenken, R. S., Improving the diagnosis of endometriosis in adolescents, <i>Sexuality, Reproduction and Menopause</i> , 6, 4-8, 2008	Narrative review
Seeber, B., Sammel, M. D., Fan, X., Gerton, G. L., Shaunik, A., Chittams, J., Barnhart, K. T., Panel of markers can accurately predict endometriosis in a subset of patients, <i>Fertility &amp; Sterility</i> , 89, 1073-81, 2008	It is a case-control study
Shen, A., Xu, S., Ma, Y., Guo, H., Li, C., Yang, C., Zou, S., Diagnostic value of serum CA125, CA19-9 and CA15-3 in endometriosis: A meta-analysis, <i>Journal of International Medical Research</i> , 43, 599-609, 2015	It is about association of biomarkers and stage of endometriosis. No outcome of interest.
Somigliana, E., Vigano, P., Candiani, M., Felicetta, I., Di Blasio, A. M., Vignali, M., Use of serum-soluble intercellular adhesion molecule-1 as a new marker of endometriosis, <i>Fertility &amp; Sterility</i> , 77, 1028-31, 2002	Women included in the study already had laparoscopy prior to CA-125 serum collection
Somigliana, E., Vigano, P., Tirelli, A. S., Felicetta, I., Torresani, E., Vignali, M., Di Blasio, A. M., Use of the concomitant serum dosage of CA 125, CA 19-9 and interleukin-6 to detect the presence of endometriosis. Results from a series of reproductive age women undergoing laparoscopic surgery for benign gynaecological conditions, <i>Human Reproduction</i> , 19, 1871-6, 2004	Case-control study
Spencer, J. A., Weston, M. J., Imaging in endometriosis, <i>Imaging</i> , 15, 63-71, 2003	Narrative review
Stowell, S. B., Wiley, C. M., Perez-Reyes, N., Powers, C. N., Cytologic diagnosis of peritoneal fluids. Applicability to the laparoscopic diagnosis of endometriosis, <i>Acta Cytologica</i> , 41, 817-22, 1997	The diagnostic test in this study is not matched with the protocol
Szubert, M., Suzin, J., Wierzbowski, T., Kowalczyk-Amico, K., CA-125 concentration in serum and peritoneal fluid in patients with endometriosis - preliminary results, <i>Archives of Medical Science</i> , 8, 504-8, 2012	Case control study
Takahashi, K., Nagata, H., Kitao, M., CA-125 in the menstrual blood is an effective marker for diagnosing early stage endometriosis: A preliminary report, <i>Japanese Journal of Fertility and Sterility</i> , 36, 356-359, 1991	Ultrasound was used to confirm ovulatory day only

Study	Reason for Exclusion
Takahashi, K., Nagata, H., Musa, A. A., Shibukawa, T., Yamasaki, H., Kitao, M., Clinical usefulness of CA-125 levels in the menstrual discharge in patients with endometriosis, <i>Fertility &amp; Sterility</i> , 54, 360-2, 1990	The level of CA-125 has been assessed in the menstrual discharge
Takeuchi, M., Matsuzaki, K., Nishitani, H., Susceptibility-weighted MRI of endometrioma: preliminary results, <i>AJR. American Journal of Roentgenology</i> , 191, 1366-70, 2008	No outcome of interest
Tirlapur, S. A., Daniels, J. P., Khan, K. S., Medal trial collaboration, Chronic pelvic pain: how does noninvasive imaging compare with diagnostic laparoscopy?, <i>Current Opinion in Obstetrics &amp; Gynecology</i> , 27, 445-8, 2015	This systematic review has not only focused on patients with suspected endometriosis. It is more general about pelvic pain and diagnostic tools
Tumedei, U., Ciardelli, V., Paltrinieri, F., Kuria, M. S., Amadori, A., Stefanetti, M., Gori, G., Transvaginal ultrasound in the diagnosis of endometrial abnormalities, <i>Tumori</i> , 87, S15, 2001	It has focused on endometrial abnormalities not endometriosis
Van den Bosch, T., Vandendael, A., Van Schoubroeck, D., Wranz, P. A. B., Lombard, C. J., Combining vaginal ultrasonography and office endometrial sampling in the diagnosis of endometrial disease in postmenopausal women, <i>Obstetrics and Gynecology</i> , 85, 349-352, 1995	It is not about endometriosis, it has addressed endometrial diseases
Vrachnis, N., Sifakis, S., Samoli, E., Kappou, D., Pavlakis, K., Iliodromiti, Z., Botsis, D., Three-dimensional ultrasound and three-dimensional power Doppler improve the preoperative evaluation of complex benign ovarian lesions, <i>Clinical &amp; Experimental Obstetrics &amp; Gynecology</i> , 39, 474-8, 2012	No outcome of interest
Walsh, J. W., Taylor, K. J., Wasson, J. F., Schwartz, P. E., Rosenfield, A. T., Gray-scale ultrasound in 204 proved gynecologic masses: accuracy and specific diagnostic criteria, <i>Radiology</i> , 130, 391-7, 1979	No outcome of interest.
Wang, L., Liu, H. Y., Shi, H. H., Lang, J. H., Sun, W., Urine peptide patterns for non-invasive diagnosis of endometriosis: a preliminary prospective study, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 177, 23-8, 2014	Biomarker not of interest
Wessels, J. M., Kay, V. R., Leyland, N. A., Agarwal, S. K., Foster, W. G., Assessing brain-derived neurotrophic factor as a novel clinical marker of endometriosis, <i>Fertility &amp; Sterility</i> , 105, 119-128.e5, 2016	Not the test of interest
Wild, R. A., Hirisave, V., Bianco, A., Podczaski, E. S., Demers, L. M., Endometrial antibodies versus CA-125 for the detection of endometriosis, <i>Fertility &amp; Sterility</i> , 55, 90-4, 1991	The cut-off for CA-125 is 16 U/ml
Wolfler, M. M., Nagele, F., Kolbus, A., Seidl, S., Schneider, B., Huber, J. C., Tschugguel, W., A predictive model for endometriosis, <i>Human Reproduction</i> , 20, 1702-8, 2005	Biomarker not of interest

Study	Reason for Exclusion
Yamashita, Y., Torashima, M., Hatanaka, Y., Harada, M., Higashida, Y., Takahashi, M., Mizutani, H., Tashiro, H., Iwamasa, J., Miyazaki, K., et al., Adnexal masses: accuracy of characterization with transvaginal US and precontrast and postcontrast MR imaging, <i>Radiology</i> , 194, 557-65, 1995	Review of MRI and TVUS by five radiologists
Yazbek, J., Helmy, S., Ben-Nagi, J., Holland, T., Sawyer, E., Jurkovic, D., Value of preoperative ultrasound examination in the selection of women with adnexal masses for laparoscopic surgery, <i>Ultrasound in Obstetrics and Gynecology</i> , 30, 883-888, 2007	The preoperative sonography has not been used to diagnose endometriosis
Zapardiel, I., Gorostidi, M., Ravaggi, A., Allende, M. T., Silveira, M., Abehsera, D., MacUks, R., Utility Serum Marker HE4 for the Differential Diagnosis between Endometriosis and Adnexal Malignancy, <i>International Journal of Gynecological Cancer</i> , 26, 52-55, 2016	No data on surgical diagnosis
Zhang Y, Qiao C, Li L, Zhao X, Li Y. Serum HE4 is more suitable as a biomarker than CA125 in Chinese women with benign gynecologic disorders. <i>Afr Health Sci</i> , 14(4):913-8, 2014	Included in the nerve fibres question

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## H.10 Diagnosis – MRI

Study	Reason for Exclusion
Abrao, M. S., Goncalves, M. O., Dias, J. A., Jr., Podgaec, S., Chamie, L. P., Blasbalg, R., Comparison between clinical examination, transvaginal sonography and magnetic resonance imaging for the diagnosis of deep endometriosis, <i>Human Reproduction</i> , 22, 3092-7, 2007	Included as one of the studies in the Nisenblat 2016 review
Abrao, M. S., Podgaec, S., Filho, B. M., Ramos, L. O., Pinotti, J. A., de Oliveira, R. M., The use of biochemical markers in the diagnosis of pelvic endometriosis, <i>Human Reproduction</i> , 12, 2523-7, 1997	Case-control study
Abrao, M. S., Podgaec, S., Pinotti, J. A., de Oliveira, R. M., Tumor markers in endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 66, 19-22, 1999	Case-control study
Abu-Musa, A., Takahashi, K., Nagata, H., Yamasaki, H., Mizoguchi, S., Kitao, M., CA-125 in menstrual discharge in patients with chronic pelvic pain, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 37, 111-4, 1992	Not MRI, but included for CA-125
Acimovic, M., Vidakovic, S., Milic, N., Jeremic, K., Markovic, M., Milosevic-Djeric, A., Lazovic-Radonjic, G., Survivin and Vegf as Novel Biomarkers in Diagnosis of Endometriosis,	No laparoscopy/ laparotomy and no histological confirmation



Study	Reason for Exclusion
Journal of Medical Biochemistry, 35, 63-68, 2016	
Alcazar, J. L., Laparte, C., Jurado, M., Lopez-Garcia, G., The role of transvaginal ultrasonography combined with color velocity imaging and pulsed Doppler in the diagnosis of endometrioma, Fertility & Sterility, 67, 487-91, 1997	Mixed population: postmenopausal women included; 'lesion-level' analysis
Aleem, F., Pennisi, J., Zeitoun, K., Predanic, M., The role of color Doppler in diagnosis of endometriomas, Ultrasound in Obstetrics & Gynecology, 5, 51-4, 1995	The aim of this study is to describe vascular appearance in endometriomas. No outcome of interest.
Al-Jefout, M., Dezarnaulds, G., Cooper, M., Tokushige, N., Luscombe, G. M., Markham, R., Fraser, I. S., Diagnosis of endometriosis by detection of nerve fibres in an endometrial biopsy: a double blind study, Human Reproduction (Oxford, England), 24, 3019-24, 2009	Not MRI, but included for nerve fibres
Anaf, V., El Nakadi, I., De Moor, V., Coppens, E., Zalcman, M., Noel, J. C., Anatomic significance of a positive barium enema in deep infiltrating endometriosis of the large bowel, World Journal of Surgery, 33, 822-7, 2009	All patients had surgery and DCBE
Ascher, S. M., Agrawal, R., Bis, K. G., Brown, E. D., Maximovich, A., Markham, S. M., Patt, R. H., Semelka, R. C., Endometriosis: appearance and detection with conventional and contrast-enhanced fat-suppressed spin-echo techniques, Journal of Magnetic Resonance Imaging, 5, 251-7, 1995	Included as one of the studies in the Nisenblat 2016 review
Bahr, A., de Parades, V., Gadonneix, P., Etienney, I., Salet-Lizee, D., Villet, R., Atienza, P., Endorectal ultrasonography in predicting rectal wall infiltration in patients with deep pelvic endometriosis: a modern tool for an ancient disease, Diseases of the Colon & Rectum, 49, 869-75, 2006	Included for ultrasound review
Balasch, J., Creus, M., Fabregues, F., Carmona, F., Ordi, J., Martinez-Roman, S., Vanrell, J. A., Visible and non-visible endometriosis at laparoscopy in fertile and infertile women and in patients with chronic pelvic pain: a prospective study, Human Reproduction, 11, 387-91, 1996	Not a diagnostic study
Balleyguier, C., Roupert, M., Nguyen, T., Kinkel, K., Helenon, O., Chapron, C., Ureteral endometriosis: the role of magnetic resonance imaging, Journal of the American Association of Gynecologic Laparoscopists, 11, 530-6, 2004	No outcome of interest. Moreover, only 6 patients were included.
Barbati, A., Cosmi, E. V., Spaziani, R., Ventura, R., Montanino, G., Serum and peritoneal fluid CA-125 levels in patients with endometriosis, Fertility & Sterility, 61, 438-42, 1994	Case-control study
Barbieri, R. L., Niloff, J. M., Bast, R. C., Jr., Scaetzi, E., Kistner, R. W., Knapp, R. C., Elevated serum concentrations of CA-125 in	Case-control study

Study	Reason for Exclusion
patients with advanced endometriosis, <i>Fertility &amp; Sterility</i> , 45, 630-4, 1986	
Barcellos, M. B., Lasmar, B., Lasmar, R., Agreement between the preoperative findings and the operative diagnosis in patients with deep endometriosis, <i>Archives of Gynecology &amp; Obstetrics</i> Arch Gynecol Obstet, 293, 845-50, 2016	Lesion-level analysis
Bayoglu Tekin, Y., Dede, F. S., What is the success of ultrasonography of benign adnexal masses?, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 40, 473-8, 2014	Not MRI, but included for ultrasound
Bazot, M., Bornier, C., Dubernard, G., Roseau, G., Cortez, A., Darai, E., Accuracy of magnetic resonance imaging and rectal endoscopic sonography for the prediction of location of deep pelvic endometriosis, <i>Human Reproduction</i> , 22, 1457-63, 2007	Population overlap with Bazot 2009
Bazot, M., Darai, E., Hourani, R., Thomassin, I., Cortez, A., Uzan, S., Buy, J. N., Deep pelvic endometriosis: MR imaging for diagnosis and prediction of extension of disease, <i>Radiology</i> , 232, 379-89, 2004	Overlap of population from Bazot 2009
Bazot, M., Detchev, R., Cortez, A., Amouyal, P., Uzan, S., Darai, E., Transvaginal sonography and rectal endoscopic sonography for the assessment of pelvic endometriosis: a preliminary comparison, <i>Human Reproduction</i> , 18, 1686-92, 2003	Population overlapped with Bazot 2009
Bazot, M., Gasner, A., Ballester, M., Darai, E., Value of thin-section oblique axial T2-weighted magnetic resonance images to assess uterosacral ligament endometriosis, <i>Human Reproduction</i> , 26, 346-53, 2011	Retrospective selection of cases
Bazot, M., Gasner, A., Lafont, C., Ballester, M., Darai, E., Deep pelvic endometriosis: limited additional diagnostic value of postcontrast in comparison with conventional MR images, <i>European Journal of Radiology</i> , 80, e331-9, 2011	Retrospective selection of cases
Bazot, M., Lafont, C., Rouzier, R., Roseau, G., Thomassin-Naggara, I., Darai, E., Diagnostic accuracy of physical examination, transvaginal sonography, rectal endoscopic sonography, and magnetic resonance imaging to diagnose deep infiltrating endometriosis, <i>Fertility &amp; Sterility</i> , 92, 1825-33, 2009	Included as one of the studies in the Nisenblat 2016 review
Bazot, M., Malzy, P., Cortez, A., Roseau, G., Amouyal, P., Darai, E., Accuracy of transvaginal sonography and rectal endoscopic sonography in the diagnosis of deep infiltrating endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 30, 994-1001, 2007	Overlap with Bazot 2009
Bazot, M., Stivalet, A., Darai, E., Coudray, C., Thomassin-Naggara, I., Poncelet, E., Comparison of 3D and 2D FSE T2-weighted MRI in the diagnosis of deep pelvic	Included as one of the studies in the Nisenblat 2016 review

Study	Reason for Exclusion
endometriosis: preliminary results, <i>Clinical Radiology</i> , 68, 47-54, 2013	
Bazot, M., Thomassin, I., Hourani, R., Cortez, A., Darai, E., Diagnostic accuracy of transvaginal sonography for deep pelvic endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 24, 180-5, 2004	Not MRI, but included for ultrasound
Bedaiwy, M. A., Falcone, T., Laboratory testing for endometriosis, <i>Clinica Chimica Acta</i> , 340, 41-56, 2004	Narrative review
Bedaiwy, M. A., Falcone, T., Sharma, R. K., Goldberg, J. M., Attaran, M., Nelson, D. R., Agarwal, A., Prediction of endometriosis with serum and peritoneal fluid markers: a prospective controlled trial, <i>Human Reproduction</i> , 17, 426-31, 2002	Biomarkers not of interest
Belghiti, J., Thomassin-Naggara, I., Zacharopoulou, C., Zilberman, S., Jarboui, L., Bazot, M., Ballester, M., Darai, E., Contribution of Computed Tomography Enema and Magnetic Resonance Imaging to Diagnose Multifocal and Multicentric Bowel Lesions in Patients With Colorectal Endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 22, 776-84, 2015	Lesion-level analysis
Belli, P., De Gaetano, A. M., Mirk, P., Specca, S., Valentini, A. L., Uterine adenomyosis and tubal endometriosis: diagnostic imaging, <i>Rays</i> , 23, 693-701, 1998	Narrative review
Benacerraf, B. R., Finkler, N. J., Wojciechowski, C., Knapp, R. C., Sonographic accuracy in the diagnosis of ovarian masses, <i>Journal of Reproductive Medicine for the Obstetrician and Gynecologist</i> , 35, 491-495, 1990	No outcome of interest
Benacerraf, B. R., Groszmann, Y., Sonography should be the first imaging examination done to evaluate patients with suspected endometriosis, <i>Journal of Ultrasound in Medicine</i> , 31, 651-3, 2012	Narrative review
Bergamini, V., Ghezzi, F., Scarperi, S., Raffaelli, R., Cromi, A., Franchi, M., Preoperative assessment of intestinal endometriosis: A comparison of transvaginal sonography with water-contrast in the rectum, transrectal sonography, and barium enema, <i>Abdominal Imaging</i> , 35, 732-6, 2010	Not MRI, but included for ultrasound
Biscaldi, E., Ferrero, S., Leone Roberti Maggiore, U., Remorgida, V., Venturini, P. L., Rollandi, G. A., Multidetector computerized tomography enema versus magnetic resonance enema in the diagnosis of rectosigmoid endometriosis, <i>European Journal of Radiology</i> , 83, 261-7, 2014	Included as one of the studies in the Nisenblat 2016 review
Boog, G., Penot, P., Momber, A., Ultrasound as a diagnostic aid in endometriosis, <i>Contributions to Gynecology &amp; Obstetrics</i> , 16, 119-24, 1987	retrospective selection of cases
Bordin, L., Fiore, C., Dona, G., Andrisani, A., Ambrosini, G., Faggian, D., Plebani, M., Clari,	All the patients have proven endometriosis

Study	Reason for Exclusion
G., Armanini, D., Evaluation of erythrocyte band 3 phosphotyrosine level, glutathione content, CA-125, and human epididymal secretory protein E4 as combined parameters in endometriosis, <i>Fertility &amp; Sterility</i> , 94, 1616-21, 2010	
Camagna, O., Dhainaut, C., Dupuis, O., Soncini, E., Martin, B., Palazzo, L., Chosidow, D., Madelenat, P., [Surgical management of rectovaginal septum endometriosis from a continuous series of 50 cases], <i>Gynecologie, Obstetrique &amp; Fertilité</i> , 32, 199-209, 2004	Full text in French
Carbognin, G., Girardi, V., Pinali, L., Raffaelli, R., Bergamini, V., Pozzi Mucelli, R., Assessment of pelvic endometriosis: correlation of US and MRI with laparoscopic findings, <i>Radiologia Medica</i> , 111, 687-701, 2006	Analysis included lesions, not number of participants
Chamie, L. P., Blasbalg, R., Goncalves, M. O., Carvalho, F. M., Abrao, M. S., de Oliveira, I. S., Accuracy of magnetic resonance imaging for diagnosis and preoperative assessment of deeply infiltrating endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 106, 198-201, 2009	Included as one of the studies in the Nisenblat 2016 review
Chapron, C., Vieira, M., Chopin, N., Balleyguier, C., Barakat, H., Dumontier, I., Roseau, G., Fauconnier, A., Foulot, H., Dousset, B., Accuracy of rectal endoscopic ultrasonography and magnetic resonance imaging in the diagnosis of rectal involvement for patients presenting with deeply infiltrating endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 24, 175-9, 2004	Retrospective selection of cases
Chen, F. P., Soong, Y. K., Lee, N., Lo, S. K., The use of serum CA-125 as a marker for endometriosis in patients with dysmenorrhea for monitoring therapy and for recurrence of endometriosis, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 77, 665-70, 1998	Not MRI, but included for CA-125
Cheng, Y. M., Wang, S. T., Chou, C. Y., Serum CA-125 in preoperative patients at high risk for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 99, 375-80, 2002	CA-125 has been used for identifying high risk woman not as a diagnostic tool
Cho, S., Cho, H., Nam, A., Kim, H. Y., Choi, Y. S., Park, K. H., Cho, D. J., Lee, B. S., Neutrophil-to-lymphocyte ratio as an adjunct to CA-125 for the diagnosis of endometriosis, <i>Fertility &amp; Sterility</i> , 90, 2073-9, 2008	It is a case-control study
Chung, M. K., Chung, R. R., Gordon, D., Jennings, C., The evil twins of chronic pelvic pain syndrome: endometriosis and interstitial cystitis, <i>JSLS : Journal of the Society of Laparoendoscopic Surgeons / Society of Laparoendoscopic Surgeons</i> , 6, 311-314, 2002	No outcome of interest
Cicinelli, E., Resta, L., Nicoletti, R., Tartagni, M., Marinaccio, M., Bulletti, C., Colafoglio, G., Detection of chronic endometritis at fluid	Not MRI, but included for hysteroscopy

Study	Reason for Exclusion
hysteroscopy, Journal of Minimally Invasive Gynecology, 12, 514-518, 2005	
Cohen, L. S., Valle, R. F., Sabbagha, R. E., A comparison of preoperative ultrasound images of surgically proven endometriomas scanned by both transabdominal and transvaginal techniques, Journal of Gynecologic Surgery, 11, 27-32, 1995	All the patients have surgically confirmed endometriosis.
Cohen, M. R., Laparoscopy in the diagnosis and management of endometriosis, Journal of Reproductive Medicine, 27, 240-2, 1982	No outcome of interest
Colacurci, N., Fortunato, N., De Franciscis, P., Cardone, A., Relevance of CA-125 in the evaluation of endometriosis, Clinical & Experimental Obstetrics & Gynecology, 23, 150-4, 1996	Not MRI, but included for CA-125
Colacurci, N., Fortunato, N., De Franciscis, P., Fratta, M., Cioffi, M., Zarcone, R., Cardone, A., Serum and peritoneal CA-125 levels as diagnostic test for endometriosis, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 66, 41-3, 1996	Case-control study
Coleman, B. G., Arger, P. H., Mulhern, C. B., Jr., Endometriosis: clinical and ultrasonic correlation, AJR. American Journal of Roentgenology, 132, 747-9, 1979	All patients were recruited in this study, had surgically proven endometriosis
Corwin, M. T., Gerscovich, E. O., Lamba, R., Wilson, M., McGahan, J. P., Differentiation of ovarian endometriomas from hemorrhagic cysts at MR imaging: utility of the T2 dark spot sign, Radiology, 271, 126-32, 2014	Using a diagnostic test to diagnose endometriosis has not been addressed in this study. It is about a sign in MRI to distinguish between Endometrioma and haemorrhagic cysts.
Daniilidis, A., Giannoulis, H., Tantanasis, T., Papathanasiou, K., Loufopoulos, A., Tzafettas, J., Diagnostic laparoscopy, infertility, and endometriosis - 5 Years experience, Gynecological Surgery, 5, 231-234, 2008	Outcomes not of interest
de Kroon, C. D., van der Sandt, H. A., van Houwelingen, J. C., Jansen, F. W., Sonographic assessment of non-malignant ovarian cysts: does sonohistology exist?, Human Reproduction, 19, 2138-43, 2004	Not MRI, but included for ultrasound
Dechaud, H., Ali Ahmed, S. A., Aligier, N., Vergnes, C., Hedon, B., Does transvaginal hydrolaparoscopy render standard diagnostic laparoscopy obsolete for unexplained infertility investigation?, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 94, 97-102, 2001	Transvaginal hydrolaparoscopy compared with conventional laparoscopy; no data for outcomes
Delpy, R., Barthet, M., Gasmi, M., Berdah, S., Shojai, R., Desjeux, A., Boubli, L., Grimaud, J. C., Value of endorectal ultrasonography for diagnosing rectovaginal septal endometriosis infiltrating the rectum, Endoscopy, 37, 357-61, 2005	unable to construct 2 x 2 tables
Dessole, S., Farina, M., Rubattu, G., Cosmi, E., Ambrosini, G., Nardelli, G. B., Sonovaginography is a new technique for	Not MRI, but included for ultrasound

Study	Reason for Exclusion
assessing rectovaginal endometriosis, <i>Fertility &amp; Sterility</i> , 79, 1023-7, 2003	
do Amaral, V. F., Ferriani, R. A., de Sa, M. F. S., Nogueira, A. A., Silva, J. C. R., de Sa Rosa e Silva, A. C. J., de Moura, M. D., Positive correlation between serum and peritoneal fluid CA-125 levels in women with pelvic endometriosis, <i>Sao Paulo Medical Journal</i> , 124, 223-227, 2006	It is a case-control study
Dogan, M. M., Ugur, M., Soysal, S. K., Soysal, M. E., Ekici, E., Gokmen, O., Transvaginal sonographic diagnosis of ovarian endometrioma, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 52, 145-9, 1996	'Lesion-level' analysis
Dunselman, G. A. J., Vermeulen, N., Becker, C., Calhaz-Jorge, C., D'Hooghe, T., De Bie, B., Heikinheimo, O., Horne, A. W., Kiesel, L., Nap, A., Prentice, A., Saridogan, E., Soriano, D., Nelen, W., ESHRE guideline: Management of women with endometriosis, <i>Human Reproduction</i> , 29, 400-412, 2014	The individual studies in this publication have been checked for inclusion in the review
El Maati, A. A. A., Ibrahim, E. A. G., Mokhtar, F. Z., A two-stage imaging protocol for evaluating women presenting with acute pelvic pain, <i>Egyptian Journal of Radiology and Nuclear Medicine</i> , 44, 923-936, 2013	The population is women with acute pelvic pain, not suspected endometriosis
Elgafor El Sharkwy, I. A., Combination of non-invasive and semi-invasive tests for diagnosis of minimal to mild endometriosis, <i>Archives of gynecology and obstetrics</i> , 288, 793-7, 2013	The diagnostic test (IL-6 combined with nerve fibres) which has been used in this study is not matched with the protocol
Ellett, L., Readman, E., Newman, M., McIlwaine, K., Villegas, R., Jagasia, N., Maher, P., Are endometrial nerve fibres unique to endometriosis? A prospective case-control study of endometrial biopsy as a diagnostic test for endometriosis in women with pelvic pain, <i>Human Reproduction</i> , 30, 2808-15, 2015	Case-control study
Eskenazi, B., Warner, M., Bonsignore, L., Olive, D., Samuels, S., Vercellini, P., Validation study of nonsurgical diagnosis of endometriosis, <i>Fertility &amp; Sterility</i> , 76, 929-35, 2001	Not MRI, but included for ultrasound
Exacoustos, C., Luciano, D., Corbett, B., De Felice, G., Di Feliciano, M., Luciano, A., Zupi, E., The uterine junctional zone: a 3-dimensional ultrasound study of patients with endometriosis, <i>American Journal of Obstetrics &amp; Gynecology</i> , 209, 248.e1-7, 2013	In the study, the relation between thickness of uterine junctional zone and endometriosis has been evaluated. It has not been used as a diagnostic tool.
Exacoustos, C., Malzoni, M., Di Giovanni, A., Lazzeri, L., Tosti, C., Petraglia, F., Zupi, E., Ultrasound mapping system for the surgical management of deep infiltrating endometriosis, <i>Fertility &amp; Sterility</i> , 102, 143-150.e2, 2014	Not MRI, but included for ultrasound
Faccioli, N., Foti, G., Manfredi, R., Mainardi, P., Spoto, E., Ruffo, G., Minelli, L., Mucelli, R. P., Evaluation of colonic involvement in endometriosis: double-contrast barium enema	'Lesion-level' analysis

Study	Reason for Exclusion
vs. magnetic resonance imaging, Abdominal Imaging, 35, 414-21, 2010	
Faccioli, N., Manfredi, R., Mainardi, P., Dalla Chiara, E., Spoto, E., Minelli, L., Mucelli, R. P., Barium enema evaluation of colonic involvement in endometriosis, AJR. American Journal of Roentgenology, 190, 1050-4, 2008	Retrospective selection of cases; 'lesion-level' analysis
Fedele, L., Arcaini, L., Vercellini, P., Marchini, M., Baglioni, A., Bianchi, S., Serum Ca-125 concentrations in endometriosis, Acta Europaea Fertilitatis, 20, 137-9, 1989	Not MRI, but included for CA-125
Fedele, L., Bianchi, S., Portuese, A., Borruto, F., Dorta, M., Transrectal ultrasonography in the assessment of rectovaginal endometriosis, Obstetrics & Gynecology, 91, 444-8, 1998	Not MRI, but included for ultrasound
Federici, D., Muggiasca, M. L., Conti, M., Diagnostic value of laparoscopic evaluation of women with chronic pelvic pain: Our experience and a review of the literature, VALEUR DIAGNOSTIQUE DE L'EXPLORATION LAPAROSCOPIQUE DES FEMMES SOUFFRANT DE DOULEURS PELVIENNES CHRONIQUES: EXPERIENCE PERSONNELLE ET REVUE DE LA LITTERATURE, Acta Endoscopica, 22, 177-186, 1992	Narrative review
Felding, C., Mikkelsen, A. L., Peen, U., Laparoscopy and ultrasound in patients with chronic pelvic pain, Journal of Obstetrics and Gynaecology, 10, 419-422, 1990	No outcome of interest
Ferrero, S., Biscaldi, E., Morotti, M., Venturini, P. L., Remorgida, V., Rollandi, G. A., Valenzano Menada, M., Multidetector computerized tomography enteroclysis vs. rectal water contrast transvaginal ultrasonography in determining the presence and extent of bowel endometriosis, Ultrasound in Obstetrics & Gynecology, 37, 603-13, 2011	Not MRI, but included for ultrasound
Fiaschetti, V., Crusco, S., Meschini, A., Cama, V., Di Vito, L., Marziali, M., Piccione, E., Calabria, F., Simonetti, G., Deeply infiltrating endometriosis: evaluation of retro-cervical space on MRI after vaginal opacification, European Journal of Radiology, 81, 3638-45, 2012	Lesion-level analysis
Fisk, N. M., Tan, C. E., CA 125 in peritoneal fluid and serum of patients with endometriosis, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 29, 153-8, 1988	Case-control study
Foda, A. A., Aal, I. A. A., Role of some biomarkers in chronic pelvic pain for early detection of endometriosis in infertile women, Middle East Fertility Society Journal, 17, 187-194, 2012	Case-control study
Fratelli, N., Scioscia, M., Bassi, E., Musola, M., Minelli, L., Trivella, G., Transvaginal sonography for preoperative assessment of deep endometriosis, Journal of Clinical Ultrasound, 41, 69-75, 2013	Data for TVS was collected retrospectively

Study	Reason for Exclusion
Friedman, H., Vogelzang, R. L., Mendelson, E. B., Neiman, H. L., Cohen, M., Endometriosis detection by US with laparoscopic correlation, <i>Radiology</i> , 157, 217-20, 1985	No data on outcomes
Goncalves, M. O., Podgaec, S., Dias, J. A., Jr., Gonzalez, M., Abrao, M. S., Transvaginal ultrasonography with bowel preparation is able to predict the number of lesions and rectosigmoid layers affected in cases of deep endometriosis, defining surgical strategy, <i>Human Reproduction</i> , 25, 665-71, 2010	Not MRI, but included for ultrasound
Gougoutas, C. A., Siegelman, E. S., Hunt, J., Outwater, E. K., Pelvic endometriosis: various manifestations and MR imaging findings, <i>AJR. American Journal of Roentgenology</i> , 175, 353-8, 2000	Narrative review
Grasso, R. F., Di Giacomo, V., Sedati, P., Sizzi, O., Florio, G., Faiella, E., Rossetti, A., Del Vescovo, R., Zobel, B. B., Diagnosis of deep infiltrating endometriosis: accuracy of magnetic resonance imaging and transvaginal 3D ultrasonography, <i>Abdominal Imaging</i> , 35, 716-25, 2010	Included as one of the studies in the Nisenblat 2016 review
Guerriero, S., Ajossa, S., Gerada, M., Virgilio, B., Angioni, S., Melis, G. B., Diagnostic value of transvaginal 'tenderness-guided' ultrasonography for the prediction of location of deep endometriosis, <i>Human Reproduction</i> , 23, 2452-7, 2008	Not MRI, but included for ultrasound
Guerriero, S., Ajossa, S., Mais, V., Risalvato, A., Lai, M. P., Melis, G. B., The diagnosis of endometriomas using colour Doppler energy imaging, <i>Human Reproduction</i> , 13, 1691-5, 1998	Not MRI, but included for ultrasound
Guerriero, S., Ajossa, S., Minguez, J. A., Jurado, M., Mais, V., Melis, G. B., Alcazar, J. L., Accuracy of transvaginal ultrasound for diagnosis of deep endometriosis in uterosacral ligaments, rectovaginal septum, vagina and bladder: systematic review and meta-analysis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 46, 534-45, 2015	Not MRI, but included for ultrasound
Guerriero, S., Ajossa, S., Paoletti, A. M., Mais, V., Angiolucci, M., Melis, G. B., Tumor markers and transvaginal ultrasonography in the diagnosis of endometrioma, <i>Obstetrics &amp; Gynecology</i> , 88, 403-7, 1996	Not MRI, but included for ultrasound
Guerriero, S., Mais, V., Ajossa, S., Paoletti, A. M., Angiolucci, M., Labate, F., Melis, G. B., The role of endovaginal ultrasound in differentiating endometriomas from other ovarian cysts, <i>Clinical &amp; Experimental Obstetrics &amp; Gynecology</i> , 22, 20-2, 1995	Not MRI, but included for ultrasound
Guerriero, S., Mais, V., Ajossa, S., Paoletti, A. M., Angiolucci, M., Melis, G. B., Transvaginal ultrasonography combined with CA-125 plasma	Not MRI, but included for ultrasound



Study	Reason for Exclusion
levels in the diagnosis of endometrioma, Fertility & Sterility, 65, 293-8, 1996	
Guerriero, S., Mallarini, G., Ajossa, S., Risalvato, A., Satta, R., Mais, V., Angiolucci, M., Melis, G. B., Transvaginal ultrasound and computed tomography combined with clinical parameters and CA-125 determinations in the differential diagnosis of persistent ovarian cysts in premenopausal women, Ultrasound in Obstetrics & Gynecology, 9, 339-43, 1997	Not MRI, but included for ultrasound
Guerriero, S., Saba, L., Ajossa, S., Peddes, C., Angiolucci, M., Perniciano, M., Melis, G. B., Alcazar, J. L., Three-dimensional ultrasonography in the diagnosis of deep endometriosis, Human Reproduction, 29, 1189-98, 2014	Not MRI, but included for ultrasound
Gurgan, T., Kisinisci, H., Yarali, H., Aksu, T., Zeyneloglu, H., Develioglu, O., Serum and peritoneal fluid CA-125 levels in early stage endometriosis, Gynecologic & Obstetric Investigation, 30, 105-8, 1990	Not MRI, but included for CA-125
Guen, M. A., Bese, T., Demirkiran, F., Comparison of hydrosoneography and transvaginal ultrasonography in the detection of intracavitary pathologies in women with abnormal uterine bleeding, International Journal of Gynecological Cancer, 14, 57-63, 2004	The study population are women with history of abnormal uterine bleeding not women suspected to endometriosis
Ha, H. K., Lim, Y. T., Kim, H. S., Suh, T. S., Song, H. H., Kim, S. J., Diagnosis of pelvic endometriosis: fat-suppressed T1-weighted vs conventional MR images, AJR. American Journal of Roentgenology, 163, 127-31, 1994	Included as one of the studies in the Nisenblat 2016 review
Harada, T., Kubota, T., Aso, T., Usefulness of CA19-9 versus CA125 for the diagnosis of endometriosis, Fertility and Sterility, 78, 733-739, 2002	Case-control study
Holland, T. K., Cutner, A., Saridogan, E., Mavrelos, D., Pateman, K., Jurkovic, D., Ultrasound mapping of pelvic endometriosis: does the location and number of lesions affect the diagnostic accuracy? A multicentre diagnostic accuracy study, BMC Women's Health, 13, 43, 2013	Not MRI, but included for ultrasound
Hompes, P. G., Koninckx, P. R., Kennedy, S., van Kamp, G. F., Verstraeten, R. A., Cornillie, F., Serum CA-125 concentrations during midfollicular phase, a clinically useful and reproducible marker in diagnosis of advanced endometriosis, Clinical Chemistry, 42, 1871-4, 1996	Not MRI, but included for CA-125
Hornstein, M. D., Harlow, B. L., Thomas, P. P., Check, J. H., Use of a new CA 125 assay in the diagnosis of endometriosis, Human Reproduction, 10, 932-4, 1995	Diagnosis of endometriosis was made prior to serum collection for CA-125
Hottat, N., Larrousse, C., Anaf, V., Noel, J. C., Matos, C., Absil, J., Metens, T., Endometriosis: contribution of 3.0-T pelvic MR imaging in	Included as one of the studies in the Nisenblat 2016 review

Study	Reason for Exclusion
preoperative assessment--initial results, Radiology, 253, 126-34, 2009	
Howard, F. M., El-Minawi, A. M., Sanchez, R. A., Conscious pain mapping by laparoscopy in women with chronic pelvic pain, Obstetrics & Gynecology, 96, 934-9, 2000	The study investigated conscious pain mapping using laparoscopy
Hudelist, G., Ballard, K., English, J., Wright, J., Banerjee, S., Mastoroudes, H., Thomas, A., Singer, C. F., Keckstein, J., Transvaginal sonography vs. clinical examination in the preoperative diagnosis of deep infiltrating endometriosis, Ultrasound in Obstetrics & Gynecology, 37, 480-7, 2011	Not MRI, but included for ultrasound
Hudelist, G., English, J., Thomas, A. E., Tinelli, A., Singer, C. F., Keckstein, J., Diagnostic accuracy of transvaginal ultrasound for non-invasive diagnosis of bowel endometriosis: systematic review and meta-analysis, Ultrasound in Obstetrics & Gynecology, 37, 257-63, 2011	Individual studies checked for inclusion/exclusion
Hudelist, G., Oberwinkler, K. H., Singer, C. F., Tuttlies, F., Rauter, G., Ritter, O., Keckstein, J., Combination of transvaginal sonography and clinical examination for preoperative diagnosis of pelvic endometriosis, Human Reproduction, 24, 1018-24, 2009	No separate data for imaging test
Hudelist, G., Tuttlies, F., Rauter, G., Pucher, S., Keckstein, J., Can transvaginal sonography predict infiltration depth in patients with deep infiltrating endometriosis of the rectum?, Human Reproduction, 24, 1012-7, 2009	Focus on depth of invasion of endometriotic lesions
Ikeda, F., Bernardini, M. A., Vanni, D., Vasconcelos, A., Pinotti, J. A., Abrao, M. S., A comparison of microlaparoscopy under sedation, microlaparoscopy under general anesthesia and conventional laparoscopy for diagnosis and treatment of pelvic endometriosis in early stages, Fertility and sterility, 77, S21, 2002	The effectiveness of using a diagnostic tool for diagnosis of endometriosis has not been addressed.
Ismail, M. A., Rotmensch, J., Mercer, L. J., Block, B. S., Salti, G. I., Holt, J. A., CA-125 in peritoneal fluid from patients with nonmalignant gynecologic disorders, Journal of Reproductive Medicine, 39, 510-2, 1994	No outcome of interest
Jain, K. A., Friedman, D. L., Pettinger, T. W., Alagappan, R., Jeffrey, R. B., Jr., Sommer, F. G., Adnexal masses: comparison of specificity of endovaginal US and pelvic MR imaging, Radiology, 186, 697-704, 1993	'Lesion-level' analysis
Johnson, W. K., Ott, D. J., Chen, M. Y. M., Fayez, J. A., Gelfand, D. W., Efficacy of hysterosalpingography in evaluating endometriosis, Abdominal Imaging, 19, 278-280, 1994	The study evaluated the effectiveness of hysterosalpingography and laparoscopy-retrospective study
Kafali, H., Artuc, H., Demir, N., Use of CA125 fluctuation during the menstrual cycle as a tool in the clinical diagnosis of endometriosis; a preliminary report, European Journal of	It is a case-control study

Study	Reason for Exclusion
Obstetrics, Gynecology, & Reproductive Biology, 116, 85-8, 2004	
Kang, S. B., Chung, H. H., Lee, H. P., Lee, J. Y., Chang, Y. S., Impact of diagnostic laparoscopy on the management of chronic pelvic pain, Surgical Endoscopy, 21, 916-9, 2007	there was no comparison between laparoscopy and another test
Karabacak, O., Tiras, M. B., Taner, M. Z., Guner, H., Yildiz, A., Yildirim, M., Small diameter versus conventional laparoscopy: a prospective, self-controlled study, Human Reproduction, 12, 2399-401, 1997	Comparison of two types of laparoscopy
Kinkel, K., Chapron, C., Balleyguier, C., Fritel, X., Dubuisson, J. B., Moreau, J. F., Magnetic resonance imaging characteristics of deep endometriosis, Human Reproduction, 14, 1080-6, 1999	'Lesion-level' analysis
Kitawaki, J., Ishihara, H., Koshiba, H., Kiyomizu, M., Teramoto, M., Kitaoka, Y., Honjo, H., Usefulness and limits of CA-125 in diagnosis of endometriosis without associated ovarian endometriomas.[Erratum appears in Hum Reprod. 2007 Feb;22(2):627], Human Reproduction, 20, 1999-2003, 2005	Women enrolled in the study were already diagnosed with endometriosis, adenomyosis and/or leiomyomas
Koninckx, P. R., Meuleman, C., Oosterlynck, D., Cornillie, F. J., Diagnosis of deep endometriosis by clinical examination during menstruation and plasma CA-125 concentration, Fertility & Sterility, 65, 280-7, 1996	Women had laparoscopy prior to CA-125
Koninckx, P. R., Riittinen, L., Seppala, M., Cornillie, F. J., CA-125 and placental protein 14 concentrations in plasma and peritoneal fluid of women with deeply infiltrating pelvic endometriosis, Fertility & Sterility, 57, 523-30, 1992	CA-125
Kruger, K., Behrendt, K., Niedobitek-Kreuter, G., Koltermann, K., Ebert, A. D., Location-dependent value of pelvic MRI in the preoperative diagnosis of endometriosis, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 169, 93-8, 2013	'Lesion-level' analysis
Kruitwagen, R. F., Thomas, C., Poels, L. G., Koster, A. M., Willemsen, W. N., Rolland, R., High CA-125 concentrations in peritoneal fluid of normal cyclic women with various infertility-related factors as demonstrated with two-step immunoradiometric assay, Fertility & Sterility, 56, 863-9, 1991	The aim of the study was to identify CA-125 concentrations, women were not suspected of endometriosis
Kurjak, A., Kupesic, S., Scoring system for prediction of ovarian endometriosis based on transvaginal color and pulsed Doppler sonography, Fertility & Sterility, 62, 81-8, 1994	No a test of interest
Lanzone, A., Marana, R., Muscatello, R., Fulghesu, A. M., Dell'Acqua, S., Caruso, A., Mancuso, S., Serum CA-125 levels in the diagnosis and management of endometriosis, Journal of Reproductive Medicine, 36, 603-7, 1991	CA-125

Study	Reason for Exclusion
Leon, M., Vaccaro, H., Alcazar, J. L., Martinez, J., Gutierrez, J., Amor, F., Iturra, A., Sovino, H., Extended transvaginal sonography in deep infiltrating endometriosis: use of bowel preparation and an acoustic window with intravaginal gel: preliminary results, <i>Journal of Ultrasound in Medicine</i> , 33, 315-21, 2014	Not a test of interest
Leslie, C., Ma, T., McElhinney, B., Leake, R., Stewart, C. J., Is the detection of endometrial nerve fibers useful in the diagnosis of endometriosis?, <i>International Journal of Gynecological Pathology</i> , 32, 149-55, 2013	No outcome of interest
Li, G., Yu, Z., Li, K., The value of FS, NLR, and CA-125 in the diagnosis of endometriosis, <i>International journal of clinical and experimental medicine</i> , 9, 7309-7313, 2016	Not the population of interest
Macer, M. L., Mathur, M., Spektor, M., Gysler, S., Staib, L., Kodaman, P., McCarthy, S., Utility of magnetic resonance imaging in the evaluation of intraoperatively confirmed pelvic adhesions, <i>Journal of Computer Assisted Tomography</i> , 39, 896-900, 2015	Not the population of interest
Maiorana, A., Cicerone, C., Niceta, M., Alio, L., Evaluation of serum CA 125 levels in patients with pelvic pain related to endometriosis, <i>International Journal of Biological Markers</i> , 22, 200-2, 2007	CA-125
Maiorana, A., Incandela, D., Giambanco, L., Alio, W., Alio, L., Ultrasound diagnosis of pelvic endometriosis, <i>Journal of Endometriosis</i> , 3, 105-119, 2011	A narrative review
Mais, V., Guerriero, S., Ajossa, S., Angiolucci, M., Paoletti, A. M., Melis, G. B., The efficiency of transvaginal ultrasonography in the diagnosis of endometrioma, <i>Fertility &amp; Sterility</i> , 60, 776-80, 1993	'Lesion-level' analysis
Malik, E., Berg, C., Meyhofer-Malik, A., Buchweitz, O., Moubayed, P., Diedrich, K., Fluorescence diagnosis of endometriosis using 5-aminolevulinic acid, <i>Surgical Endoscopy</i> , 14, 452-5, 2000	The test is not of interest
Manganaro, L., Fierro, F., Tomei, A., Irimia, D., Lodise, P., Sergi, M. E., Vinci, V., Sollazzo, P., Porpora, M. G., Delfini, R., Vittori, G., Marini, M., Feasibility of 3.0T pelvic MR imaging in the evaluation of endometriosis, <i>European Journal of Radiology</i> , 81, 1381-7, 2012	Included as one of the studies in the Nisenblat 2016 review
Manganaro, L., Vittori, G., Vinci, V., Fierro, F., Tomei, A., Lodise, P., Sollazzo, P., Sergi, M. E., Bernardo, S., Ballesio, L., Marini, M., Porpora, M. G., Beyond laparoscopy: 3-T magnetic resonance imaging in the evaluation of posterior cul-de-sac obliteration, <i>Magnetic Resonance Imaging</i> , 30, 1432-8, 2012	Included as one of the studies in the Nisenblat 2016 review
Marasinghe, J. P., Senanayake, H., Saravanabhava, N., Arambepola, C., Condous, G., Greenwood, P., History, pelvic examination	Aim of study was to look at mobility of ovaries as a marker of endometriosis

Study	Reason for Exclusion
findings and mobility of ovaries as a sonographic marker to detect pelvic adhesions with fixed ovaries, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 40, 785-90, 2014	
Mathlouthi, N., Ayed, B. B., Dhoubi, M., Chaabene, K., Trabelsi, K., Amouri, H., Guerhazi, M., Confrontation ultrasonography-CA125-histology in the management of ovarian cysts: A prospective study about 77 cases, <i>Tunisie Medicale</i> , 89, 686-692, 2011	Full-text in French
May, K. E., Conduit-Hulbert, S. A., Villar, J., Kirtley, S., Kennedy, S. H., Becker, C. M., Peripheral biomarkers of endometriosis: a systematic review, <i>Human Reproduction Update</i> , 16, 651-74, 2010	Individual studies checked for inclusion/exclusion
McBride, N., Newman, R. L., Diagnostic laparoscopy, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 15, 556-8, 1978	No outcome of interest
McKinnon, B., Mueller, M. D., Nirgianakis, K., Bersinger, N. A., Comparison of ovarian cancer markers in endometriosis favours HE4 over CA125, <i>Molecular Medicine Reports</i> , 12, 5179-84, 2015	No data reported to calculate sensitivity
Medeiros, L. R., Rosa, M. I., Silva, B. R., Reis, M. E., Simon, C. S., Dondossola, E. R., da Cunha Filho, J. S., Accuracy of magnetic resonance in deeply infiltrating endometriosis: a systematic review and meta-analysis, <i>Archives of Gynecology &amp; Obstetrics</i> , 291, 611-21, 2015	Single studies in the review were assessed for inclusion
Medl, M., Ogris, E., Peters-Engl, C., Mierau, M., Buxbaum, P., Leodolter, S., Serum levels of the tumour-associated trypsin inhibitor in patients with endometriosis, <i>British Journal of Obstetrics &amp; Gynaecology</i> , 104, 78-81, 1997	The tumour-associated trypsin inhibitors
Melega, C., Marchesini, F. P., Bellettini, L., Biscontin, S., Flamigni, C., Diagnostic value of laparoscopy in endometriosis and infertility, <i>Journal of Reproductive Medicine</i> , 29, 597-600, 1984	No outcome of interest
Melis, G. B., Ajossa, S., Guerriero, S., Paoletti, A. M., Angiolucci, M., Piras, B., Caffiero, A., Mais, V., Epidemiology and diagnosis of endometriosis, <i>Annals of the New York Academy of Sciences</i> , 734, 352-7, 1994	Analysis include lesions, not number of participants
Menada, M. V., Remorgida, V., Abbamonte, L. H., Fulcheri, E., Ragni, N., Ferrero, S., Transvaginal ultrasonography combined with water-contrast in the rectum in the diagnosis of rectovaginal endometriosis infiltrating the bowel, <i>Fertility &amp; Sterility</i> , 89, 699-700, 2008	Not a test of interest
Mezzi, G., Ferrari, S., Arcidiacono, P. G., Di Puppo, F., Candiani, M., Testoni, P. A., Endoscopic rectal ultrasound and elastosonography are useful in flow chart for the diagnosis of deep pelvic endometriosis with rectal involvement, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 37, 586-90, 2011	There was no comparison with surgery

Study	Reason for Exclusion
Millischer, A. E., Salomon, L. J., Santulli, P., Borghese, B., Dousset, B., Chapron, C., Fusion imaging for evaluation of deep infiltrating endometriosis: feasibility and preliminary results, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 46, 109-17, 2015	No data or surgical diagnosis
Miyagi, E., Maruyama, Y., Mogami, T., Numazaki, R., Ikeda, A., Yamamoto, H., Hirahara, F., Comparison of plasma amino acid profile-based index and CA125 in the diagnosis of epithelial ovarian cancers and borderline malignant tumors, <i>International Journal of Clinical Oncology</i> , 1-8, 2016	Not the population of interest
Mol, B. W., Bayram, N., Lijmer, J. G., Wiegerinck, M. A., Bongers, M. Y., van der Veen, F., Bossuyt, P. M., The performance of CA-125 measurement in the detection of endometriosis: a meta-analysis, <i>Fertility &amp; Sterility</i> , 70, 1101-8, 1998	CA-125
Molo, M. W., Kelly, M., Radwanska, E., Binor, Z., Preoperative serum CA-125 and CA-72 in predicting endometriosis in infertility patients, <i>Journal of Reproductive Medicine</i> , 39, 964-6, 1994	CA-125
Moloney, M. D., Thornton, J. G., Cooper, E. H., Serum CA 125 antigen levels and disease severity in patients with endometriosis, <i>Obstetrics &amp; Gynecology</i> , 73, 767-9, 1989	Women had laparoscopically confirmed endometriosis
Moore, J., Copley, S., Morris, J., Lindsell, D., Golding, S., Kennedy, S., A systematic review of the accuracy of ultrasound in the diagnosis of endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 20, 630-4, 2002	Individual studies checked for inclusion/exclusion
Moretuzzo, R. W., DiLauro, S., Jenison, E., Chen, S. L., Reindollar, R. H., McDonough, P. G., Serum and peritoneal lavage fluid CA-125 levels in endometriosis, <i>Fertility &amp; Sterility</i> , 50, 430-3, 1988	No outcome of interest
Muscatello, R., Cucinelli, F., Fulghesu, A., Lanzone, A., Caruso, A., Mancuso, S., Multiple serum marker assay in the diagnosis of endometriosis, <i>Gynecological Endocrinology</i> , 6, 265-9, 1992	No outcome of interest
O'Shaughnessy, A., Check, J. H., Nowroozi, K., Lurie, D., CA 125 levels measured in different phases of the menstrual cycle in screening for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 81, 99-103, 1993	CA-125.
Ota, H., Maki, M., Evaluation of autoantibody and CA125 in the diagnosis of endometriosis or adenomyosis, <i>Medical Science Research</i> , 18, 309-310, 1990	All the participants had known condition.
Othman, E. E. D. R., Hornung, D., Al-Hendy, A., Biomarkers of endometriosis, <i>Expert Opinion on Medical Diagnostics</i> , 2, 741-752, 2008	Narrative review

Study	Reason for Exclusion
Ozaksit, G., Caglar, T., Cicek, N., Kuscu, E., Batioglu, S., Gokmen, O., Serum CA 125 levels before, during and after treatment for endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 50, 269-73, 1995	Women had a confirmed diagnosis of endometriosis prior to CA-125 test
Panidis, D., Vlassis, G., Matalliotakis, J., Skiadopoulou, S., Kalogeropoulos, A., Serum levels of the oncofetal antigens CA-125, CA 19-9 and CA 15-3 in patients with endometriosis, <i>Journal of Endocrinological Investigation</i> , 11, 801-804, 1988	All women who involved in the study have proven endometriosis
Pascual, M. A., Guerriero, S., Hereter, L., Barri-Soldevila, P., Ajossa, S., Graupera, B., Rodriguez, I., Diagnosis of endometriosis of the rectovaginal septum using introital three-dimensional ultrasonography, <i>Fertility &amp; Sterility</i> , 94, 2761-5, 2010	Not a test of interest
Pascual, M. A., Tresserra, F., Lopez-Marin, L., Ubeda, A., Grases, P. J., Dexeus, S., Role of color Doppler ultrasonography in the diagnosis of endometriotic cyst, <i>Journal of Ultrasound in Medicine</i> , 19, 695-9, 2000	Data not reported properly
Pastorfide, G., Fong, Y. F., Use of narrowband imaging for the detection of endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 22, 535, 2015	No outcome of interest
Patel, M. D., Feldstein, V. A., Chen, D. C., Lipson, S. D., Filly, R. A., Endometriomas: diagnostic performance of US.[Erratum appears in <i>Radiology</i> 1999 Dec;213(3):930], <i>Radiology</i> , 210, 739-45, 1999	retrospective selection of cases; 'lesion-level' analysis
Patel, M. D., Feldstein, V. A., Filly, R. A., The likelihood ratio of sonographic findings for the diagnosis of hemorrhagic ovarian cysts, <i>Journal of Ultrasound in Medicine</i> , 24, 607-14; quiz 615, 2005	It is about diagnosis of haemorrhagic ovarian cyst not endometrioma
Patton, P. E., Field, C. S., Harms, R. W., Coulam, C. B., CA-125 levels in endometriosis, <i>Fertility &amp; Sterility</i> , 45, 770-3, 1986	CA-125
Philip, C. A., Bisch, C., Coulon, A., de Saint-Hilaire, P., Rudigoz, R. C., Dubernard, G., Correlation between three-dimensional rectosonography and magnetic resonance imaging in the diagnosis of rectosigmoid endometriosis: a preliminary study on the first fifty cases, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 187, 35-40, 2015	MRI was the reference test
Piessens, S., Healey, M., Maher, P., Tsaltas, J., Rombauts, L., Can anyone screen for deep infiltrating endometriosis with transvaginal ultrasound?, <i>Australian &amp; New Zealand Journal of Obstetrics &amp; Gynaecology</i> , 54, 462-8, 2014	Women included in the study had the ultrasound test after diagnosis of endometriosis by surgery
Piketty, M., Chopin, N., Dousset, B., Millischer-Bellaische, A. E., Roseau, G., Leconte, M., Borghese, B., Chapron, C., Preoperative work-up for patients with deeply infiltrating	Women had histological confirmation of deep infiltrating endometriosis

Study	Reason for Exclusion
endometriosis: transvaginal ultrasonography must definitely be the first-line imaging examination, Human Reproduction, 24, 602-7, 2009	
Pittaway, D. E., Douglas, J. W., Serum CA-125 in women with endometriosis and chronic pelvic pain, Fertility & Sterility, 51, 68-70, 1989	CA-125
Pittaway, D. E., Fayez, J. A., The use of CA-125 in the diagnosis and management of endometriosis, Fertility & Sterility, 46, 790-5, 1986	CA-125
Polisseni, F., Bambirra, E. A., Camargos, A. F., Detection of chronic endometritis by diagnostic hysteroscopy in asymptomatic infertile patients, Gynecologic & Obstetric Investigation, 55, 205-10, 2003	Not a test of interest
Preutthipan,S., Hesla,J.S., A comparative study between pelvic ultrasonography and laparoscopy in the detection of pelvic pathology in the initial workup of subfertile women, Journal of the Medical Association of Thailand, 78, 596-599, 1995	No separate data for endometriosis for analysis
Randall, G. W., Gantt, P. A., Poe-Zeigler, R. L., Bergmann, C. A., Noel, M. E., Strawbridge, W. R., Richardson-Cox, B., Hereford, J. R., Reiff, R. H., Serum antiendometrial antibodies and diagnosis of endometriosis, American Journal of Reproductive Immunology, 58, 374-82, 2007	The diagnostic test which has been used in this study is not matched with the protocol
Redwine, D. B., Ovarian endometriosis: A marker for more extensive pelvic and intestinal disease, Fertility and Sterility, 72, 310-315, 1999	All the patients have endometriosis
Reid, S., Lu, C., Casikar, I., Reid, G., Abbott, J., Cario, G., Chou, D., Kowalski, D., Cooper, M., Condous, G., Prediction of pouch of Douglas obliteration in women with suspected endometriosis using a new real-time dynamic transvaginal ultrasound technique: the sliding sign, Ultrasound in Obstetrics & Gynecology, 41, 685-91, 2013	Not a test of interest
Reid, S., Lu, C., Hardy, N., Casikar, I., Reid, G., Cario, G., Chou, D., Almashat, D., Condous, G., Office gel sonovaginography for the prediction of posterior deep infiltrating endometriosis: a multicenter prospective observational study, Ultrasound in Obstetrics & Gynecology, 44, 710-8, 2014	Not a test of interest
Ribeiro, H. S., Ribeiro, P. A., Rossini, L., Rodrigues, F. C., Donadio, N., Aoki, T., Double-contrast barium enema and transrectal endoscopic ultrasonography in the diagnosis of intestinal deeply infiltrating endometriosis, Journal of Minimally Invasive Gynecology, 15, 315-20, 2008	Not the test of interest
Rosa, E. Silva A. C., Rosa, E. Silva J. C., Ferriani, R. A., Serum CA-125 in the diagnosis of endometriosis, International Journal of Gynaecology & Obstetrics, 96, 206-7, 2007	Retrospective study. Women included in the study already had a diagnosis of endometriosis prior to CA-125 serum collection



Study	Reason for Exclusion
Saba, L., Guerriero, S., Sulcis, R., Ajossa, S., Melis, G., Mallarini, G., Agreement and reproducibility in identification of endometriosis using magnetic resonance imaging, <i>Acta Radiologica</i> , 51, 573-80, 2010	No the outcome of interest
Saba, L., Guerriero, S., Sulcis, R., Pilloni, M., Ajossa, S., Melis, G., Mallarini, G., MRI and "tenderness guided" transvaginal ultrasonography in the diagnosis of recto-sigmoid endometriosis, <i>Journal of Magnetic Resonance Imaging</i> , 35, 352-60, 2012	Only women with positive index test had surgery
Saba, L., Guerriero, S., Sulis, R., Pilloni, M., Ajossa, S., Melis, G., Mallarini, G., Learning curve in the detection of ovarian and deep endometriosis by using Magnetic Resonance: comparison with surgical results, <i>European Journal of Radiology</i> , 79, 237-44, 2011	The aim of the study was to determine whether diagnostic accuracy is correlated to radiologist expertise
Saccardi, C., Cosmi, E., Borghero, A., Tregnaghi, A., Dessole, S., Litta, P., Comparison between transvaginal sonography, saline contrast sonovaginography and magnetic resonance imaging in the diagnosis of posterior deep infiltrating endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 40, 464-9, 2012	Only women with positive index test had surgery
Said, T. H., Azzam, A. Z., Prediction of endometriosis by transvaginal ultrasound in reproductive-age women with normal ovarian size, <i>Middle East Fertility Society Journal</i> , 19, 197-207, 2014	Not a test of interest
Savelli, L., Manuzzi, L., Coe, M., Mabrouk, M., Di Donato, N., Venturoli, S., Seracchioli, R., Comparison of transvaginal sonography and double-contrast barium enema for diagnosing deep infiltrating endometriosis of the posterior compartment, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 38, 466-71, 2011	Not the test of interest
Savelli, L., Manuzzi, L., Pollastri, P., Mabrouk, M., Seracchioli, R., Venturoli, S., Diagnostic accuracy and potential limitations of transvaginal sonography for bladder endometriosis, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 34, 595-600, 2009	Not MRI, but included for ultrasound
Sayasneh, A., Kaijser, J., Preisler, J., Smith, A. A., Raslan, F., Johnson, S., Husicka, R., Ferrara, L., Stalder, C., Ghaem-Maghani, S., Timmerman, D., Bourne, T., Accuracy of ultrasonography performed by examiners with varied training and experience in predicting specific pathology of adnexal masses, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 45, 605-12, 2015	Not MRI, but included for ultrasound
Scardapane, A., Bettocchi, S., Lorusso, F., Stabile Ianora, A. A., Vimercati, A., Ceci, O., Lasciarrea, M., Angelelli, G., Diagnosis of colorectal endometriosis: contribution of contrast enhanced MR-colonography, <i>European Radiology</i> , 21, 1553-63, 2011	Comparison of MRI between two radiologists

Study	Reason for Exclusion
Scardapane, A., Lorusso, F., Bettocchi, S., Moschetta, M., Fiume, M., Vimercati, A., Pepe, M. L., Angelelli, G., Stabile Ianora, A. A., Deep pelvic endometriosis: accuracy of pelvic MRI completed by MR colonography, <i>Radiologia Medica</i> , 118, 323-38, 2013	'Lesion-level' analysis
Scardapane, A., Lorusso, F., Scioscia, M., Ferrante, A., Stabile Ianora, A. A., Angelelli, G., Standard high-resolution pelvic MRI vs. low-resolution pelvic MRI in the evaluation of deep infiltrating endometriosis, <i>European Radiology</i> , 24, 2590-6, 2014	Comparison of MRI carried out by two different radiologists
Schenken, R. S., Improving the diagnosis of endometriosis in adolescents, <i>Sexuality, Reproduction and Menopause</i> , 6, 4-8, 2008	Narrative review
Seeber, B., Sammel, M. D., Fan, X., Gerton, G. L., Shaunik, A., Chittams, J., Barnhart, K. T., Panel of markers can accurately predict endometriosis in a subset of patients, <i>Fertility &amp; Sterility</i> , 89, 1073-81, 2008	It is a case-control study
Shen, A., Xu, S., Ma, Y., Guo, H., Li, C., Yang, C., Zou, S., Diagnostic value of serum CA125, CA19-9 and CA15-3 in endometriosis: A meta-analysis, <i>Journal of International Medical Research</i> , 43, 599-609, 2015	It is about association of biomarkers and stage of endometriosis. No outcome of interest.
Sherif, M. F., Badawy, M. E., Elkholy, D. G. E. Y., Accuracy of magnetic resonance imaging in diagnosis of deeply infiltrating endometriosis, <i>Egyptian Journal of Radiology and Nuclear Medicine</i> , 46, 159-165, 2015	Unclear how outcomes were obtained, data for each of the tests not available from the paper. Also, description of sites may have overlap, unclear classification of endometriosis sites
Sokalska, A., Timmerman, D., Testa, A. C., Van Holsbeke, C., Lissoni, A. A., Leone, F. P., Jurkovic, D., Valentin, L., Diagnostic accuracy of transvaginal ultrasound examination for assigning a specific diagnosis to adnexal masses, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 34, 462-70, 2009	Not MRI, but included for ultrasound
Somigliana, E., Vigano, P., Candiani, M., Felicetta, I., Di Blasio, A. M., Vignali, M., Use of serum-soluble intercellular adhesion molecule-1 as a new marker of endometriosis, <i>Fertility &amp; Sterility</i> , 77, 1028-31, 2002	Women included in the study already had laparoscopy prior to CA-125 serum collection
Somigliana, E., Vigano, P., Tirelli, A. S., Felicetta, I., Torresani, E., Vignali, M., Di Blasio, A. M., Use of the concomitant serum dosage of CA 125, CA 19-9 and interleukin-6 to detect the presence of endometriosis. Results from a series of reproductive age women undergoing laparoscopic surgery for benign gynaecological conditions, <i>Human Reproduction</i> , 19, 1871-6, 2004	Case-control study
Spencer, J. A., Weston, M. J., Imaging in endometriosis, <i>Imaging</i> , 15, 63-71, 2003	Narrative review
Stowell, S. B., Wiley, C. M., Perez-Reyes, N., Powers, C. N., Cytologic diagnosis of peritoneal fluids. Applicability to the laparoscopic diagnosis	The diagnostic test in this study is not matched with the protocol

Study	Reason for Exclusion
of endometriosis, <i>Acta Cytologica</i> , 41, 817-22, 1997	
Stratton, P., Winkel, C., Premkumar, A., Chow, C., Wilson, J., Hearn-Stokes, R., Heo, S., Merino, M., Nieman, L. K., Diagnostic accuracy of laparoscopy, magnetic resonance imaging, and histopathologic examination for the detection of endometriosis, <i>Fertility &amp; Sterility</i> , 79, 1078-85, 2003	Included as one of the studies in the Nisenblat 2016 review
Sugimura, K., Okizuka, H., Imaoka, I., Kaji, Y., Takahashi, K., Kitao, M., Ishida, T., Pelvic endometriosis: detection and diagnosis with chemical shift MR imaging, <i>Radiology</i> , 188, 435-8, 1993	Included as one of the studies in the Nisenblat 2016 review
Szubert, M., Suzin, J., Wierzbowski, T., Kowalczyk-Amico, K., CA-125 concentration in serum and peritoneal fluid in patients with endometriosis - preliminary results, <i>Archives of Medical Science</i> , 8, 504-8, 2012	Case-control study
Takahashi, K., Nagata, H., Kitao, M., CA-125 in the menstrual blood is an effective marker for diagnosing early stage endometriosis: A preliminary report, <i>Japanese Journal of Fertility and Sterility</i> , 36, 356-359, 1991	Ultrasound was used to confirm ovulatory day only
Takahashi, K., Nagata, H., Musa, A. A., Shibukawa, T., Yamasaki, H., Kitao, M., Clinical usefulness of CA-125 levels in the menstrual discharge in patients with endometriosis, <i>Fertility &amp; Sterility</i> , 54, 360-2, 1990	Not MRI, but included for CA-125
Takahashi, K., Okada, S., Ozaki, T., Kitao, M., Sugimura, K., Diagnosis of pelvic endometriosis by magnetic resonance imaging using "fat-saturation" technique, <i>Fertility &amp; Sterility</i> , 62, 973-7, 1994	Population appears to overlap with Sigumura 1993 (which is included in the review)
Takeuchi, H., Kuwatsuru, R., Kitade, M., Sakurai, A., Kikuchi, I., Shimanuki, H., Kinoshita, K., A novel technique using magnetic resonance imaging jelly for evaluation of rectovaginal endometriosis, <i>Fertility &amp; Sterility</i> , 83, 442-7, 2005	Included as one of the studies in the Nisenblat 2016 review
Takeuchi, M., Matsuzaki, K., Nishitani, H., Susceptibility-weighted MRI of endometrioma: preliminary results, <i>AJR. American Journal of Roentgenology</i> , 191, 1366-70, 2008	No outcome of interest
Theodoridis, T. D., Zepiridis, L., Mikos, T., Grimbizis, G. F., Dinas, K., Athanasiadis, A., Bontis, J. N., Comparison of diagnostic accuracy of transvaginal ultrasound with laparoscopy in the management of patients with adnexal masses, <i>Archives of Gynecology &amp; Obstetrics</i> , 280, 767-73, 2009	Not MRI, but included for ultrasound
Thomeer, M. G., Steensma, A. B., van Santbrink, E. J., Willemsen, F. E., Wielopolski, P. A., Hunink, M. G., Spronk, S., Laven, J. S., Krestin, G. P., Can magnetic resonance imaging at 3.0-Tesla reliably detect patients with endometriosis? Initial results, <i>Journal of</i>	Included as one of the studies in the Nisenblat 2016 review

Study	Reason for Exclusion
Obstetrics & Gynaecology Research, 40, 1051-8, 2014	
Tirlapur, S. A., Daniels, J. P., Khan, K. S., Medal trial collaboration, Chronic pelvic pain: how does noninvasive imaging compare with diagnostic laparoscopy?, Current Opinion in Obstetrics & Gynecology, 27, 445-8, 2015	This systematic review has not only focused on patients with suspected endometriosis. It is more general about pelvic pain and diagnostic tools.
Togashi, K., Nishimura, K., Kimura, I., Tsuda, Y., Yamashita, K., Shibata, T., Nakano, Y., Konishi, J., Konishi, I., Mori, T., Endometrial cysts: diagnosis with MR imaging, Radiology, 180, 73-8, 1991	A mixed population - some women are postmenopausal (age range 9 to 85 yrs.)
Tumedei, U., Ciardelli, V., Paltrinieri, F., Kuria, M. S., Amadori, A., Stefanetti, M., Gori, G., Transvaginal ultrasound in the diagnosis of endometrial abnormalities, Tumori, 87, S15, 2001	It has focused on endometrial abnormalities not endometriosis
Valenzano Menada, M., Remorgida, V., Abbamonte, L. H., Nicoletti, A., Ragni, N., Ferrero, S., Does transvaginal ultrasonography combined with water-contrast in the rectum aid in the diagnosis of rectovaginal endometriosis infiltrating the bowel?, Human Reproduction, 23, 1069-75, 2008	Not MRI, but included for ultrasound
Van den Bosch, T., Vandendael, A., Van Schoubroeck, D., Wranz, P. A. B., Lombard, C. J., Combining vaginal ultrasonography and office endometrial sampling in the diagnosis of endometrial disease in postmenopausal women, Obstetrics and Gynecology, 85, 349-352, 1995	It is not about endometriosis, it has addressed endometrial diseases
Van Holsbeke, C., Van Calster, B., Guerriero, S., Savelli, L., Leone, F., Fischerova, D., Czekierdowski, A., Fruscio, R., Veldman, J., Van de Putte, G., Testa, A. C., Bourne, T., Valentin, L., Timmerman, D., Imaging in gynaecology: How good are we in identifying endometriomas?, Facts Views & Vision in Obgyn, 1, 7-17, 2009	Not MRI, but included for ultrasound
Vercellini, P., Oldani, S., Felicetta, I., Bramante, T., Rognoni, M. T., Crosignani, P. G., The value of cyst puncture in the differential diagnosis of benign ovarian tumours, Human Reproduction, 10, 1465-9, 1995	Not MRI, but included for CA-125
Vimercati, A., Achillarre, M. T., Scardapane, A., Lorusso, F., Ceci, O., Mangiatordi, G., Angelelli, G., Van Herendael, B., Selvaggi, L., Bettocchi, S., Accuracy of transvaginal sonography and contrast-enhanced magnetic resonance-colonography for the presurgical staging of deep infiltrating endometriosis, Ultrasound in Obstetrics & Gynecology, 40, 592-603, 2012	Not a test of interest
Volpi, E., De Grandis, T., Zuccaro, G., La Vista, A., Sismondi, P., Role of transvaginal sonography in the detection of endometriomata, Journal of Clinical Ultrasound, 23, 163-7, 1995	Not MRI, but included for ultrasound
Vrachnis, N., Sifakis, S., Samoli, E., Kappou, D., Pavlakis, K., Iliodromiti, Z., Botsis, D., Three-	No outcome of interest; no data for endometriosis

Study	Reason for Exclusion
dimensional ultrasound and three-dimensional power Doppler improve the preoperative evaluation of complex benign ovarian lesions, <i>Clinical &amp; Experimental Obstetrics &amp; Gynecology</i> , 39, 474-8, 2012	
Walsh, J. W., Taylor, K. J., Wasson, J. F., Schwartz, P. E., Rosenfield, A. T., Gray-scale ultrasound in 204 proved gynecologic masses: accuracy and specific diagnostic criteria, <i>Radiology</i> , 130, 391-7, 1979	No outcome of interest
Wang, L., Liu, H. Y., Shi, H. H., Lang, J. H., Sun, W., Urine peptide patterns for non-invasive diagnosis of endometriosis: a preliminary prospective study, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 177, 23-8, 2014	Biomarker not of interest
Weerakiet, S., Wongkularb, A., Rochanawutanon, M., Rojanasakul, A., Transvaginal ultrasonography combined with pelvic examination in the diagnosis of ovarian endometrioma, <i>Journal of the Medical Association of Thailand</i> , 83, 523-8, 2000	Not MRI, but included for ultrasound
Wessels, J. M., Kay, V. R., Leyland, N. A., Agarwal, S. K., Foster, W. G., Assessing brain-derived neurotrophic factor as a novel clinical marker of endometriosis, <i>Fertility &amp; Sterility</i> , 105, 119-128.e5, 2016	Not the test of interest
Wild, R. A., Hirisave, V., Bianco, A., Podczaski, E. S., Demers, L. M., Endometrial antibodies versus CA-125 for the detection of endometriosis, <i>Fertility &amp; Sterility</i> , 55, 90-4, 1991	Not MRI, but included for CA-125
Wolfler, M. M., Nagele, F., Kolbus, A., Seidl, S., Schneider, B., Huber, J. C., Tschugguel, W., A predictive model for endometriosis, <i>Human Reproduction</i> , 20, 1702-8, 2005	Biomarker not of interest
Wykes, C. B., Clark, T. J., Khan, K. S., Accuracy of laparoscopy in the diagnosis of endometriosis: A systematic quantitative review, <i>BJOG: An International Journal of Obstetrics and Gynaecology</i> , 111, 1204-1212, 2004	Not MRI, but included for Laparoscopy
Yamashita, Y., Torashima, M., Hatanaka, Y., Harada, M., Higashida, Y., Takahashi, M., Mizutani, H., Tashiro, H., Iwamasa, J., Miyazaki, K., et al., Adnexal masses: accuracy of characterization with transvaginal US and precontrast and postcontrast MR imaging, <i>Radiology</i> , 194, 557-65, 1995	Review of MRI and TVUS by five radiologists
Yazbek, J., Helmy, S., Ben-Nagi, J., Holland, T., Sawyer, E., Jurkovic, D., Value of preoperative ultrasound examination in the selection of women with adnexal masses for laparoscopic surgery, <i>Ultrasound in Obstetrics and Gynecology</i> , 30, 883-888, 2007	The preoperative sonography has not been used to diagnose endometriosis.
Zanardi, R., Del Frate, C., Zuiani, C., Bazzocchi, M., Staging of pelvic endometriosis based on MRI findings versus laparoscopic classification	No data to calculate specificity

Study	Reason for Exclusion
according to the American Fertility Society, Abdominal Imaging, 28, 733-42, 2003	
Zapardiel, I., Gorostidi, M., Ravaggi, A., Allende, M. T., Silveira, M., Abehsera, D., MacUks, R., Utility Serum Marker HE4 for the Differential Diagnosis between Endometriosis and Adnexal Malignancy, International Journal of Gynecological Cancer, 26, 52-55, 2016	No data on surgical diagnosis
Zhang, Y., Qiao, C., Li, L., Zhao, X., Li, Y., Serum HE4 is more suitable as a biomarker than CA125 in Chinese women with benign gynecologic disorders, African Health Sciences, 14, 913-8, 2014	Not MRI, but included for CA-125

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## H.14 Diagnosis – Surgical diagnosis with or without histological confirmation

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Study	Reason for Exclusion
Abrao, M. S., Podgaec, S., Filho, B. M., Ramos, L. O., Pinotti, J. A., de Oliveira, R. M., The use of biochemical markers in the diagnosis of pelvic endometriosis, Human Reproduction, 12, 2523-7, 1997	Case-control study
Abrao, M. S., Podgaec, S., Pinotti, J. A., de Oliveira, R. M., Tumor markers in endometriosis, International Journal of Gynaecology & Obstetrics, 66, 19-22, 1999	Case-control study
Abu-Musa, A., Takahashi, K., Nagata, H., Yamasaki, H., Mizoguchi, S., Kitao, M., CA-125 in menstrual discharge in patients with chronic pelvic pain, International Journal of Gynaecology & Obstetrics, 37, 111-4, 1992	The level of CA-125 in menstrual discharge has been assessed
Acimovic, M., Vidakovic, S., Milic, N., Jeremic, K., Markovic, M., Milosevic-Djeric, A., Lazovic-Radonjic, G., Survivin and Vegf as Novel Biomarkers in Diagnosis of Endometriosis, Journal of Medical Biochemistry, 35, 63-68, 2016	No laparoscopy/ laparotomy and no histological confirmation
Aleem, F., Pennisi, J., Zeitoun, K., Predanic, M., The role of color Doppler in diagnosis of endometriomas, Ultrasound in Obstetrics & Gynecology, 5, 51-4, 1995	The aim of this study is to describe vascular appearance in endometriomas. No outcome of interest
Anaf, V., El Nakadi, I., De Moor, V., Coppens, E., Zalcman, M., Noel, J. C., Anatomic significance of a positive barium enema in deep infiltrating endometriosis of the large bowel, World Journal of Surgery, 33, 822-7, 2009	All patients had surgery and DCBE
Bagan, P., Berna, P., Assouad, J., Hupertan, V., Le Pimpec Barthes, F., Riquet, M., Value of cancer antigen 125 for diagnosis of pleural endometriosis in females with recurrent	The control group are males.

Study	Reason for Exclusion
pneumothorax, European Respiratory Journal, 31, 140-2, 2008	
Balleyguier, C., Roupret, M., Nguyen, T., Kinkel, K., Helenon, O., Chapron, C., Ureteral endometriosis: the role of magnetic resonance imaging, Journal of the American Association of Gynecologic Laparoscopists, 11, 530-6, 2004	No outcome of interest. Moreover, only 6 patients were included.
Barcellos, M. B., Lasmar, B., Lasmar, R., Agreement between the preoperative findings and the operative diagnosis in patients with deep endometriosis, Archives of Gynecology & ObstetricsArch Gynecol Obstet, 293, 845-50, 2016	Lesion-level analysis
Bazot, M., Gasner, A., Ballester, M., Darai, E., Value of thin-section oblique axial T2-weighted magnetic resonance images to assess uterosacral ligament endometriosis, Human Reproduction, 26, 346-53, 2011	Retrospective study; one MRI technique compared to conventional technique
Bazot, M., Gasner, A., Lafont, C., Ballester, M., Darai, E., Deep pelvic endometriosis: limited additional diagnostic value of postcontrast in comparison with conventional MR images, European Journal of Radiology, 80, e331-9, 2011	Retrospective study; comparison of post-contrast MRI versus conventional MRI
Bedaiwy, M. A., Falcone, T., Laboratory testing for endometriosis, Clinica Chimica Acta, 340, 41-56, 2004	Narrative review
Bedaiwy, M. A., Falcone, T., Sharma, R. K., Goldberg, J. M., Attaran, M., Nelson, D. R., Agarwal, A., Prediction of endometriosis with serum and peritoneal fluid markers: a prospective controlled trial, Human Reproduction, 17, 426-31, 2002	Biomarkers not of interest
Belghiti, J., Thomassin-Naggara, I., Zacharopoulou, C., Zilberman, S., Jarboui, L., Bazot, M., Ballester, M., Darai, E., Contribution of Computed Tomography Enema and Magnetic Resonance Imaging to Diagnose Multifocal and Multicentric Bowel Lesions in Patients With Colorectal Endometriosis, Journal of Minimally Invasive Gynecology, 22, 776-84, 2015	Lesion-level analysis
Belli, P., De Gaetano, A. M., Mirk, P., Specca, S., Valentini, A. L., Uterine adenomyosis and tubal endometriosis: diagnostic imaging, Rays, 23, 693-701, 1998	Narrative review
Benacerraf, B. R., Finkler, N. J., Wojciechowski, C., Knapp, R. C., Sonographic accuracy in the diagnosis of ovarian masses, Journal of Reproductive Medicine for the Obstetrician and Gynecologist, 35, 491-495, 1990	No outcome of interest
Benacerraf, B. R., Groszmann, Y., Sonography should be the first imaging examination done to evaluate patients with suspected endometriosis, Journal of Ultrasound in Medicine, 31, 651-3, 2012	Narrative review
Bordin, L., Fiore, C., Dona, G., Andrisani, A., Ambrosini, G., Faggian, D., Plebani, M., Clari,	All the patients have proven endometriosis

Study	Reason for Exclusion
G., Armanini, D., Evaluation of erythrocyte band 3 phosphotyrosine level, glutathione content, CA-125, and human epididymal secretory protein E4 as combined parameters in endometriosis, <i>Fertility &amp; Sterility</i> , 94, 1616-21, 2010	
Buchweitz, O., Staebler, A., Tio, J., Kiesel, L., Detection of peritoneal endometriotic lesions by autofluorescence laparoscopy, <i>American Journal of Obstetrics &amp; Gynecology</i> , 195, 949-54, 2006	Not entirely clear but it looks like laparoscopy in white light mode was the reference standard
Cheng, Y. M., Wang, S. T., Chou, C. Y., Serum CA-125 in preoperative patients at high risk for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 99, 375-80, 2002	CA-125 has been used for identifying high risk woman not as a diagnostic tool
Cho, S., Cho, H., Nam, A., Kim, H. Y., Choi, Y. S., Park, K. H., Cho, D. J., Lee, B. S., Neutrophil-to-lymphocyte ratio as an adjunct to CA-125 for the diagnosis of endometriosis, <i>Fertility &amp; Sterility</i> , 90, 2073-9, 2008	It is a case-control study
Chung, M. K., Chung, R. R., Gordon, D., Jennings, C., The evil twins of chronic pelvic pain syndrome: endometriosis and interstitial cystitis, <i>JSLS : Journal of the Society of Laparoendoscopic Surgeons / Society of Laparoendoscopic Surgeons</i> , 6, 311-314, 2002	Irrelevant comparison; includes post-menopausal women
Cohen, L. S., Valle, R. F., Sabbagha, R. E., A comparison of preoperative ultrasound images of surgically proven endometriomas scanned by both transabdominal and transvaginal techniques, <i>Journal of Gynecologic Surgery</i> , 11, 27-32, 1995	All the patients have surgically confirmed endometriosis.
Cohen, M. R., Laparoscopy in the diagnosis and management of endometriosis, <i>Journal of Reproductive Medicine</i> , 27, 240-2, 1982	No outcome of interest
Colacurci, N., Fortunato, N., De Franciscis, P., Fratta, M., Cioffi, M., Zarcone, R., Cardone, A., Serum and peritoneal CA-125 levels as diagnostic test for endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 66, 41-3, 1996	Case control study
Coleman, B. G., Arger, P. H., Mulhern, C. B., Jr., Endometriosis: clinical and ultrasonic correlation, <i>AJR. American Journal of Roentgenology</i> , 132, 747-9, 1979	All patients were recruited in this study, had surgically proven endometriosis
Corwin, M. T., Gerscovich, E. O., Lamba, R., Wilson, M., McGahan, J. P., Differentiation of ovarian endometriomas from hemorrhagic cysts at MR imaging: utility of the T2 dark spot sign, <i>Radiology</i> , 271, 126-32, 2014	Using a diagnostic test to diagnose endometriosis has not been addressed in this study. It is about a sign in MRI to distinguish between Endometrioma and haemorrhagic cysts.
Daniilidis, A., Giannoulis, H., Tantanasis, T., Papathanasiou, K., Loufopoulos, A., Tzafettas, J., Diagnostic laparoscopy, infertility, and endometriosis - 5 Years experience, <i>Gynecological Surgery</i> , 5, 231-234, 2008	Outcomes not of interest



Study	Reason for Exclusion
Dechaud, H., Ali Ahmed, S. A., Aligier, N., Vergnes, C., Hedon, B., Does transvaginal hydrolaparoscopy render standard diagnostic laparoscopy obsolete for unexplained infertility investigation?, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 94, 97-102, 2001	Transvaginal hydrolaparoscopy compared with conventional laparoscopy; no data for outcomes
do Amaral, V. F., Ferriani, R. A., de Sa, M. F. S., Nogueira, A. A., Silva, J. C. R., de Sa Rosa e Silva, A. C. J., de Moura, M. D., Positive correlation between serum and peritoneal fluid CA-125 levels in women with pelvic endometriosis, <i>Sao Paulo Medical Journal</i> , 124, 223-227, 2006	It is a case-control study
Donnez, J., Nisolle, M., Smoes, P., Gillet, N., Beguin, S., Casanas-Roux, F., Peritoneal endometriosis and "endometriotic" nodules of the rectovaginal septum are two different entities, <i>Fertility &amp; Sterility</i> , 66, 362-8, 1996	Not relevant comparison
Dunselman, G. A. J., Vermeulen, N., Becker, C., Calhaz-Jorge, C., D'Hooghe, T., De Bie, B., Heikinheimo, O., Horne, A. W., Kiesel, L., Nap, A., Prentice, A., Saridogan, E., Soriano, D., Nelen, W., ESHRE guideline: Management of women with endometriosis, <i>Human Reproduction</i> , 29, 400-412, 2014	The individual studies in this publication have been checked for inclusion in the review
El Maati, A. A. A., Ibrahim, E. A. G., Mokhtar, F. Z., A two-stage imaging protocol for evaluating women presenting with acute pelvic pain, <i>Egyptian Journal of Radiology and Nuclear Medicine</i> , 44, 923-936, 2013	The population is women with acute pelvic pain, not suspected endometriosis
Elgafor El Sharkwy, I. A., Combination of non-invasive and semi-invasive tests for diagnosis of minimal to mild endometriosis, <i>Archives of gynecology and obstetrics</i> , 288, 793-7, 2013	The diagnostic test (IL-6 combined with nerve fibres) which has been used in this study is not matched with the protocol.
Ellett, L., Readman, E., Newman, M., McIlwaine, K., Villegas, R., Jagasia, N., Maher, P., Are endometrial nerve fibres unique to endometriosis? A prospective case-control study of endometrial biopsy as a diagnostic test for endometriosis in women with pelvic pain, <i>Human Reproduction</i> , 30, 2808-15, 2015	Case-control study
Exacoustos, C., Luciano, D., Corbett, B., De Felice, G., Di Feliciano, M., Luciano, A., Zupi, E., The uterine junctional zone: a 3-dimensional ultrasound study of patients with endometriosis, <i>American Journal of Obstetrics &amp; Gynecology</i> , 209, 248.e1-7, 2013	In the study, the relation between thickness of uterine junctional zone and endometriosis has been evaluated. It has not been used as a diagnostic tool.
Faccioli, N., Manfredi, R., Mainardi, P., Dalla Chiara, E., Spoto, E., Minelli, L., Mucelli, R. P., Barium enema evaluation of colonic involvement in endometriosis, <i>AJR. American Journal of Roentgenology</i> , 190, 1050-4, 2008	The diagnostic test (Barium enema) which has been used in this study is not matched with the protocol.
Federici, D., Muggiasca, M. L., Conti, M., Diagnostic value of laparoscopic evaluation of women with chronic pelvic pain: Our experience and a review of the literature, <i>VALEUR</i>	Narrative review

Study	Reason for Exclusion
DIAGNOSTIQUE DE L'EXPLORATION LAPAROSCOPIQUE DES FEMMES SOUFFRANT DE DOULEURS PELVIENNES CHRONIQUES: EXPERIENCE PERSONNELLE ET REVUE DE LA LITTERATURE, Acta Endoscopica, 22, 177-186, 1992	
Felding, C., Mikkelsen, A. L., Peen, U., Laparoscopy and ultrasound in patients with chronic pelvic pain, Journal of Obstetrics and Gynaecology, 10, 419-422, 1990	No outcome of interest
Fisk, N. M., Tan, C. E., CA 125 in peritoneal fluid and serum of patients with endometriosis, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 29, 153-8, 1988	Casecontrol study
Foda, A. A., Aal, I. A. A., Role of some biomarkers in chronic pelvic pain for early detection of endometriosis in infertile women, Middle East Fertility Society Journal, 17, 187-194, 2012	Case-control study
Fratelli, N., Scioscia, M., Bassi, E., Musola, M., Minelli, L., Trivella, G., Transvaginal sonography for preoperative assessment of deep endometriosis, Journal of Clinical Ultrasound, 41, 69-75, 2013	Data for TVS was collected retrospectively
Friedman, H., Vogelzang, R. L., Mendelson, E. B., Neiman, H. L., Cohen, M., Endometriosis detection by US with laparoscopic correlation, Radiology, 157, 217-20, 1985	No data on outcomes
Gougoutas, C. A., Siegelman, E. S., Hunt, J., Outwater, E. K., Pelvic endometriosis: various manifestations and MR imaging findings, AJR. American Journal of Roentgenology, 175, 353-8, 2000	Narrative review
Gurgan, T., Kisinisci, H., Yarali, H., Aksu, T., Zeyneloglu, H., Develioglu, O., Serum and peritoneal fluid CA-125 levels in early stage endometriosis, Gynecologic & Obstetric Investigation, 30, 105-8, 1990	The cut-off for CA-125 is 16 U/ml
Güven, M. A., Bese, T., Demirkiran, F., Comparison of hydrosonography and transvaginal ultrasonography in the detection of intracavitary pathologies in women with abnormal uterine bleeding, International Journal of Gynecological Cancer, 14, 57-63, 2004	The study population are women with history of abnormal uterine bleeding not women suspected to endometriosis
Harada, T., Kubota, T., Aso, T., Usefulness of CA19-9 versus CA125 for the diagnosis of endometriosis, Fertility and Sterility, 78, 733-739, 2002	Case-control study
Hayata, T., Matsuki, S., Miyakawa, I., Low rate of histological confirmation of macroscopic endometriotic lesions, International Journal of Gynaecology & Obstetrics, 47, 167-8, 1994	A letter, no description of the population, not sufficient data
Hompes, P. G., Koninckx, P. R., Kennedy, S., van Kamp, G. F., Verstraeten, R. A., Cornillie, F., Serum CA-125 concentrations during midfollicular phase, a clinically useful and reproducible marker in diagnosis of advanced	No outcome of interest has been reported

Study	Reason for Exclusion
endometriosis, <i>Clinical Chemistry</i> , 42, 1871-4, 1996	
Hornstein, M. D., Harlow, B. L., Thomas, P. P., Check, J. H., Use of a new CA 125 assay in the diagnosis of endometriosis, <i>Human Reproduction</i> , 10, 932-4, 1995	The reported result has adjusted for prevalence of endometriosis in the community. This data is not useful for our systematic review.
Howard, F. M., El-Minawi, A. M., Sanchez, R. A., Conscious pain mapping by laparoscopy in women with chronic pelvic pain, <i>Obstetrics &amp; Gynecology</i> , 96, 934-9, 2000	Not relevant comparison
Ikeda, F., Bernardini, M. A., Vanni, D., Vasconcelos, A., Pinotti, J. A., Abrao, M. S., A comparison of microlaparoscopy under sedation, microlaparoscopy under general anesthesia and conventional laparoscopy for diagnosis and treatment of pelvic endometriosis in early stages, <i>Fertility and sterility</i> , 77, S21, 2002	The effectiveness of using a diagnostic tool for diagnosis of endometriosis has not been addressed
Ismail, M. A., Rotmensch, J., Mercer, L. J., Block, B. S., Salti, G. I., Holt, J. A., CA-125 in peritoneal fluid from patients with nonmalignant gynecologic disorders, <i>Journal of Reproductive Medicine</i> , 39, 510-2, 1994	The women without any symptom who went through laparoscopic sterilization have been considered as control group
Johnson, W. K., Ott, D. J., Chen, M. Y. M., Fayez, J. A., Gelfand, D. W., Efficacy of hysterosalpingography in evaluating endometriosis, <i>Abdominal Imaging</i> , 19, 278-280, 1994	The study evaluated the effectiveness of hysterosalpingography and laparoscopy-retrospective study
Kafali, H., Artuc, H., Demir, N., Use of CA125 fluctuation during the menstrual cycle as a tool in the clinical diagnosis of endometriosis; a preliminary report, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 116, 85-8, 2004	It is a case-control study
Kang, S. B., Chung, H. H., Lee, H. P., Lee, J. Y., Chang, Y. S., Impact of diagnostic laparoscopy on the management of chronic pelvic pain, <i>Surgical Endoscopy</i> , 21, 916-9, 2007	there was no comparison between laparoscopy and another test
Karabacak, O., Tiras, M. B., Taner, M. Z., Guner, H., Yildiz, A., Yildirim, M., Small diameter versus conventional laparoscopy: a prospective, self-controlled study, <i>Human Reproduction</i> , 12, 2399-401, 1997	Comparison of two types of laparoscopy
Kitawaki, J., Ishihara, H., Koshiba, H., Kiyomizu, M., Teramoto, M., Kitaoka, Y., Honjo, H., Usefulness and limits of CA-125 in diagnosis of endometriosis without associated ovarian endometriomas.[Erratum appears in <i>Hum Reprod.</i> 2007 Feb;22(2):627], <i>Human Reproduction</i> , 20, 1999-2003, 2005	Women enrolled in the study were already diagnosed with endometriosis, adenomyosis and/or leiomyomas
Koninckx, P. R., Riittinen, L., Seppala, M., Cornillie, F. J., CA-125 and placental protein 14 concentrations in plasma and peritoneal fluid of women with deeply infiltrating pelvic endometriosis, <i>Fertility &amp; Sterility</i> , 57, 523-30, 1992	Wrong data and result have been reported

Study	Reason for Exclusion
Kruger, K., Behrendt, K., Niedobitek-Kreuter, G., Koltermann, K., Ebert, A. D., Location-dependent value of pelvic MRI in the preoperative diagnosis of endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 169, 93-8, 2013	Pelvic MRI retrospectively assessed with histology
Kruitwagen, R. F., Thomas, C., Poels, L. G., Koster, A. M., Willemsen, W. N., Rolland, R., High CA-125 concentrations in peritoneal fluid of normal cyclic women with various infertility-related factors as demonstrated with two-step immunoradiometric assay, <i>Fertility &amp; Sterility</i> , 56, 863-9, 1991	The outcome of interest has not been reported
Leslie, C., Ma, T., McElhinney, B., Leake, R., Stewart, C. J., Is the detection of endometrial nerve fibers useful in the diagnosis of endometriosis?, <i>International Journal of Gynecological Pathology</i> , 32, 149-55, 2013	No outcome of interest
Li, G., Yu, Z., Li, K., The value of FS, NLR, and CA-125 in the diagnosis of endometriosis, <i>International journal of clinical and experimental medicine</i> , 9, 7309-7313, 2016	Not the population of interest
Macer, M. L., Mathur, M., Spektor, M., Gysler, S., Staib, L., Kodaman, P., McCarthy, S., Utility of magnetic resonance imaging in the evaluation of intraoperatively confirmed pelvic adhesions, <i>Journal of Computer Assisted Tomography</i> , 39, 896-900, 2015	Not the population of interest
Manganaro, L., Fierro, F., Tomei, A., Irimia, D., Lodise, P., Sergi, M. E., Vinci, V., Sollazzo, P., Porpora, M. G., Delfini, R., Vittori, G., Marini, M., Feasibility of 3.0T pelvic MR imaging in the evaluation of endometriosis, <i>European Journal of Radiology</i> , 81, 1381-7, 2012	Women in the study already had a diagnosis of endometriosis by transvaginal ultrasound
Martin, D. C., Hubert, G. D., Vander Zwaag, R., el-Zeky, F. A., Laparoscopic appearances of peritoneal endometriosis, <i>Fertility &amp; Sterility</i> , 51, 63-7, 1989	No outcome of interest
Martinez, S., Garrido, N., Coperias, J. L., Pardo, F., Desco, J., Garcia-Velasco, J. A., Simon, C., Pellicer, A., Serum interleukin-6 levels are elevated in women with minimal-mild endometriosis, <i>Human Reproduction</i> , 22, 836-42, 2007	It is a case-control study
Mathlouthi, N., Ayed, B. B., Dhouib, M., Chaabene, K., Trabelsi, K., Amouri, H., Guerhazi, M., Confrontation ultrasonography-CA125-histology in the management of ovarian cysts: A prospective study about 77 cases, <i>Tunisie Medicale</i> , 89, 686-692, 2011	Full-text in French
May, K. E., Conduit-Hulbert, S. A., Villar, J., Kirtley, S., Kennedy, S. H., Becker, C. M., Peripheral biomarkers of endometriosis: a systematic review, <i>Human Reproduction Update</i> , 16, 651-74, 2010	This systematic review includes papers also regarding other biomarkers. The full texts of individual related studies were retrieved and reviewed.

Study	Reason for Exclusion
McBride, N., Newman, R. L., Diagnostic laparoscopy, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 15, 556-8, 1978	No outcome of interest
McKinnon, B., Mueller, M. D., Nirgianakis, K., Bersinger, N. A., Comparison of ovarian cancer markers in endometriosis favours HE4 over CA125, <i>Molecular Medicine Reports</i> , 12, 5179-84, 2015	No data reported to calculate sensitivity
Medl, M., Ogris, E., Peters-Engl, C., Mierau, M., Buxbaum, P., Leodolter, S., Serum levels of the tumour-associated trypsin inhibitor in patients with endometriosis, <i>British Journal of Obstetrics &amp; Gynaecology</i> , 104, 78-81, 1997	Wrong data and result have been reported.
Melega, C., Marchesini, F. P., Bellettini, L., Biscontin, S., Flamigni, C., Diagnostic value of laparoscopy in endometriosis and infertility, <i>Journal of Reproductive Medicine</i> , 29, 597-600, 1984	No outcome of interest
Mezzi, G., Ferrari, S., Arcidiacono, P. G., Di Puppo, F., Candiani, M., Testoni, P. A., Endoscopic rectal ultrasound and elastosonography are useful in flow chart for the diagnosis of deep pelvic endometriosis with rectal involvement, <i>Journal of Obstetrics &amp; Gynaecology Research</i> , 37, 586-90, 2011	There was no comparison with surgery
Mikami, M., Tanabe, K., Matsuo, K., Miyazaki, Y., Miyazawa, M., Hayashi, M., Asai, S., Ikeda, M., Shida, M., Hirasawa, T., Kojima, N., Sho, R., Iijima, S., Fully-sialylated alpha-chain of complement 4-binding protein: Diagnostic utility for ovarian clear cell carcinoma, <i>Gynecologic Oncology</i> , 139, 520-528, 2015	Not the population of interest
Millischer, A. E., Salomon, L. J., Santulli, P., Borghese, B., Dousset, B., Chapron, C., Fusion imaging for evaluation of deep infiltrating endometriosis: feasibility and preliminary results, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 46, 109-17, 2015	No data on surgical diagnosis
Miyagi, E., Maruyama, Y., Mogami, T., Numazaki, R., Ikeda, A., Yamamoto, H., Hirahara, F., Comparison of plasma amino acid profile-based index and CA125 in the diagnosis of epithelial ovarian cancers and borderline malignant tumors, <i>International Journal of Clinical Oncology</i> , 1-8, 2016	Not the population of interest
Mol, B. W., Bayram, N., Lijmer, J. G., Wiegerinck, M. A., Bongers, M. Y., van der Veen, F., Bossuyt, P. M., The performance of CA-125 measurement in the detection of endometriosis: a meta-analysis, <i>Fertility &amp; Sterility</i> , 70, 1101-8, 1998	All the studies included in this systematic review could not be included in our systematic review. The full-texts of all individual studies were retrieved and reviewed and related studies were included in our review.
Moloney, M. D., Thornton, J. G., Cooper, E. H., Serum CA 125 antigen levels and disease severity in patients with endometriosis, <i>Obstetrics &amp; Gynecology</i> , 73, 767-9, 1989	Women had laparoscopically confirmed endometriosis and then CA-125 level has been evaluated
Moretuzzo, R. W., DiLauro, S., Jenison, E., Chen, S. L., Reindollar, R. H., McDonough, P.	No outcome of interest

Study	Reason for Exclusion
G., Serum and peritoneal lavage fluid CA-125 levels in endometriosis, <i>Fertility &amp; Sterility</i> , 50, 430-3, 1988	
Nezhat, F., Allan, C. J., Nezhat, C., Martin, D. C., Nonvisualized endometriosis at laparoscopy, <i>International Journal of Fertility</i> , 36, 340-3, 1991	Not possible to extract data
Nisolle, M., Casanas-Roux, F., Anaf, V., Mine, J. M., Donnez, J., Morphometric study of the stromal vascularization in peritoneal endometriosis, <i>Fertility &amp; Sterility</i> , 59, 681-4, 1993	A morphometric study
O'Shaughnessy, A., Check, J. H., Nowroozi, K., Lurie, D., CA 125 levels measured in different phases of the menstrual cycle in screening for endometriosis, <i>Obstetrics &amp; Gynecology</i> , 81, 99-103, 1993	Wrong data and result have been reported
Ota, H., Maki, M., Evaluation of autoantibody and CA125 in the diagnosis of endometriosis or adenomyosis, <i>Medical Science Research</i> , 18, 309-310, 1990	All the participants had known condition
Othman, E. E. D. R., Hornung, D., Al-Hendy, A., Biomarkers of endometriosis, <i>Expert Opinion on Medical Diagnostics</i> , 2, 741-752, 2008	Narrative review
Ozaksit, G., Caglar, T., Cicek, N., Kuscu, E., Batioglu, S., Gokmen, O., Serum CA 125 levels before, during and after treatment for endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 50, 269-73, 1995	Women had a confirmed diagnosis of endometriosis prior to CA-125 test
Paiva, P., Lappas, M., Barker, G., Healey, M., Using symptom scores, lifestyle measures and biochemical markers to create a test for endometriosis, <i>Journal of Endometriosis and Pelvic Pain Disorders</i> , 6, 135-143, 2014	No outcome of interest
Panidis, D., Vlassis, G., Matalliotakis, J., Skiadopoulos, S., Kalogeropoulos, A., Serum levels of the oncofetal antigens CA-125, CA 19-9 and CA 15-3 in patients with endometriosis, <i>Journal of Endocrinological Investigation</i> , 11, 801-804, 1988	All women who involved in the study have proven endometriosis
Pastorfide, G., Fong, Y. F., Use of narrowband imaging for the detection of endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 22, 535, 2015	No outcome of interest
Patel, M. D., Feldstein, V. A., Chen, D. C., Lipson, S. D., Filly, R. A., Endometriomas: diagnostic performance of US.[Erratum appears in <i>Radiology</i> 1999 Dec;213(3):930], <i>Radiology</i> , 210, 739-45, 1999	Retrospective review of sonograms by two sonologists
Patel, M. D., Feldstein, V. A., Filly, R. A., The likelihood ratio of sonographic findings for the diagnosis of hemorrhagic ovarian cysts, <i>Journal of Ultrasound in Medicine</i> , 24, 607-14; quiz 615, 2005	It is about diagnosis of haemorrhagic ovarian cyst not endometrioma
Patton, P. E., Field, C. S., Harms, R. W., Coulam, C. B., CA-125 levels in endometriosis, <i>Fertility &amp; Sterility</i> , 45, 770-3, 1986	Women who come for elective sterilization have been also included in this study, while they are not suspected for endometriosis.

Study	Reason for Exclusion
Philip, C. A., Bisch, C., Coulon, A., de Saint-Hilaire, P., Rudigoz, R. C., Dubernard, G., Correlation between three-dimensional rectosonography and magnetic resonance imaging in the diagnosis of rectosigmoid endometriosis: a preliminary study on the first fifty cases, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 187, 35-40, 2015	MRI was the reference test
Piessens, S., Healey, M., Maher, P., Tsaltas, J., Rombauts, L., Can anyone screen for deep infiltrating endometriosis with transvaginal ultrasound?, <i>Australian &amp; New Zealand Journal of Obstetrics &amp; Gynaecology</i> , 54, 462-8, 2014	Women included in the study had the ultrasound test after diagnosis of endometriosis by surgery
Pittaway, D. E., Douglas, J. W., Serum CA-125 in women with endometriosis and chronic pelvic pain, <i>Fertility &amp; Sterility</i> , 51, 68-70, 1989	The cut-off for CA-125 is 16 U/ml
Portuondo, J. A., Herran, C., Echanojauregui, A. D., Riego, A. G., Peritoneal flushing and biopsy in laparoscopically diagnosed endometriosis, <i>Fertility &amp; Sterility</i> , 38, 538-41, 1982	Not relevant comparison
Punnonen, R., Diagnostic gynecologic laparoscopy--analysis of 1226 cases, <i>Asia-Oceania Journal of Obstetrics &amp; Gynaecology</i> , 9, 199-202, 1983	No pathology
Randall, G. W., Gantt, P. A., Poe-Zeigler, R. L., Bergmann, C. A., Noel, M. E., Strawbridge, W. R., Richardson-Cox, B., Hereford, J. R., Reiff, R. H., Serum antiendometrial antibodies and diagnosis of endometriosis, <i>American Journal of Reproductive Immunology</i> , 58, 374-82, 2007	The diagnostic test which has been used in this study is not matched with the protocol
Redwine, D. B., Ovarian endometriosis: A marker for more extensive pelvic and intestinal disease, <i>Fertility and Sterility</i> , 72, 310-315, 1999	All the patients have endometriosis
Reid, S., Lu, C., Casikar, I., Reid, G., Abbott, J., Cario, G., Chou, D., Kowalski, D., Cooper, M., Condous, G., Prediction of pouch of Douglas obliteration in women with suspected endometriosis using a new real-time dynamic transvaginal ultrasound technique: the sliding sign, <i>Ultrasound in Obstetrics &amp; Gynecology</i> , 41, 685-91, 2013	It has focused on the pouch of Douglas obliteration not only endometriosis
Rosa, E. Silva A. C., Rosa, E. Silva J. C., Ferriani, R. A., Serum CA-125 in the diagnosis of endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 96, 206-7, 2007	Retrospective study. Women included in the study already had a diagnosis of endometriosis prior to CA-125 serum collection.
Saba, L., Guerriero, S., Sulcis, R., Ajossa, S., Melis, G., Mallarini, G., Agreement and reproducibility in identification of endometriosis using magnetic resonance imaging, <i>Acta Radiologica</i> , 51, 573-80, 2010	No outcome of interest
Saba, L., Guerriero, S., Sulis, R., Pilloni, M., Ajossa, S., Melis, G., Mallarini, G., Learning curve in the detection of ovarian and deep endometriosis by using Magnetic Resonance: comparison with surgical results, <i>European Journal of Radiology</i> , 79, 237-44, 2011	The aim of the study was to determine whether diagnostic accuracy is correlated to radiologist expertise

Study	Reason for Exclusion
Samuelsson, S., Sjøvall, A., On the diagnostic value of laparoscopy in ovarian endometriosis, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 47, 350-360, 1968	No pathology
Scardapane, A., Bettocchi, S., Lorusso, F., Stabile Ianora, A. A., Vimercati, A., Ceci, O., Lasciarrea, M., Angelelli, G., Diagnosis of colorectal endometriosis: contribution of contrast enhanced MR-colonography, <i>European Radiology</i> , 21, 1553-63, 2011	Comparison of MRI between two radiologists
Scardapane, A., Lorusso, F., Scioscia, M., Ferrante, A., Stabile Ianora, A. A., Angelelli, G., Standard high-resolution pelvic MRI vs. low-resolution pelvic MRI in the evaluation of deep infiltrating endometriosis, <i>European Radiology</i> , 24, 2590-6, 2014	Comparison of MRI carried out by two different radiologists
Schenken, R. S., Improving the diagnosis of endometriosis in adolescents, <i>Sexuality, Reproduction and Menopause</i> , 6, 4-8, 2008	Narrative review
Seeber, B., Sammel, M. D., Fan, X., Gerton, G. L., Shaunik, A., Chittams, J., Barnhart, K. T., Panel of markers can accurately predict endometriosis in a subset of patients, <i>Fertility &amp; Sterility</i> , 89, 1073-81, 2008	It is a case-control study
Shen, A., Xu, S., Ma, Y., Guo, H., Li, C., Yang, C., Zou, S., Diagnostic value of serum CA125, CA19-9 and CA15-3 in endometriosis: A meta-analysis, <i>Journal of International Medical Research</i> , 43, 599-609, 2015	It is about association of biomarkers and stage of endometriosis. No outcome of interest.
Somigliana, E., Vigano, P., Candiani, M., Felicetta, I., Di Blasio, A. M., Vignali, M., Use of serum-soluble intercellular adhesion molecule-1 as a new marker of endometriosis, <i>Fertility &amp; Sterility</i> , 77, 1028-31, 2002	Women included in the study already had laparoscopy prior to CA-125 serum collection
Somigliana, E., Vigano, P., Tirelli, A. S., Felicetta, I., Torresani, E., Vignali, M., Di Blasio, A. M., Use of the concomitant serum dosage of CA 125, CA 19-9 and interleukin-6 to detect the presence of endometriosis. Results from a series of reproductive age women undergoing laparoscopic surgery for benign gynaecological conditions, <i>Human Reproduction</i> , 19, 1871-6, 2004	Case-control study
Spencer, J. A., Weston, M. J., Imaging in endometriosis, <i>Imaging</i> , 15, 63-71, 2003	Narrative review
Stegmann, B. J., Funk, M. J., Sinaii, N., Hartmann, K. E., Segars, J., Nieman, L. K., Stratton, P., A logistic model for the prediction of endometriosis, <i>Fertility &amp; Sterility</i> , 91, 51-5, 2009	It is about prediction of endometriosis
Stowell, S. B., Wiley, C. M., Perez-Reyes, N., Powers, C. N., Cytologic diagnosis of peritoneal fluids. Applicability to the laparoscopic diagnosis of endometriosis, <i>Acta Cytologica</i> , 41, 817-22, 1997	The diagnostic test in this study is not matched with the protocol
Stratton, P., Winkel, C., Premkumar, A., Chow, C., Wilson, J., Hearn-Stokes, R., Heo, S.,	Not relevant comparison



Study	Reason for Exclusion
Merino, M., Nieman, L. K., Diagnostic accuracy of laparoscopy, magnetic resonance imaging, and histopathologic examination for the detection of endometriosis, <i>Fertility &amp; Sterility</i> , 79, 1078-85, 2003	
Szubert, M., Suzin, J., Wierzbowski, T., Kowalczyk-Amico, K., CA-125 concentration in serum and peritoneal fluid in patients with endometriosis - preliminary results, <i>Archives of Medical Science</i> , 8, 504-8, 2012	Case-control study
Takahashi, K., Nagata, H., Kitao, M., CA-125 in the menstrual blood is an effective marker for diagnosing early stage endometriosis: A preliminary report, <i>Japanese Journal of Fertility and Sterility</i> , 36, 356-359, 1991	Ultrasound was used to confirm ovulatory day only
Takahashi, K., Nagata, H., Musa, A. A., Shibukawa, T., Yamasaki, H., Kitao, M., Clinical usefulness of CA-125 levels in the menstrual discharge in patients with endometriosis, <i>Fertility &amp; Sterility</i> , 54, 360-2, 1990	The level of CA-125 has been assessed in the menstrual discharge
Takeuchi, M., Matsuzaki, K., Nishitani, H., Susceptibility-weighted MRI of endometrioma: preliminary results, <i>AJR. American Journal of Roentgenology</i> , 191, 1366-70, 2008	No outcome of interest
Tirlapur, S. A., Daniels, J. P., Khan, K. S., Medal trial collaboration, Chronic pelvic pain: how does noninvasive imaging compare with diagnostic laparoscopy?, <i>Current Opinion in Obstetrics &amp; Gynecology</i> , 27, 445-8, 2015	This systematic review has not only focused on patients with suspected endometriosis. It is more general about pelvic pain and diagnostic tools.
Tumedei, U., Ciardelli, V., Paltrinieri, F., Kuria, M. S., Amadori, A., Stefanetti, M., Gori, G., Transvaginal ultrasound in the diagnosis of endometrial abnormalities, <i>Tumori</i> , 87, S15, 2001	It has focused on endometrial abnormalities not endometriosis.
Ueki, M., Saeki, M., Tsurunaga, T., Ueda, M., Ushiroyama, N., Sugimoto, O., Visual findings and histologic diagnosis of pelvic endometriosis under laparoscopy and laparotomy, <i>International Journal of Fertility &amp; Menopausal Studies</i> , 40, 248-53, 1995	Post-menopausal women included
Van den Bosch, T., Vandendael, A., Van Schoubroeck, D., Wranz, P. A. B., Lombard, C. J., Combining vaginal ultrasonography and office endometrial sampling in the diagnosis of endometrial disease in postmenopausal women, <i>Obstetrics and Gynecology</i> , 85, 349-352, 1995	It is not about endometriosis, it has addressed endometrial diseases
Vercellini, P., Fedele, L., Molteni, P., Arcaini, L., Bianchi, S., Candiani, G. B., Laparoscopy in the diagnosis of gynecologic chronic pelvic pain, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 32, 261-5, 1990	No pathology
Vrachnis, N., Sifakis, S., Samoli, E., Kappou, D., Pavlakis, K., Iliodromiti, Z., Botsis, D., Three-dimensional ultrasound and three-dimensional power Doppler improve the preoperative evaluation of complex benign ovarian lesions,	No outcome of interest

Study	Reason for Exclusion
Clinical & Experimental Obstetrics & Gynecology, 39, 474-8, 2012	
Walsh, J. W., Taylor, K. J., Wasson, J. F., Schwartz, P. E., Rosenfield, A. T., Gray-scale ultrasound in 204 proved gynecologic masses: accuracy and specific diagnostic criteria, Radiology, 130, 391-7, 1979	No outcome of interest
Wang, L., Liu, H. Y., Shi, H. H., Lang, J. H., Sun, W., Urine peptide patterns for non-invasive diagnosis of endometriosis: a preliminary prospective study, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 177, 23-8, 2014	Biomarker not of interest
Wessels, J. M., Kay, V. R., Leyland, N. A., Agarwal, S. K., Foster, W. G., Assessing brain-derived neurotrophic factor as a novel clinical marker of endometriosis, Fertility & Sterility, 105, 119-128.e5, 2016	Not the test of interest
Wild, R. A., Hirisave, V., Bianco, A., Podczaski, E. S., Demers, L. M., Endometrial antibodies versus CA-125 for the detection of endometriosis, Fertility & Sterility, 55, 90-4, 1991	The cut-off for CA-125 is 16 U/ml
Wolfler, M. M., Nagele, F., Kolbus, A., Seidl, S., Schneider, B., Huber, J. C., Tschugguel, W., A predictive model for endometriosis, Human Reproduction, 20, 1702-8, 2005	Biomarker not of interest
Wykes, C. B., Clark, T. J., Khan, K. S., Accuracy of laparoscopy in the diagnosis of endometriosis: A systematic quantitative review, BJOG: An International Journal of Obstetrics and Gynaecology, 111, 1204-1212, 2004	Single studies included in the review were assessed for inclusion
Yamashita, Y., Torashima, M., Hatanaka, Y., Harada, M., Higashida, Y., Takahashi, M., Mizutani, H., Tashiro, H., Iwamasa, J., Miyazaki, K., et al., Adnexal masses: accuracy of characterization with transvaginal US and precontrast and postcontrast MR imaging, Radiology, 194, 557-65, 1995	Review of MRI and TVUS by five radiologists
Yazbek, J., Helmy, S., Ben-Nagi, J., Holland, T., Sawyer, E., Jurkovic, D., Value of preoperative ultrasound examination in the selection of women with adnexal masses for laparoscopic surgery, Ultrasound in Obstetrics and Gynecology, 30, 883-888, 2007	The preoperative sonography has not been used to diagnose endometriosis

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## H.12 Staging Systems

Study	Reason for Exclusion
Classification of endometriosis, Fertility and sterility, 32, 633, 1979	Narrative review
Acosta, A. A., Buttram, V. C., Jr., Besch, P. K., Malinak, L. R., Franklin, R. R., Vanderheyden, J. D., A proposed classification of pelvic	A classification system has been proposed but its effectiveness has not been evaluated

Study	Reason for Exclusion
endometriosis, <i>Obstetrics &amp; Gynecology</i> , 42, 19-25, 1973	
Anonymous, Classification of endometriosis. <i>The American Fertility Society, Fertility &amp; Sterility</i> , 32, 633-4, 1979	Letter
Bardis, N., Pistofidis, G. A., Chatzirafail, V., Balinakos, P., Filippidis, M., Enzian Scoring System (ESS) for the assessment of pelvic pain in women with deep comparison between the American Fertility Society (AFS) scoring system versus the infiltrating endometriosis, <i>Gynecological Surgery</i> , 6, S160, 2009	Surgical outcomes not evaluated
Bassil Lasmar, R., Simoes Abraao, M., Lasmar, R. B., Leon Dewilde, R., Simplified approach to the treatment of endometriosis - ECO system, <i>Minerva Ginecologica</i> , 64, 331-335, 2012	It has focused on development of a classification system while the effectiveness of the system has not been evaluated
Bauer, E., Widschwendter, P., Stuck, D., Gundelach, T., Wulff, C., Janni, W., Hancke, K., Endometriosis Health Profile scores and their association with surgical diagnosis in premenopausal women, <i>Journal of Endometriosis</i> , 5, S31-S32, 2013	The effectiveness of using staging systems to guide treatment has not been assessed
Beecham, C. T., Classification of endometriosis, <i>Obstetrics &amp; Gynecology</i> , 28, 437, 1966	Editorial/letter
Borase, H., Hillman-Cooper, C., Khan, A., Reddy, K., Endometriosis infertility index (EFI) - A retrospective analysis of the use of this new tool in the management of infertile women with endometriosis, <i>Human Fertility</i> , 14, 23-24, 2011	The clinical and cost-effectiveness of using staging system has not been evaluated.
Boujenah, J., Bonneau, C., Hugues, J. N., Sifer, C., Poncelet, C., External validation of the Endometriosis Fertility Index in a French population, <i>Fertility &amp; Sterility</i> , 104, 119-123.e1, 2015	The effectiveness of using staging system to guide the treatment has not been addressed
Boujenah, J., Hugues, J. N., Sifer, C., Bricou, A., Cedrin-Durnerin, I., Sonigo, C., Monforte, M., Poncelet, C., Endometriosis Fertility Index, or classification of the American Society of Reproductive Medicine for postoperative endometriosis patients with infertility: Which is more relevant?, <i>Gynecologie Obstetrique Fertile</i> , 43, 806-809, 2015	Foreign Language Paper. It is unclear from the abstract whether this paper reports on a primary study.
Buttram Jr, V. C., Classification of endometriosis, <i>Contributions to Gynecology and Obstetrics</i> , 16, 73-83, 1987	Narrative review
Candiani, G. B., Vercellini, P., Fedele, L., Clinical staging and therapeutic choices in endometriosis, <i>New Trends in Gynaecology and Obstetrics</i> , 2, 379-386, 1986	Narrative review
Chapron, C., Fauconnier, A., Dubuisson, J. B., Barakat, H., Vieira, M., Breart, G., Deep infiltrating endometriosis: relation between severity of dysmenorrhoea and extent of disease, <i>Human Reproduction</i> , 18, 760-766, 2003	There is no comparison group and the effectiveness of using staging system has not been assessed
Choi, B. R., Jeon, Y. E., Kim, H. Y., Seo, S. K., Choi, Y. S., Cho, S., Lee, B. S., Prognostic value	Clinical effectiveness of the staging systems to guide treatment decisions was not assessed

Study	Reason for Exclusion
of the revised American fertility society classification system and preoperative serum CA-125 level for the first recurrence of advanced endometriosis after conservative laparoscopy, Fertility and sterility, 1), S220, 2012	
Chopin, N., Vieira, M., Borghese, B., Foulot, H., Dousset, B., Coste, J., Mignon, A., Fauconnier, A., Chapron, C., Operative management of deeply infiltrating endometriosis: results on pelvic pain symptoms according to a surgical classification, Journal of Minimally Invasive Gynecology, 12, 106-12, 2005	Clinical effectiveness of the staging systems has not been assessed
Coccia, M. E., Rizzello, F., Palagianò, A., Scarselli, G., Long-term follow-up after laparoscopic treatment for endometriosis: multivariate analysis of predictive factors for recurrence of endometriotic lesions and pain, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 157, 78-83, 2011	The intervention has not used staging system. There is no comparison group and no outcome of interest.
Di Paola, V., Manfredi, R., Castelli, F., Negrelli, R., Mehrabi, S., Pozzi Mucelli, R., Detection and localization of deep endometriosis by means of MRI and correlation with the ENZIAN score, European Journal of Radiology, 84, 568-74, 2015	The clinical and cost-effectiveness of using staging systems has not been evaluated
Dmowski, W. P., Visual assessment of peritoneal implants for staging endometriosis: do number and cumulative size of lesions reflect the severity of a systemic disease?, Fertility & Sterility, 47, 382-4, 1987	Narrative review
Elsheikh, A., Milingos, S., Loutradis, D., Kallipolitis, G., Michalas, S., Endometriosis and reproductive disorders, Annals of the New York Academy of Sciences, 997, 247-54, 2003	It is focused on the relationship between severity of endometriosis and pregnancy rate after surgery. It has not used the staging system to guide treatment.
Emilio, P., Control of pelvic pain and quality of life following treatment of symptomatic endometriosis, Journal of Psychosomatic Obstetrics and Gynecology, 31, 21, 2010	Not looking at staging systems to guide treatment decisions
Fasciani, A., Repetti, F., Binda, G. A., Puntoni, M., Meroni, M. G., Bocci, G., Endometriosis Index: A software-derived score to predict the presence and severity of the disease, Journal of Endometriosis, 2, 79-86, 2010	Data on surgical outcomes not provided.
Fedele, L., Parazzini, F., Bianchi, S., Arcaini, L., Candiani, G. B., Stage and localization of pelvic endometriosis and pain, Fertility & Sterility, 53, 155-8, 1990	Clinical effectiveness of the staging systems has not assessed
Gillett, W. R., Lamont, J. M., Peek, J. C., Herbison, G. P., Effect of severity of endometriosis on prioritisation for infertility treatment in New Zealand, Human Reproduction, 28, i245-i246, 2013	The study has addressed the severity of endometriosis and pregnancy rate. It has not evaluated the effectiveness of classification systems.
Guzick, D. S., Bross, D. S., Rock, J. A., Assessing the efficacy of The American Fertility Society's classification of endometriosis: application of a dose-response methodology, Fertility & Sterility, 38, 171-6, 1982	The effectiveness of using staging systems has not been assessed

Study	Reason for Exclusion
Haas, D., Chvatal, R., Habelsberger, A., Wurm, P., Schimetta, W., Oppelt, P., Comparison of revised American Fertility Society and ENZIAN staging: a critical evaluation of classifications of endometriosis on the basis of our patient population, <i>Fertility &amp; Sterility</i> , 95, 1574-8, 2011	The effectiveness of the staging systems has not been addressed
Haas, D., Chvatal, R., Wurm, P., Habelsberger, A., Oppelt, P., Endometriosis between AFS and ENZIAN: A critical assessment of classification systems for endometriosis staging in an own patient group, <i>Archives of gynecology and obstetrics</i> , 282, S175, 2010	The effectiveness of using staging systems to guide treatment has not been assessed
Haas, D., Oppelt, P., Shebl, O., Shamiyeh, A., Schimetta, W., Mayer, R., Enzian classification: does it correlate with clinical symptoms and the rASRM score?, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 92, 562-6, 2013	There is no comparison group. The intervention has not used staging system to guide treatment
Haas, D., Oppelt, P., Shebl, O., Shamiyeh, A., Schimetta, W., Mayer, R., Enzian classification: Does it correlate with clinical symptoms and the rASRM score?, <i>Journal of Endometriosis</i> , 5, S39, 2013	The effectiveness of using staging systems to guide treatment has not been assessed
Haas, D., Wurm, P., Shamiyeh, A., Shebl, O., Chvatal, R., Oppelt, P., Efficacy of the revised Enzian classification: a retrospective analysis. Does the revised Enzian classification solve the problem of duplicate classification in rASRM and Enzian?, <i>Archives of Gynecology &amp; Obstetrics</i> , 287, 941-5, 2013	The effectiveness of using staging system to guide treatment has not been assessed
Hackethal, A., Luck, C., Konrad, L., Muenstedt, K., Tinneberg, H. R., Oehmke, F., Deep infiltrating endometriosis is frequent in all stages of endometriosis and the depth of infiltration influences surgical parameters proportionally, <i>Journal of Endometriosis</i> , 2, 205-212, 2010	No information about outcomes after surgery.
Hancke, K., Friedl, T., Widschwendter, P., Stuck, D., Gundelach, T., Janni, W., Bauer, E., Endometriosis health profile (EHP-30) scores and their association with surgical diagnosis in premenopausal women, <i>Human Reproduction</i> , 29, i208-i209, 2014	Not using staging systems to guide treatment decisions
Hassa, H., What is the problem with the current classification system and how can we improve it?, <i>Journal of Endometriosis</i> , 4 (3), 131-132, 2012	Literature review of different staging systems
Hoshiai, H., Ishikawa, M., Sawatari, Y., Noda, K., Fukaya, T., Laparoscopic evaluation of the onset and progression of endometriosis, <i>American Journal of Obstetrics and Gynecology</i> , 169, 714-719, 1993	The effectiveness of the staging systems has not been assessed
Jayakrishnan, N., Predicting the reproductive outcome in endometriosis-a comparison between EFI and AFS scores, <i>Human Reproduction</i> , 30, i54, 2015	Study does not use staging systems to guide treatment decisions
Kistner, R. W., Siegler, A. M., Behrman, S. J., Suggested classification for endometriosis:	Narrative review

Study	Reason for Exclusion
relationship to infertility, <i>Fertility &amp; Sterility</i> , 28, 1008-10, 1977	
Li, X., Tang, H., The value of endometriosis fertility index in predicting the pregnancy outcome after laparoscopy for minimal or mild endometriosis associated infertility, <i>International Journal of Gynecology and Obstetrics</i> , 131, E293, 2015	Correlation of stages within a single classification to an outcome. Not used to guide treatment decisions
Malinak, L. R., Infertility and endometriosis operative technique, clinical staging, and prognosis, <i>Clinical Obstetrics &amp; Gynecology</i> , 23, 925-35, 1980	The effectiveness of using staging systems has not been assessed
Momoeda, M., Taketani, Y., Terakawa, N., Hoshiai, H., Tanaka, K., Tsutsumi, O., Osuga, Y., Maruyama, M., Harada, T., Obata, K., Hayashi, K., Is endometriosis really associated with pain?, <i>Gynecologic &amp; Obstetric Investigation</i> , 54 Suppl 1, 18-21; discussion 21-3, 2002	The effectiveness of using staging systems has not been addressed
Muse, K., Clinical manifestations and classification of endometriosis, <i>Clinical Obstetrics &amp; Gynecology</i> , 31, 813-22, 1988	It is a narrative review article explaining the clinical presentations of endometriosis and classification system
Nezhat, C., Nezhat, F., Nezhat, C., Seidman, D. S., Classification of endometriosis. Improving the classification of endometriotic ovarian cysts, <i>Human Reproduction</i> , 9, 2212-3, 1994	It is a debate about classification of endometriosis not a study evaluating the effectiveness of using staging systems
Palmisano, G. P., Adamson, G. D., Lamb, E. J., Can staging systems for endometriosis based on anatomic location and lesion type predict pregnancy rates?, <i>International Journal of Fertility &amp; Menopausal Studies</i> , 38, 241-9, 1993	The effectiveness of using endometriosis to guide the treatment has not been evaluated
Pistofidis, G. A., Bardis, N. S., Koukoura, O. G., Balinakos, P. M., Filippidis, M. S., Comparison of the Enzian Scoring system with the American Fertility Society scoring system for the assessment of pelvic pain in women with deep infiltrating endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 1), S27, 2010	Pelvic pain and severity of the disease according to the scoring systems have been evaluated. Effectiveness of the staging systems to guide the treatment has not been assessed.
Pop-Trajkovic, S., Popovic, J., Antic, V., Radovic, D., Stefanovic, M., Vukomanovic, P., Stages of endometriosis: does it affect in vitro fertilization outcome.[Erratum appears in <i>Taiwan J Obstet Gynecol</i> . 2015 Dec;54(6):806 Note: Stavanovic, Milan [Corrected to Stefanovic, Milan]], <i>Taiwanese Journal of Obstetrics &amp; Gynecology</i> , 53, 224-6, 2014	Does not compare staging classification systems. Only looks at treatment outcomes for one system.
Porpora, M.G., Koninckx, P.R., Piazze, J., Natili, M., Colagrande, S., Cosmi, E.V., Correlation between endometriosis and pelvic pain, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 6, 429-434, 1999	The effectiveness of the staging systems has not been assessed
Renner, S., Rix, S., Lermann, J., Thiel, F., Oppelt, P., Beckmann, M. W., Fasching, P., Pain as risk factor for recurrence in patients with endometriosis, <i>Gynecological Surgery</i> , 8, S38, 2011	It has addressed pain as a risk factor for recurrence. The effectiveness of the staging systems has not been assessed.

Study	Reason for Exclusion
Sun, A., Han, M., A proposed clinical classification of pelvic endometriosis, Proceedings of the Chinese Academy of Medical Sciences & the Peking Union Medical College, 5, 163-7, 1990	The effectiveness of using staging system has not been assessed
Szendei, G., Hernadi, Z., Devenyi, N., Csapo, Z., Is there any correlation between stages of endometriosis and severity of chronic pelvic pain? Possibilities of treatment, Gynecological Endocrinology, 21, 93-100, 2005	The relationship between pain and the severity of endometriosis has been assessed. The effectiveness of using staging system has not been addressed.
Tomassetti, C., Geysenbergh, B., Meuleman, C., Fieuws, S., D'Hooghe, T., External valid ation of the EFI (Endometriosis Fertility Index) staging system for predicting non-ART pregnancy after endometriosis surgery, Human Reproduction, 27, 2012	The effectiveness of using staging system has not been assessed
Vercellini, P., Fedele, L., Aimi, G., De Giorgi, O., Consonni, D., Crosignani, P. G., Reproductive performance, pain recurrence and disease relapse after conservative surgical treatment for endometriosis: the predictive value of the current classification system, Human Reproduction, 21, 2679-85, 2006	The research question is focused on association of the classification system and clinical outcomes after the surgery not the effectiveness of using staging systems
Vercellini, P., Fedele, L., Aimi, G., Pietropaolo, G., Consonni, D., Crosignani, P. G., Association between endometriosis stage, lesion type, patient characteristics and severity of pelvic pain symptoms: a multivariate analysis of over 1000 patients, Human Reproduction, 22, 266-71, 2007	The effectiveness of using staging system has not been assessed
Vercellini, P., Trespidi, L., De Giorgi, O., Cortesi, I., Parazzini, F., Crosignani, P. G., Endometriosis and pelvic pain: relation to disease stage and localization, Fertility & Sterility, 65, 299-304, 1996	It has focused on relation between stages of endometriosis and Pelvic pain not using staging system to guide the treatment
Wang, W., Li, R., Fang, T., Huang, L., Ouyang, N., Wang, L., Zhang, Q., Yang, D., Endometriosis fertility index score maybe more accurate for predicting the outcomes of in vitro fertilisation than r-AFS classification in women with endometriosis, Reproductive Biology & Endocrinology, 11, 112, 2013	The effectiveness of staging system has not been evaluated. The study has addressed the predictive value of the staging system in IVF outcome after surgery.
Yun, B. H., Jeon, Y. E., Chon, S. J., Park, J. H., Seo, S. K., Cho, S., Choi, Y. S., Lee, J. S., Lee, B. S., The prognostic value of individual adhesion scores from the revised American fertility society classification system for recurrent endometriosis, Yonsei medical journal, 56, 1079-1086, 2015	The study has not evaluated the effectiveness of using staging systems
Zeng, C., Xu, J. N., Zhou, Y., Zhou, Y. F., Zhu, S. N., Xue, Q., Reproductive performance after surgery for endometriosis: predictive value of the revised American Fertility Society classification and the endometriosis fertility index, Gynecologic & Obstetric Investigation, 77, 180-5, 2014	It has addressed the predictive value of staging system for pregnancy rate. The effectiveness of using staging systems has not been evaluated.

Study	Reason for Exclusion
Zhang, X., Liu, C., Fu, J., Feng, X., Huang, W., Li, X., Predictive value of endometriosis fertility index (EFI) for natural pregnancy rate after laparoscopy treatment in Chinese women with endometriosis associated infertility, International Journal of Gynecology and Obstetrics, 131, E229, 2015	The effectiveness of using staging systems to guide the treatment has not been assessed

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## H.13 Pharmacological management – Analgesics

Reference	Reason for Exclusion
Allen, Claire, Hopewell, Sally, Prentice, Andrew, Gregory, Daisy, Nonsteroidal anti-inflammatory drugs for pain in women with endometriosis, Cochrane Database of Systematic Reviews, -, 2010	Checked for relevant RCTs and data from one RCT (Kauppila 1985) is included in preference to the data presented in this Cochrane systematic review
Brown, J., Farquhar, C., Endometriosis: an overview of Cochrane Reviews, Cochrane Database of Systematic Reviews, 3, CD009590, 2014	Overview of Cochrane Reviews. The one relevant Cochrane review (Allen 2010) was checked for relevant RCTs and excluded
Cheong, Y. C., Smotra, G., Williams, A. C., Non-surgical interventions for the management of chronic pelvic pain, Cochrane Database of Systematic Reviews, 3, CD008797, 2014	No analgesic treatment investigated
Cobellis, L., Razzi, S., De Simone, S., Sartini, A., Fava, A., Danero, S., Gioffre, W., Mazzini, M., Petraglia, F. The treatment with a COX-2 specific inhibitor is effective in the management of pain related to endometriosis. European Journal of Obstetrics, Gynecology, & Reproductive Biology, 116, 100-2, 2004	Rofecoxib effect was investigated. The drug was withdrawn from the marketplace on the basis of the safety in November 2004, therefore inappropriate for inclusion.
Ferrero, S., Remorgida, V., Venturini, P. L., Current pharmacotherapy for endometriosis, Expert Opinion on Pharmacotherapy, 11, 1123-34, 2010	Narrative review
Howard, F. M., An evidence-based medicine approach to the treatment of endometriosis-associated chronic pelvic pain: placebo-controlled studies, Journal of the American Association of Gynecologic Laparoscopists, 7, 477-88, 2000	No analgesic treatment investigated
Kauppila, A., Puolakka, J., Ylikorkala, O., Prostaglandin biosynthesis inhibitors and endometriosis, Prostaglandins, 18, 655-61, 1979	Data analysis was flawed: data were not presented per women and pairing within each treatment group not taken into account
Koninckx, P. R., Craessaerts, M., Timmerman, D., Cornillie, F., Kennedy, S., Anti-TNF-alpha treatment for deep endometriosis-associated pain: a randomized placebo-controlled trial, Human Reproduction, 23, 2017-23, 2008	No analgesic treatment investigated
Leanza, V., Ciotta, L., Bellanca, S., Leanza, G., Medical therapy for endometriosis: A literature review, Giornale Italiano di Ostetricia e Ginecologia, 37, 71-76, 2015	Narrative review with no analgesic treatment investigated



Lu,D., Song,H., Shi,G., Anti-TNF-alpha treatment for pelvic pain associated with endometriosis, The Cochrane database of systematic reviews, 3, CD008088-, 2013	No analgesic treatment investigated
Setala, M., Hurskainen, R., Kauko, M., Kujansuu, E., Tiitinen, A., Vuorma, S., Makela, M., Treatment of pain caused by endometriosis (Structured abstract), 2015	A short report with no data
Vercellini, P., Crosignani, P. G., Somigliana, E., Berlanda, N., Barbara, G., Fedele, L., Medical treatment for rectovaginal endometriosis: what is the evidence?, Human Reproduction, 24, 2504-14, 2009	Only hormonal treatment investigated
Won, H. R., Abbott, J., Optimal management of chronic cyclical pelvic pain: An evidence-based and pragmatic approach, International Journal of Women's Health, 2, 263-277, 2010	Narrative review

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## H.14 Pharmacological management – Neuromodulators

Reference	Reason for Exclusion
Ali, A. F., Farid, L., Fouad, M., Faird, M. A., Endometriosis medical therapy from (2010-2013) a systematic review, Journal of Endometriosis, 5, S68-S69, 2013	A conference abstract
Andrews, J., Yunker, A., Reynolds, W. S., Likis, F. E., Sathe, N. A., Jerome, R. N., Noncyclic chronic pelvic pain therapies for women: comparative effectiveness (Structured abstract), 2015	Population not in line with protocol
Api, M., Surgery for endometriosis related pain, Journal of Endometriosis, 4 (3), 133, 2012	Abstract of narrative reviews
Arnold, J., Barcena de Arellano, M. L., Buttner, A., Vercellino, G. F., Chiantera, V., Schneider, A., Mechsner, S., Neuroendocrine modulations of the sensory and sympathetic nerve fibre imbalance in peritoneal endometriosis, Human Reproduction, 27, 2012	Analysis of sensory nerve fibres rather than analysis of women with endometriosis
Bahat, P. Y., Neuraltherapy for treatment of endometriosis, Journal of the Turkish German Gynecology Association, 17, S119-S120, 2016	Abstract of a cohort study of neuromodulation for endometriosis. No full paper available.
Barcena de Arellano, M. L., Arnold, J., Vercellino, G. F., Chiantera, V., Schneider, A., Mechsner, S., Endometriosis-associated neurotrophic properties promote sensory outgrowth, Human Reproduction, 27, 2012	Intervention does not meet the protocol
Bazarra-Fernandez, A., Endometriosis pain and infertility, Journal fur Reproduktionsmedizin und Endokrinologie, 7 (4), 299, 2010	Abstract of review
Bignardi,Tommaso, Khong,SuYen, Lam,Alan, Excisional versus ablative surgery for peritoneal endometriosis, Cochrane Database of Systematic Reviews, -, 2011	Protocol
Blake, C. D., Dinmore, R. C., Kerr, R. K., Surgical Treatment of Endometriosis, Rocky Mountain Medical Journal, 60, 29-30, 1963	Intervention not in line with protocol

Reference	Reason for Exclusion
Carter, J. E., Laparoscopic presacral neurectomy utilizing contact-tip Nd: YAG laser, <i>The Keio journal of medicine</i> , 45, 332-335, 1996	Intervention not in line with protocol
Centre for Reviews and Dissemination, The evidence for the management of endometriosis (Structured abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	Review
Centre for Reviews and Dissemination, Surgical management of endometriosis (Structured abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	Intervention did not meet protocol
Centre for Reviews and Dissemination, Individual patient data meta-analysis of randomized evidence to assess the effectiveness of laparoscopic uterosacral nerve ablation in chronic pelvic pain (Structured abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	Intervention did not meet protocol
Chen, F. P., Soong, Y. K., The efficacy and complications of laparoscopic presacral neurectomy in pelvic pain, <i>Obstetrics &amp; Gynecology</i> , 90, 974-7, 1997	Intervention not in line with protocol
Cheong, Y., William Stones, R., Chronic pelvic pain: aetiology and therapy, <i>Best Practice &amp; Research in Clinical Obstetrics &amp; Gynaecology</i> , 20, 695-711, 2006	Population not in line with protocol
Corson, S. L., Woodland, M., Frishman, G., Batzer, F. R., Gocial, B., Maislin, G., Treatment of endometriosis with a Nd:YAG tissue-contact laser probe via laparoscopy, <i>International Journal of Fertility</i> , 34, 284-8, 1989	Intervention is not in line with protocol
Costello, M.F., Abbott, J., Katz, S., Vancaille, T., Wilson, S., A prospective, randomized, double-blind, placebo-controlled trial of multimodal intraoperative analgesia for laparoscopic excision of endometriosis, <i>Fertility and Sterility</i> , 94, 436-443, 2010	Intervention not in line with protocol
Daniels, J., Gray, R., Hills, R. K., Latthe, P., Buckley, L., Gupta, J., Selman, T., Adey, E., Xiong, T., Champaneria, R., Lilford, R., Khan, K. S., Laparoscopic uterosacral nerve ablation for alleviating chronic pelvic pain: A randomized controlled trial, <i>JAMA - Journal of the American Medical Association</i> , 302, 955-961, 2009	Intervention not in line with protocol
Dover, R. W., Pooley, A. Haines P. Sutton C. J. G., Prospective randomised, double-blind trial of laparoscopic laser uterine nerve ablation in the treatment of pelvic pain associated with endometriosis. A provisional report, <i>Gynaecological Endoscopy Abstract from the 6th Annual Congress of the European Society for Gynaecological Endoscopy</i> , Birmingham, UK. 6, 45, 1997	Intervention does not meet the inclusion criteria
Dover, R. W., Pooley, A., Haines, P., Sutton, C. J. G., Prospective, randomised, double-blind controlled trial of laparoscopic laser uterine nerve ablation in the treatment of pelvic pain associated with endometriosis, <i>Abstract from the 7th Congress of the European Society for Gynaecological Endoscopy</i> . Lausanne, 9, 1998	Intervention not in line with the protocol
Dover, R. W., Pooley, A., Hanines, P., Sutton, C. J. G., A prospective randomised double-blind trial of laparoscopic laser uterine nerve ablation in the treatment of pelvic pain associated with endometriosis: a provisional report, <i>British journal of obstetrics and gynaecology</i> , 105, 48, 1998	Intervention not in line with protocol
Duffy, M. N. James, Arambage, Kirana, Correa, J. S. Frederico, Olive, David, Farquhar, Cindy, Garry, Ray, Barlow, David H., Jacobson, Tal Z., Laparoscopic surgery for	Intervention did not meet the inclusion criteria of the review

Reference	Reason for Exclusion
endometriosis, Cochrane Database of Systematic Reviews, 2014	
El-Din Shawki, H., The efficacy of laparoscopic uterosacral nerve ablation (LUNA) in the treatment of unexplained chronic pelvic pain: A randomized controlled trial, <i>Gynecological surgery</i> , 8, 31-39, 2011	Intervention not in line with protocol
Evans, S., Moalem-Taylor, G., Tracey, D. J., Pain and endometriosis, <i>Pain</i> , 132, S22-S25, 2007	Review
Ewen, S. P., Sutton, C. J. G., A combined approach for painful heavy periods: Laparoscopic laser uterine nerve ablation and endometrial resection, <i>Gynaecological Endoscopy</i> , 3, 167-168, 1994	Intervention not in line with protocol
Freier, A., Pelvic Neurectomy in Gynecology, <i>Obstetrics &amp; Gynecology</i> , 25, 48-55, 1965	Intervention not in line with protocol
Gelbaya, T. A., El-Halwagy, H. E., Focus on primary care: chronic pelvic pain in women, <i>Obstetrical &amp; Gynecological Survey</i> , 56, 757-64, 2001	Narrative review
Gordon, S. J., Maher, P. J., Hiscock, R., The effect of intraperitoneal ropivacaine on pain after laparoscopic excision of endometriosis, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 9, 29-34, 2002	Treatment of post-operative pain rather than general pain management
Jacobs, W. M., Conner, J. S., Rogers, S. F., Presacral neurectomy, <i>American Journal of Obstetrics &amp; Gynecology</i> , 85, 437-9, 1963	Intervention not in protocol
Johnson, N. P., Farquhar, C. M., Crossley, S., Yu, Y., Van Peperstraten, A. M., Sprecher, M., Suckling, J., A double-blind randomised controlled trial of laparoscopic uterine nerve ablation for women with chronic pelvic pain, <i>BJOG: An International Journal of Obstetrics &amp; Gynaecology</i> , 111, 950-9, 2004	Intervention not in line with protocol
Johnson, N., Wilson, M., Farquhar, C., Surgical pelvic neuroablation for chronic pelvic pain: A systematic review, <i>Gynaecological Endoscopy</i> , 9, 351-361, 2000	Intervention not in line with protocol
Khan, K. S., Khan, S. F., Nwosu, C. R., Dwarakanath, L. S., Chien, P. F. W., Laparoscopic uterosacral nerve ablation in chronic pelvic pain: An overview, <i>Gynaecological Endoscopy</i> , 8, 257-265, 1999	Intervention not in line with protocol
Latthe, P. M., Proctor, M. L., Farquhar, C. M., Johnson, N., Khan, K. S., Surgical interruption of pelvic nerve pathways in dysmenorrhea: a systematic review of effectiveness, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 86, 4-15, 2007	Intervention not in line with protocol
Papasakelariou, C., Long-term results of laparoscopic uterosacral nerve ablation, <i>Gynaecological Endoscopy</i> , 5, 177-179, 1996	Intervention not in line with protocol
Proctor, M. L., Latthe, P. M., Farquhar, C. M., Khan, K. S., Johnson, N. P., Surgical interruption of pelvic nerve pathways for primary and secondary dysmenorrhoea, <i>Cochrane Database of Systematic Reviews</i> , CD001896, 2005	Intervention not in line with protocol
Proctor,Michelle, Latthe,Pallavi, Farquhar,Cindy, Khan,Khalid, Johnson,Neil, Surgical interruption of pelvic nerve pathways for primary and secondary dysmenorrhoea, <i>Cochrane Database of Systematic Reviews</i> , -, 2010	Intervention not in line with protocol
Soares, S. R., Martinez-Varea, A., Hidalgo-Mora, J. J., Pellicer, A., Pharmacologic therapies in endometriosis: a systematic review, <i>Fertility &amp; Sterility</i> , 98, 529-55, 2012	Intervention not in line with protocol

Reference	Reason for Exclusion
Sutton, C. J. G., Ewen, S. P., Whitelaw, N., Haines, P., Prospective, randomized, double-blind, controlled trial of laser laparoscopy in the treatment of pelvic pain associated with minimal, mild, and moderate endometriosis, <i>Fertility and Sterility</i> , 62, 696-700, 1994	Intervention is not in line with protocol
Sutton, C., Pooley, A. S., Jones, K. D., Dover, R. W., Haines, P., A prospective, randomized, double-blind controlled trial of laparoscopic uterine nerve ablation in the treatment of pelvic pain associated with endometriosis, <i>Gynaecological Endoscopy</i> , 10, 217-22, 2001	Intervention not in line with protocol
Tjaden, B., Schlaff, W. D., Kimball, A., Rock, J. A., The efficacy of presacral neurectomy for the relief of midline dysmenorrhea, <i>Obstetrics &amp; Gynecology</i> , 76, 89-91, 1990	Intervention not in line with protocol
Vercellini, P., De Giorgi, O., Pisacreta, A., Pesole, A. P., Vicentini, S., Crosignani, P. G., Surgical management of endometriosis, <i>Best Practice &amp; Research in Clinical Obstetrics &amp; Gynaecology</i> , 14, 501-23, 2000	intervention not in line with protocol
Vercellini, P., Fedele, L., Bianchi, S., Candiani, G. B., Pelvic denervation for chronic pain associated with endometriosis: fact or fancy?, <i>American Journal of Obstetrics &amp; Gynecology</i> , 165, 745-9, 1991	Intervention not in line with protocol
Whitlow, B. J., Lovell, D., Maher, R., Wright, J. T., A double-blind trial of hypogastric nerve block for postoperative pain relief following laparoscopic excision of endometriosis, <i>Gynecological surgery</i> , 2, 5-6, 2005	Publication focuses on postoperative pain, rather than general pain management
Wilson, M. L., Farquhar, C. M., Sinclair, O. J., Johnson, N. P., Surgical interruption of pelvic nerve pathways for primary and secondary dysmenorrhoea, <i>Cochrane Database of Systematic Reviews</i> , CD001896, 2000	Population does not meet the inclusion criteria
Zullo, F., Palomba, S., Zupi, E., Russo, T., Morelli, M., Cappiello, F., Mastrantonio, P., Effectiveness of presacral neurectomy in women with severe dysmenorrhea caused by endometriosis who were treated with laparoscopic conservative surgery: a 1-year prospective randomized double-blind controlled trial, <i>American Journal of Obstetrics &amp; Gynecology</i> , 189, 5-10, 2003	Intervention not in line with protocol
Zullo, F., Palomba, S., Zupi, E., Russo, T., Morelli, M., Sena, T., Pellicano, M., Mastrantonio, P., Long-term effectiveness of presacral neurectomy for the treatment of severe dysmenorrhea due to endometriosis, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 11, 23-8, 2004	Intervention not in line with protocol
Zullo, F., Pellicano, M., De Stefano, R., Mastrantonio, P., Mencaglia, L., Stampini, A., Zupi, E., Busacca, M., Efficacy of laparoscopic pelvic denervation in central-type chronic pelvic pain: A multicenter study, <i>Journal of Gynecologic Surgery</i> , 12, 35-40, 1996	Intervention not in line with protocol

## H.15 Pharmacological, non-pharmacological, surgical and combination management strategies (NMA and pairwise comparisons and fertility (NMA))

Study	Reason for Exclusion
Abbott, J., Hawe, J., Hunter, D., Holmes, M., Finn, P., Garry, R., Sowter, M. C., Laparoscopic treatment of endometriosis improved pain and quality of life, but there was also a strong placebo effect, Evidence-based Obstetrics and Gynecology, 7, 139-140, 2005	Review article of Abbott 2004
Abu Hashim, H., Gonadotrophin-releasing hormone analogues and endometriosis: current strategies and new insights, Gynecological Endocrinology, 28, 314-21, 2012	Systematic review - included studies checked for relevance to the protocol?
Abu Hashim, H., El Rakhawy, M., Abd Elaal, I., Randomized comparison of superovulation with letrozole vs. clomiphene citrate in an IUI program for women with recently surgically treated minimal to mild endometriosis, Acta Obstetrica et Gynecologica Scandinavica, 91, 338-45, 2012	Comparison is not relevant to protocol
Acien, P., Quereda, F., Campos, A., Gomez-Torres, M.J., Velasco, I., Gutierrez, M., Use of intraperitoneal interferon alpha-2b therapy after conservative surgery for endometriosis and postoperative medical treatment with depot gonadotropin-releasing hormone analog: a randomized clinical trial, Fertility and Sterility, 78, 705-711, 2002	No outcomes of interest reported
Adamson, G. D., Kwei, L., Edgren, R. A., Pain of endometriosis: effects of nafarelin and danazol therapy, International Journal of Fertility & Menopausal Studies, 39, 215-7, 1994	No outcomes of interest
Adamson, G.D., Nelson, H.P., Medical and surgical treatment of endometriosis, Endocrinologist, 6, 384-391, 1996	Review
Agarwal, S. K., Daniels, A., Drosman, S. R., Udoff, L., Foster, W. G., Pike, M. C., Spicer, D. V., Daniels, J. R., Treatment of Endometriosis with the GnRHa Deslorelin and Add-Back Estradiol and Supplementary Testosterone, BioMed Research International, 2015, 934164, 2015	Treatment not included in protocol
Ahn, A. C., Schnyer, R., Conboy, L., Laufer, M. R., Wayne, P. M., Electrodermal measures of Jing-Well points and their clinical relevance in endometriosis-related chronic pelvic pain, Journal of Alternative & Complementary Medicine, 15, 1293-305, 2009	Insufficient data reported for the inclusion in the review
Aisaka, K., Morioka, H., Watanabe, T., Nishihira, M., Takiaki, F., Trial of long term Gn-RH agonist administration for the treatment of endometriosis with estrogen-progestogen add back therapy, Fertility and sterility, 70, S259, 1998	Study not randomised
Aisaka, K., Nakagawa, K., Uesato, T., Miwa, A., Koshino, T., Ooka, F., Nishihira, M., Sadatsuki,	Conference abstract: insufficient information

Study	Reason for Exclusion
M., Liang, S., Kaibara, M., Mori, H., Effectiveness of long term GN-RH agonist administration for treatment of endometriosis combined with estrogen-progestogen add back therapy, XVI FIGO World Congress of O & G, 4, 2000	
Al Kadri, H., Hassan, S., Al-Fozan, H. M., Hajeer, A., Hormone therapy for endometriosis and surgical menopause, Cochrane Database of Systematic Reviews, CD005997, 2009	Both included RCTs (Fedele 1999 and Matorras 2002) already checked for relevance to the protocol and review
Alborzi, S., Ghotbi, S., Parsanezhad, M. E., Dehbashi, S., Alborzi, S., Alborzi, M., Pentoxifylline therapy after laparoscopic surgery for different stages of endometriosis: a prospective, double-blind, randomized, placebo-controlled study, Journal of Minimally Invasive Gynecology, 14, 54-8, 2007	Pentoxifylline intervention is not relevant to protocol
Alborzi, S., Momtahan, M., Parsanezhad, M. E., Dehbashi, S., Zolghadri, J., Alborzi, S., A prospective, randomized study comparing laparoscopic ovarian cystectomy versus fenestration and coagulation in patients with endometriomas, Fertility & Sterility, 82, 1633-7, 2004	Included in a systematic review which is already included (Hart 2011)
Alborzi, S., Ravanbakhsh, R., Parsanezhad, M. E., Alborzi, M., Alborzi, S., Dehbashi, S., A comparison of follicular response of ovaries to ovulation induction after laparoscopic ovarian cystectomy or fenestration and coagulation versus normal ovaries in patients with endometrioma, Fertility & Sterility, 88, 507-9, 2007	Fertility treatment
Ali, A. F. Farid L. A. Fouad M. Omar E. D., Continuous oral contraception and Leuprolidein the treatment of Endometriosis associated pelvic pain, Journal of Endometriosis, 5, 2013	No relevant comparison
Al-Inany, H., Houston, B., Farquhar, C., Abousetta, A., Postoperative application of LNG-IUD for symptomatic endometriosis, Human Reproduction, 28, 2013	Insufficient information to extract data
Al-Inany, H., Wahba, A., Abousetta, A., Is dienogest effective in postoperative management of endometriosis compared to GNRH a?, International Journal of Gynecological Cancer, 23, 1054, 2013	No relevant comparison
Alkatout, I., Mettler, L., Beteta, C., Hedderich, J., Jonat, W., Schollmeyer, T., Salmassi, A., Combined surgical and hormone therapy for endometriosis is the most effective treatment: prospective, randomized, controlled trial, Journal of Minimally Invasive Gynecology, 20, 473-81, 2013	Report of the same study as Mettler 2014. Checked for any further relevant outcomes before exclusion
Almassinokiani, F., Mehdizadeh, A., Sariri, E., Rezaei, M., Almasi, A., Akbari, H., Pazouki, A., Solaymani-Dodaran, M., Asadollah, S., Amirkhani, J., Chaichian, S., Vahdat, M., Moosavi, A., Ashouri, M., Tamannaie, Z., Effects	No relevant comparison

Study	Reason for Exclusion
of simvastatin in prevention of pain recurrences after surgery for endometriosis, Medical Science Monitor, 19, 534-539, 2013	
Angioni, S., Cofelice, V., Sedda, F., Loi, E. S., Multinu, F., Pontis, A., Melis, G. B., Progestins for symptomatic endometriosis: Results of clinical studies, Current Drug Therapy, 10, 91-104, 2015	All studies in review assessed for inclusion/exclusion
Angioni, S., Pontis, A., Dessole, M., Surico, D., De Cicco Nardone, C., Melis, I., Pain control and quality of life after laparoscopic en-block resection of deep infiltrating endometriosis (DIE) vs. incomplete surgical treatment with or without GnRHa administration after surgery, Archives of Gynecology & Obstetrics, 291, 363-70, 2015	Comparison not relevant to protocol
Anonymous,, Gestrinone versus a gonadotropin-releasing hormone agonist for the treatment of pelvic pain associated with endometriosis: a multicenter, randomized, double-blind study. Gestrinone Italian Study Group, Fertility & Sterility, 66, 911-9, 1996	No relevant comparison
Audebert, A., Descamps, P., Marret, H., Ory-Lavollee, L., Bailleul, F., Hamamah, S., Pre or post-operative medical treatment with nafarelin in stage III-IV endometriosis: a French multicenter study, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 79, 145-8, 1998	Data for pain outcomes use incorrect denominators and correct data cannot be determined
Audebert,A., Lucas,C., Joubert-Collin,M., Efficacy and safety of slow-release leuprorelin 3,75 mg compared to Danazol treatment. <ORIGINAL> EFFICACITE ET TOLERANCE DE LA LEUPRORELIN 3,75 MG A LIBERATION PROLONGEE DANS LE TRAITEMENT DE L'ENDOMETRIOSE EN COMPARAISON AU DANAZOL, References En Gynecologie Obstetrique, 5, 49-57, 1997	Study not in English. Details reported in Cochrane review
Bartley, J., Ebert, A. D., Schweppe, K. H., A safety and efficacy study on long term treatment with Letrozole after GnRH A down-regulation in premenopausal patients with moderate and severe endometriosis, Human Reproduction, 29, i196-i197, 2014	Insufficient numerical details reported
Batioglu, S., Haberal, A., Celikkanat, H., Comparison of GnRH agonist administration before and after laparoscopic drainage of endometriomas, Journal of Gynecologic Surgery, 13, 17-21, 1997	Randomisation of women within the study but unit of analysis is endometrioma
Bayoglu Tekin, Y., Dilbaz, B., Altinbas, S. K., Dilbaz, S., Postoperative medical treatment of chronic pelvic pain related to severe endometriosis: levonorgestrel-releasing intrauterine system versus gonadotropin-releasing hormone analogue, Fertility & Sterility, 95, 492-6, 2011	No relevant comparison (post surgical hormonal treatment comparison)

Study	Reason for Exclusion
Benschop,Laura, Farquhar,Cindy, van der Poel,Nicolien, Heineman,Jan Maas, Interventions for women with endometrioma prior to assisted reproductive technology, Cochrane Database of Systematic Reviews, -, 2012	No intervention of interest for this review: medical treatments and combined surgical treatments
Beretta, P., Franchi, M., Ghezzi, F., Busacca, M., Zupi, E., Bolis, P., Randomized clinical trial of two laparoscopic treatments of endometriomas: cystectomy versus drainage and coagulation, Fertility & Sterility, 70, 1176-80, 1998	Included in a systematic review which is already included (Hart 2011)
Bergquist,C., Effects of nafarelin versus danazol on lipids and calcium metabolism, American Journal of Obstetrics and Gynecology, 162, 589-591, 1990	No outcomes of interest reported
Bergqvist, A., Theorell, T., Changes in quality of life after hormonal treatment of endometriosis, Acta Obstetrica et Gynecologica Scandinavica, 80, 628-37, 2001	Already included in Brown 2012 systematic review
Bianchi, S., Agnoli, B., Sgherzi, M. R., Candiani, M., Busacca, M., Effect of three-month treatment with Danazol after laparoscopic surgery for stage III-IV endometriosis: a randomized clinical trial, Fertility and sterility. S22 23p, 1997	No relevant comparison (post surgical hormonal treatment comparison)
Bonoche, C. M., Montenegro, M. L., Rosa, E. Silva J. C., Ferriani, R. A., Meola, J., Endometriosis and physical exercises: a systematic review, Reproductive Biology & Endocrinology, 12, 4, 2014	Not RCT
Bromham, D. R., Booker, M. W., Rose, G. L., Wardle, P. G., Newton, J. R., A multicentre comparative study of gestrinone and danazol in the treatment of endometriosis, Journal of Obstetrics and Gynaecology, 15, 188-94, 1995	No relevant comparison (gestrinone is not available in the UK)
Burry,K.A., Patton,P.E., Illingworth,D.R., Metabolic changes during medical treatment of endometriosis: nafarelin acetate versus danazol.[Erratum appears in Am J Obstet Gynecol 1989 Dec;161(6 Pt 1):1755], American Journal of Obstetrics and Gynecology, 160, 1454-1459, 1989	Not full text article
Cagnacci, A., Tirelli, A., Cannoletta, M., Pirillo, D., Volpe, A., Effect on insulin sensitivity of Implanon vs. GnRH agonist in women with endometriosis, Contraception, 72, 443-6, 2005	No outcomes of interest reported
Carbonell, J. L., Riveron, A. M., Leonard, Y., Gonzalez, J., Heredia, B., Sanchez, C., Mifepristone 2.5, 5, 10 mg versus placebo in the treatment of endometriosis, Journal of Reproductive Health and Medicine, 2, 17-25, 2016	Treatment not included in protocol
Carpenter, S. E., Tjaden, B., Rock, J. A., Kimball, A., The effect of regular exercise on women receiving danazol for treatment of endometriosis, International Journal of Gynaecology & Obstetrics, 49, 299-304, 1995	Not the outcome of interest



Study	Reason for Exclusion
Carr, B., Giudice, L., Dmowski, W. P., O'Brien, C., Jiang, P., Burke, J., Jimenez, R., Hass, S., Fuldeore, M., Chwalisz, K., Elagolix, an oral GnRH antagonist for endometriosis-associated pain: A randomized controlled study, <i>Journal of Endometriosis</i> , 5, 105-115, 2013	Length of follow up is not within protocol (8 weeks)
Centre for Reviews and Dissemination, Surgical management of endometriosis (Structured abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	Duplicate of old article previously reviewed
Centre for Reviews and Dissemination, Effectiveness and safety of different laparoscopic surgeries for ovarian endometrioma: a systematic review (Provisional abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	Duplicate of article already assessed for inclusion/exclusion
Centre for Reviews and Dissemination, Effectiveness of conservative surgery and adjunctive hormone suppression therapy versus surgery alone in the treatment of symptomatic endometriosis: a systematic review with meta-analysis (Provisional abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	All studies included in study have already been assessed for inclusion/exclusion
Centre for Reviews and Dissemination, Dyspareunia and quality of sex life after surgical excision of endometriosis: a systematic review (Provisional abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	All studies included in study have already been assessed for inclusion/exclusion
Centre for Reviews and Dissemination, Excisional surgery versus ablative surgery for ovarian endometriomata: a Cochrane Review (Structured abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	All studies included in study have already been assessed for inclusion/exclusion
Centre for Reviews and Dissemination, Analysis of the levonorgestrel-releasing intrauterine system in women with endometriosis (Provisional abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	All studies included in study have already been assessed for inclusion/exclusion
Chang, S. P., Ng, H. T., A randomized comparative study of the effect of leuprorelin acetate depot and danazol in the treatment of endometriosis, <i>Chung Hua i Hsueh Tsa Chih - Chinese Medical Journal</i> , 57, 431-7, 1996	Details reported in Cochrane review
Chang, F.H., Chou, H.H., Soong, Y.K., Chang, M.Y., Lee, C.L., Lai, Y.M., Efficacy of isotopic 13CO <sub>2</sub> laser laparoscopic evaporation in the treatment of infertile patients with minimal and mild endometriosis: a life table cumulative pregnancy rates study, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 4, 219-223, 1997	Not randomised
Charles, C., Muneyyirci-Delale, O., Sinaii, N., Dalloul, M., Stratton, P., Effect of lupron vs norethindrone treatment on lipid profile of women with symptomatic endometriosis, <i>Fertility and Sterility</i> , 1), e161, 2015	Insufficient numerical details reported

Study	Reason for Exclusion
Cheewadhanaraks, S., Choksuchat, C., Dhanaworavibul, K., Liabsuetrakul, T., Postoperative depot medroxyprogesterone acetate versus continuous oral contraceptive pills in the treatment of endometriosis-associated pain: a randomized comparative trial, <i>Gynecologic &amp; Obstetric Investigation</i> , 74, 151-6, 2012	Comparison of pharmacological treatments after surgery
Cheewadhanaraks, S., Peeyananjarassri, K., Choksuchat, C., Dhanaworavibul, K., Choobun, T., Bunyapipat, S., Interval of injections of intramuscular depot medroxyprogesterone acetate in the long-term treatment of endometriosis-associated pain: a randomized comparative trial, <i>Gynecologic and Obstetric Investigation</i> , 68, 116-121, 2009	No relevant comparison (dose comparison)
Chen, M., Zhang, H., Li, J., Dong, G. R., [Clinical observation on acupuncture combined with acupoint sticking therapy for treatment of dysmenorrhea caused by endometriosis], <i>Zhongguo zhen jiu [Chinese acupuncture &amp; moxibustion]</i> , 30, 725-8, 2010	Chinese language
Chen, S. H., Li, Z. A., Du, X. P., Robot-assisted versus conventional laparoscopic surgery in the treatment of advanced stage endometriosis: a meta-analysis, <i>Clinical &amp; Experimental Obstetrics &amp; Gynecology</i> , 43, 422-6, 2016	Study of endometrial cancer
Cheng, M. H., Yu, B. K. J., Chang, S. P., Wang, P. H., A randomized, parallel, comparative study of the efficacy and safety of nafarelin versus danazol in the treatment of endometriosis in Taiwan, <i>Journal of the Chinese Medical Association</i> , 68, 307-314, 2005	Relevant data included from Brown 2010 Cochrane systematic review
Cheong, Y. C., Smotra, G., Williams, A. C., Non-surgical interventions for the management of chronic pelvic pain, <i>Cochrane Database of Systematic Reviews</i> , 3, CD008797, 2014	Women with a diagnosis of pelvic congestion syndrome or adhesions and pain not due to endometriosis.
Chwalisz, K., Mattia-Goldberg, C., Lee, M., Elger, W., Edmonds, A., Treatment of endometriosis with the novel selective progesterone receptor modulator (SPRM) asoprisnil, <i>Fertility and sterility</i> , 82, S83-84, 2004	Conference abstract: insufficient information
Cirkel, U., Ochs, H., Schneider, H. P., A randomized, comparative trial of triptorelin depot (D-Trp6-LHRH) and danazol in the treatment of endometriosis, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 59, 61-9, 1995	Details of scale (outcome) not reported)
Cirkel, U., Schweppe, K. W., Ochs, H., Schneider, H. P., Effect of LH-RH agonist therapy in the treatment of endometriosis (German experience), <i>Progress in Clinical &amp; Biological Research</i> , 225, 189-99, 1986	Not a RCT
Claesson, B., Bergquist, C., Clinical experience treating endometriosis with nafarelin, <i>Journal of Reproductive Medicine</i> , 34, 1025-8, 1989	No outcomes of interest reported

Study	Reason for Exclusion
Cosson, M., Querleu, D., Donnez, J., Madelenat, P., Konincks, P., Audebert, A., Manhes, H., Dienogest is as effective as triptorelin in the treatment of endometriosis after laparoscopic surgery: results of a prospective, multicenter, randomized study, <i>Fertility and Sterility</i> , 77, 684-692, 2002	Not the comparison of interest (dienogest alone vs triptorelin)
Crosignani, P. G., Gastaldi, A., Lombardi, P. L., Montemagno, U., Vignali, M., Serra, G. B., Stella, C., Leuprorelin acetate depot vs danazol in the treatment of endometriosis: results of an open multicentre trial, <i>Clinical Therapeutics</i> , 14 Suppl A, 29-36, 1992	Relevant numerical data cannot be extracted (narrative representation)
Cucinella, G., Granese, R., Calagna, G., Svelato, A., Saitta, S., Tonni, G., De Franciscis, P., Colacurci, N., Perino, A., Oral contraceptives in the prevention of endometrioma recurrence: does the different progestins used make a difference?, <i>Archives of Gynecology &amp; Obstetrics</i> , 288, 821-7, 2013	Insufficient data reported for inclusion in the review
Daniels, J., Gray, R., Hills, R. K., Latthe, P., Buckley, L., Gupta, J., Selman, T., Adey, E., Xiong, T., Champaneria, R., Lilford, R., Khan, K. S., Luna Trial Collaboration, Laparoscopic uterosacral nerve ablation for alleviating chronic pelvic pain: a randomized controlled trial, <i>JAMA</i> , 302, 955-61, 2009	Majority of women did not have endometriosis
Daniels, J., Middleton, L., Gennard, L., Tryposkiadis, K., Leighton, L., Bhattacharya, S., Preventing recurrence of endometriosis by means of long-acting progestogen therapy: The PRE-EMPT pilot study, <i>Bipolar Disorders</i> , 18, 225, 2016	Preliminary results only - no outcomes of interest reported
Davis, C. J., McMillan, L., Pain in endometriosis: effectiveness of medical and surgical management, <i>Current Opinion in Obstetrics &amp; Gynecology</i> , 15, 507-12, 2003	Review
Dawood, M. Y., Ramos, J., Khan-Dawood, F. S., Depot leuprolide acetate versus danazol for treatment of pelvic endometriosis: changes in vertebral bone mass and serum estradiol and calcitonin, <i>Fertility &amp; Sterility</i> , 63, 1177-83, 1995	No outcomes of interest reported
Dawood, M. Y., Spellacy, W. N., Dmowski, W. P., Gambrell, R. D., Jr., Greenblatt, R. B., Girard, Y., Lemay, A., Mishell, D. R., Jr., Nagamani, M., Pepperell, R. J., et al., A comparison of the efficacy and safety of buserelin vs danazol in the treatment of endometriosis. Protocol 310 Study Group, <i>Progress in Clinical &amp; Biological Research</i> , 323, 253-67, 1990	No outcomes of interest reported
de Sa Rosa e Silva, A. C., Rosa e Silva, J. C., Nogueira, A. A., Petta, C. A., Abrao, M. S., Ferriani, R. A., The levonorgestrel-releasing intrauterine device reduces CA-125 serum levels in patients with endometriosis, <i>Fertility &amp; Sterility</i> , 86, 742-4, 2006	No outcomes of interest reported

Study	Reason for Exclusion
Deans, R., Hawe, J., Hunter, D., Garry, R., Holmes, M., Abbott, J., A double-blind RCT of surgical excision of endometriosis: Secondary outcomes, <i>Gynecological surgery</i> , 6, S86, 2009	Abstract only
Deaton, J.L., Gibson, M., Blackmer, K.M., Nakajima, S.T., Badger, G.J., Brumsted, J.R., A randomized, controlled trial of clomiphene citrate and intrauterine insemination in couples with unexplained infertility or surgically corrected endometriosis, <i>Fertility and Sterility</i> , 54, 1083-1088, 1990	No relevant comparison
Demiroglu, A., Guven, S., Baykal, C., Gurgan, T., Effect of endometrioma cystectomy on IVF outcome: a prospective randomized study, <i>Reproductive Biomedicine Online</i> , 12, 639-643, 2006	Fertility treatment
Detorakis, S. Protopapas A. Louradou D. Giannoulis G. Chatzipapas I. Loutradis D., Bipolar energy for ovarian hemostasis in endometrioma surgery: During, after, or not at all?: Presentation of 3 different cystectomy techniques compared in an ongoing rct, <i>Gynecological Surgery</i> , 11 Suppl 1, 54-5, 2014	Article is a protocol
D'Hooghe, T., Dunselman, G. A. J., Saridogan, E., Kiesel, L., Guideline Development Group, E., Vermeulen, N., Treatment of endometriosis-associated pain according to the 2014 eshre guidelines, <i>Gynecological surgery</i> , 1), 260-261, 2014	Conference abstract
Di Donato, N. Bertoldo V. Vicenzi C. Benfenati A. Giovanardi G. Leonardi D. Monti G. Seracchioli R., The role of ovariectomy on reducing post-surgical ovarian adhesions in women with severe endometriosis: A randomized, controlled study, <i>Journal of Minimally Invasive Gynecology</i> , 20 Suppl 1, S38, 2013	No outcomes of interest reported
Dicker, D., Goldman, J.A., Levy, T., Feldberg, D., Ashkenazi, J., The impact of long-term gonadotropin-releasing hormone analogue treatment on preclinical abortions in patients with severe endometriosis undergoing in vitro fertilization-embryo transfer, <i>Fertility and Sterility</i> , 57, 597-600, 1992	All participants had prior IVF treatment
Ding, Z., Lian, F., Traditional Chinese medical herbs staged therapy in infertile women with endometriosis: A clinical study, <i>International Journal of Clinical and Experimental Medicine</i> , 8, 14085-14089, 2015	Not relevant as mifepristone is only licensed for termination of pregnancy and available in big dose of 200mg in the UK
DiVasta, A. D. Feldman H. A. Gallagher J. S. Laufer M. R. Hornstein M. D. Gordon C. M., The effect of hormonal add-back therapy in adolescents treated with a gonadotropin releasing hormone (GnRH) agonist for endometriosis: A randomized trial, <i>Journal of Adolescent Health</i> , 56 Suppl 1, S24, 2015	Conference abstract: insufficient information

Study	Reason for Exclusion
DiVasta, A. D., Feldman, H. A., Sadler Gallagher, J., Stokes, N. A., Laufer, M. R., Hornstein, M. D., Gordon, C. M., Hormonal Add-Back Therapy for Females Treated With Gonadotropin-Releasing Hormone Agonist for Endometriosis: A Randomized Controlled Trial, <i>Obstetrics &amp; Gynecology</i> , 126, 617-27, 2015	Not included in NMA; Interventions not relevant for pairwise analysis
Dmowski, W. P., Kapetanakis, E., Scommegna, A., Variable effects of danazol on endometriosis at 4 low-dose levels, <i>Obstetrics &amp; Gynecology</i> , 59, 408-15, 1982	No relevant comparison (dose comparison)
Dmowski,W.P., Radwanska,E., Binor,Z., Tummon,I., Pepping,P., Ovarian suppression induced with Buserelin or danazol in the management of endometriosis: a randomized, comparative study, <i>Fertility and Sterility</i> , 51, 395-400, 1989	Sample size of subfertile participants too small
Dodin, S., Lemay, A., Maheux, R., Dumont, M., Turcot Lemay, L., Bone mass in endometriosis patients treated with GnRH agonist implant or danazol, <i>Obstetrics and gynecology</i> , 77, 410-5, 1991	No outcomes of interest reported
Donnez, J., Dewart, P. J., Hedon, B., Perino, A., Schindler, A. E., Blumberg, J., Querleu, D., Equivalence of the 3-month and 28-day formulations of triptorelin with regard to achievement and maintenance of medical castration in women with endometriosis, <i>Fertility &amp; Sterility</i> , 81, 297-304, 2004	No outcomes of interest reported
Donnez,J., Nisolle,M., Clerckx,F., Casanas,F., Evaluation of preoperative use of danazol, gestrinone, lynestrenol, buserelin spray and buserelin implant, in the treatment of endometriosis associated infertility, <i>Progress in Clinical and Biological Research</i> , 323, 427-442, 1990	Patients not randomised
Donnez,J., Nisolle,M., Gillerot,S., Anaf,V., Clerckx-Braun,F., Casanas-Roux,F., Ovarian endometrial cysts: the role of gonadotropin-releasing hormone agonist and/or drainage, <i>Fertility and Sterility</i> , 62, 63-66, 1994	No outcomes of interest reported
Donnez,J., Nisolle-Pochet,M., Clerckx-Braun,F., Sandow,J., Casanas-Roux,F., Administration of nasal Buserelin as compared with subcutaneous Buserelin implant for endometriosis, <i>Fertility and Sterility</i> , 52, 27-30, 1989	No relevant comparison (dose comparison)
Duffy,James M., Johnson,Neil, Ahmad,Gaity, Watson,Andrew, Postoperative procedures for improving fertility following pelvic reproductive surgery, <i>Cochrane Database of Systematic Reviews</i> , -, 2009	Cochrane review - Studies are not of patients with endometriosis
Emilio, P., Control of pelvic pain and quality of life following treatment of symptomatic endometriosis, <i>Journal of Psychosomatic Obstetrics and Gynecology</i> , 31, 21, 2010	Conference abstract
Falcone,T., Goldberg,J.M., Miller,K.F., Endometriosis: Medical and surgical	Review

Study	Reason for Exclusion
intervention, Current Opinion in Obstetrics and Gynecology, 8, 178-183, 1996	
Faustmann,T., Seitz,C., Marr,J., Gerlinger,C., Strowitzki,T., Safety of dienogest for the treatment of endometriosis: A 24-week, randomised, open-label trial versus leuprolide acetate, International Journal of Gynecology and Obstetrics, 107, S179-, 2009	Conference abstract: insufficient information
Fedele, L., Arcaini, L., Bianchi, S., Baglioni, A., Vercellini, P., Comparison of cyproterone acetate and danazol in the treatment of pelvic pain associated with endometriosis, Obstetrics & Gynecology, 73, 1000-4, 1989	Cyproterone acetate not included in review; Study not included in NMA and so cannot provide indirect information
Fedele, L., Bianchi, S., Bocciolone, L., Di Nola, G., Franchi, D., Buserelin acetate in the treatment of pelvic pain associated with minimal and mild endometriosis: a controlled study, Fertility & Sterility, 59, 516-21, 1993	Participants' primary presentation was subfertility; No relevant outcomes assessed
Fedele, L., Bianchi, S., Montefusco, S., Frontino, G., Carmignani, L., A gonadotropin-releasing hormone agonist versus a continuous oral contraceptive pill in the treatment of bladder endometriosis, Fertility and sterility, 90, 183-4, 2008	No outcomes of interest reported
Fedele,L., Bianchi,S., Raffaelli,R., Zanconato,G., Comparison of transdermal estradiol and tibolone for the treatment of oophorectomized women with deep residual endometriosis, Maturitas, 32, 189-193, 1999	No outcomes of interest
Fedele,L., Bianchi,S., Viezzoli,T., Arcaini,L., Candiani,G.B., Gestrinone versus danazol in the treatment of endometriosis, Fertility and Sterility, 51, 781-785, 1989	No relevant comparison (gestrinone is not available in the UK)
Federici, D., Brambilla, T., Lacelli, B., Arcaini, L., Motta, G., Agarossi, A., Muggiasca, L., Conti, M., Pain relief after combined medical and laparoscopic conservative treatment of stage III-IV endometriosis: A comparison with medical therapy, Minimally Invasive Therapy and Allied Technologies, 5, 547-54, 1996	Study has not been randomised
Felix Wong, W. S., Danforn Lim, C. E., Hormonal treatment for endometriosis associated pelvic pain, Iranian Journal of Reproductive MedicineIran, 9, 163-70, 2011	All studies included in study have already been assessed for inclusion/exclusion
Ferrero, S., Abbamonte, L. H., Parisi, M., Ragni, N., Remorgida, V., Dyspareunia and quality of sex life after laparoscopic excision of endometriosis and postoperative administration of triptorelin, Fertility & Sterility, 87, 227-9, 2007	Not a RCT
Ferrero, S., Camerini, G., Seracchioli, R., Ragni, N., Venturini, P. L., Remorgida, V., Letrozole combined with norethisterone acetate compared with norethisterone acetate alone in the treatment of pain symptoms caused by endometriosis, Human Reproduction, 24, 3033-41, 2009	Not a RCT

Study	Reason for Exclusion
Ferrero, S., Venturini, P. L., Gillott, D. J., Remorgida, V., Letrozole and norethisterone acetate versus letrozole and triptorelin in the treatment of endometriosis related pain symptoms: a randomized controlled trial, <i>Reproductive Biology &amp; Endocrinology</i> , 9, 88, 2011	Treatment not connected to NMA network
Fjerbaek, A., Knudsen, U. B., Endometriosis, dysmenorrhea and diet--what is the evidence?, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 132, 140-7, 2007	Review - RCTs discussed in this paper have been included
Franssen, A. M., van der Heijden, P. F., Thomas, C. M., Doesburg, W. H., Willemsen, W. N., Rolland, R., On the origin and significance of serum CA-125 concentrations in 97 patients with endometriosis before, during, and after buserelin acetate, nafarelin, or danazol, <i>Fertility &amp; Sterility</i> , 57, 974-9, 1992	Study design does not match the inclusion criteria
Freundl, G., Godtke, K., Gnoth, C., Godehardt, E., Kienle, E., Steroidal 'add-back' therapy in patients treated with GnRH agonists, <i>Gynecologic &amp; Obstetric Investigation</i> , 45 Suppl 1, 22-30; discussion 35, 1998	No outcomes of interest
Fritzer, N., Hudelist, G., Love is a pain? Quality of sex life after surgical resection of endometriosis: A review, <i>European Journal of Obstetrics Gynecology and Reproductive Biology</i> , 31, 2016	Study contains insufficient detail on methods and population
Fritzer, N., Tammaa, A., Salzer, H., Hudelist, G., Dyspareunia and quality of sex life after surgical excision of endometriosis: a systematic review, <i>European Journal of Obstetrics, Gynecology, &amp; Reproductive Biology</i> , 173, 1-6, 2014	Systematic review of non-comparative studies
Frontino, G., Vercellini, P., De Giorgi, O., Aimi, G., Zaina, B., Crosignani, P. G., Levonorgestrel-releasing intrauterine device (Lng-IUD) versus expectant management after conservative surgery for symptomatic endometriosis. A pilot study, <i>Fertility and sterility</i> , 77 Suppl 1, S25-26, 2002	Conference abstract: insufficient information
Fukushima, M., Changes in bone mineral content following hormone treatment for endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 50 Suppl 1, S17-22, 1995	No outcomes of interest reported
Fukushima, M., Shindo, M., Sato, K., Hormone treatment related bone mineral content changes in Japanese women with endometriosis, <i>Asia-Oceania Journal of Obstetrics &amp; Gynaecology</i> , 19, 299-307, 1993	No outcomes of interest reported
Garry, R., Abbott, J., A placebo-controlled randomised controlled trial of laparoscopic excision of endometriosis, <i>European Journal of Obstetrics &amp; Gynecology and Reproductive Biology</i> , 123, S8, 2005	Abstract only
Gelbaya, T. A., El-Halwagy, H. E., Focus on primary care: chronic pelvic pain in women,	Population is not endometriosis

Study	Reason for Exclusion
Obstetrical & Gynecological Survey, 56, 757-64, 2001	
Georgievska, J., Sapunov, S., Cekovska, S., Vasilevska, K., Effect of two laparoscopic techniques for treatment of ovarian endometrioma on ovarian reserve, Medicinski Arhiv, 69, 88-90, 2015	Not RCT
Ghahiri, A., Najafian, A., Ghasemi, M., Najafian, A., Comparison study on effectiveness of pentoxifyllin with LD to prevent recurrent endometriosis, Iranian Journal of Reproductive Medicine, 10, 219-22, 2012	No relevant comparison
Giannini, A., Palla, G., Goglia, L., Genazzani, A. R., Genazzani, A., Simoncini, T., Effects of preoperative and perioperative administration of wobenzym vital on minimal-mild endometriosis, Journal of Endometriosis, 7, 71-77, 2015	No data reported for outcomes of interest
Gnoth, C. H., Godtke, K., Freundl, G., Godehardt, E., Kienle, E., Effects of add-back therapy on bone mineral density and pyridinium crosslinks in patients with endometriosis treated with gonadotropin-releasing hormone agonists, Gynecologic & Obstetric Investigation, 47, 37-41, 1999	No outcomes of interest reported
Goncalves, F. C., Andres, M. P., Passman, L. J., Goncalves, M. O., Podgaec, S., A systematic review of ultrasonography-guided transvaginal aspiration of recurrent ovarian endometrioma, International Journal of Gynaecology & Obstetrics, 134, 3-7, 2016	All studies included in study have already been assessed for inclusion/exclusion
Gong, L., Zhang, S., Han, Y., Long, Q., Zou, S., Cao, Y., Initiation of GnRH agonist treatment on 3-5 days postoperatively in endometriosis patients: A randomized controlled trial, Journal of Clinical Pharmacology, 55, 848-853, 2015	Treatment not connected to NMA network
Gregoriou, O., Konidaris, S., Vitoratos, N., Papadias, C., Papoulias, I., Chryssicopoulos, A., Gonadotropin-releasing hormone analogue plus hormone replacement therapy for the treatment of endometriosis: A randomized controlled trial, International journal of fertility and women's medicine, 42, 406-411, 1997	Relevant numerical data cannot be extracted (graphical and narrative representation)
Grimes, David A., Jones, B. LaShawn, Lopez, Lauren M., Schulz, Kenneth F., Oral contraceptives for functional ovarian cysts, Cochrane Database of Systematic Reviews, 2014	Women do not have suspected/confirmed endometriosis
Gupta, JK, Daniels, JP, Middleton, LJ, Pattison, HM, Prileszky, G, Roberts, TE, Sanghera, S, Barton, P, Gray, R, Kai, J, A randomised controlled trial of the clinical effectiveness and cost-effectiveness of the levonorgestrel-releasing intrauterine system in primary care against standard treatment for menorrhagia: the ECLIPSE trial (Structured abstract), Health Technology Assessment Database, 2016	Women do not have endometriosis



Study	Reason for Exclusion
Halbe, H. W., Nakamura, M. S., Da Silveira, G. P., Carvalho, W. P., Updating the clinical experience in endometriosis--the Brazilian perspective, <i>British Journal of Obstetrics &amp; Gynaecology</i> , 102 Suppl 12, 17-21, 1995	Within-class comparison in NMA. No information added
Hamid, A. M., Madkour, W. A., Moawad, A., Elzaher, M. A., Roberts, M. P., Does cabergoline help in decreasing endometrioma size compared to LHRH agonist? A prospective randomized study, <i>Archives of Gynecology &amp; Obstetrics</i> , 290, 677-82, 2014	No relevant comparison
Han, Y., Zou, S. E., Long, Q. Q., Zhang, S. F., The incidence and characteristics of uterine bleeding during postoperative GnRH agonist treatment combined with estrogen-progestogen add-back therapy in endometriosis patients of reproductive age, <i>International journal of clinical and experimental medicine</i> , 6, 583-8, 2013	Comparison of pharmacological treatments after surgery.
Hardcastle, R. J., A randomised, single-blind clinical trial to investigate the effectiveness of bipolar versus monopolar diathermy treatment on pain symptoms for women with newly diagnosed superficial endometriosis: The set study (superficial endometriosis treatment), <i>Journal of Minimally Invasive Gynecology</i> , 1), S176-S177, 2015	Trial still awaiting results
Harrison, R. F., Barry-Kinsella, C., Efficacy of medroxyprogesterone treatment in infertile women with endometriosis: a prospective, randomized, placebo-controlled study, <i>Fertility &amp; Sterility</i> , 74, 24-30, 2000	Medroxyprogesterone acetate dose is greater than that specified in the British National Formulary
Hefni, M. A., Apoola, A., Omran, O., Comparison between medical treatment by GnRH analogue (goserelin) and conservative surgery by laparoscopic diathermy for the management of endometriosis, <i>Gynaecological Endoscopy</i> , 7, 37-41, 1998	No outcomes of interest reported
Heinrichs, W. L., Henzl, M. R., Human issues and medical economics of endometriosis. Three- vs. six-month GnRH-agonist therapy, <i>Journal of Reproductive Medicine</i> , 43, 299-308, 1998	Narrative review
Henzl, M. R., Monroe, S. E., Nafarelin: a new medical therapy for endometriosis, <i>Progress in clinical and biological research</i> , 323, 343-55, 1990	Study already included in Brown 2010 Cochrane review
Henzl, M. R., Corson, S. L., Moghissi, K., Buttram, V. C., Berqvist, C., Jacobson, J., Administration of nasal nafarelin as compared with oral danazol for endometriosis. A multicenter double-blind comparative clinical trial, <i>New England Journal of Medicine</i> , 318, 485-489, 1988	No outcomes of interest
Hornstein, M. D., Gleason, R. E., Barbieri, R. L., A randomized double-blind prospective trial of two doses of gestrinone in the treatment of endometriosis, <i>Fertility &amp; Sterility</i> , 53, 237-41, 1990	No relevant comparison (gestrinone is not available in the UK)

Study	Reason for Exclusion
Hornstein, M. D., Hemmings, R., Yuzpe, A. A., LeRoy Heinrichs, W., Use of nafarelin versus placebo after reductive laparoscopic surgery for endometriosis, <i>Fertility and sterility</i> , 68, 860-864, 1997	Included within Furness 2011 Cochrane review. Full text checked for any further outcomes before exclusion. No relevant outcomes were reported
Hornstein, M. D., Yuzpe, A. A., Burry, K. A., Heinrichs, L. R., Buttram, V. L., Jr., Orwoll, E. S., Prospective randomized double-blind trial of 3 versus 6 months of nafarelin therapy for endometriosis associated pelvic pain, <i>Fertility &amp; Sterility</i> , 63, 955-62, 1995	No relevant comparison (treatment duration)
Hornstein, M. D., Yuzpe, A. A., Burry, K. A., Heinrichs, L. R., Buttram, V. L., Orwoll, E. S., Prospective randomized double-blind trial of 3 versus 6 months of nafarelin therapy for endometriosis associated pelvic pain, <i>Fertility and sterility</i> , 63, 955-62, 1995	No relevant comparison (treatment duration)
Howard, F. M., An evidence-based medicine approach to the treatment of endometriosis-associated chronic pelvic pain: placebo-controlled studies, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 7, 477-88, 2000	Narrative review
Howell, R., Edmonds, D.K., Dowsett, M., Crook, D., Lees, B., Stevenson, J.C., Gonadotropin-releasing hormone analogue (goserelin) plus hormone replacement therapy for the treatment of endometriosis: a randomized controlled trial, <i>Fertility and Sterility</i> , 64, 474-481, 1995	Study adds no information to NMA network
Hurst, B. S., Gardner, S. C., Tucker, K. E., Awoniyi, C. A., Schlaff, W. D., Delayed oral estradiol combined with leuprolide increases endometriosis-related pain, <i>Journal of the Society of Laparoendoscopic Surgeons</i> , 4, 97-101, 2000	Sample size too small (N=13)
Irahara, M., Uemura, H., Yasui, T., Kinoshita, H., Yamada, M., Tezuka, M., Kiyokawa, M., Kamada, M., Aono, T., Efficacy of every-other-day administration of conjugated equine estrogen and medroxyprogesterone acetate on gonadotropin-releasing hormone agonists treatment in women with endometriosis, <i>Gynecologic &amp; Obstetric Investigation</i> , 52, 217-22, 2001	No outcomes of interest reported
Jacobs, L., Field, C., Thie, J., Coulam, C., Treatment of endometriosis with the GnRH agonist nafarelin acetate, <i>International journal of fertility</i> , 36, 30-5, 1991	No study sample size: < 10 participants
Jacobson, Tal Z., Duffy, M. N. James, Barlow, David H., Farquhar, Cindy, Koninckx, Philippe R., Olive, David, Laparoscopic surgery for subfertility associated with endometriosis, <i>Cochrane Database of Systematic Reviews</i> , 2014	This review has been replaced by a review entitled 'Laparoscopic surgery for endometriosis', published in issue 4 of The Cochrane Library, 2014
Jarrell, J., Mohindra, R., Ross, S., Taenzer, P., Brant, R., Laparoscopy and reported pain	Included in a systematic review which is already included (Duffy 2014)

Study	Reason for Exclusion
among patients with endometriosis, <i>Journal of Obstetrics &amp; Gynaecology Canada: JOGC</i> , 27, 477-85, 2005	
Jin, X., Ruiz Beguerie, J., Laparoscopic surgery for subfertility related to endometriosis: a meta-analysis, <i>Taiwanese Journal of Obstetrics &amp; Gynecology</i> , 53, 303-8, 2014	Systematic review of non-randomised studies
Jin, Y. B., Sun, Z. L., Jin, H. F., [Randomized controlled study on ear-electroacupuncture treatment of endometriosis-induced dysmenorrhea in patients], <i>Zhen ci yan jiu [Acupuncture research]</i> , 34, 188-92, 2009	Chinese language
Johnson, N. P., Farquhar, C. M., Crossley, S., Yu, Y., Van Peperstraten, A. M., Sprecher, M., Suckling, J., A double-blind randomised controlled trial of laparoscopic uterine nerve ablation for women with chronic pelvic pain, <i>BJOG: An International Journal of Obstetrics &amp; Gynaecology</i> , 111, 950-9, 2004	Population includes many women without endometriosis
Kauppila, A., Telimaa, S., Ronnberg, L., Vuori, J., Placebo-controlled study on serum concentrations of CA-125 before and after treatment of endometriosis with danazol or high-dose medroxyprogesterone acetate alone or after surgery, <i>Fertility &amp; Sterility</i> , 49, 37-41, 1988	No outcomes of interest reported
Kitade, M., Kikuchi, I., Kumakiri, J., Mastuoka, S., Takeda, S., An open-label, randomized, comparative study of the efficacy and safety of preoperative GnRH agonist therapy for laparoscopic myomectomy, <i>Gynecological Surgery</i> , 7, S87, 2010	Conference abstract: insufficient information
Kohler, G., Faustmann, T. A., Gerlinger, C., Seitz, C., Mueck, A. O., A dose-ranging study to determine the efficacy and safety of 1, 2, and 4mg of dienogest daily for endometriosis, <i>International journal of gynaecology and obstetrics</i> , 108, 21-5, 2010	No relevant comparison (dose comparison)
Lagana, A. S., Cucinella, G., Calagna, G., Pinelli, M., Adile, G., Perino, A., Granese, R., Control of symptoms relapse after conservative surgery for endometriosis: Advantages of using dienogest plus estradiol valerate, <i>Journal of Endometriosis</i> , 5, 2013	Data not reported for outcomes of interest
Lalchandani, S., Baxter, A., Phillips, K., Is helium thermal coagulator therapy for the treatment of women with minimal to moderate endometriosis cost-effective? A prospective randomised controlled trial, <i>Gynecological Surgery</i> , 2, 255-258, 2005	No outcomes of interest reported
Lalchandani, S., Baxter, A., Phillips, K., A prospective randomised comparison of laparoscopic treatment and treatment with gonadotrophin releasing hormone analogue in patients with mild to moderate endometriosis, <i>International Journal of Obstetrics &amp; Gynecology</i> , 83, 48, 2003	Preliminary report of Lalchandani 2005 (ID: 370702)

Study	Reason for Exclusion
Lee, D. Y., Lee, J. Y., Seo, J. W., Yoon, B. K., Choi, D., Gonadotropin-releasing hormone agonist with add-back treatment is as effective and tolerable as dienogest in preventing pain recurrence after laparoscopic surgery for endometriosis, <i>Archives of Gynecology &amp; Obstetrics</i> , 294, 1257-1263, 2016	Non-randomised trial
Lemay, A., Maheux, R., Huot, C., Blanchet, J., Faure, N., Efficacy of intranasal or subcutaneous luteinizing hormone-releasing hormone agonist inhibiting of ovarian function in the treatment of endometriosis, <i>American Journal of Obstetrics and Gynecology</i> , 158, 233-236, 1988	No relevant comparison (dose comparison)
Lewis, M., Baker, V., Nezhat, C., The impact on ovarian reserve after laparoscopic ovarian cystectomy versus three-stage management in patients with endometriomas: A prospective randomized study, <i>Fertility and sterility</i> , 94, e81-e82, 2010	Letter to editor
Li, L, Ceng, Y, Administration of mifepristone followed by laparoscopic surgery for ovarian endometriosis cyst: a 35 cases-clinical observation, <i>Matern Child Health Care Chin</i> , 22, 3446-7, 2007	Not a RCT
Li, Z., Zhang, H. Y., Zhu, Y. J., Hu, Y. J., Qu, P. P., A randomized study comparing the side effects and hormonal status of triptorelin and leuprorelin following conservative laparoscopic surgery for ovarian endometriosis in Chinese women, <i>European Journal of Obstetrics, Gynecology, and Reproductive Biology</i> , 183, 164-168, 2014	Comparison of pharmacological treatments after conservative surgery
Lim, P. S., Hasnur, C. H., Nirmala, K., Natasha, M. N., Oma, M. H., A pilot study: Short term danazol in adjunct with GnRH agonist to reduce flare ups for treatment of endometriosis, <i>Journal of obstetrics and gynaecology research</i> , 41, 2015	No outcomes of interest reported
Lindsay, P. C., Shaw, R. W., Bennink, H. J., Kicovic, P., The effect of add-back treatment with tibolone (Livial) on patients treated with the gonadotropin-releasing hormone agonist triptorelin (Decapeptyl), <i>Fertility &amp; Sterility</i> , 65, 342-8, 1996	No outcomes of interest
Loverro, G., Santillo, V., Pansini, M., Lorusso, F., Depalo, R., Selvaggi, L., Are GnRH agonists helpful in the therapy of endometriosis after surgical treatment?, <i>Human Reproduction (Oxford, England)</i> , 16, 96, 2001	Included within Furness 2011 Cochrane review. Full text (conference abstract) checked for any further relevant outcomes before exclusion.
Low, R. A., Roberts, A. D., Lees, D. A., A comparative study of various dosages of danazol in the treatment of endometriosis, <i>British Journal of Obstetrics &amp; Gynaecology</i> , 91, 167-71, 1984	No relevant comparison (dose comparison)
Lund, I., Lundeberg, T., Is acupuncture effective in the treatment of pain in endometriosis?, <i>Journal of Pain Research</i> , 9, 157-165, 2016	A narrative review

Study	Reason for Exclusion
Makarainen, L., Ronnberg, L., Kauppila, A., Medroxyprogesterone acetate supplementation diminishes the hypoestrogenic side effects of gonadotropin-releasing hormone agonist without changing its efficacy in endometriosis, <i>Fertility &amp; Sterility</i> , 65, 29-34, 1996	Relevant numerical data cannot be extracted (graphical and narrative representation)
Maouris, P., Pseudomenopause Treatment for Endometriosis: The Endocrine Effects of Danazol Compared with the use of the LH-RH Agonist Goserelin, <i>Journal of Obstetrics and Gynaecology</i> , 11, 123-7, 1991	No relevant outcomes reported
Marqui, A. B., Evaluation of endometriosis-associated pain and influence of conventional treatment: a systematic review, <i>Revista Da Associacao Medica Brasileira</i> , 61, 507-18, 2015	All studies included in study have already been assessed for inclusion/exclusion
Matta, W., Shaw, R., A comparative study between buserelin and danazol in the treatment of endometriosis, <i>British Journal of Clinical Practice</i> , 40, 69-72, 1988	No relevant outcomes reported
Meden-Vrtovec, H., Treatment of laparoscopically confirmed endometriosis with danazol, <i>British Journal of Clinical Practice</i> , 43, 161-6, 1989	Study not randomised
Medhurst, R, Endometriosis and its management using homeopathy, <i>Journal - Australian Traditional-Medicine Society</i> , 18, 155-6., 2012	Description of various herbs
Meissner, K., Schweizer-Arau, A., Limmer, A., Preibisch, C., Popovici, R. M., Lange, I., de Oriol, B., Beissner, F., Psychotherapy With Somatosensory Stimulation for Endometriosis-Associated Pain: A Randomized Controlled Trial, <i>Obstetrics &amp; Gynecology</i> , 128, 1134-1142, 2016	Not a specific generalizable intervention
Melin, A. S., Lundholm, C., Malki, N., Swahn, M. L., Sparen, P., Bergqvist, A., Hormonal and surgical treatments for endometriosis and risk of epithelial ovarian cancer, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 92, 546-54, 2013	Case-control study evaluating cancer risk
Mendes, C., Dias, L., Klajner, R., Montero, T., Pereira, M., Prevalence of the reduction of symptoms and endometriotic lesions in patients using dienogest 2 mg (continuous use) compared to other treatments for endometriosis, <i>International Journal of Gynecology and Obstetrics</i> , 131, E381, 2015	Systematic review - insufficient detail reported (conference abstract)
Mettler, L., Beteta, C., Alkatout, I., Salmassi, A., Prospective randomized controlled study (Canadian task force classification) on hormonal or operative therapy of endometriosis-who wins the battle, <i>Human Reproduction</i> , 29, 2014	Results for treatments not presented separately
Michalopoulos, G., Makris, V., Daniilidis, A., Sardeli, C., Dinas, K., Giannoulis, C., Loufopoulos, P. D., Surgical treatment of endometriosis, <i>Current Women's Health Reviews</i> , 8, 131-137, 2012	Narrative review

Study	Reason for Exclusion
Miller, J. D., Leuprolide acetate for the treatment of endometriosis, <i>Progress in Clinical &amp; Biological Research</i> , 323, 337-41, 1990	Insufficient numerical details of results reported
Miller, J. D., Quantification of endometriosis-associated pain and quality of life during the stimulatory phase of gonadotropin-releasing hormone agonist therapy: a double-blind, randomized, placebo-controlled trial, <i>American Journal of Obstetrics &amp; Gynecology</i> , 182, 1483-8, 2000	Outcome measurement period too short (4 weeks)
Minaguchi, H., Uemura, T., Shirasu, K., Clinical study on finding optimal dose of a potent LHRH agonist (buserelin) for the treatment of endometriosis--multicenter trial in Japan, <i>Progress in Clinical &amp; Biological Research</i> , 225, 211-25, 1986	No relevant comparison (dose comparison)
Moghissi, K. S., Corson, S. L., Buttram, V., Henzl, M. R., Evaluation of a GnRH Agonist (Nafarelin) versus Danazol for Treatment of Endometriosis, <i>Contributions to gynecology and obstetrics</i> , 16, 1987	Results not reported numerically. Non-validated pain scale used
Moghissi, K. S., Schlaff, W. D., Olive, D. L., Skinner, M. A., Yin, H., Goserelin acetate (Zoladex) with or without hormone replacement therapy for the treatment of endometriosis, <i>Fertility &amp; Sterility</i> , 69, 1056-62, 1998	Relevant numerical data cannot be extracted (graphical and narrative representation)
Montanino, G., Porpora, M. G., Montanino Oliva, M., Gulemi, L., Boninfante, M., Cosmi, E. V., Laparoscopic treatment of ovarian endometrioma. One year follow-up, <i>Clinical &amp; Experimental Obstetrics &amp; Gynecology</i> , 23, 70-2, 1996	Study not randomised
Moore, E. E., Harger, J. H., Rock, J. A., Archer, D. F., Management of pelvic endometriosis with low-dose danazol, <i>Fertility &amp; Sterility</i> , 36, 15-9, 1981	No relevant comparison (dose comparison)
Morgante, G., Ditto, A., La Marca, A., De Leo, V., Low-dose danazol after combined surgical and medical therapy reduces the incidence of pelvic pain in women with moderate and severe endometriosis, <i>Human Reproduction</i> , 14, 2371-4, 1999	Comparison of pharmacological treatments after laparoscopic surgery
Morita, M., Yano, Y., Sukegawa, Y., Ishizuka, J., Takita, M., The use of danazol in women with endometriosis-associated infertility and pain for laparoscopic surgery, <i>Gynaecological Endoscopy</i> , 6, 28, 1997	Insufficient details on patient characteristics
Moscarini, M., Milazzo, G. N., Assorgi, C., Pacchiarotti, A., Caserta, D., Ovarian stripping versus cystectomy: Recurrence of endometriosis and pregnancy rate, <i>Archives of gynecology and obstetrics</i> , 290, 163-7, 2014	Non-RCT
Mossa, B., Ebano, V., Tucci, S., Rega, C., Dolce, E., Frega, A., Marziani, R., Laparoscopic surgery for the management of ovarian endometriomas, <i>Medical Science Monitor</i> , 16, MT45-50, 2010	Two different laparoscopic excision techniques compared

Study	Reason for Exclusion
Moustafa, M. M., Elnasharty, M. A. A., Systematic review of the outcome associated with the different surgical treatment of bowel and rectovaginal endometriosis, <i>Gynecological Surgery</i> , 11, 37-52, 2014	Systematic review included non-randomised studies
Muneyyirci-Delale, O., Charles, C., Sinaii, N., Dalloul, M., Stratton, P., Improvement in endometriosis-related pelvic pain with leuprolide or norethindrone treatment, <i>Fertility and Sterility</i> , 1), e163-e164, 2015	Insufficient numerical details reported
Muzii, L., Achilli, C., Bergamini, V., Candiani, M., Garavaglia, E., Lazzeri, L., Lecce, F., Maiorana, A., Maneschi, F., Marana, R., Perandini, A., Porpora, M. G., Seracchioli, R., Spagnolo, E., Vignali, M., Benedetti Panici, P., Comparison between the stripping technique and the combined excisional/ablative technique for the treatment of bilateral ovarian endometriomas: a multicentre RCT, <i>Human Reproduction</i> , 31, 339-44, 2016	Mixed population - women have either pain or infertility. Results are not reported by subgroup
Muzii, L., Achilli, C., Bergamini, V., Candiani, M., Garavaglia, E., Lazzeri, L., Lecce, F., Maiorana, A., Maneschi, F., Marana, R., Perandini, A., Porpora, M. G., Seracchioli, R., Spagnolo, E., Vignali, M., Benedetti Panici, P., Comparison between the stripping technique and the combined excisional/ablative technique for the treatment of bilateral ovarian endometriomas: A multicentre RCT, <i>Human reproduction (Oxford, England)</i> , 31, 339-44, 2015	Too few women presenting with pain
Muzii, L., Bellati, F., Palaia, I., Plotti, F., Mancini, N., Zullo, M. A., Angioli, R., Panici, P. B., Laparoscopic stripping of endometriomas: a randomized trial on different surgical techniques. Part I: clinical results, <i>Human Reproduction</i> , 20, 1981-6, 2005	No outcomes of interest
Muzii, L., Di Tucci, C., Achilli, C., Di Donato, V., Musella, A., Palaia, I., Panici, P. B., Continuous versus cyclic oral contraceptives after laparoscopic excision of ovarian endometriomas: a systematic review and metaanalysis, <i>American Journal of Obstetrics &amp; Gynecology</i> , 214, 203-11, 2016	All studies included in study have already been assessed for inclusion/exclusion
Muzii, L., Maneschi, F., Marana, R., Porpora, M. G., Zupi, E., Bellati, F., Angioli, R., Benedetti Panici, P., Oral estroprogestins after laparoscopic surgery to excise endometriomas: continuous or cyclic administration? Results of a multicenter randomized study, <i>Journal of Minimally Invasive Gynecology</i> , 18, 173-8, 2011	Comparison of pharmacological treatments after laparoscopic surgery
Muzii, L., Marana, R., Caruana, P., Mancuso, S., The impact of preoperative gonadotropin-releasing hormone agonist treatment on laparoscopic excision of ovarian endometriotic cysts, <i>Fertility &amp; Sterility</i> , 65, 1235-7, 1996	Not a RCT
Nesbitt-Hawes, E. M., Campbell, N., Maley, P. E., Won, H., Hooshmand, D., Henry, A., Ledger,	Non-RCT

Study	Reason for Exclusion
W., Abbott, J. A., The Surgical Treatment of Severe Endometriosis Positively Affects the Chance of Natural or Assisted Pregnancy Postoperatively, BioMed Research International, 2015, 438790, 2015	
Nezhat, C. H., Nezhat, F., Borhan, S., Seidman, D. S., Nezhat, C. R., Is hormonal treatment efficacious in the management of ovarian cysts in women with histories of endometriosis?, Human Reproduction, 11, 874-7, 1996	Study only randomised for first 6 weeks - duration too short
Ng, J. W., Chwalisz, K., Carter, D., Williams, L. A., Klein, C. E., Dose-dependent suppression of gonadotropins and ovarian hormones by elagolix in healthy premenopausal females, Reproductive Sciences/Reprod Sci, 1), 330A-331A, 2016	No numerical details reported
Nieto, A., Tacuri, C., Serra, M., Keller, J., Cortes-Prieto, J., Long term follow-up of endometriosis after two different therapies (Gestrinone and Buserelin), Clinical and Experimental Obstetrics and Gynecology, 23, -204, 1996	Gestrinone not included in review protocol
Noble, A. D., Letchworth, A. T., Medical treatment of endometriosis: a comparative trial, Postgraduate Medical Journal, 55 Suppl 5, 37-9, 1979	Fertility only relevant outcome. Not all participants were infertile
Nowroozi, K., Chase, J. S., Check, J. H., Wu, C. H., The importance of laparoscopic coagulation of mild endometriosis in infertile women, International Journal of Fertility, 32, 442-4, 1987	No intervention of interest; effect of fulguration of endometriotic implants evaluated
Orwoll, E. S., Yuzpe, A. A., Burry, K. A., Heinrichs, L., Buttram, V. C., Jr., Hornstein, M. D., Nafarelin therapy in endometriosis: long-term effects on bone mineral density, American Journal of Obstetrics & Gynecology, 171, 1221-5, 1994	No relevant outcome
Pabuccu, Onalan, G., Goktolga, U., Kucuk, T., Orhon, E., Ceyhan, T., Aspiration of ovarian endometriomas before intracytoplasmic sperm injection, Fertility and sterility, 82, 705-11, 2004	Fertility treatment
Pabuccu, R., Onalan, G., Kaya, C., GnRH agonist and antagonist protocols for stage I-II endometriosis and endometrioma in in vitro fertilization/intracytoplasmic sperm injection cycles, Fertility and Sterility, 88, 832-839, 2007	Fertility treatment
Palagiano, A., Capuano, V., Medical treatment of endometriosis: Comparative study between leuprolide ac. and danazol. <ORIGINAL> TERAPIA MEDICA DELL'ENDOMETRIOSI: STUDIO COMPARATIVO FRA IL LEUPROLIDE ACETATO ED IL DANAZOLO, Minerva Ginecol, 46, 173-7, 1994	Study not in English. Details reported in Cochrane review
Parazzini, F., Ablation of lesions or no treatment in minimal-mild endometriosis in infertile women: a randomized trial. Gruppo Italiano per lo Studio dell'Endometriosi, Human Reproduction, 14, 1332-4, 1999	No intervention of interest; combined surgical treatments



Study	Reason for Exclusion
Park, H. J., Koo, Y. A., Yoon, B. K., Choi, D., Postoperative long-term maintenance therapy with oral contraceptives after gonadotropin-releasing hormone analog treatment in women with ovarian endometrioma, <i>Journal of Minimally Invasive Gynecology</i> , 16, 34-9, 2009	Retrospective study
Pattanittum, Porjai, Kunyanone, Naowarat, Brown, Julie, Sangkomkamhang, Ussanee S., Barnes, Joanne, Seyfoddin, Vahid, Marjoribanks, Jane, Dietary supplements for dysmenorrhoea, <i>Cochrane Database of Systematic Reviews</i> , 2016	Women do not have endometriosis
Pierce, S. J., Gazvani, M. R., Farquharson, R. G., Long-term use of gonadotropin-releasing hormone analogs and hormone replacement therapy in the management of endometriosis: a randomized trial with a 6-year follow-up, <i>Fertility &amp; Sterility</i> , 74, 964-8, 2000	Not a RCT ("partially randomized")
Radosa, M.P., Bernardi, T.S., Georgiev, I., Diebolder, H., Camara, O., Runnebaum, I.B., Coagulation versus excision of primary superficial endometriosis: a 2-year follow-up, <i>European Journal of Obstetrics Gynecology and Reproductive Biology</i> , 150, 195-198, 2010	Non-RCT
Regidor, P.A., Regidor, M., Schmidt, M., Ruwe, B., Lubben, G., Fortig, P., Kienle, E., Schindler, A.E., Prospective randomized study comparing the GnRH-agonist leuprorelin acetate and the gestagen lynestrenol in the treatment of severe endometriosis, <i>Gynecological Endocrinology</i> , 15, 202-209, 2001	Lynestrenol not included in review protocol
Rickes, D., Nickel, I., Kropf, S., Kleinstein, J., Increased pregnancy rates after ultralong postoperative therapy with gonadotropin-releasing hormone analogs in patients with endometriosis, <i>Fertility and Sterility</i> , 78, 757-762, 2002	No relevant comparison (post surgical hormonal treatment comparison)
Riley, K. A., Benton, A. S., Deimling, T. A., Kunselman, A. R., Harkins, G. J., Robotic surgical management of endometriosis: A prospective randomized trial, <i>Journal of Minimally Invasive Gynecology</i> , 23 (7 Supplement 1), S106, 2016	Abstract - insufficient details reported
Roghaei, M. A., Tehrani, H. G., Taherian, A., Koleini, N., Effects of Letrozole compared with Danazol on patients with confirmed endometriosis: A randomized clinical trial, <i>International Journal of Fertility and Sterility</i> , 4, 67-72, 2010	All women had cauterisation
Roghaei, M., Ghasemi Tehrani, H., Taherian, A. A., Comparing the effects of letrozole with danazole in patients with endometriosis: A randomized clinical trial, <i>Iranian Journal of Reproductive Medicine</i> , 8, 75-76, 2010	Insufficient numerical details reported
Roman, H., Huet, E., Bridoux, V., Khalil, H., Darai, E., Collinet, P., Tuech, J. J., Colorectal resection versus rectal conservative surgery in	No outcomes of interest

Study	Reason for Exclusion
the management of rectal endometriosis: Preliminary results-of endore randomized trial, Surgical Endoscopy and Other Interventional Techniques, 30, S25, 2016	
Roshni, P., Suneetha Susan Cleave, A., Suresh, P. K., Complementary and alternative medicine (CAM) therapies for management of pain related to endometriosis, International Research Journal of Pharmacy, 3, 30-34, 2012	A narrative review of various complementary and alternative medicines.
Rubi-Klein, K., Kucera-Sliutz, E., Nissel, H., Bijak, M., Stockenhuber, D., Fink, M., Wolkenstein, E., Is acupuncture in addition to conventional medicine effective as pain treatment for endometriosis? A randomised controlled cross-over trial, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 153, 90-3, 2010	Insufficient data reported for the inclusion in the review.
Scarpellini, F., Sbracia, M., Aromatase Inhibitor plus GnRH analogue in the treatment of patient with ovarian endometriosis recurrence after surgery: A controlled trial, Human ReproductionHum Reprod, 29, i11, 2014	Women given IVF
Schweizer-Arau, A., Popoici, R., Preibisch, C., Beissner, F., Meissner, K., Treatment of recurrent endometriosis induced pa in combing psychotherapy and acupuncture (SART ). First results from a randomized controlled study with follow-up, Journal of Endometriosis, 5, S21, 2013	Conference abstract
Schwertner, A., Conceicao Dos Santos, C. C., Costa, G. D., Deitos, A., De Souza, A., De Souza, I. C. C., Torres, I. L. S., Da Cunha Filho, J. S. L., Caumo, W., Efficacy of melatonin in the treatment of endometriosis: A phase II, randomized, double-blind, placebo-controlled trial, Pain, 154, 874-881, 2013	Not relevant comparison
Seiler, J.C., Gidwani, G., Ballard, L., Laparoscopic cauterization of endometriosis for fertility: a controlled study, Fertility and Sterility, 46, 1098-1100, 1986	No intervention of interest for this review
Seracchioli, R., Mabrouk, M., Manuzzi, L., Vicenzi, C., Frasca, C., Elmakky, A., Venturoli, S., Post-operative use of oral contraceptive pills for prevention of anatomical relapse or symptom-recurrence after conservative surgery for endometriosis, Human Reproduction, 24, 2729-35, 2009	Narrative systematic review. Included studies checked for relevance before exclusion.
Sesti, F., Capozzolo, T., Pietropolli, A., Bollea, M., Piccione, E., Postoperative dietary supplementation with omega-3 fatty acids and antioxidants after conservative surgery for symptomatic endometriosis, International Journal of Gynecology and Obstetrics, 107, S630, 2009	Conference abstract
Shaw, R., Garry, R., McMillan, L., Sutton, C., Wood, S., Harrison, R., Das, R., A prospective randomized open study comparing goserelin	The comparison is not relevant to the protocol

Study	Reason for Exclusion
(Zoladex) plus surgery and surgery alone in the management of ovarian endometriomas, <i>Gynaecological Endoscopy</i> , 10, 151-7, 2001	
Shaw,R.W., Matta,W., Reversible pituitary ovarian suppression induced by an LHRH agonist in the treatment of endometriosis--comparison of two dose regimens, <i>Clinical Reproduction and Fertility</i> , 4, 329-336, 1986	No relevant comparison (dose comparison)
Shawki, O., Hamza, H., Sattar, M., Mild endometriosis, to treat or not treat: randomized controlled trial comparing diagnostic laparoscopy with no further treatment versus post-operative Zoladex in cases with infertility associated with stage I, II endometriosis, <i>Fertility and sterility</i> , 77, S13, 2002	Relevant outcomes reported in NMA
Shohayeb, A., Wahba, A., Abousetta, A., Al-inany, H., Is dienogest effective in postoperative management of endometriosis compared to GnRH a, <i>Human Reproduction</i> , 28, 2013	Conference abstract: insufficient information
Sillem, M., Parviz, M., Woitge, H. W., Kiesel, L., Ulrich, U., von Holst, T., Runnebaum, B., Ziegler, R., Seibel, M. J., Add-back medrogestone does not prevent bone loss in premenopausal women treated with goserelin, <i>Experimental &amp; Clinical Endocrinology &amp; Diabetes</i> , 107, 379-85, 1999	No outcomes of interest reported
Skrzypulec, V., Walaszek, A., Drosdzol, A., Nowosielski, K., Piela, B., Rozmus-Warcholinska, W., Influence of GnRH analogue on the intensification of endometriosis symptoms and infertility treatment. [Polish], <i>Wiadomosci lekarskie (Warsaw, Poland : 1960)</i> 57, 301-4, 2004	Study not in English
Smith, Caroline A., Armour, Mike, Zhu, Xiaoshu, Li, Xun, Lu, Yong Zhi, Song, Jing, Acupuncture for dysmenorrhoea, <i>Cochrane Database of Systematic Reviews</i> , 2016	Women do not have endometriosis
Soong,Y.K., Chang,F.H., Chou,H.H., Chang,M.Y., Lee,C.L., Lai,Y.M., Chang,S.Y., Life table analysis of pregnancy rates in women with moderate or severe endometriosis comparing danazol therapy after carbon dioxide laser laparoscopy plus electrocoagulation or laparotomy plus electrocoagulation versus danazol therapy only, <i>Journal of the American Association of Gynecologic Laparoscopists</i> , 4, 225-230, 1997	Study reported estimated cumulative pregnancy rates
Soysal,S., Soysal,M.E., Ozer,S., Gul,N., Gezgin,T., The effects of post-surgical administration of goserelin plus anastrozole compared to goserelin alone in patients with severe endometriosis: a prospective randomized trial, <i>Human Reproduction</i> , 19, 160-167, 2004	Comparison of pharmacological treatments after surgery
Stones, R. W., Mountfield, J., Interventions for treating chronic pelvic pain in women, <i>Cochrane Database of Systematic Reviews</i> , CD000387, 2000	Women with chronic pelvic pain with a diagnosis of pelvic congestion syndrome and not endometriosis.

Study	Reason for Exclusion
Stratton, P., Sinaii, N., Segars, J., Koziol, D., Wesley, R., Zimmer, C., Winkel, C., Nieman, L. K., Return of chronic pelvic pain from endometriosis after raloxifene treatment: a randomized controlled trial, <i>Obstetrics &amp; Gynecology</i> , 111, 88-96, 2008	Intervention (raloxifene) is not relevant to the protocol and provides no additional information
Strowitzki, T., Faustmann, T., Gerlinger, C., Schumacher, U., Ahlers, C., Seitz, C., Safety and tolerability of dienogest in endometriosis: pooled analysis from the European clinical study program, <i>International Journal of Women's Health</i> , 7, 393-401, 2015	Dienogest not included in review protocol
Strowitzki, T., Marr, J., Gerlinger, C., Faustmann, T., Seitz, C., Detailed analysis of a randomized, multicenter, comparative trial of dienogest versus leuprolide acetate in endometriosis, <i>International Journal of Gynaecology &amp; Obstetrics</i> , 117, 228-33, 2012	Relevant numerical data cannot be extracted (graphical and narrative representation)
Sun, Y. Z., Chen, H. L., [Controlled study on Shu-Mu point combination for treatment of endometriosis], <i>Zhongguo zhen jiu [Chinese acupuncture &amp; moxibustion]</i> , 26, 863-5, 2006	Chinese language
Surrey, E. S., Hornstein, M. D., Prolonged GnRH agonist and add-back therapy for symptomatic endometriosis: long-term follow-up, <i>Obstetrics &amp; Gynecology</i> , 99, 709-19, 2002	No outcomes of interest
Surrey, E. S., Judd, H. L., Reduction of vasomotor symptoms and bone mineral density loss with combined norethindrone and long-acting gonadotropin-releasing hormone agonist therapy of symptomatic endometriosis: a prospective randomized trial, <i>Journal of Clinical Endocrinology &amp; Metabolism</i> , 75, 558-63, 1992	No relevant outcomes reported
Surrey, E.S., Silverberg, K.M., Surrey, M.W., Schoolcraft, W.B., Effect of prolonged gonadotropin-releasing hormone agonist therapy on the outcome of in vitro fertilization-embryo transfer in patients with endometriosis, <i>Fertility and Sterility</i> , 78, 699-704, 2002	All participants had IVF treatment
Sutton, C. J., Pooley, A. S., Ewen, S. P., Haines, P., Follow-up report on a randomized controlled trial of laser laparoscopy in the treatment of pelvic pain associated with minimal to moderate endometriosis, <i>Fertility &amp; Sterility</i> , 68, 1070-4, 1997	Included in a systematic review which is already included (Duffy 2014)
Tahara, M., Matsuoka, T., Yokoi, T., Tasaka, K., Kurachi, H., Murata, Y., Treatment of endometriosis with a decreasing dosage of a gonadotropin-releasing hormone agonist (nafarelin): a pilot study with low-dose agonist therapy ("draw-back" therapy), <i>Fertility &amp; Sterility</i> , 73, 799-804, 2000	No relevant comparison
Takaesu, Y. Nishi H. Sasaki T. Kojima J. Sagawa Y. Isaka K., Dienogest compared with gonadotrophin-releasing hormone agonist after conservative surgery for endometriosis: A	Not an RCT

Study	Reason for Exclusion
randomized controlled trial, Journal of Minimally Invasive Gynecology, 20 Suppl 1, S28, 2013	
Takaesu, Y., Nishi, H., Kojima, J., Sasaki, T., Nagamitsu, Y., Kato, R., Isaka, K., Dienogest compared with gonadotropin-releasing hormone agonist after conservative surgery for endometriosis, Journal of Obstetrics and Gynaecology Research, 42, 1152-1158, 2016	Dienogest was not the drug of interest
Takenaka, M., Yano, R., Hiraku, Y., Shibata, M., Hatano, K., Yamamoto, S., Sato, K., Yamamoto, K., Morishige, K. I., Exploratory study of pre-surgical medications with dienogest or leuprorelin in laparoscopic cystectomy of endometrial cysts, Journal of obstetrics and gynaecology research, 41, 1234-1239, 2015	Not included in NMA; Comparison of pharmacological treatments before surgery
Tanmahasamut, P., Rattanachaiyanont, M., Angsuwathana, S., Techatrasak, K., Indhavivadhana, S., Leerasiri, P., Postoperative levonorgestrel-releasing intrauterine system for pelvic endometriosis-related pain: a randomized controlled trial, Obstetrics & Gynecology, 119, 519-26, 2012	No relevant comparison (post surgical hormonal treatment comparison)
Taskin, O., Yalcinoglu, A. I., Kucuk, S., Uryan, I., Buhur, A., Burak, F., Effectiveness of tibolone on hypoestrogenic symptoms induced by goserelin treatment in patients with endometriosis, Fertility and Sterility, 67, 40-45, 1997	No relevant outcomes
Telimaa, S., Danazol and medroxyprogesterone acetate ineffective in the treatment of infertility in endometriosis, Fertility & Sterility, 50, 872-5, 1988	N<10 and surgery pharma / pharma alone results not presented separately
Telimaa, S., Apter, D., Reinila, M., Ronnberg, L., Kauppila, A., Placebo-controlled comparison of hormonal and biochemical effects of danazol and high-dose medroxyprogesterone acetate, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 36, 97-105, 1990	No outcomes of interest reported
Telimaa, S., Ronnberg, L., Kauppila, A., Placebo-controlled comparison of danazol and high-dose medroxyprogesterone acetate in the treatment of endometriosis after conservative surgery, Gynecological Endocrinology, 1, 363-71, 1987	No relevant outcomes reported
Thomas, E. J., Cooke, I. D., Impact of gestrinone on the course of asymptomatic endometriosis, British Medical Journal Clinical Research Ed., 294, 272-4, 1987	Comparison is not relevant (gestrinone); Study not included in NMA
Thomassen, H., Berthelsen, H. G., Treatment of endometriosis with progestogens, Danish Medical Bulletin, 13, 33-5, 1966	Study not randomised
Tsai, Y. L., Hwang, J. L., Loo, T. C., Cheng, W. C., Chuang, J., Seow, K. M., Short-term postoperative GnRH analogue or danazol treatment after conservative surgery for stage III or IV endometriosis before ovarian stimulation: a prospective, randomized study, Journal of Reproductive Medicine, 49, 955-959, 2004	Patients are undergoing ovarian stimulation

Study	Reason for Exclusion
Tummon, I. S., Ali, A., Pepping, M. E., Radwanska, E., Binor, Z., Dmowski, W. P., Bone mineral density in women with endometriosis before and during ovarian suppression with gonadotropin-releasing hormone agonists or danazol, <i>Fertility &amp; Sterility</i> , 49, 792-6, 1988	No relevant outcomes reported
Tummon, I.S., Pepping, M.E., Binor, Z., Radwanska, E., Dmowski, W.P., A randomized, prospective comparison of endocrine changes induced with intranasal leuprolide or danazol for treatment of endometriosis, <i>Fertility and Sterility</i> , 51, 390-394, 1989	N = 15 (too small for inclusion)
Var, T., Batioglu, S., Tonguc, E., Kahyaoglu, I., The effect of laparoscopic ovarian cystectomy versus coagulation in bilateral endometriomas on ovarian reserve as determined by antral follicle count and ovarian volume: a prospective randomized study, <i>Fertility and Sterility</i> , 95, 2247-2250, 2011	No relevant outcomes
Vercellini, P., Chapron, C., De Giorgi, O., Consonni, D., Frontino, G., Crosignani, P. G., Coagulation or excision of ovarian endometriomas?, <i>American Journal of Obstetrics &amp; Gynecology</i> , 188, 606-10, 2003	Systematic includes non-randomised studies
Vercellini, P., Crosignani, P. G., Fadini, R., Radici, E., Belloni, C., Sismondi, P., A gonadotrophin-releasing hormone agonist compared with expectant management after conservative surgery for symptomatic endometriosis, <i>British Journal of Obstetrics &amp; Gynaecology</i> , 106, 672-7, 1999	No relevant comparison (post surgical hormonal treatment comparison)
Vercellini, P., Crosignani, P. G., Somigliana, E., Berlanda, N., Barbara, G., Fedele, L., Medical treatment for rectovaginal endometriosis: what is the evidence?, <i>Human Reproduction</i> , 24, 2504-14, 2009	Systematic review – included studies checked for relevance
Vercellini, P., D. E. Matteis S, Somigliana, E., Buggio, L., Frattaruolo, M. P., Fedele, L., Long-term adjuvant therapy for the prevention of postoperative endometrioma recurrence: a systematic review and meta-analysis, <i>Acta Obstetrica et Gynecologica Scandinavica</i> , 92, 8-16, 2013	Systematic review - relevant RCTs already included/excluded
Vercellini, P., De Giorgi, O., Mosconi, P., Stellato, G., Vicentini, S., Crosignani, P. G., Cyproterone acetate versus a continuous monophasic oral contraceptive in the treatment of recurrent pelvic pain after conservative surgery for symptomatic endometriosis, <i>Fertility &amp; Sterility</i> , 77, 52-61, 2002	Cyproterone acetate is not listed in the BNF
Vercellini, P., Frattaruolo, M. P., Somigliana, E., Jones, G. L., Consonni, D., Alberico, D., Fedele, L., Surgical versus low-dose progestin treatment for endometriosis-associated severe deep dyspareunia II: effect on sexual functioning, psychological status and health-related quality of life, <i>Human Reproduction</i> , 28, 1221-30, 2013	Non-RCT

Study	Reason for Exclusion
Vercellini, P., Frontino, G., De Giorgi, O., Aimi, G., Zaina, B., Crosignani, P. G., Comparison of a levonorgestrel-releasing intrauterine device versus expectant management after conservative surgery for symptomatic endometriosis: a pilot study, <i>Fertility &amp; Sterility</i> , 80, 305-9, 2003	No relevant comparison (post surgical hormonal treatment comparison)
Vercellini, P., Pietropaolo, G., De Giorgi, O., Pasin, R., Chiodini, A., Crosignani, P. G., Treatment of symptomatic rectovaginal endometriosis with an estrogen-progestogen combination versus low-dose norethindrone acetate, <i>Fertility &amp; Sterility</i> , 84, 1375-87, 2005	Hormonal formulation not used in clinical practice. Population has post-surgical pain
Vercellini, P., Somigliana, E., Consonni, D., Frattaruolo, M. P., De Giorgi, O., Fedele, L., Surgical versus medical treatment for endometriosis-associated severe deep dyspareunia: I. Effect on pain during intercourse and patient satisfaction, <i>Human Reproduction</i> , 27, 3450-9, 2012	Not a RCT
Vercellini, P., Somigliana, E., Vigano, P., De Matteis, S., Barbara, G., Fedele, L., Post-operative endometriosis recurrence: a plea for prevention based on pathogenetic, epidemiological and clinical evidence, <i>Reproductive Biomedicine Online</i> , 21, 259-65, 2010	Review
Vercellini, P., Trespidi, L., Colombo, A., Vendola, N., Marchini, M., Crosignani, P. G., A gonadotropin-releasing hormone agonist versus a low-dose oral contraceptive for pelvic pain associated with endometriosis, <i>Fertility and Sterility</i> , 60, 75-79, 1993	Study already included in Davis 2007 systematic review
Vercellini, P., Trespidi, L., Panazza, S., Bramante, T., Mauro, F., Crosignani, P. G., Very low dose danazol for relief of endometriosis-associated pelvic pain: A pilot study, <i>Fertility and Sterility</i> , 62, 1136-1142, 1994	Very low dose of danazol not used in practice
Weng, Q., Ding, Z. M., Lv, X. L., Yang, D. X., Song, Y. Z., Wang, F. F., Ye, Y. H., Qu, F., Chinese medicinal plants for advanced endometriosis after conservative surgery: a prospective, multi-center and controlled trial, <i>International journal of clinical and experimental medicine</i> , 8, 11307-11, 2015	No relevant outcomes reported
Wheeler, J. M., Knittle, J. D., Miller, J. D., Depot leuprolide versus danazol in treatment of women with symptomatic endometriosis. I. Efficacy results, <i>American Journal of Obstetrics &amp; Gynecology</i> , 167, 1367-71, 1992	Other study (Wheeler 1993) detailing this RCT has been included already
Whitehouse, R. W., Adams, J. E., Bancroft, K., Vaughan-Williams, C. A., Elstein, M., The effects of nafarelin and danazol on vertebral trabecular bone mass in patients with endometriosis, <i>Clinical Endocrinology</i> , 33, 365-73, 1990	No outcomes of interest reported
Whitelaw, N., Haines, P., Ewen, S., Sutton, C., Assessing the efficacy of laser laparoscopy in	Insufficient study/participant details provided

Study	Reason for Exclusion
the treatment of endometriosis, Journal of obstetrics and gynaecology, 13, 486, 1993	
Winkel,C.A., Scialli,A.R., Medical and surgical therapies for pain associated with endometriosis, Journal of Women's Health and Gender-Based Medicine, 10, 137-Based, 2001	Review
Witt, C. M., A pilot study testing the feasibility of Japanese-style acupuncture for endometriosis-related pelvic pain in adolescents and young women, Focus on Alternative and Complementary Therapies, 14, 36-37, 2009	Insufficient information to extract data
Wong, A. Y., Tang, L., An open and randomized study comparing the efficacy of standard danazol and modified triptorelin regimens for postoperative disease management of moderate to severe endometriosis, Fertility & Sterility, 81, 1522-7, 2004	No relevant comparison (post surgical hormonal treatment comparison)
Worthington,M., Irvine,L.M., Crook,D., Lees,B., Shaw,R.W., Stevenson,J.C., A randomized comparative study of the metabolic effects of two regimens of gestrinone in the treatment of endometriosis, Fertility and Sterility, 59, 522-526, 1993	No relevant comparison (dose comparison)
Wright,S., Valdes,C.T., Dunn,R.C., Franklin,R.R., Short-term Lupron or danazol therapy for pelvic endometriosis, Fertility and Sterility, 63, 504-507, 1995	No relevant outcomes reported
Yang, D. X., Ma, W. G., Qu, F., Ma, B. Z., Comparative study on the efficacy of Yiweining and Gestrinone for post-operational treatment of stage III endometriosis, Chinese Journal of Integrative Medicine, 12, 218-20, 2006	No relevant comparison (post surgical hormonal treatment comparison); Not included in NMA
Yang, Y., Zhao, R., Hao, Z., Li, L., Xu, C., Cui, Y., Effects of danchi decoction on P450arom, survivin of eutopic endometrium of patients with endometriosis after conservative surgery, African Journal of Traditional, Complementary and Alternative Medicines, 12, 65-71, 2015	No outcomes of interest
Yeung, P., Jr., Tu, F., Bajzak, K., Lamvu, G., Guzovsky, O., Agnelli, R., Peavey, M., Winer, W., Albee, R., Sinervo, K., A pilot feasibility multicenter study of patients after excision of endometriosis, Journal of the Society of Laparoendoscopic Surgeons, 17, 88-94, 2013	Non-comparative study
Zhang, Y. X., Effect of mifepristone in the different treatments of endometriosis, Clinical and experimental obstetrics & gynecology, 43, 350-3, 2016	Study uses mifepristone (antiprogestogen) which the Committee were not interested in making recommendations and does not provide indirect evidence in the NMA
Zhao, R. H., Hao, Z. P., Zhang, Y., Lian, F. M., Sun, W. W., Liu, Y., Wang, R., Long, L., Cheng, L., Ding, Y. F., Song, D. R., Meng, Q. W., Wang, A. M., Controlling the recurrence of pelvic endometriosis after a conservative operation: comparison between Chinese herbal medicine and western medicine, Chinese Journal of Integrative Medicine, 19, 820-5, 2013	No relevant comparison (post surgical treatment comparison); Not included in NMA



Study	Reason for Exclusion
Zhao, R. H., Liu, Y., Tan, Y., Hao, Z. P., Meng, Q. W., Wang, R., Long, D., Ding, Y. F., Song, D. R., Xu, C., Ren, Z. Z., Yang, Y. H., Wang, A. M., Chinese medicine improves postoperative quality of life in endometriosis patients: a randomized controlled trial, Chinese Journal of Integrative Medicine, 19, 15-21, 2013	One comparison group was administered GnRHa or gestrinone. Gestrinone is not available in the UK.
Zhao, S. Z., Kellerman, L. A., Francisco, C. A., Wong, J. M., Impact of nafarelin and leuprolide for endometriosis on quality of life and subjective clinical measures, Journal of Reproductive Medicine, 44, 1000-6, 1999	QoL scale not validated; No other outcomes of interest
Zheng, Q., Mao, H., Xu, Y., Zhao, J., Wei, X., Liu, P., Can postoperative GnRH agonist treatment prevent endometriosis recurrence? A meta-analysis, Archives of gynecology and obstetrics, 294, 201-207, 2016	All studies included in study have already been assessed for inclusion/exclusion
Zhu, X., Hamilton, K. D., McNicol, E. D., Acupuncture for pain in endometriosis, Cochrane Database of Systematic Reviews, CD007864, 2011	Paper from this review included in the review.
Zou, S., Long, Q., Zhang, S., Han, Y., Zhang, W., Oral continuous combined 0.5 mg estradiol valerate and 5 mg dydrogesterone as daily add-back therapy during post-operative GnRH agonist treatment for endometriosis in Chinese women, International journal of clinical and experimental medicine, 6, 67-73, 2013	No outcomes of interest
Zullo, F., Venturella, R., Mocciaro, R., Cappiello, F., Morelli, M., Letrozole vs. Clomiphene citrate plus IUI for women recently surgically treated for severe or recurrent endometriosis: A randomized controlled trial, Journal of Minimally Invasive Gynecology, 19 Suppl 1, S48, 2012	Conference abstract: insufficient information
Zupi, E., Marconi, D., Sbracia, M., Zullo, F., De Vivo, B., Exacustos, C., Sorrenti, G., Add-back therapy in the treatment of endometriosis-associated pain, Fertility & Sterility, 82, 1303-8, 2004	No relevant comparison (post surgical hormonal treatment comparison); Not included in NMA

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## H.16 Hysterectomy with or without oophorectomy

Reference	Reason for exclusion
Anonymous, ACOG criteria set. Quality evaluation and improvement in practice: Abdominal hysterectomy with or without adnexectomy for endometriosis. Number 27, October 1997. Committee on Quality Assessment. American College of Obstetricians and Gynecologists, International Journal of Gynaecology & Obstetrics, 60, 92-3, 1998	Questionnaire/criteria for hysterectomy for women with endometriosis
Baig, S., Lyons, T. L., Stepanian, A. A., 12 Year follow up of 1000 laparoscopic supracervical hysterectomies at a single center, Journal of Minimally Invasive Gynecology, 1), S160, 2010	There was no information about population (e.g., age), all women underwent laparoscopic supracervical hysterectomy, no comparator group

Reference	Reason for exclusion
Bedaiwy, M. A., Abdel Rahman, M. Y., Chapman, M., Frasure, H., Mahajan, S., von Gruenigen, V. E., Hurd, W., Zanutti, K., Robotic-assisted hysterectomy for the management of severe endometriosis: A retrospective review of short-term surgical outcomes, <i>Journal of the Society of Laparoendoscopic Surgeons</i> , 17, 95-99, 2013	The comparison was hysterectomy plus unilateral or hysterectomy plus bilateral oophorectomy. This did not meet the PICO for the review protocol.
Brudie, L. A., Gaia, G., Ahmad, S., Finkler, N. J., Bigsby, G. E. th, Ghurani, G. B., Kendrick, J. E. th, Rakowski, J. A., Groton, J. H., Holloway, R. W., Peri-operative outcomes of patients with stage IV endometriosis undergoing robotic-assisted laparoscopic surgery, <i>Journal of Robotic Surgery</i> , 6, 317-22, 2012	Results are not provided for hysterectomy separately from hysterectomy oophorectomy.
Centre for Reviews and Dissemination, Surgical management of endometriosis (Structured abstract), <i>Database of Abstracts of Reviews of Effects</i> , 2015	Structured abstract and commentary from DARE. Original review was 346981, which was excluded.
Chalermchockchareonkit, A., Tekasakul, P., Chaisilwattana, P., Sirimai, K., Wahab, N., Laparoscopic hysterectomy versus abdominal hysterectomy for severe pelvic endometriosis, <i>International Journal of Gynecology and Obstetrics</i> , 116, 109-111, 2012	Study investigated laparoscopic hysterectomy vs abdominal hysterectomy for severe pelvic endometriosis, but no indication of oophorectomy in either group. Did not meet PICO
Chandakas, S., Hill, N., Erian, J., A multicentered series of over 1000 laparoscopic subtotal hysterectomies in the UK and Greece: The new approach to hysterectomy, <i>Gynecological Surgery</i> , 6, S187-S188, 2009	Abstract did not provide all data for outcomes, only 21% of the population had endometriosis. Authors were investigating the efficacy of laparoscopic subtotal hysterectomy, no comparison group
Chien, H., Matsumoto, T., Saeki, A., Oku, H., Total laparoscopic retrograde hysterectomy for extensive endometriosis with complete obliteration of the posterior cul-de-sac, <i>Journal of Minimally Invasive Gynecology</i> , 1), S99-S100, 2012	The study investigated the use of different techniques for total laparoscopic hysterectomy.
Chu, C. M., Chang-Jackson, S. C., Nezhat, F. R., Retrospective study assessing laparoscopic versus robotic assisted laparoscopic treatment of severe endometriosis, <i>Journal of Minimally Invasive Gynecology</i> , 1), S101, 2011	Two different technologies were compared for hysterectomy but individual treatment groups not reported
Clayton, R. D., Hawe, J. A., Love, J. C., Wilkinson, N., Garry, R., Recurrent pain after hysterectomy and bilateral salpingo-oophorectomy for endometriosis: Evaluation of laparoscopic excision of residual endometriosis, <i>British Journal of Obstetrics and Gynaecology</i> , 106, 740-744, 1999	5 consecutive women who had undergone hysterectomy and bilateral oophorectomy (without symptom relief) prior to start of study. They were then managed by laparoscopic excision of residual endometriosis.
Coronado, C., Franklin, R. R., Lotze, E. C., Bailey, H. R., Valdes, C. T., Surgical treatment of symptomatic colorectal endometriosis, <i>Fertility and Sterility</i> , 53, 411-416, 1990	The intervention investigated in the study was full thickness resection of the colon for the treatment of deep colorectal endometriosis. Also, the study design did not match the protocol
Dave, A., Dabelea, V., Intraoperative and immediate postoperative outcomes after robotic hysterectomy in a community hospital: A review of 78 consecutive cases, <i>Journal of Minimally Invasive Gynecology</i> , 1), S205-S206, 2014	This study was not a comparative study (case series)

Reference	Reason for exclusion
Duffy, M. N. James, Arambage, Kirana, Correa, J. S. Frederico, Olive, David, Farquhar, Cindy, Garry, Ray, Barlow, David H., Jacobson, Tal Z., Laparoscopic surgery for endometriosis, Cochrane Database of Systematic Reviews, 2014	Interventions of interest were not included in the Cochrane review.
Jihad, D., Fritz, J., Outcome of total laparoscopic hysterectomy, Gynecological Surgery, 8, S137, 2011	Only investigated the safety of total laparoscopic hysterectomy in majority cases of uterine leiomyomas (51%), adenomyosis (15%), endometrial hyperplasia (13%), intraepithelial neoplasia (12%), and endometrial polyps (7%).
Johnson, N., Endometriosis, Clinical Evidence, 2326-39, 2005	This review did not include studies that matched the PICO of the protocol for our review
Kayani, S. I., Pundir, J., Omanwa, K., Quality of life after total laparoscopic hysterectomy: a one-year follow-up study, Minerva Ginecologica, 68, 412-7, 2016	Hysterectomy for benign conditions. Not specifically endometriosis.
Lieng, M., Lomo, A. B., Qvigstad, E., Long-term outcomes following laparoscopic and abdominal supracervical hysterectomies, Obstetrics & Gynecology International, 2010, 989127, 2010	The study compared laparoscopic and abdominal supracervical hysterectomy, no indication of oophorectomy in either group.
Lieng, M., Qvigstad, E., Istre, O., Langebrekke, A., Ballard, K., Long-term outcomes following laparoscopic supracervical hysterectomy, BJOG: An International Journal of Obstetrics and Gynaecology, 115, 1605-1610, 2008	All women in the study had laparoscopic supracervical hysterectomy (no oophorectomy group)
MacDonald, S. R., Klock, S. C., Milad, M. P., Long-term outcome of nonconservative surgery (hysterectomy) for endometriosis-associated pain in women <30 years old, American Journal of Obstetrics & Gynecology, 180, 1360-3, 1999	Comparison groups were not of interest (hysterectomy stratified by age)
Maher, P. J., Wood, E. C., Hill, D. J., Lolatgis, N. A., Laparoscopically assisted hysterectomy, Medical Journal of Australia, 156, 316-8, 1992	Only 17 participants in the study, with only one intervention (laparoscopic hysterectomy). Only one participant had endometriosis.
Malhas, R., Cole, J., Kumar, M., Outcome of laparoscopic hysterectomy in the UK: A retrospective study, BJOG: An International Journal of Obstetrics and Gynaecology, 121, 49, 2014	Unclear if women had endometriosis. Two women had total abdominal hysterectomy, and majority of women had laparoscopic hysterectomy.
Marqueta, L., Munoz, L., Tejerizo, A., Lopez, G., Lorenzo, E., Munoz, J. L., Jimenez, J. S., Multidisciplinary approach in the management of deep infiltrating endometriosis. 5 years follow up, Journal of Minimally Invasive Gynecology, 1), S126, 2012	Only one woman had hysterectomy only out of 92 patients.
Martin, D. C., Hysterectomy for treatment of pain associated with endometriosis, Journal of Minimally Invasive Gynecology, 13, 566-72, 2006	Narrative review
McCoubrey, A., Hunter, D., Khosraviani, K., Surgical management of recto-sigmoidal endometriosis, Gynecological Surgery, 1), S52-S53, 2012	Only 18 women total in study, there were no comparison groups.
McNamee, K. M., Anagnostopoulos, A., McCormack, J., Hawe, J., Total and subtotal laparoscopic hysterectomy can safely reduce	Cases in the study were of mixed ages (26-85years), without subgroups. Only 20% of the

Reference	Reason for exclusion
total abdominal hysterectomy rates, BJOG: An International Journal of Obstetrics and Gynaecology, 120, 397-398, 2013	cases had endometriosis, without any subgroup data.
Mehra, G., Hotchandani, M., Khatri, I. B., Verma, M., Mehra, S., Surgical complications of laparoscopic hysterectomy-a review of large single-centre series in India, BJOG: An International Journal of Obstetrics and Gynaecology, 121, 67, 2014	Population was not stratified according to condition, intervention was laparoscopic hysterectomy, no comparator group.
Mills, C. W., Abdominal Hysterectomy--Indications and Technique, The Journal of abdominal surgery, 31, 37-40, 1964	Narrative review of abdominal hysterectomy technique
Mills, W. G., Endometriosis, Nursing Times, 61, 9-11, 1965	Narrative review of endometriosis followed by description of three individual cases.
Miranda,C.S., Carvajal,A.R., Complications of operative gynecological laparoscopy, Journal of the Society of Laparoendoscopic Surgeons, 7, 53-58, 2003	Study design did not match the PICO for the review
Miranda,C.S., Carvajal,A.R., Escobar,P., Complications of operative laparoscopy, Gynaecological Endoscopy, 9, 161-165, 2000	Study design did not meet the PICO for the review protocol
Mohan, S., Crouch, N., Amin, T., Chilcott, I., Watson, N., Kothari, A., Outcomes of laparoscopic hysterectomy-at introduction and 3 years, Gynecological Surgery, 8, S138, 2011	Study investigated women who had laparoscopic hysterectomy only. No other comparator group.
Murtada, R., Meza, C., Centini, G., Castellano, J., Afors, K., Wattiez, A., Long-term outcomes after hysterectomy for pelvic pain attributed to endometriosis, Gynecological Surgery, 1), 102-103, 2014	No information about intervention/comparator was reported.
Nathorst-Boos, J., Fuchs, T., von Schoultz, B., Consumer's attitude to hysterectomy. The experience of 678 women, Acta Obstetrica et Gynecologica Scandinavica, 71, 230-4, 1992	Unclear about which group had hysterectomy plus oophorectomy.
Nezhat, C., Kho, K., Robot-assisted laparoscopic hysterectomy utilizing the 5 mm daVinci system, Journal of Minimally Invasive Gynecology, 1), S36, 2010	Study looked at the daVinci system (robotic-assisted laparoscopic hysterectomy)
Nezhat, F., Mahdavi, A., Nagarsheth, N. P., Total laparoscopic radical hysterectomy and pelvic lymphadenectomy using harmonic shears, Journal of Minimally Invasive Gynecology, 13, 20-25, 2006	Intervention did not match the protocol for our review. There was no comparator group, Only one patient out of 7 had endometriosis
Niblock, K., Johnston, K., Morgan, D., McCracken, G., A review of major complications associated with 832 operative gynaecological laparoscopies, Gynecological Surgery, 1), S1-S2, 2012	Only 16% of the cases had laparoscopic excisions for endometriosis, and did not include the comparisons for our review
Nichols, P., Miligkos, D., Di Fabio, F., Moors, A., Surgery for deep infiltrating endometriosis is associated with long-term improvement of pain and quality of life: A prospective study from a joint gyne/colorectal team, Colorectal Disease, 16, 207, 2014	The population included women with severe endometriosis who had either undergone hysterectomy or just uni/bilateral oophorectomy
Nisolle, M., Nervo, P., Brichant, G., Foidart, J. M., Is there a place for hysterectomy in	Narrative abstract

Reference	Reason for exclusion
endometriotic pelvic pain?, International Journal of Gynecology and Obstetrics, 107, S60, 2009	
O'Brien, S., Munro, K., Vyas, S., Audit of clinical outcomes from total laparoscopic hysterectomies at Southmead Hospital, Bristol, September 2009-2013, BJOG: An International Journal of Obstetrics and Gynaecology, 121, 3-4, 2014	Abstract did not report information on population, and there was no comparator group.
Ojeda, V. J., The pathology of hysterectomy specimens, New Zealand Medical Journal, 89, 169-171, 1979	No indication of endometriosis
Okaro, E. O., Jones, K. D., Sutton, C., Long term outcome following laparoscopic supracervical hysterectomy, British Journal of Obstetrics and Gynaecology, 108, 1017-1020, 2001	There was no comparator in the study. Only 4 women had endometriosis from histology. Analysis of patient case records
Oshinowo, A. E., Noam Smorgick-Rosenbaum, N., Advincula, A., As-Sanie, S., Robot-assisted hysterectomies for advanced endometriosis, Journal of Minimally Invasive Gynecology, 1), S4, 2012	Comparing two technical interventions for hysterectomy, did not meet our review protocol
Ouahba, J., Madelenat, P., Poncelet, C., Transient abdominal ovariopexy for adhesion prevention in patients who underwent surgery for severe pelvic endometriosis, Fertility and Sterility, 82, 1407-1411, 2004	Outcomes not of interest, subgroups for population not reported in study
Ozdemir, E., Ozturk, U., Celen, S., Sucak, A., Gunel, M., Guney, G., Imamoglu, M. A., Danisman, A. N., Iatrogenic urinary tract system injuries in obstetrics and gynecology operations, European Urology, Supplements, 9 (6), 566, 2010	Population was not endometriosis
Parsons, L., Conservative surgical management of external endometriosis, Obstetrics & Gynecology, 32, 576-9, 1968	Narrative editorial comment
Raney, B., Endometriosis. 3. Complete operations. Reasons, sequelae, treatment, American Journal of Obstetrics & Gynecology, 109, 1137-44, 1971	All women with endometriosis had hysterectomy plus salpingo-oophorectomy. There was no comparison with women who had hysterectomy alone
Raney, B., Endometriosis. I. Conservative operations, American Journal of Obstetrics & Gynecology, 107, 743-53, 1970	Women who had endometriosis had hysterectomy only, there was no comparison group of hysterectomy plus oophorectomy
Reddy, S., Rock, J. A., Treatment of endometriosis, Clinical Obstetrics & Gynecology, 41, 387-92, 1998	Narrative review
Sirota, I., Mrkaic, A., Apostol, R., Nezhat, F., Comparison of long term outcomes in robotic versus conventional laparoscopy for treatment of advanced-stage endometriosis: Which is the preferred discipline?, Journal of Minimally Invasive Gynecology, 1), S39, 2014	Study looked at comparison of two techniques for robotic versus conventional laparoscopy
Smith, T., The surgical treatment of endometriosis, Clinics in Obstetrics & Gynaecology, 5, 557-70, 1978	Narrative review
Taskiran, C., Oktem, O., Turkgeldi, E., Celik, S., Urman, B., Type 3 like total laparoscopic	Narrative abstract

Reference	Reason for exclusion
hysterectomy because of endometriosis, Journal of Minimally Invasive Gynecology, 1), S31, 2013	
Tran, K. T., Kuijpers, H. C., Willemsen, W. N., Bulten, H., Surgical treatment of symptomatic rectosigmoid endometriosis, European Journal of Surgery, 162, 139-41, 1996	Hysterectomy and oophorectomy was reported as separate groups.
Vercellini, P., De Giorgi, O., Pisacreta, A., Pesole, A. P., Vicentini, S., Crosignani, P. G., Surgical management of endometriosis, Best Practice & Research in Clinical Obstetrics & Gynaecology, 14, 501-23, 2000	Intervention included pre-sacral neuroectomy and uterosacral ligament resection
Winkel, C.A., Scialli, A.R., Medical and surgical therapies for pain associated with endometriosis, Journal of Women's Health and Gender-Based Medicine, 10, 137-146, 2001	No relevant outcomes

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## H.17 Management strategies to improve spontaneous pregnancy rates

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## H.18 Economic evidence

Study	Reason for Exclusion
Allaire, C., MacRae, G. S., Nishi, C., Chen, I. Hospital-related costs for endometriosis in Canada	Costs only
Araujo, D., Passos, R. B. F., Souza, C. P. R., Silva, A. P., Marques, M. Cost effectiveness analysis of goserelin empiric therapy for deep endometriosis treatment	Costs only
Attilia, B. K., Griffiths, A. N., Penketh, R. J. Regression analysis of predicted and actual operating duration for advanced laparoscopic excisional endometriosis surgery	Costs only
Banta, H. D. The cost-effectiveness of 10 selected applications in minimally invasive therapy	No conclusions reached in endometriosis section
Becker, I., Parlayan, S., Baumgarten, C., Dakkak, R., Rosenow, G., Von Kleinsorgen, C., Halis, G., Fuhr, N., Ebert, A. D. Inpatient costs for women with deep infiltrating endometriosis: A comparison of data from the years 2006 and 2007 of the Deutsche Endometriosezentrum Berlin (DEZB) Stufe III	Costs only
Bostrom, P., Lovkvist, L., Edlund, M., Olovsson, M. Burden of illness in women with endometriosis	Burden of illness
Bostrom, P., Lovkvist, L., Gustafsson, M., Alexandersson, O., Bruse, C., Liffner, C., Holmberg, J., Edlund, M., Olovsson, M. Cost of illness in women with endometriosis	Costs only
Brandes, I., Kleine-Budde, K., Halis, G. Quality of life results from the EndoCost study	Quality of Life only

Study	Reason for Exclusion
Choi, S. E., Lim, E. A., Park, J. H., Lee, M. K., Jung, S. W., Cho, H. Y. Economic evaluation of dienogest for endometriosis in the context of Korea national health insurance	Abstract only
Chvatal, R., Reichert, B., Renner, S., Oppelt, P. Cost of inpatient treatment for endometriosis in Germany: An analysis based on the G-DRG-coding	Costs only
De Graaff, A. A., D'Hooghe, T. M., Dunselman, G. A., Dirksen, C. D., Hummelshoj, L., Werf EndoCost Consortium, Simoens, S. The significant effect of endometriosis on physical, mental and social wellbeing: results from an international cross-sectional survey	Quality of Life
D'Hooghe, T., Dirksen, C. D., Dunselman, G. A. J., De Graaff, A., EndoCost Consortium, W. E. R. F., Simoens, S. The costs of endometriosis: It's the economy, stupid	Costs only
Ebert, A. D., Rosenow, G., Kruger, K., Liehr, R. M., Adam, U., Braunig, P., Haselmann, J., Freitag, A., Papadopolous, T., Von Kleinsorgen, C. Development of centres of excellence for endometriosis - The Berlin experiences	No HE data
Ferracini, M., Nakada, C. P. Cost minimization analysis of the dienogest use in patients with endometris under Brazilian public and private perspective	Costs only
Ferracini, M., Nakada, C. P. Cost minimization analysis of the dienogest use in patients with endometris under Brazilian public and private perspective	No numerical analysis
Fuldeore, M., Chwalisz, K., Marx, S., Wu, N., Boulanger, L., Ma, L., Lamothe, K. Surgical procedures and their cost estimates among women with newly diagnosed endometriosis: a US database study	Costs only
Fuldeore, M., Yang, H., Du, E. X., Soliman, A. M., Wu, E. Q., Winkel, C. Healthcare utilization and costs in women diagnosed with endometriosis before and after diagnosis: a longitudinal analysis of claims databases	Costs only
Fuldeore, M., Wu, N., Boulanger, L., Chwalisz, K., Marx, S. Prevalence rate and direct cost of surgical procedures among women with newly diagnosed endometriosis	Costs only
Gao, X., Outley, J., Botteman, M., Spalding, J., Simon, J. A., Pashos, C. L. Economic burden of endometriosis	Systematic review
Glasser, M. The clinical and economic benefits of GnRH agonist in treating endometriosis	No numerical analysis
Heinrichs, W. L., Henzl, M. R. Human issues and medical economics of endometriosis. Three- vs. six-month GnRH-agonist therapy	Quality of Life only
Hummelshoj, L. Worldwide studies have proven the challenge of endometriosis, its impact, and global costs	Abstract only

Study	Reason for Exclusion
Hummelshoj, L., Nnoaham, K. E., Zondervan, K. T., Jenkinson, C., Webster, P., Kennedy, S. H. Life impact and life planning for women with endometriosis	Trial protocol
Jia, S.Z., Leng, J.H., Shi, J.H., Sun, P.R., Lang, J.H. Health-related quality of life in women with endometriosis: A systematic review	Systematic review
Klein, S., D'Hooghe, T., Meuleman, C., Dirksen, C., Dunselman, G., Simoens, S. What is the societal burden of endometriosis-associated symptoms? a prospective Belgian study	Costs only
Knight, C., Colligs, A., Lipinski, J. A budget impact analysis of dienogest in treating endometriosis associated pelvic pain in Germany	Abstract only
Koltermann, K. C., Mpinou, L. E., Niedobitek-Kreuter, G., Kruger, K., Thiel-Moder, U., Mechsner, S., Ebert, A. D. Symptomatic and asymptomatic bowel endometriosis in health economic focus in Germany	Could not retrieve
Lei, L. Economic burden of surgery on endometriosis	Costs only
Levy, A. R., Osenenko, K. M., Lozano-Ortega, G., Sambrook, R., Jeddi, M., Belisle, S., Reid, R. L. Economic burden of surgically confirmed endometriosis in Canada	Costs only
Long, C. Y., Fang, J. H., Chen, W. C., Su, J. H., Hsu, S. C. Comparison of total laparoscopic hysterectomy and laparoscopically assisted vaginal hysterectomy	Endometriosis costs not given
Luciano, A. A., Lowney, J., Jacobs, S. L. Endoscopic treatment of endometriosis-associated infertility. Therapeutic, economic and social benefits	Costs only
Lyttle-Nguessan, C., Campbell, E. S. Cost-effectiveness of early detection of endometriosis: A systematic review	Economic costs not considered (no opportunity cost)
Marmarali, B., Deger, C., Memis, S. A., Parali, E., Sumer, F., Karakeben, K., Kayadibinli, M. Cost effectiveness comparison between dienogest and gonadotropin-releasing hormone analogs in Turkey	Abstract only
Mirkin, D., Murphy-Barron, C., Iwasaki, K. Actuarial analysis of private payer administrative claims data for women with endometriosis	Costs only
Naughton, M. J., McBee, W. L. Health-related quality of life after hysterectomy	Endometriosis costs not given
Nnoaham, K. E., Hummelshoj, L., Webster, P., d'Hooghe, T., de Cicco Nardone, F., de Cicco Nardone, C., Jenkinson, C., Kennedy, S. H., Zondervan, K. T., World Endometriosis Research Foundation Global Study of Women's Health, consortium Impact of endometriosis on quality of life and work productivity: a multicenter study across ten countries	Duplicate



Study	Reason for Exclusion
Oehmke, F., Weyand, J., Hackethal, A., Konrad, L., Omwandho, C., Tinneberg, H. R. Impact of endometriosis on quality of life: a pilot study	Quality of Life
Oppelt, P., Chavtal, R., Haas, D., Reichert, B., Wagner, S., Muller, A., Lermann, J. H., Renner, S. P. Costs of in-patient treatment for endometriosis in Germany 2006: An analysis based on the G-DRG-Coding	Costs only
Parali, E., Deger, C., Marmarali, B., Memis, S. A., Sumer, F., Karakeben, K., Kayadibinli, M. Effects of different clinical practices of laparoscopic surgery for endometriosis treatment on cost of therapy	Costs only
Piniashko, O., Zalis'ka, O., Vernikovskyy, I. The prevalence and cost of illness in women with endometriosis in Ukraine	No HE information
Redwine, D. B., Koning, M., Sharpe, D. R. Laparoscopically assisted transvaginal segmental resection of the rectosigmoid colon for endometriosis	Costs only
Sacher, F., Fritsch, M., Schulze-Rath, R., Xia, F., Law, A. A retrospective cohort study of women who have had a diagnosis of endometriosis at discharge in a hospital database in the us to characterize subentities of the disease	Abstract only
Schindler, A. E. Oral hormonal contraceptives and endometriosis	Not HE
Simoens, S., Dunselman, G., Dirksen, C., Hummelshoj, L., Bokor, A., Brandes, I., Brodzsky, V., Canis, M., Colombo, G. L., DeLeire, T., Falcone, T., Graham, B., Halis, G., Horne, A., Kanj, O., Kjer, J. J., Kristensen, J., Lebovic, D., Mueller, M., Vigano, P., Wullschleger, M., D'Hooghe, T. The burden of endometriosis: costs and quality of life of women with endometriosis and treated in referral centres.[Erratum appears in Hum Reprod. 2014 Sep;29(9):2073]	Abstract only
Simoens, S., Hummelshoj, L., D'Hooghe, T. Endometriosis: cost estimates and methodological perspective	Costs only
Simoens, S., Hummelshoj, L., Dunselman, G., Brandes, I., Dirksen, C., D'Hooghe, T., EndoCost, Consortium Endometriosis cost assessment (the EndoCost study): a cost-of-illness study protocol	Protocol only
Simoens, S., Hummelshoj, L., Dunselman, G., Dirksen, C., Endocost Consortium, W., D'Hooghe, T. The burden of endometriosis: Costs and quality of life of women with endometriosis treated in referral centres	Abstract only
Simoens, S., Meuleman, C., D'Hooghe, T. Non-health-care costs associated with endometriosis	QoL metric not appropriate for NICE analysis

Study	Reason for Exclusion
Sugimura, K., Imaoka, I., Okizuka, H. Pelvic endometriosis: impact of magnetic resonance imaging on treatment decisions and costs	Costs only
Tselos, E., Whitlow, B. Patient level information costing systems (PLICS): Could be used to get right tariffs for endometriosis cases?	Abstract only
Vercellini, P., Frattaruolo, M. P., Somigliana, E., Jones, G. L., Consonni, D., Alberico, D., Fedele, L. Surgical versus low-dose progestin treatment for endometriosis-associated severe deep dyspareunia II: effect on sexual functioning, psychological status and health-related quality of life	Quality of Life only
Vercellini, P., Somigliana, E., Vigano, P., Abbiati, A., Daguati, R., Crosignani, P. G. Endometriosis: current and future medical therapies	Modelling information only
Wasiak, R., Hjalte, F., Ragnarson Tennvall, G., Olovsson, M. Cost of illness for endometriosis in Sweden	Costs only
Wasiak, R., Manson, S., Ryan, J., Petri, J. C. Treatment and cost for patients with endometriosis in the United Kingdom	Costs only
Winkel, C. A. Modeling of medical and surgical treatment costs of chronic pelvic pain: new paradigms for making clinical decisions	Chronic pelvic pain
Wong, A. Y., Tang, L. An open and randomized study comparing the efficacy of standard danazol and modified triptorelin regimens for postoperative disease management of moderate to severe endometriosis	Quality of Life
Wullschleger, M. F., Imboden, S., Wanner, J., Mueller, M. D. Minimally invasive surgery when treating endometriosis has a positive effect on health and on quality of work life of affected women	QoL metric not appropriate for NICE analysis
Zhao, S. Z., Wong, J. M., Davis, M. B., Gersh, G. E., Johnson, K. E. The cost of inpatient endometriosis treatment: An analysis based on the healthcare cost and utilization project nationwide inpatient sample	Costs only

1  
2

# 1 Appendix I: Forest plots

## I.1 Specialist services

3 No evidence found

## I.2 Timing of interventions: association between duration of symptoms before laparoscopy and treatment outcomes

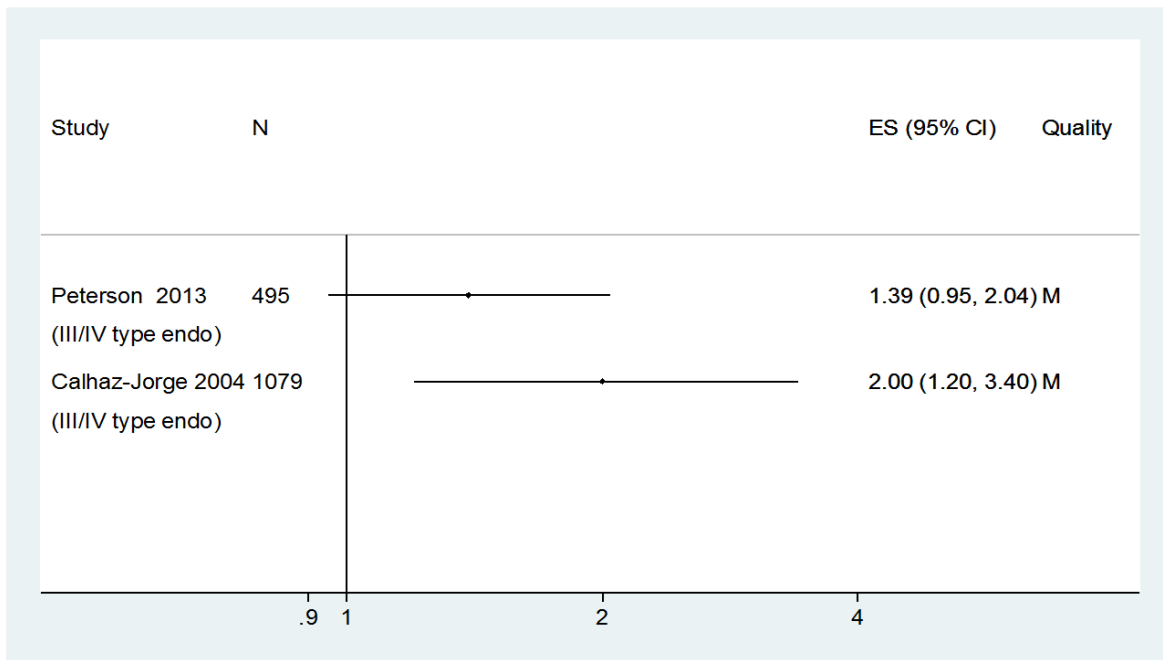
5

6 No evidence found

## I.3 Signs and symptoms of endometriosis (monitoring and referral)

8

9 **Figure 17: Pelvic pain**

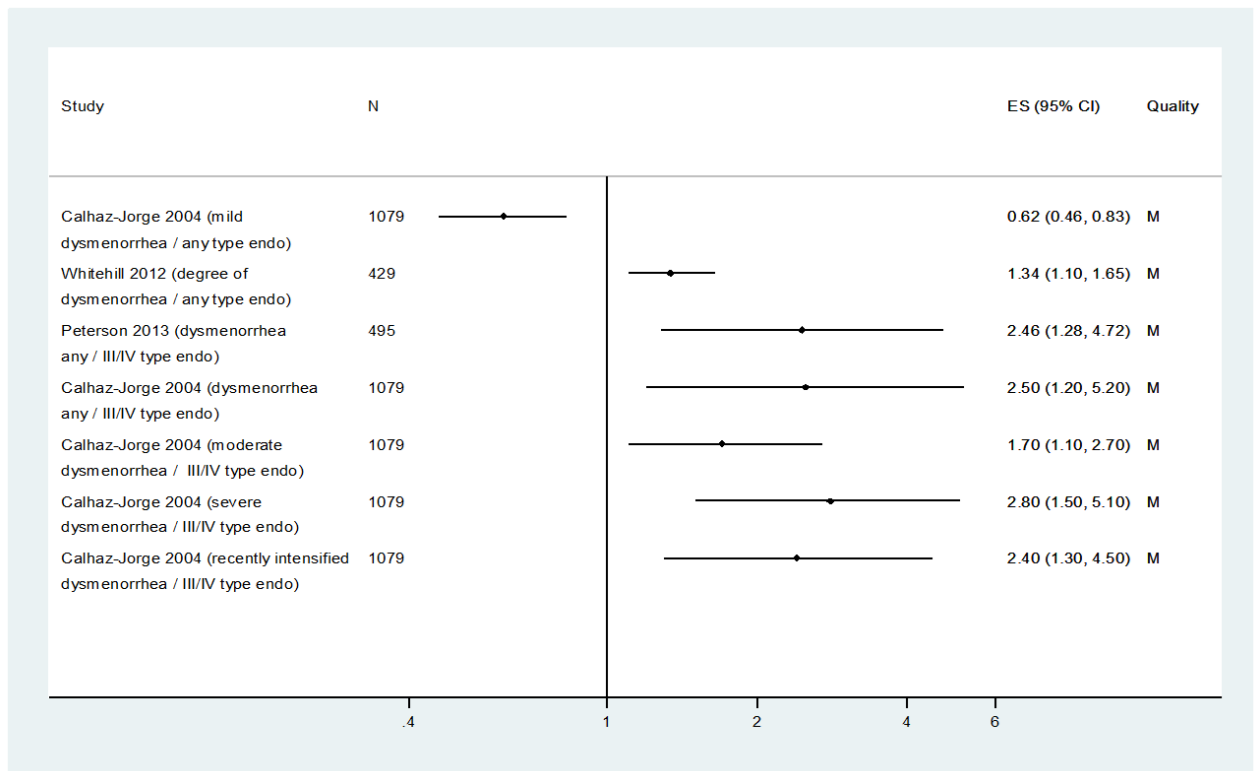


10

11

*ES, adjusted odds ratios; CI, confidence intervals*

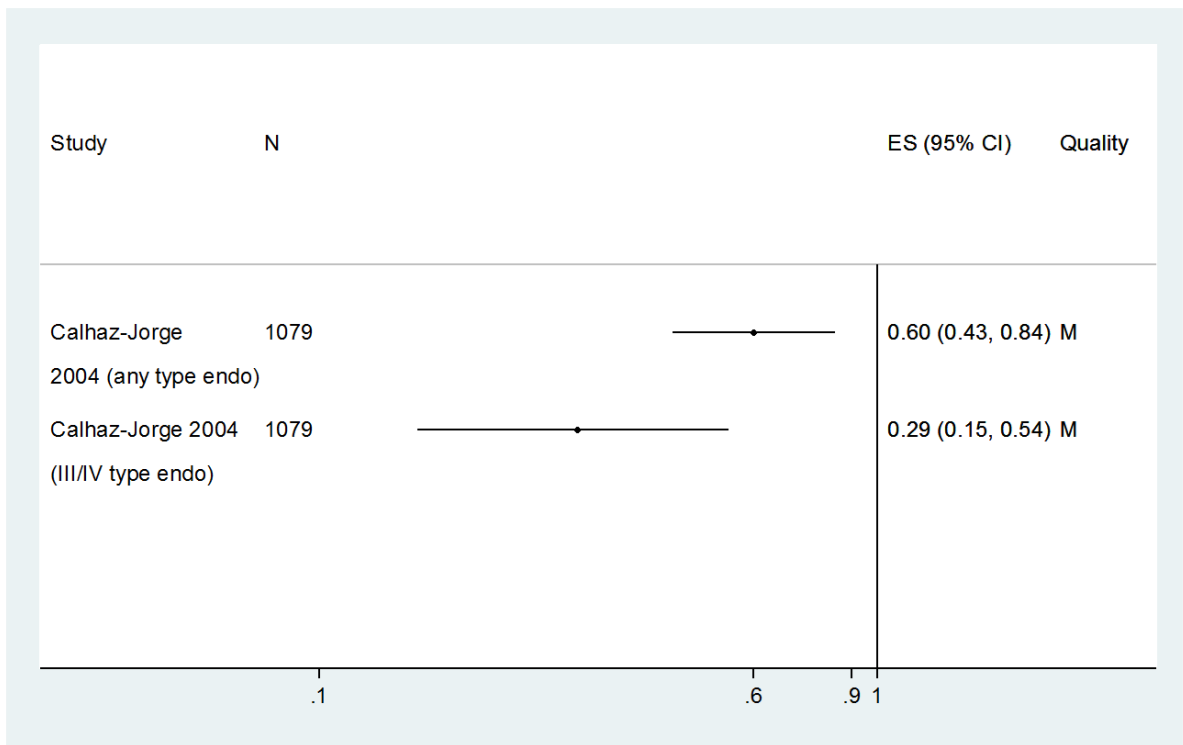
1 **Figure 18: Dysmenorrhea**



2

3 *ES, adjusted odds ratios; CI, confidence intervals*

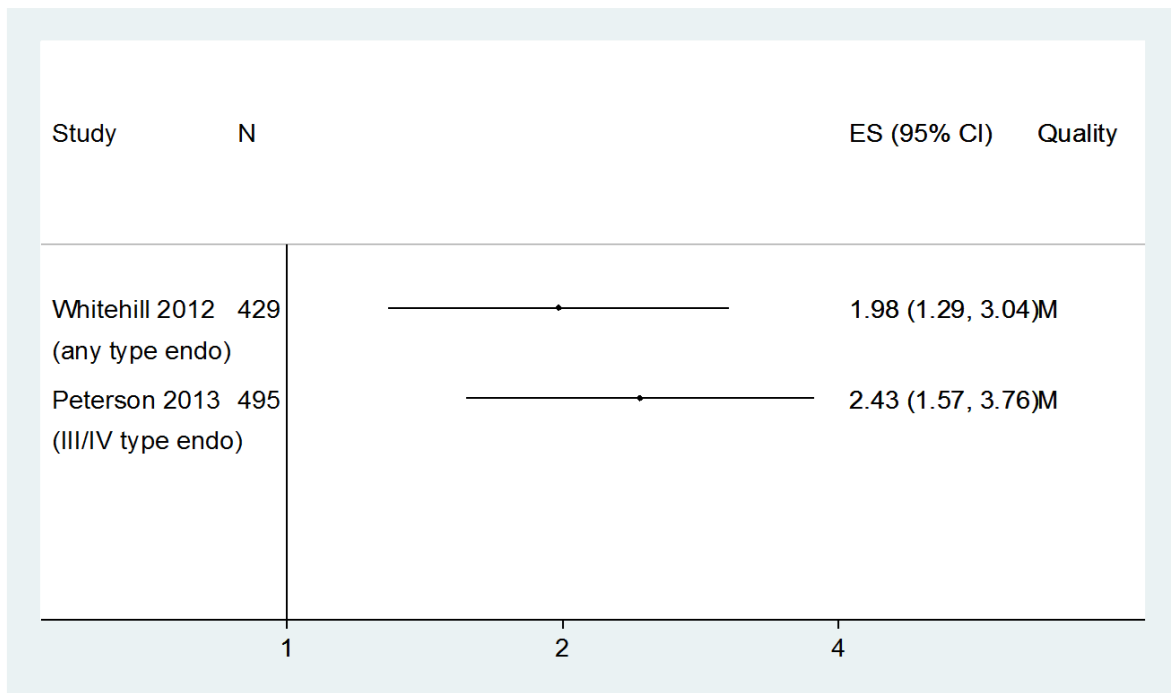
4 **Figure 19: Irregular cycle**



5

6 *ES, adjusted odds ratios; CI, confidence intervals*

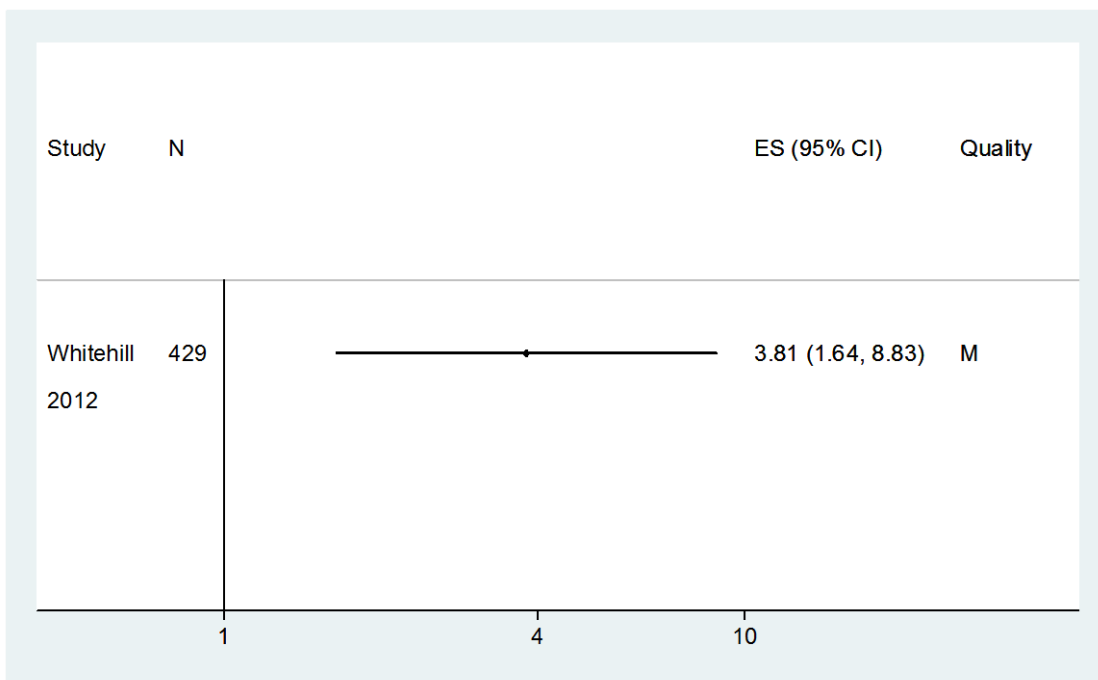
1 **Figure 20: Infertility history**



2

3 *ES, adjusted odds ratios; CI, confidence intervals*

4 **Figure 21: Pelvic signs**



5

6 *ES, adjusted odds ratios; CI, confidence intervals*

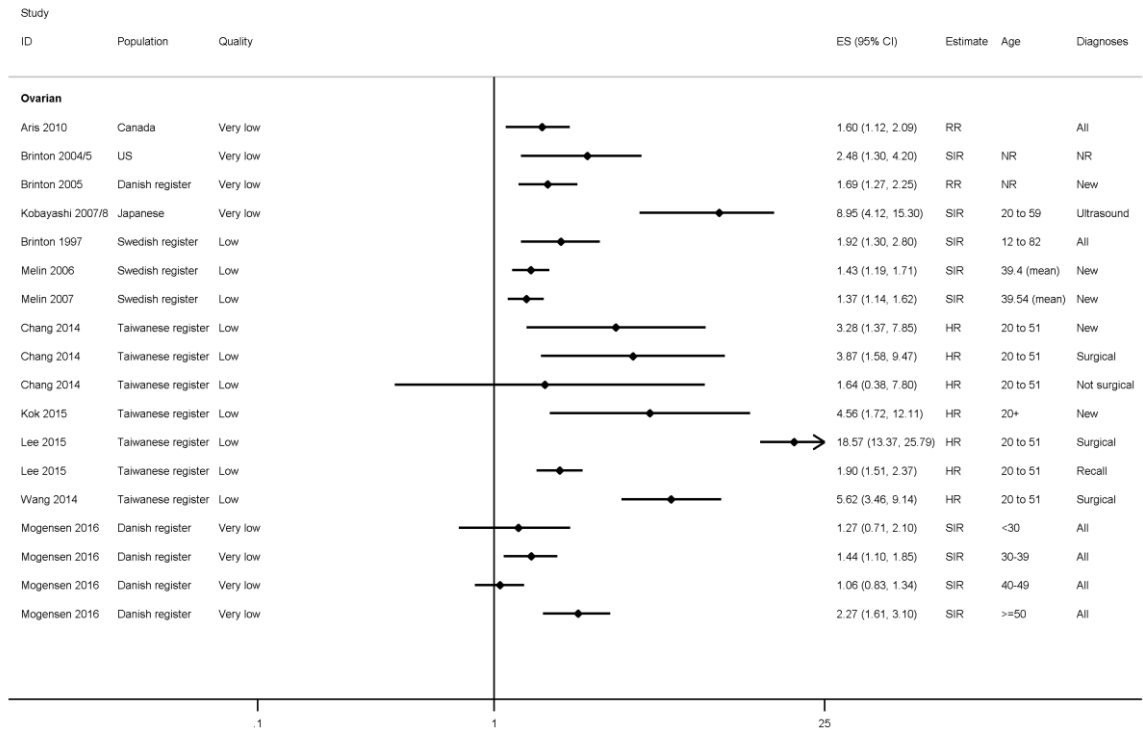
7

8 **1.4 Information and support**

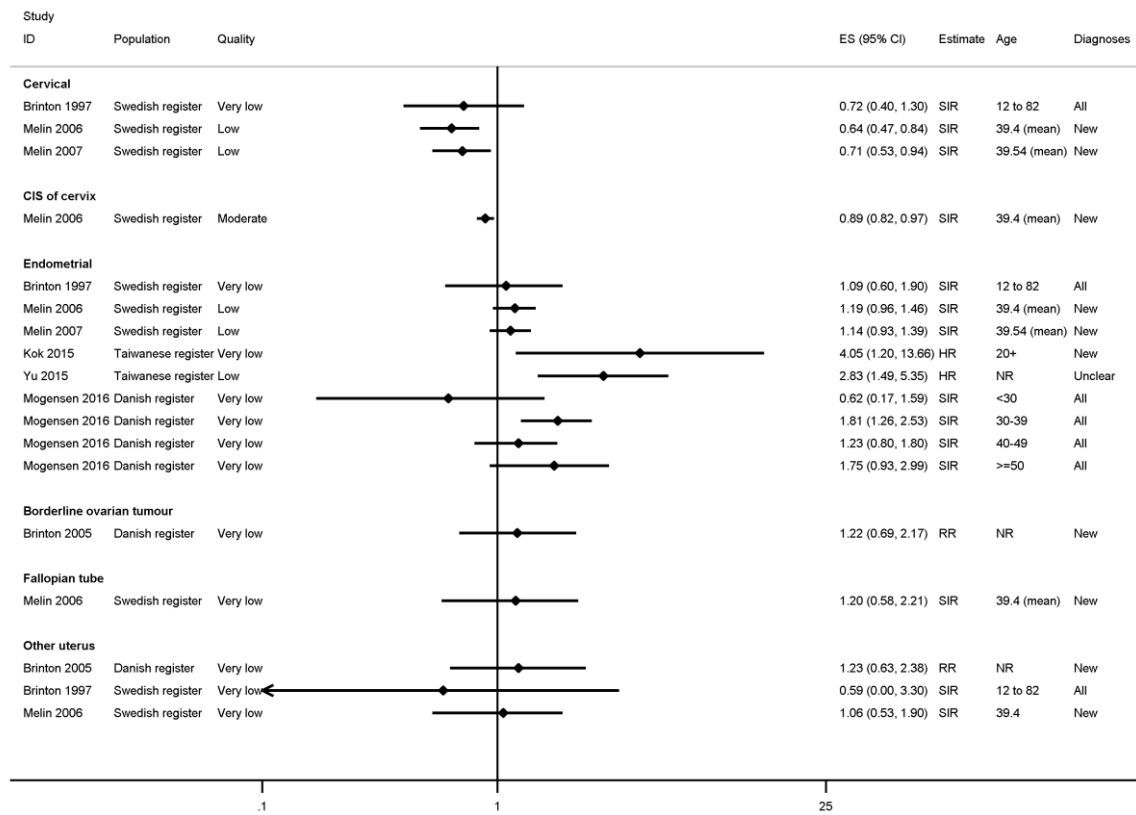
9 Not applicable

## I.5 Risk of reproductive cancer

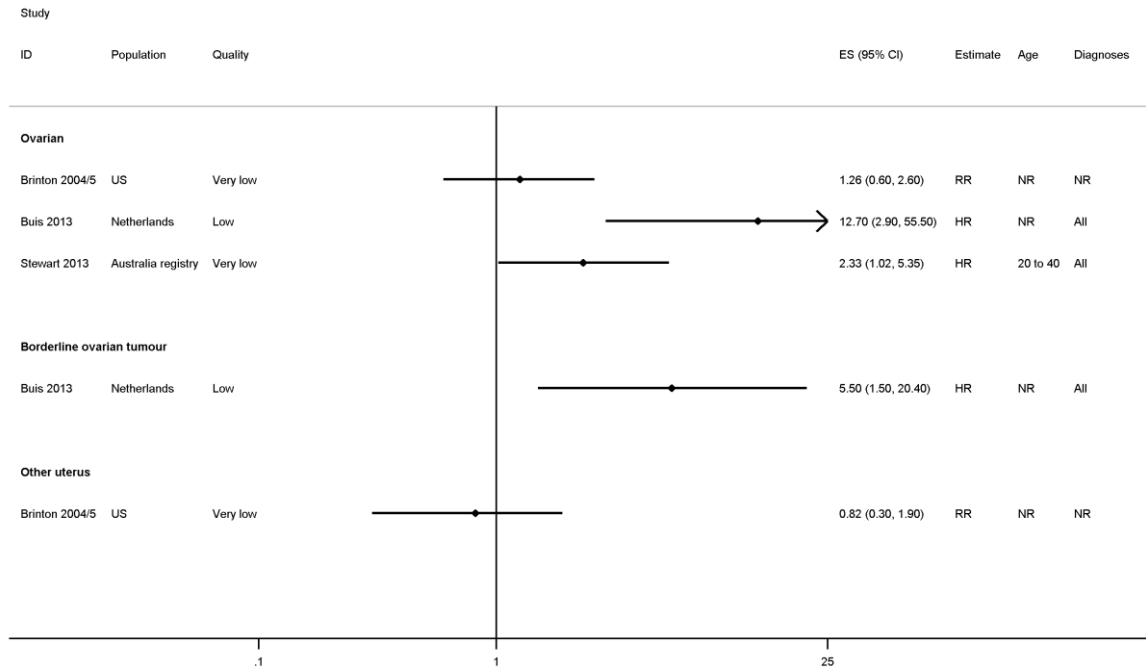
**Figure 22: Rate of ovarian cancer in women with endometriosis compared to those without endometriosis**



**Figure 23: Rate of other cancers (subgrouped into the different cancer types) in women with endometriosis compared to those without endometriosis**



**Figure 24: Rate of cancers (subgrouped into the different cancer types) in women with endometriosis compared to those without endometriosis who are subfertile**



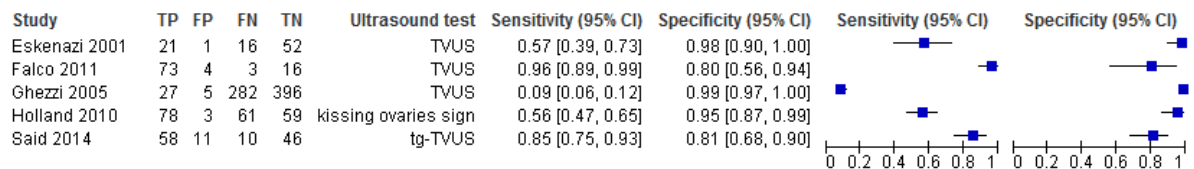
1

2

## I.6 Diagnosis – Ultrasound

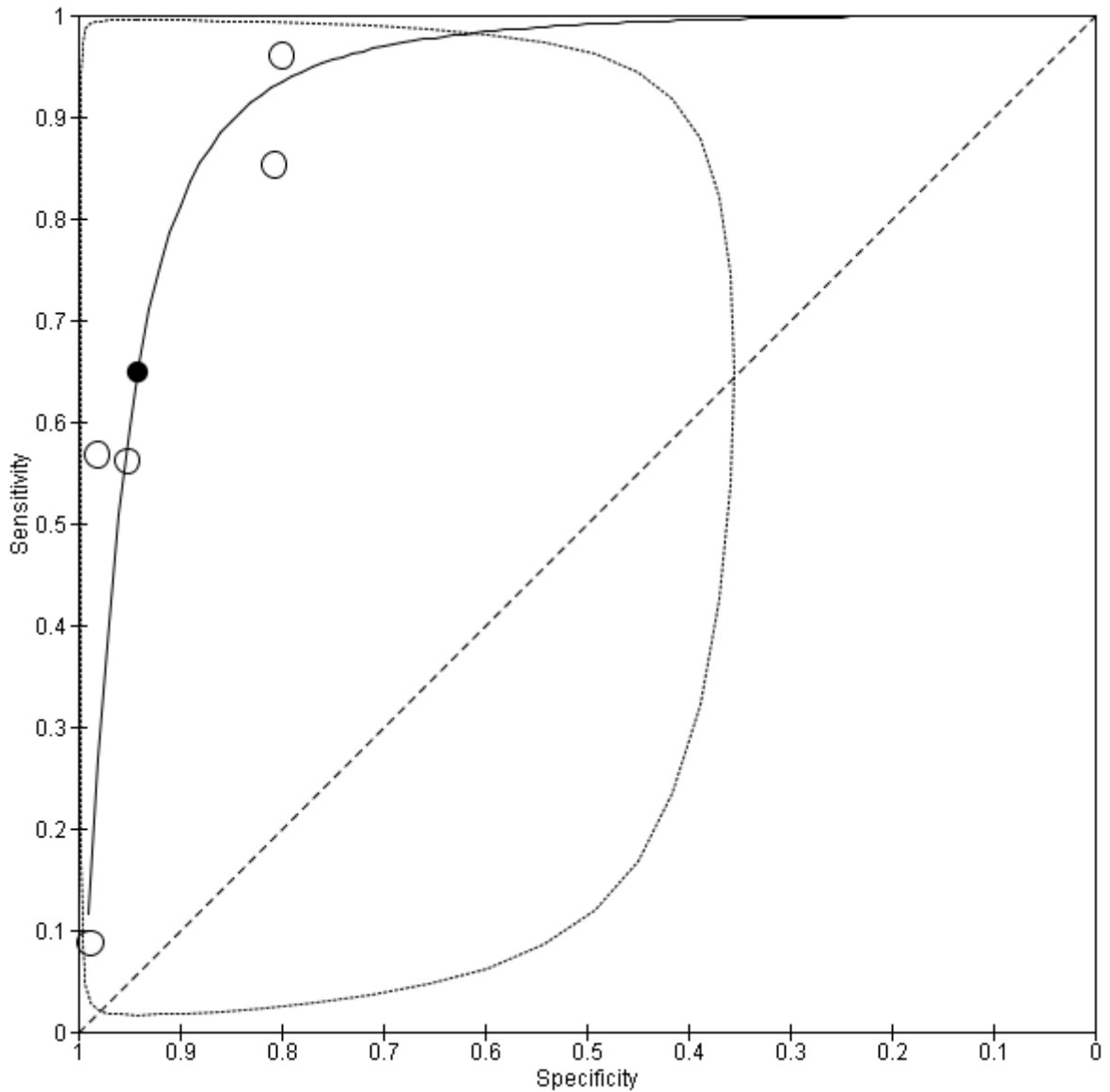
### I.6.1 Pelvic endometriosis

**Figure 25: Forest plot of TVUS detection of pelvic endometriosis**





**Figure 26: Summary ROC plot of TVUS for detection of pelvic endometriosis**



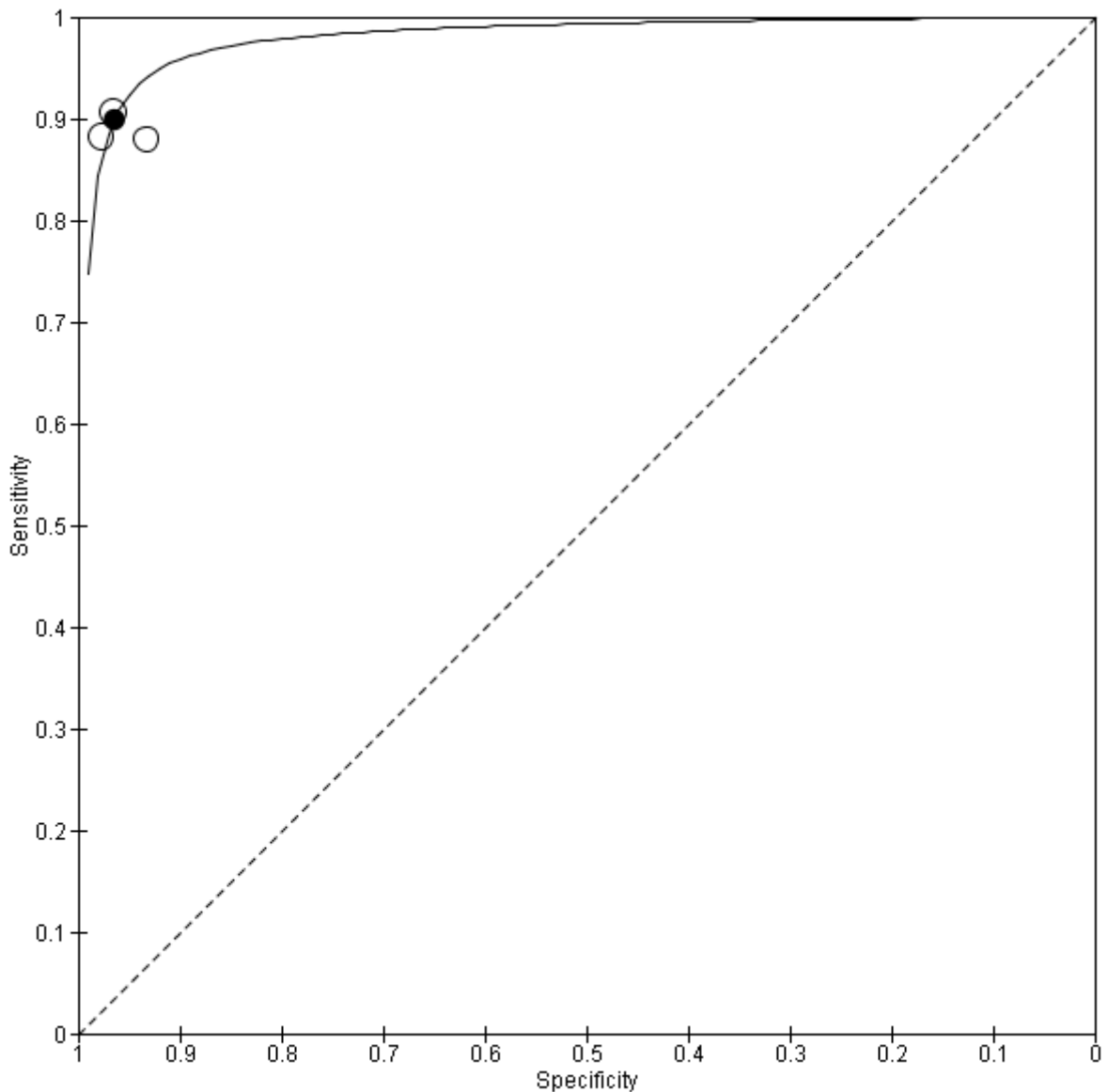
Pooled sensitivity and specificity: 62% (18 to 94) and 93% (78 to 99)

## I.6.2 Bowel endometriosis

**Figure 27: Forest plot of TVUS detection of bowel endometriosis**

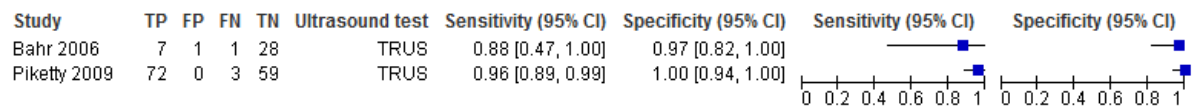
Study	TP	FP	FN	TN	Ultrasound test	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Ferrero 2011	45	1	6	44	RWC-TVUS	0.88 [0.76, 0.96]	0.98 [0.88, 1.00]	■	■
Piessens 2014	22	4	3	56	TVUS-BP	0.88 [0.69, 0.97]	0.93 [0.84, 0.98]	■	■
Piketty 2009	68	2	7	56	TVUS	0.91 [0.82, 0.96]	0.97 [0.88, 1.00]	■	■

**Figure 28: Summary ROC plot of TVUS for detection of bowel endometriosis**



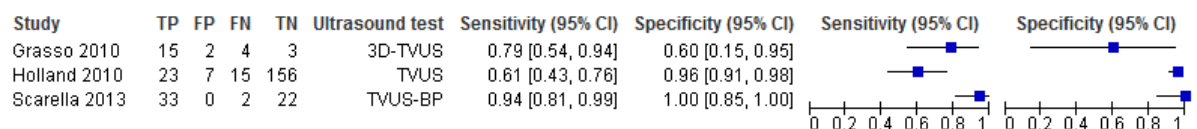
*Pooled sensitivity and specificity: 88% (70 to 97) and 95% (85 to 99)*

**Figure 29: Forest plot of TRUS detection of bowel endometriosis**

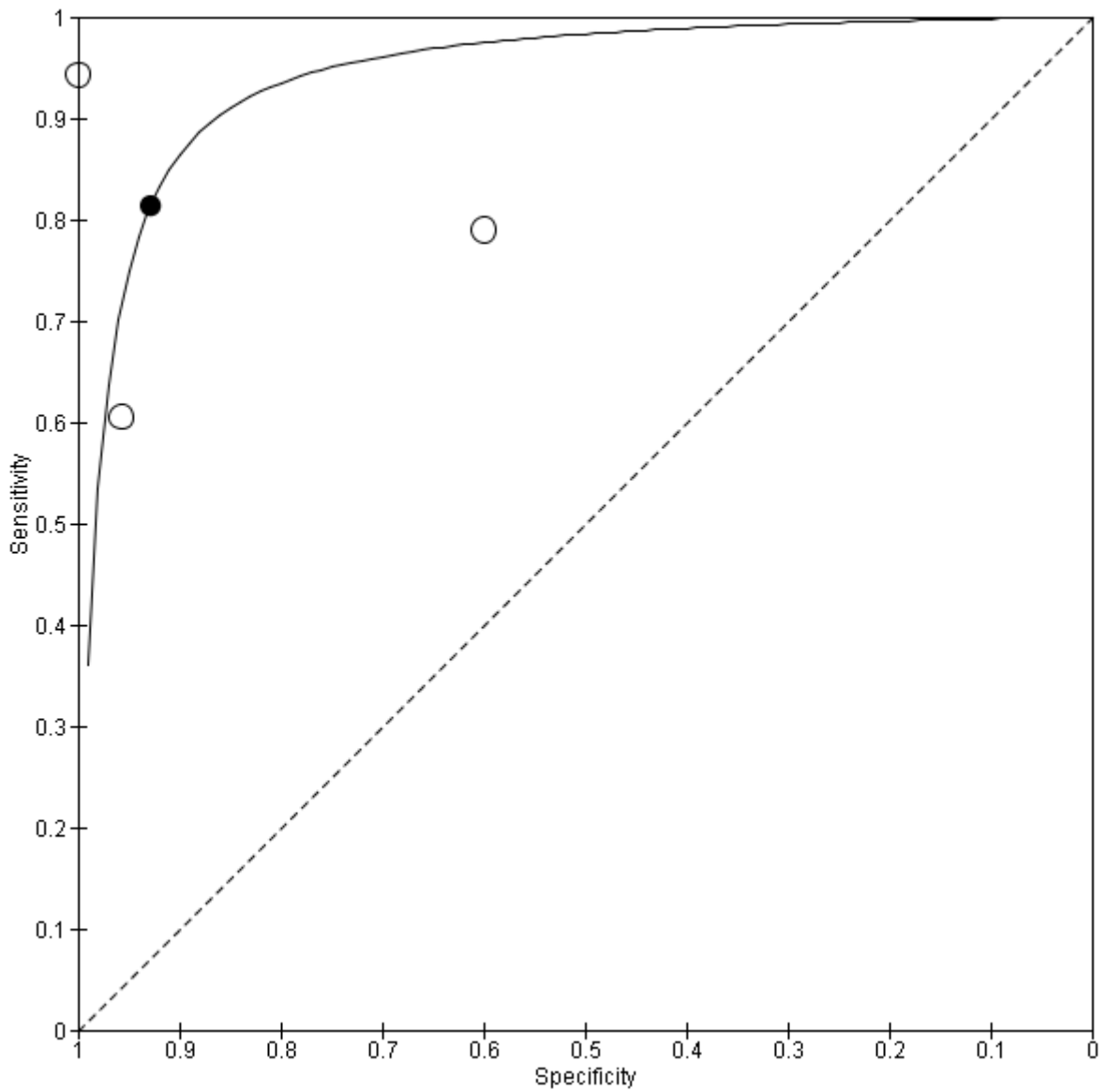


### I.6.3 DIE, posterior and anterior DIE

**Figure 30: Forest plot of TVUS detection of DIE**

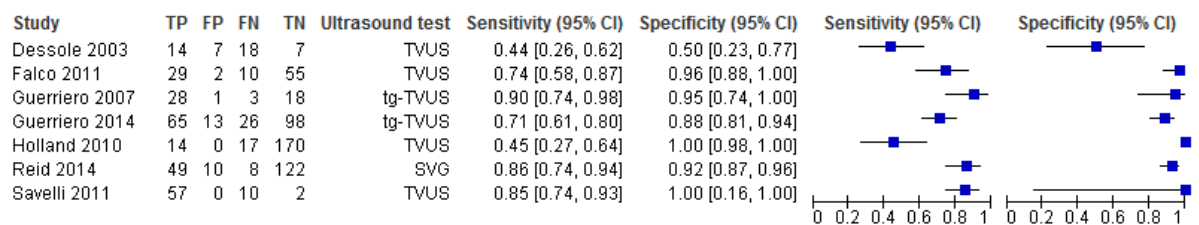


**Figure 31: Summary ROC plot of TVUS for detection of DIE**

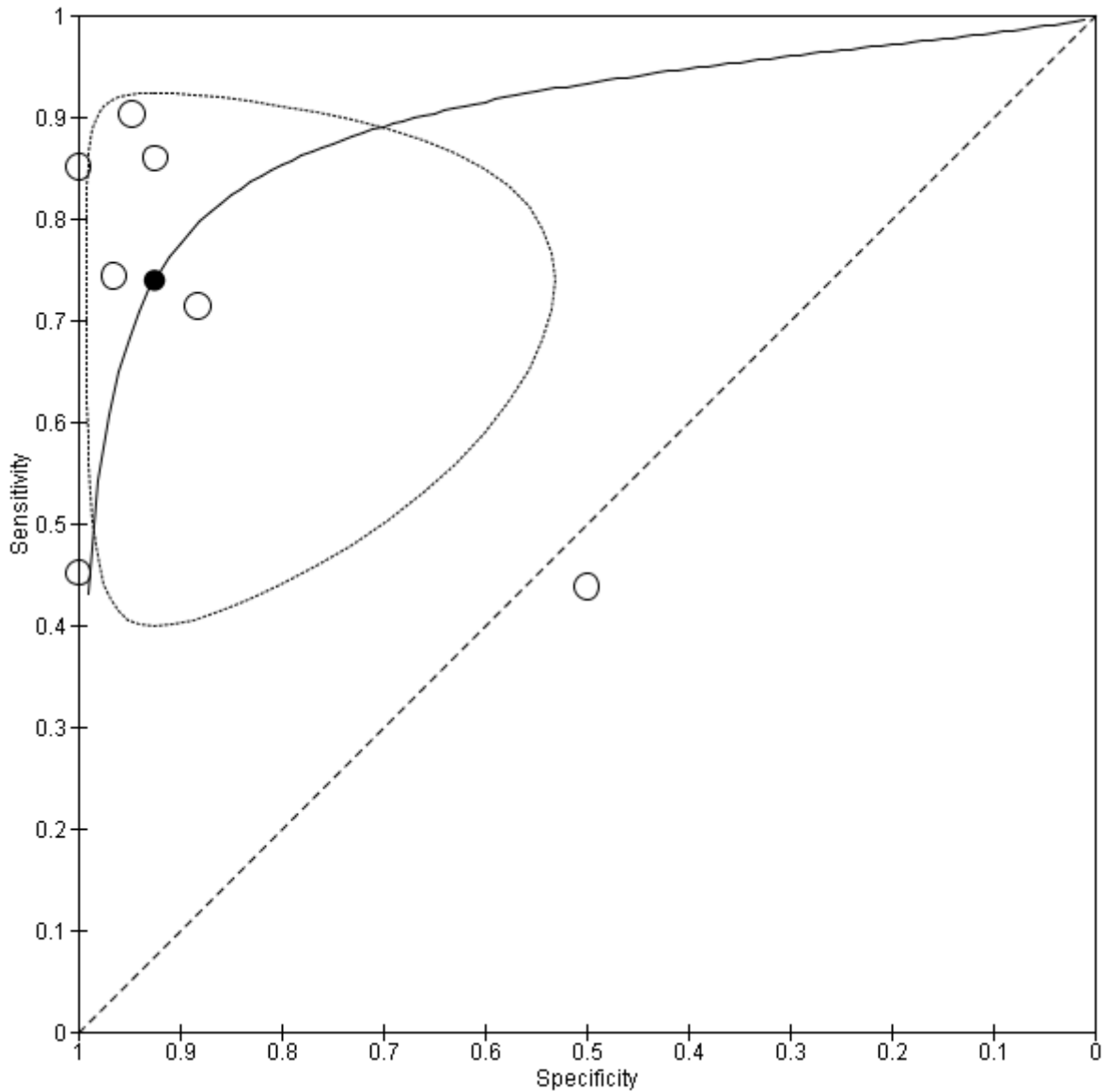


Pooled sensitivity and specificity: 78% (37 to 97) and 90% (58 to 99)

**Figure 32: Forest plot of TVUS for detection of posterior DIE**

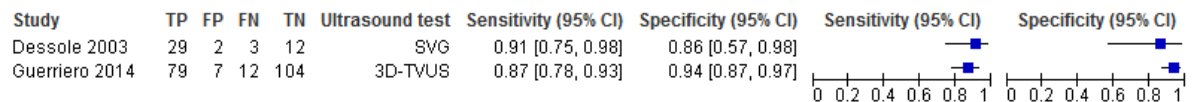


**Figure 33: Summary ROC plot of TVUS for detection of posterior DIE**

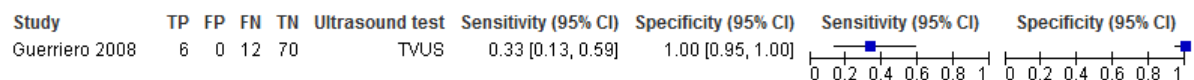


*Pooled sensitivity and specificity: 73% (55 to 87) and 91% (76 to 98)*

**Figure 34: Forest plot of TVUS (SVG & 3D-TVUS) for detection of posterior DIE**

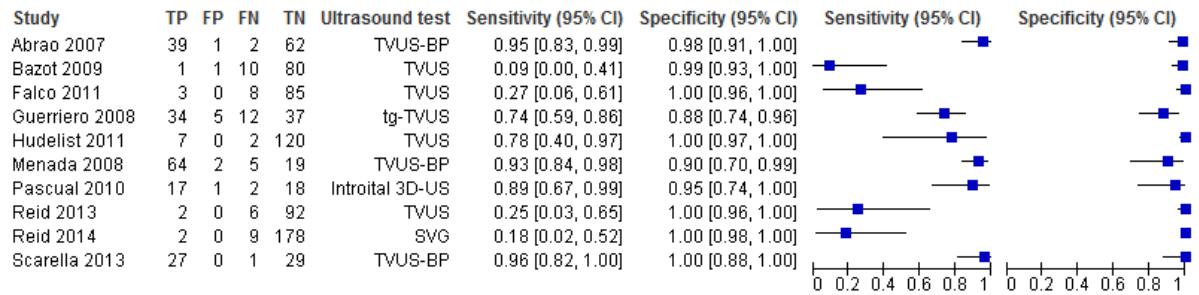


**Figure 35: Forest plot of TVUS for detection of anterior DIE**

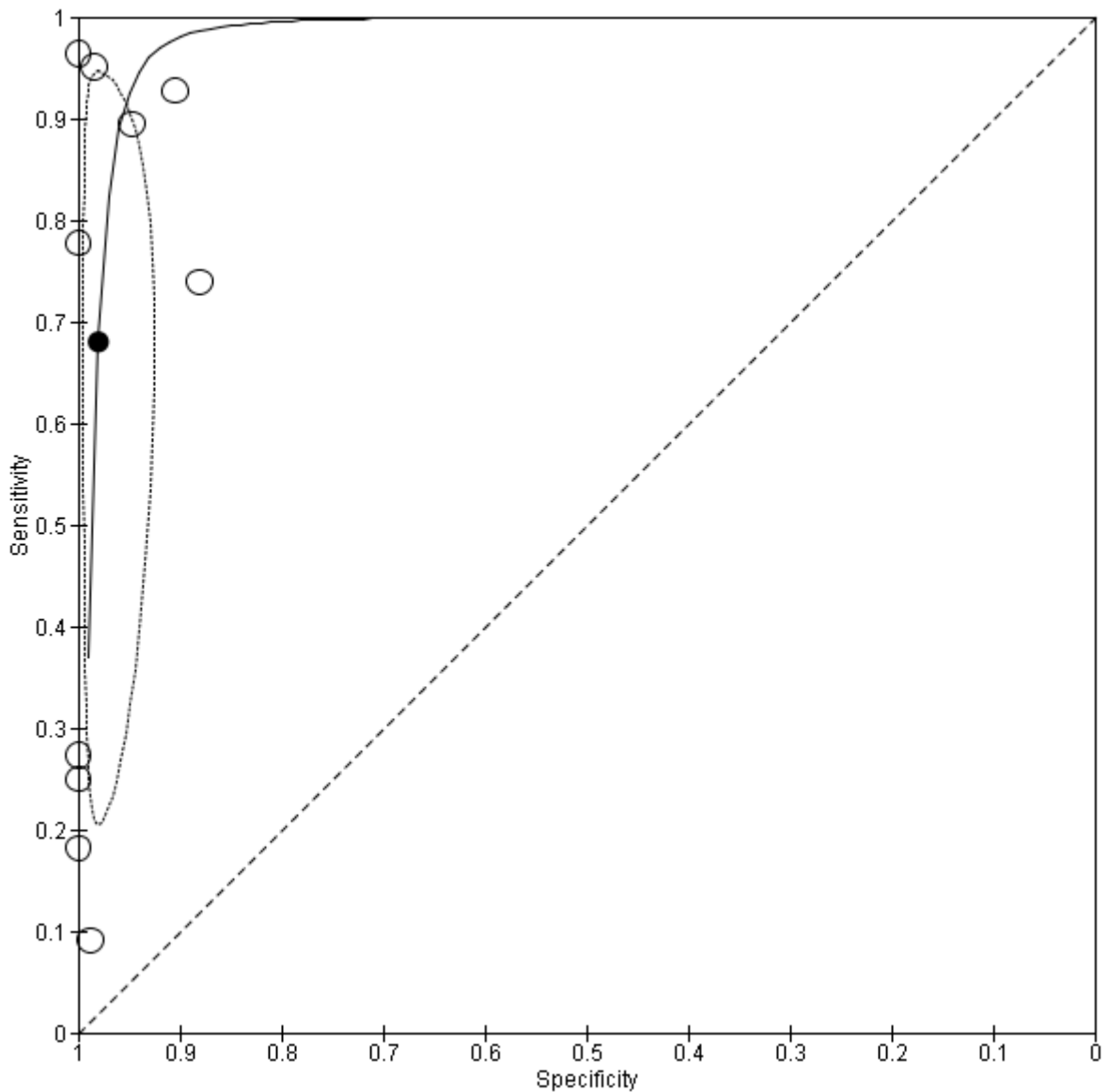


### I.6.4 Rectovaginal endometriosis

**Figure 36: Forest plot of TVUS for detection of rectovaginal endometriosis**

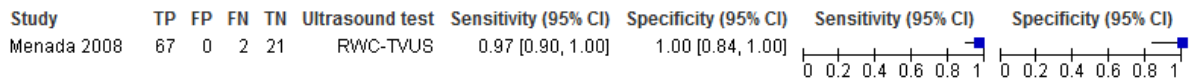


**Figure 37: Summary ROC plot of TVUS for detection of rectovaginal endometriosis**

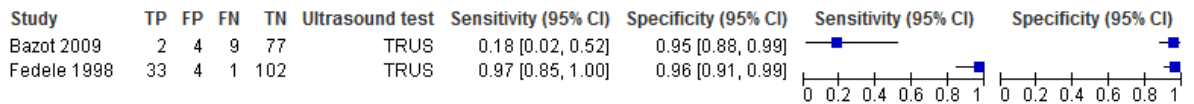


*Pooled sensitivity and specificity: 66% (33 to 90) and 98% (95 to 99)*

**Figure 38: Forest plot of TVUS (RWC-TVUS) for detection of rectovaginal endometriosis**

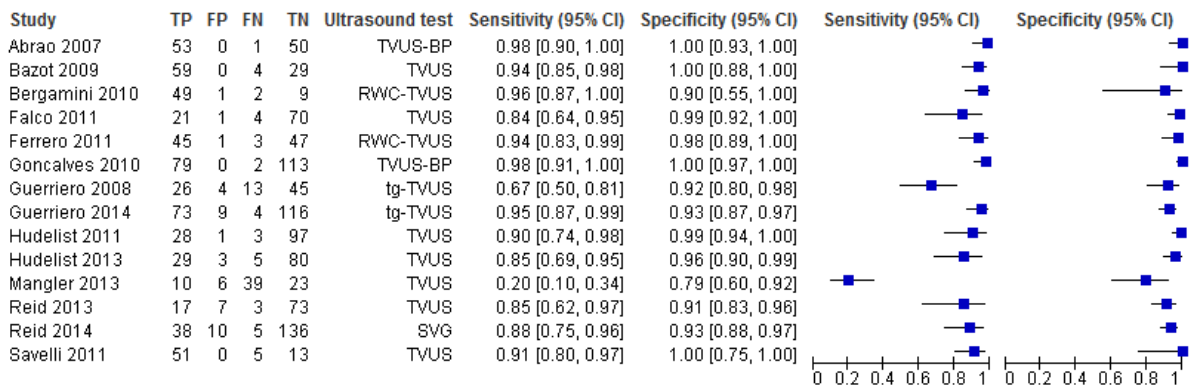


**Figure 39: Forest plot of TRUS for detection of rectovaginal endometriosis**

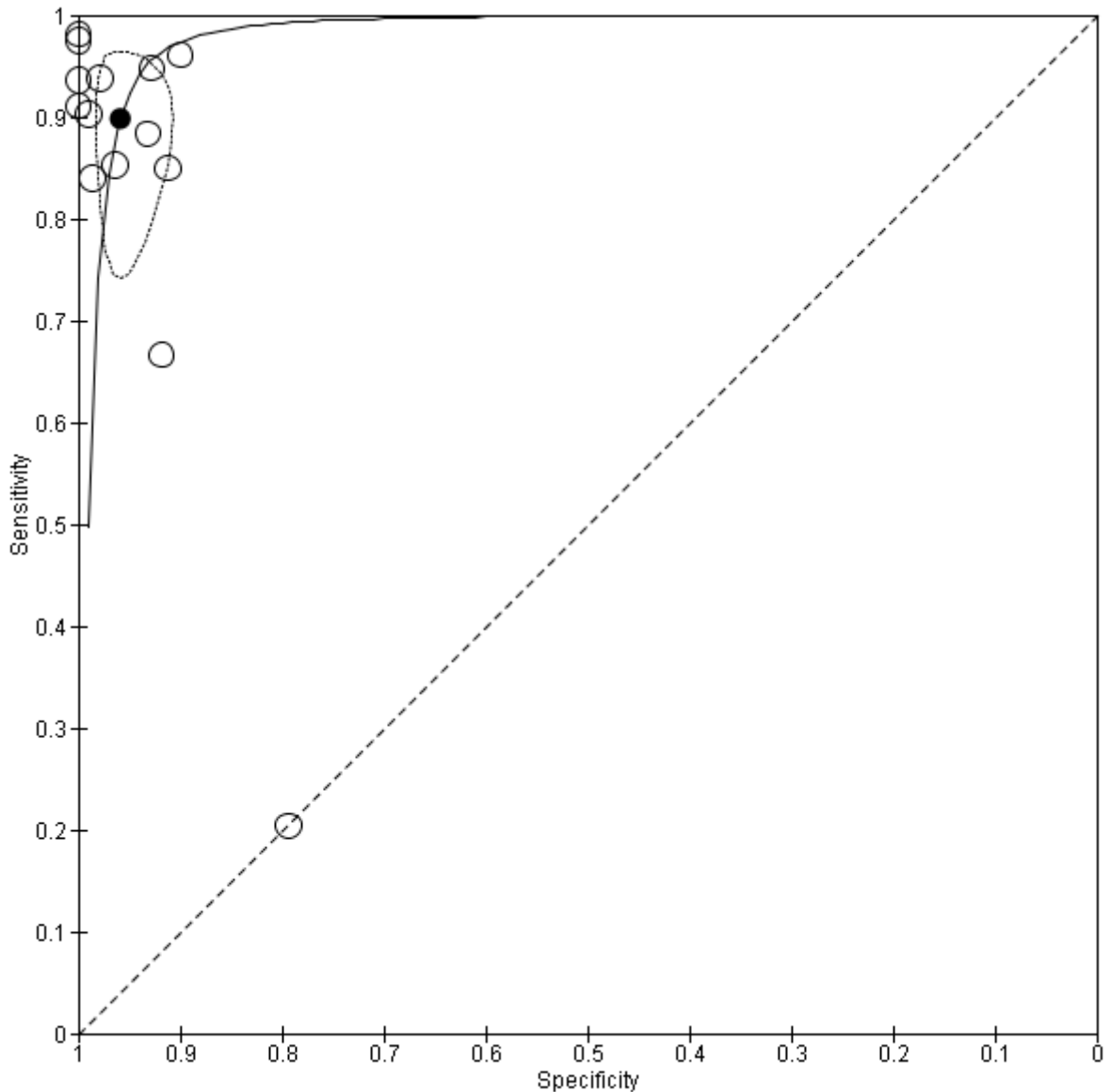


### I.6.5 Rectosigmoid endometriosis

**Figure 40: Forest plot of TVUS for detection of rectosigmoid endometriosis**



**Figure 41: Summary ROC plot of TVUS for detection of rectosigmoid endometriosis**



Pooled sensitivity and specificity: 89% (80 to 95) and 96% (93 to 98)

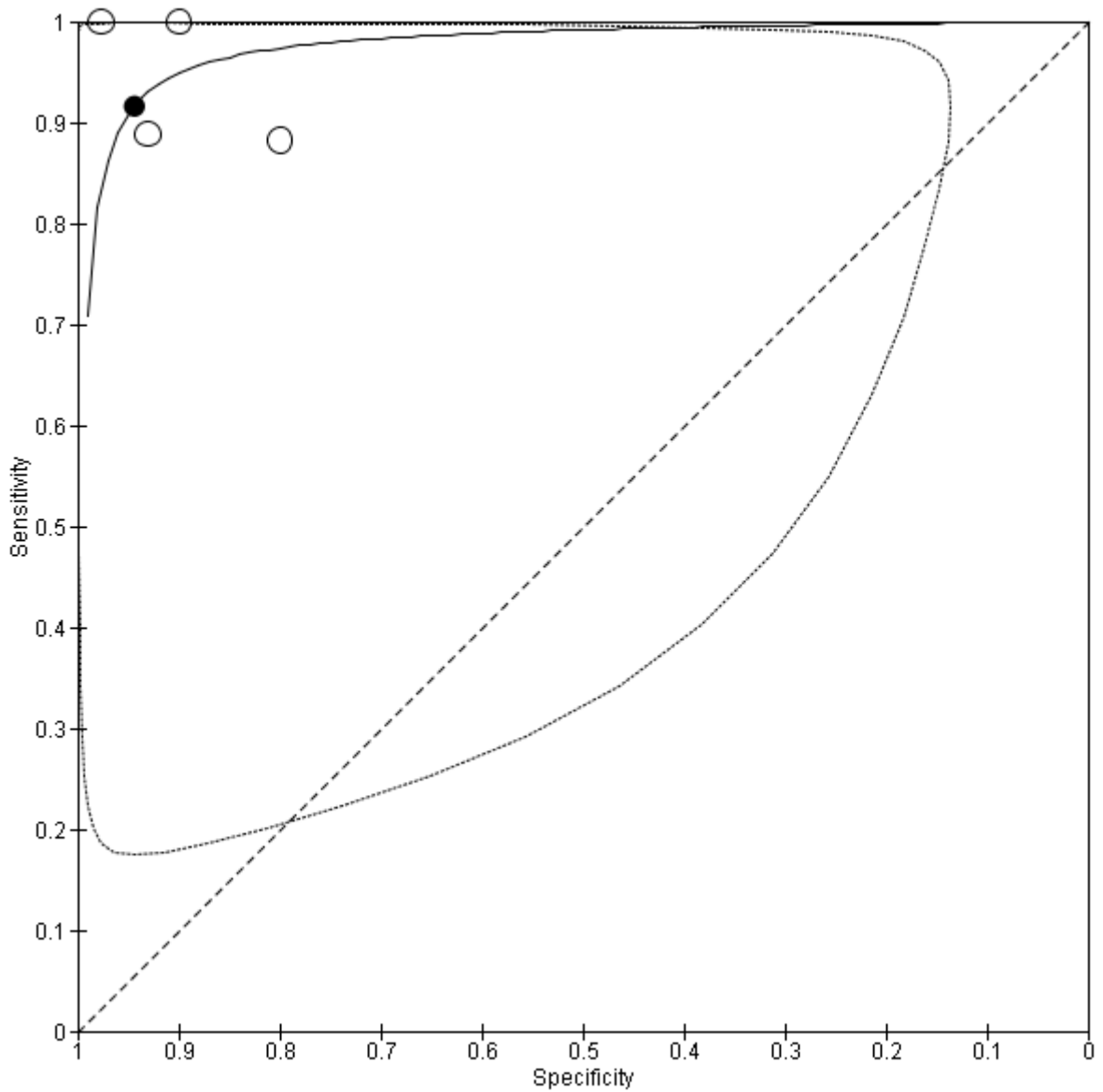
**Figure 42: Forest plots for TVUS (3D-TVUS) for detection of rectosigmoid endometriosis**

Study	TP	FP	FN	TN	Ultrasound test	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Guerriero 2014	70	4	7	121	3D-TVUS	0.91 [0.82, 0.96]	0.97 [0.92, 0.99]		

**Figure 43: Forest plots for TRUS for detection of rectosigmoid endometriosis**

Study	TP	FP	FN	TN	Ultrasound test	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Bazot 2009	56	2	7	27	TRUS	0.89 [0.78, 0.95]	0.93 [0.77, 0.99]		
Bergamini 2010	45	2	6	8	TRUS	0.88 [0.76, 0.96]	0.80 [0.44, 0.97]		
Fedele 1998	9	3	0	128	TRUS	1.00 [0.66, 1.00]	0.98 [0.93, 1.00]		
Ribeiro 2008	27	1	0	9	TRUS	1.00 [0.87, 1.00]	0.90 [0.55, 1.00]		

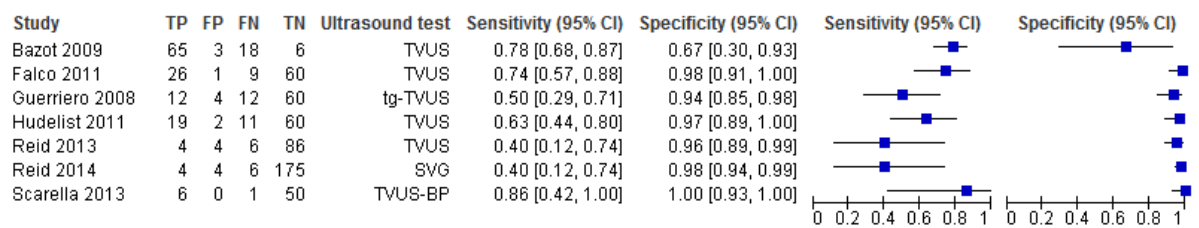
**Figure 44: Summary ROC plot of TRUS for detection of rectosigmoid endometriosis**



*Pooled sensitivity and specificity: 90% (77 to 98) and 93% (79 to 99)*

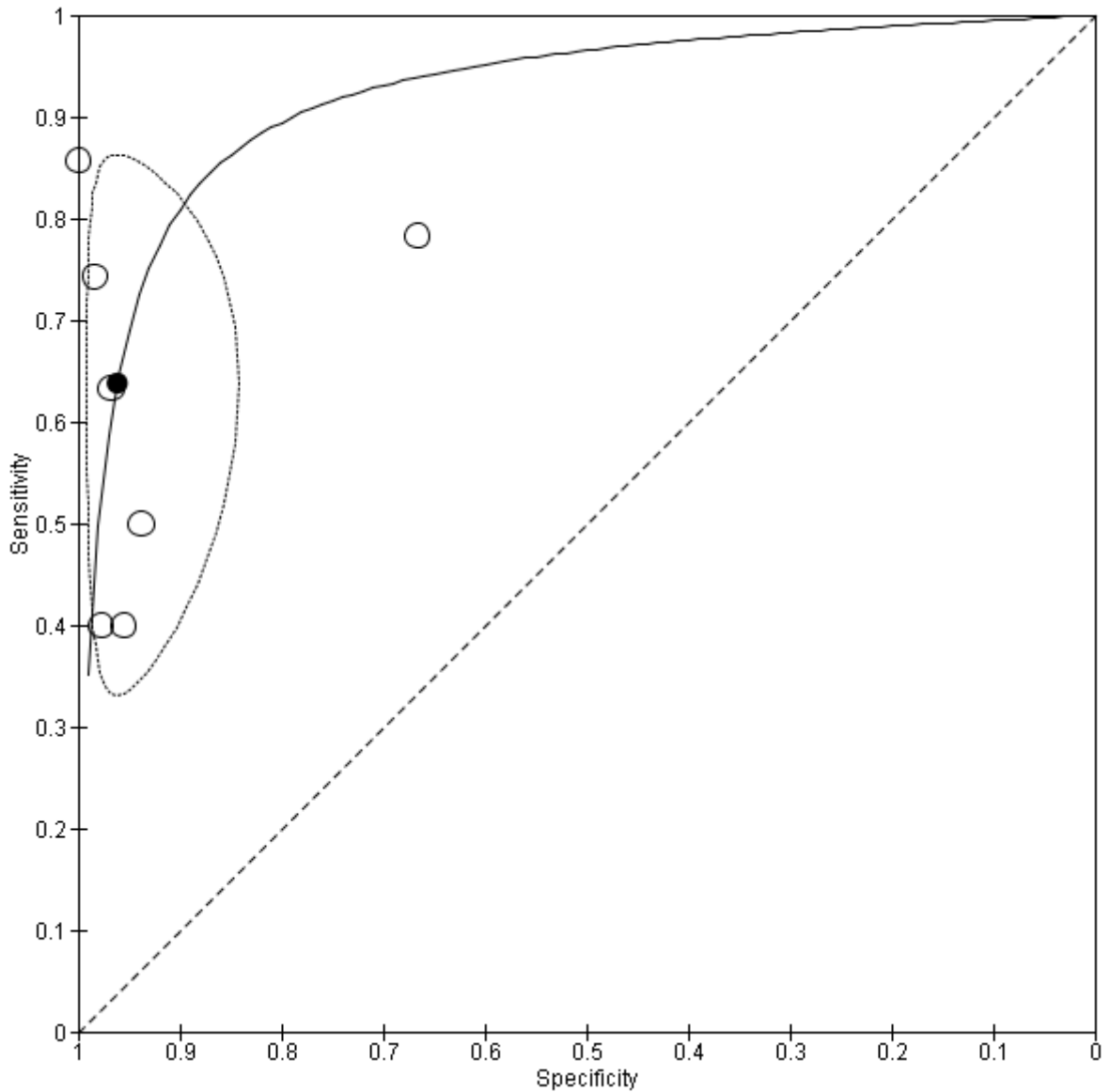
### I.6.6 Uterosacral ligament endometriosis

**Figure 45: Forest plot of TVUS for detection of USL involvement by endometriosis**





**Figure 46: Summary ROC plot of TVUS for detection of USL involvement endometriosis**



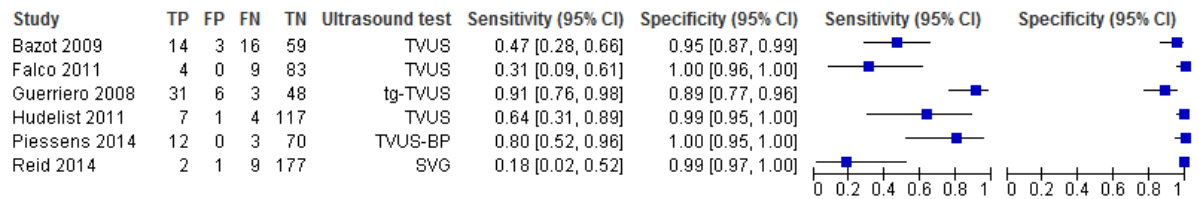
*Pooled sensitivity and specificity: 63% (45 to 79) and 96% (91 to 98)*

**Figure 47: Forest plot of TRUS for detection of USL involvement by endometriosis**

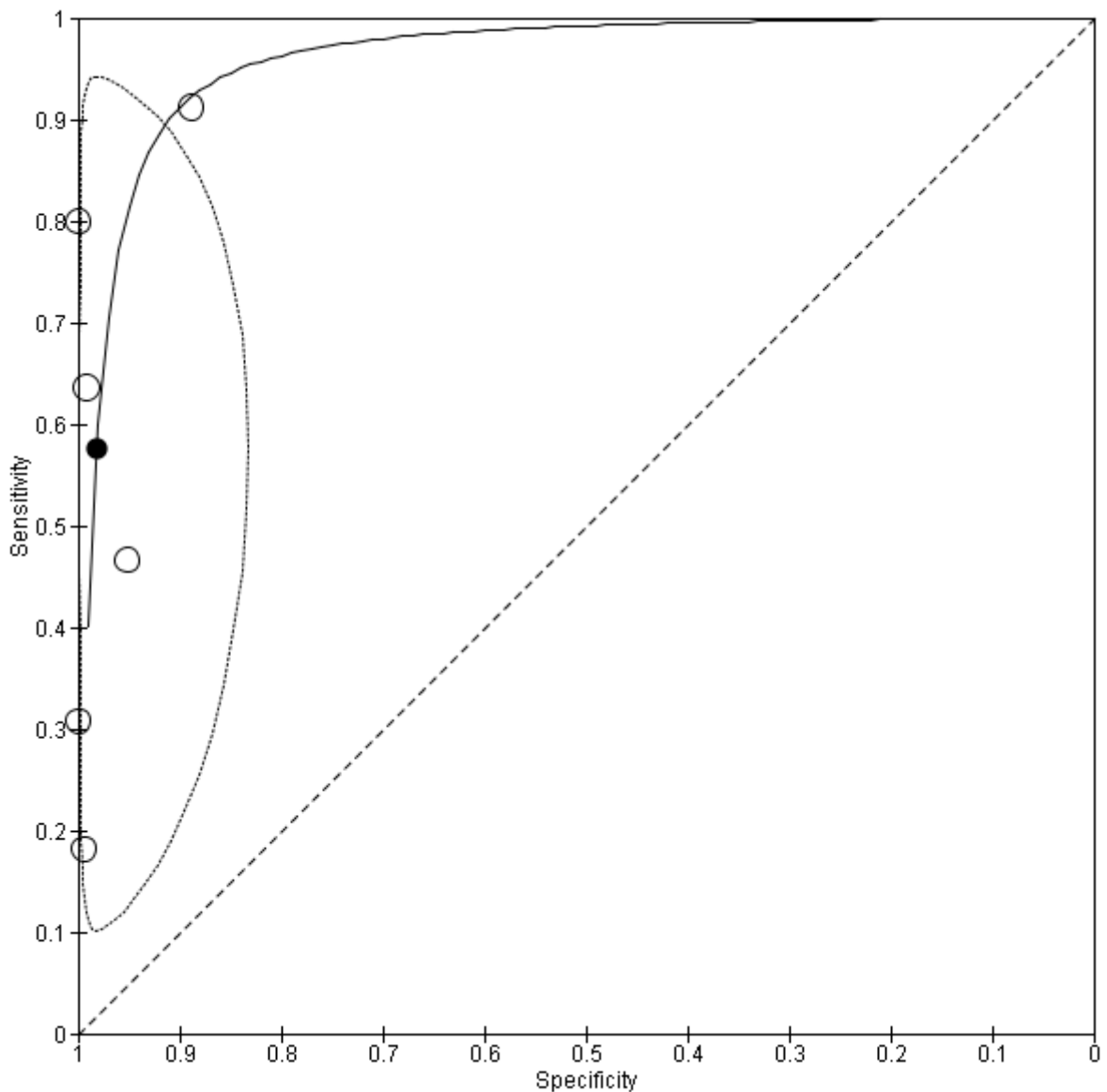
Study	TP	FP	FN	TN	Ultrasound test	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Bazot 2009	40	5	43	4	TRUS	0.48 [0.37, 0.59]	0.44 [0.14, 0.79]		
Fedele 1998	8	3	2	127	TRUS	0.80 [0.44, 0.97]	0.98 [0.93, 1.00]		

### I.6.17 Vaginal wall involvement by endometriosis

**Figure 48: Forest plot of TVUS for detection of vaginal wall involvement by endometriosis**

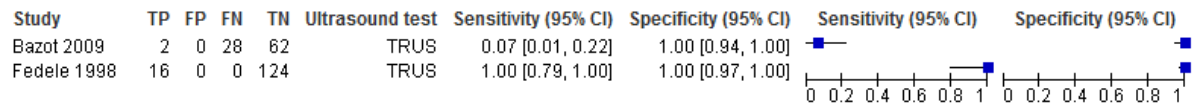


**Figure 49: Summary ROC plot of TVUS for detection of vaginal wall involvement of endometriosis**



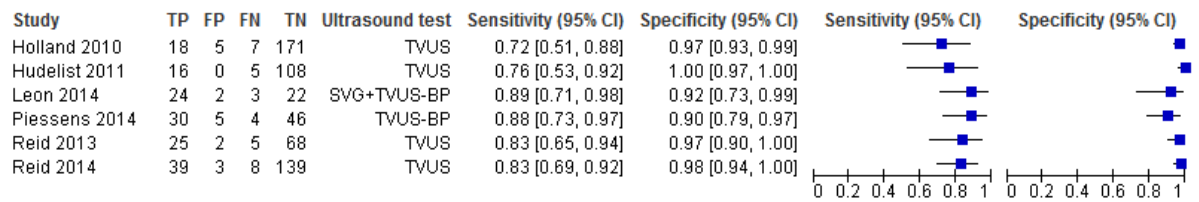
*Pooled sensitivity and specificity: 57% (26 to 84) and 98% (94 to 100)*

**Figure 50: Forest plot of TRUS for detection of vaginal wall involvement by endometriosis**

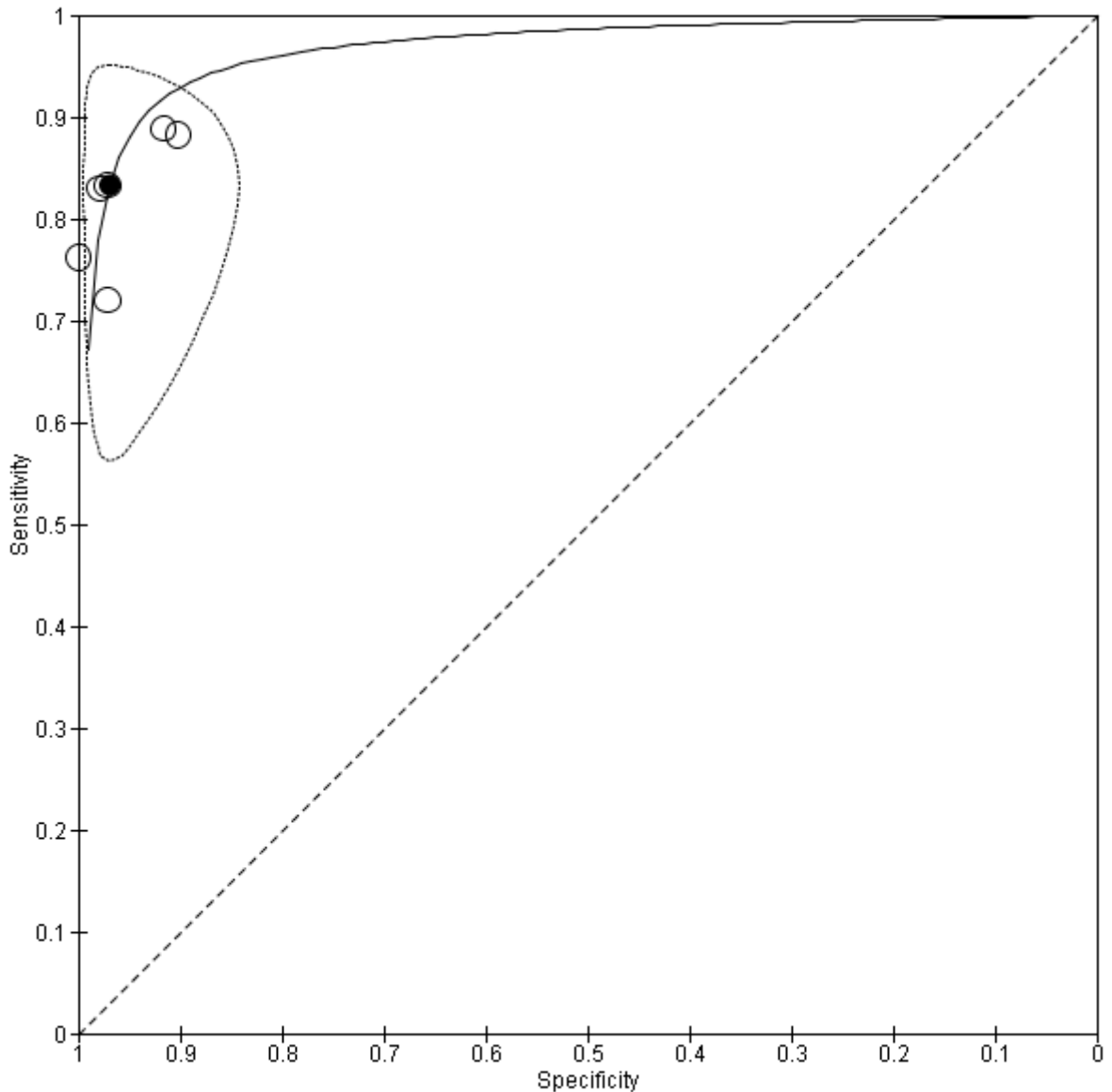


### I.6.8 Pouch of Douglas endometriosis

**Figure 51: Forest plot of TVUS for detection of POD obliteration by endometriosis**



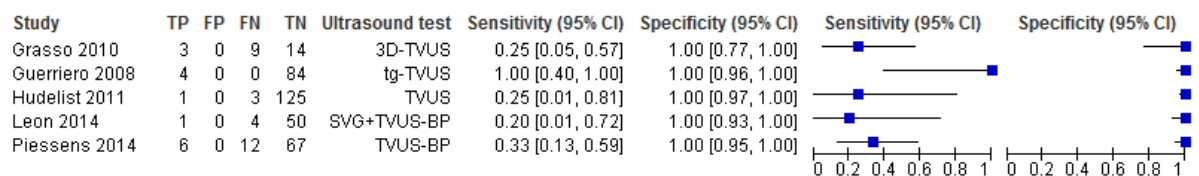
**Figure 52: Summary ROC plot of TVUS for detection of POD obliteration by endometriosis**



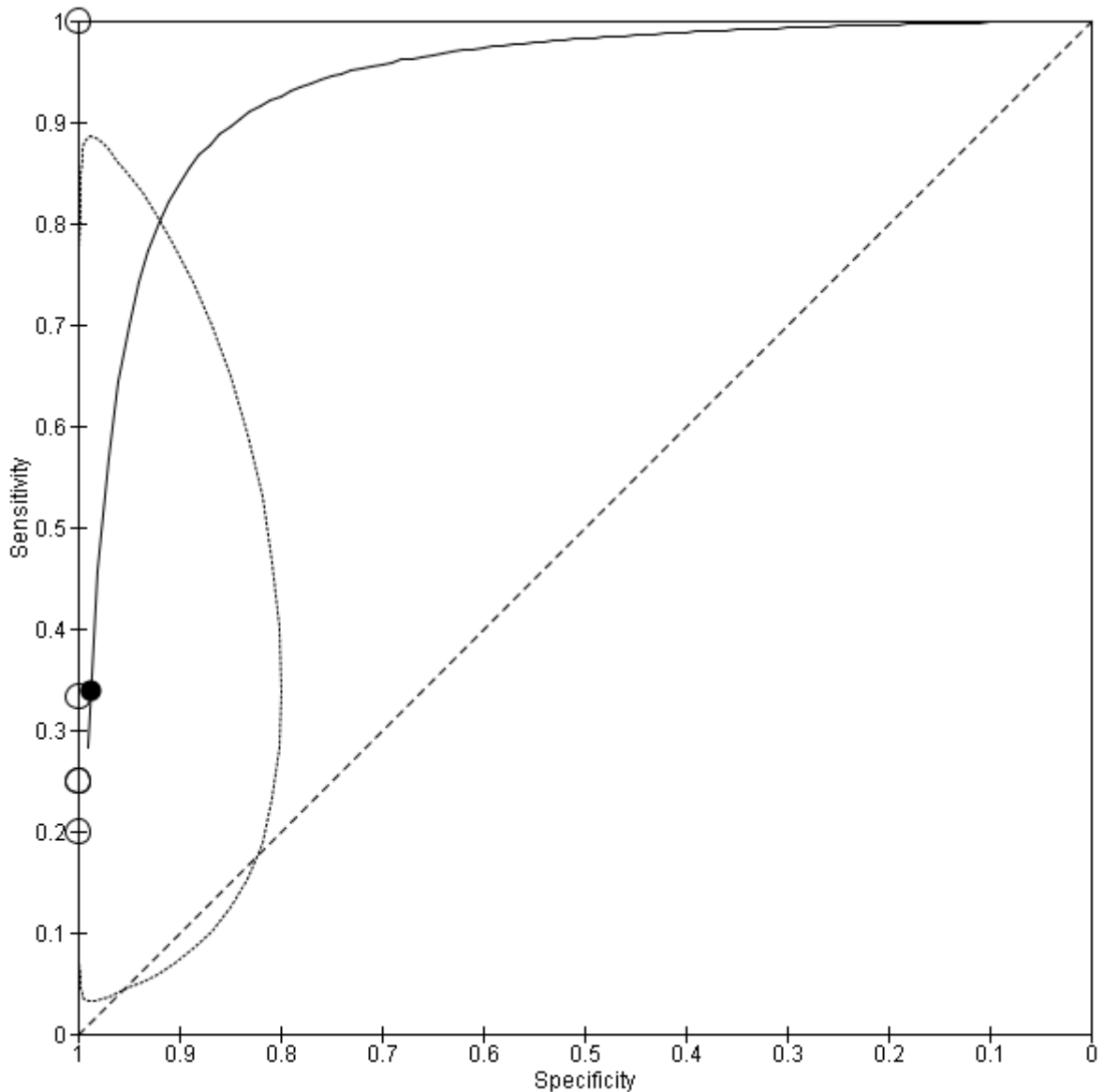
*Pooled sensitivity and specificity: 83% (71 to 91) and 97% (93 to 99)*

### I.6.9 Bladder endometriosis

**Figure 53: Forest plot of TVUS for detection of bladder endometriosis**



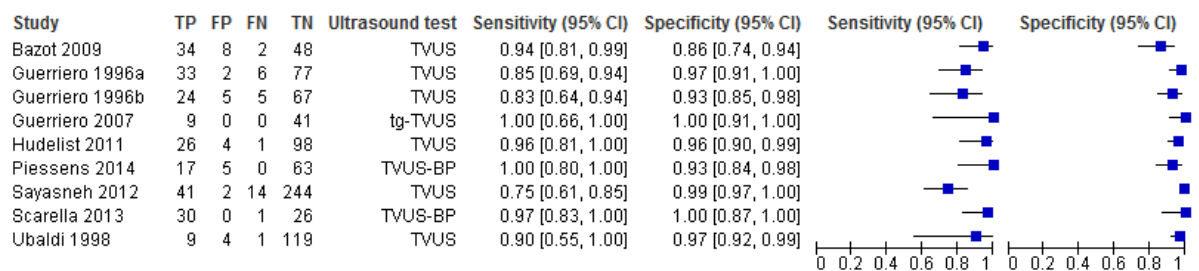
**Figure 54: Summary ROC plot of TVUS for detection of bladder endometriosis**



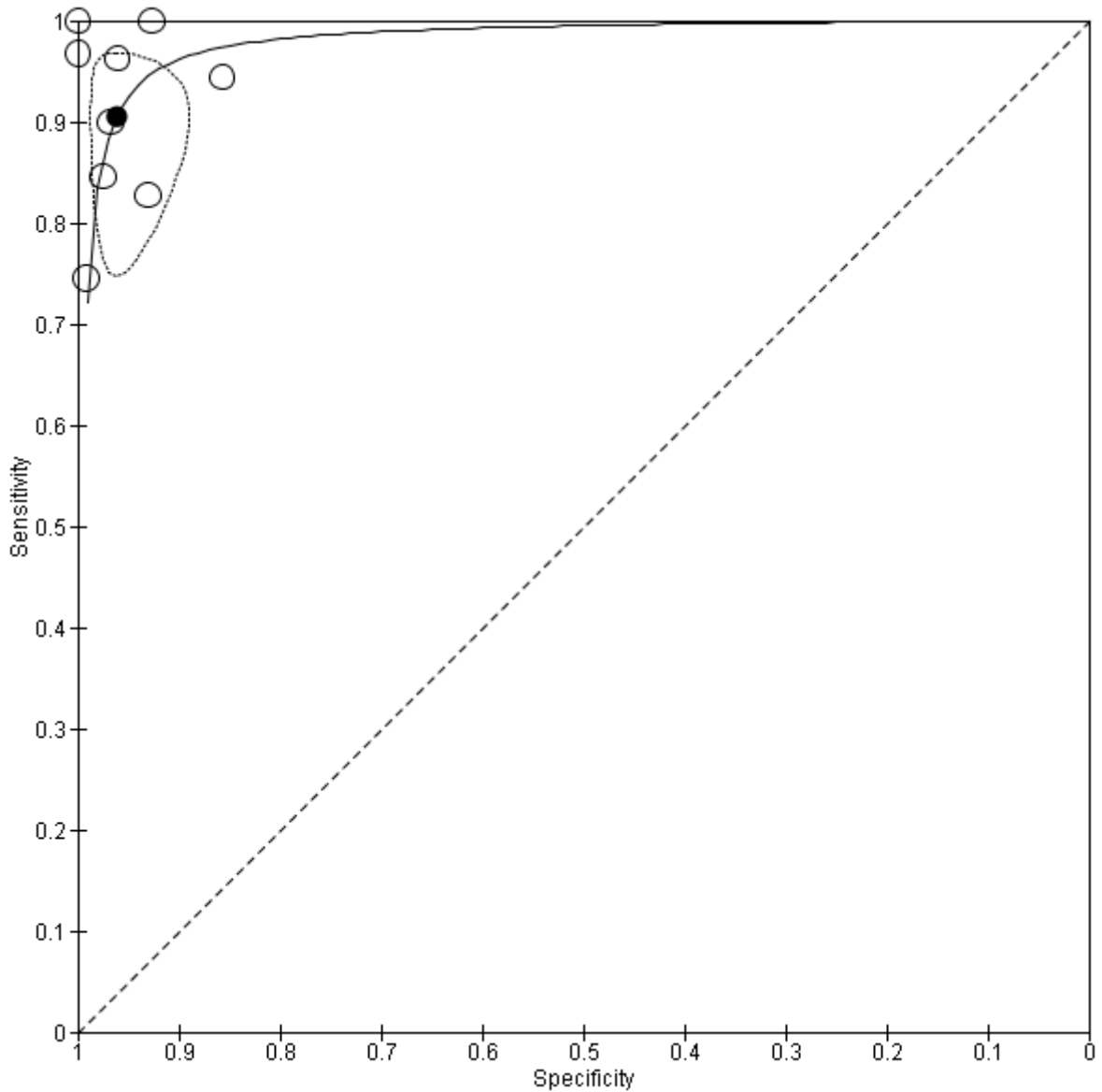
*Pooled sensitivity and specificity: 35% (13 to 63) and 98% (96 to 100)*

### I.6.10 Ovarian endometriosis

**Figure 55: Forest plot of TVUS for detection of ovarian endometriosis**



**Figure 56: Summary ROC plot of ultrasound for detection of ovarian endometriosis**



*Pooled sensitivity and specificity: 90% (83 to 96) and 96% (93 to 98)*

**Figure 57: Forest plot of TRUS for detection of ovarian endometriosis**

Study	TP	FP	FN	TN	Ultrasound test	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Bazot 2009	32	13	4	43	TVUS	0.89 [0.74, 0.97]	0.77 [0.64, 0.87]		

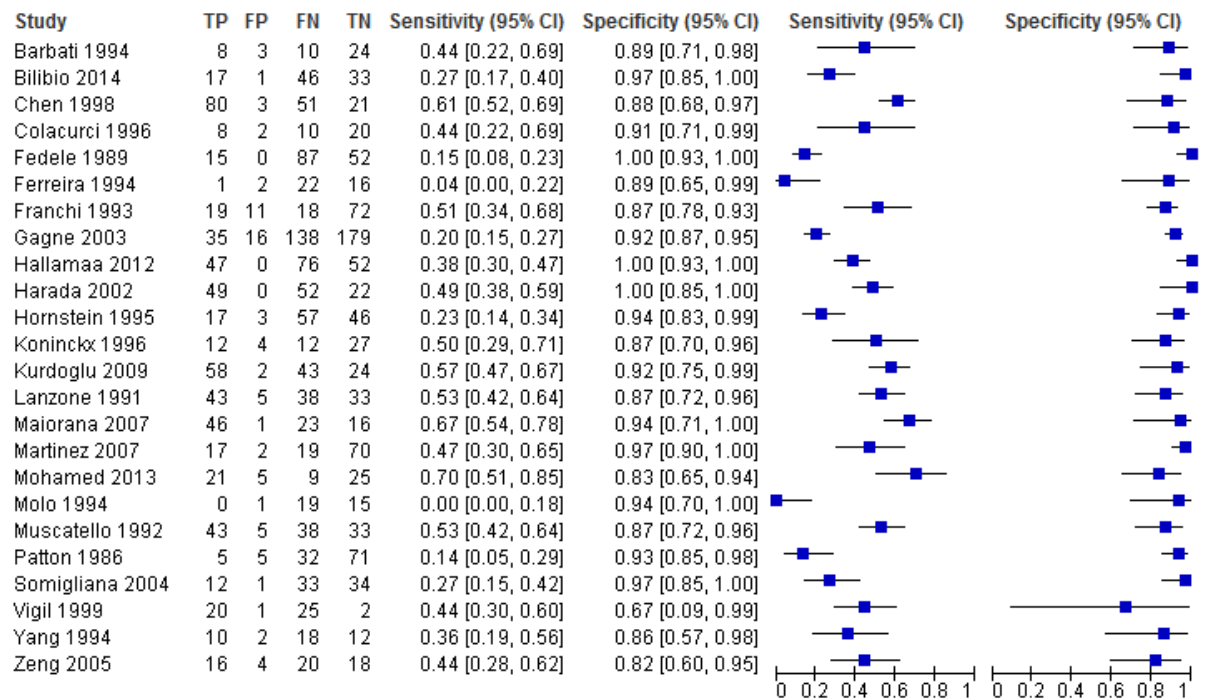
1  
2

## I.7 Diagnosis – Biomarkers: CA-125

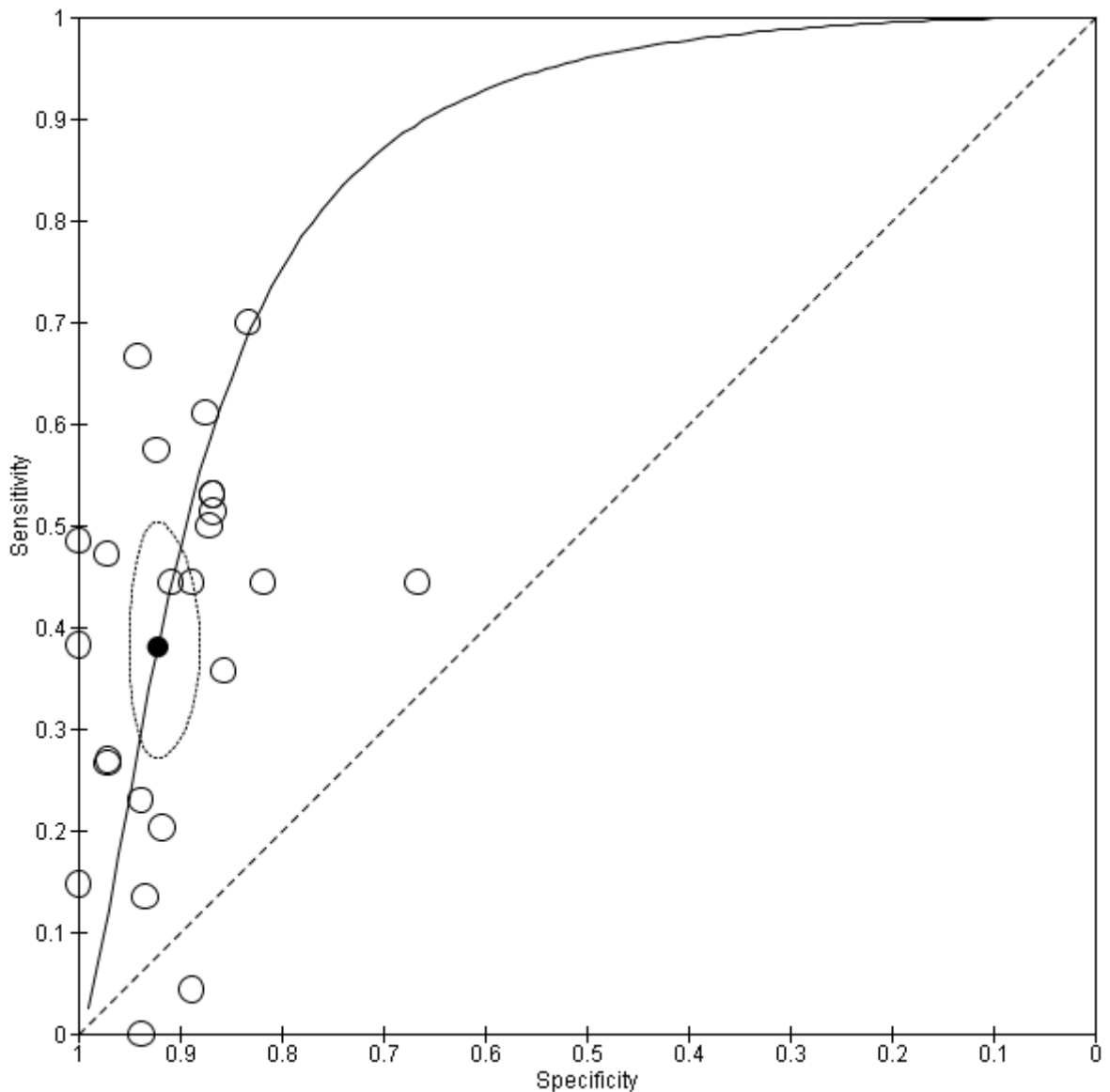
### I.7.21 Serum CA-125 compared to surgery – sensitivity / specificity forest plot and ROC plot

3

**Figure 58:** Forest plot of serum CA-125 detection of endometriosis



**Figure 59: Summary ROC plot of serum CA-125 for detection of endometriosis**



*Pooled sensitivity and specificity: 38% (30 to 47) and 92% (89 to 94)*

**1 Figure 60: Forest plot of serum CA-125 detection of endometrioma**

Study	TP	FP	FN	TN	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
Guerrero 1996	17	15	12	57	0.59 [0.39, 0.78]	0.79 [0.68, 0.88]		

2

3

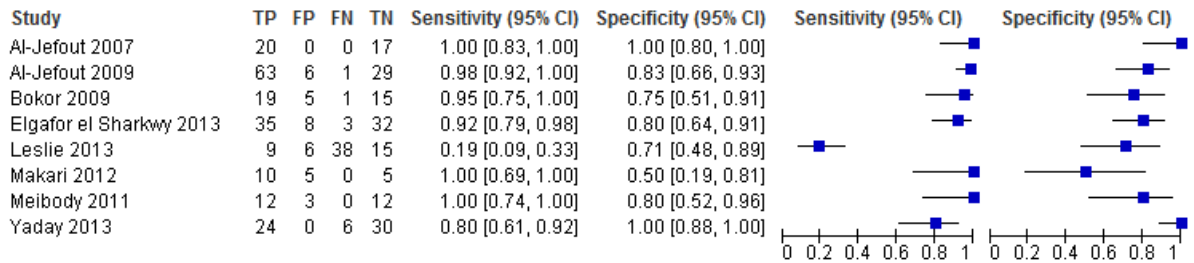
## **I.8 Diagnosis – Biomarkers: HE-4**

5 Not applicable

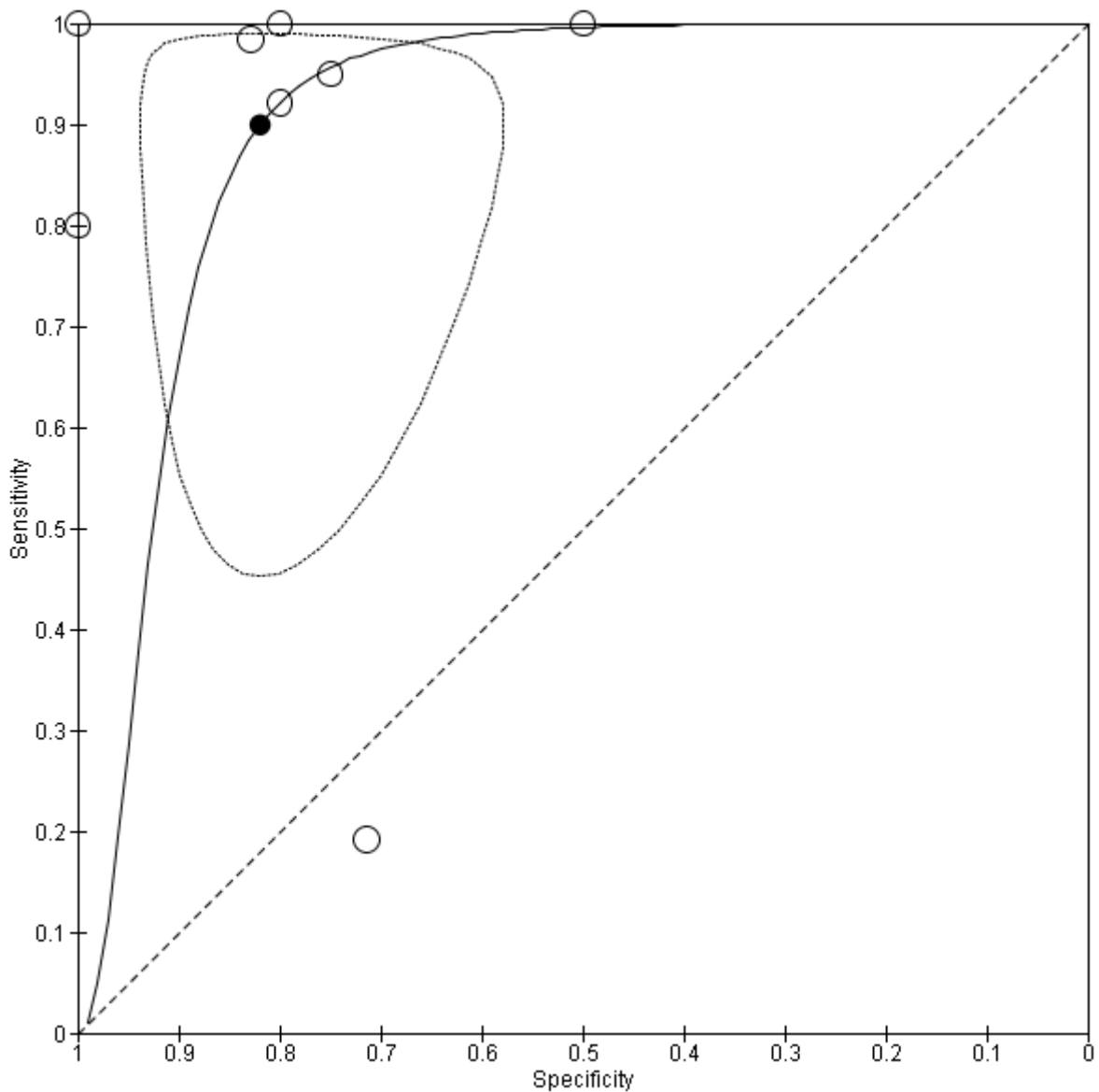


## I.9 Diagnosis – Biomarkers: Nerve fibre marker Protein Gene Product 9.5 (PGP 9.5)

**Figure 61: Forest plot of PGP 9.5 detection of endometriosis**



**Figure 62: Summary ROC plot of PGP 9.5 detection of endometriosis**



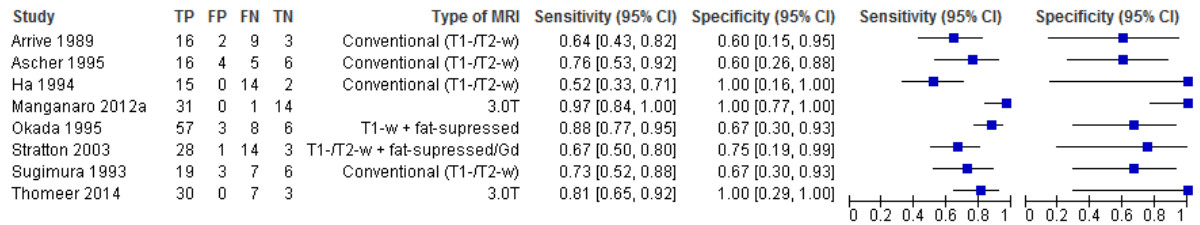
*Pooled sensitivity and specificity: 88% (69 to 98) and 81% (69 to 91)*

1

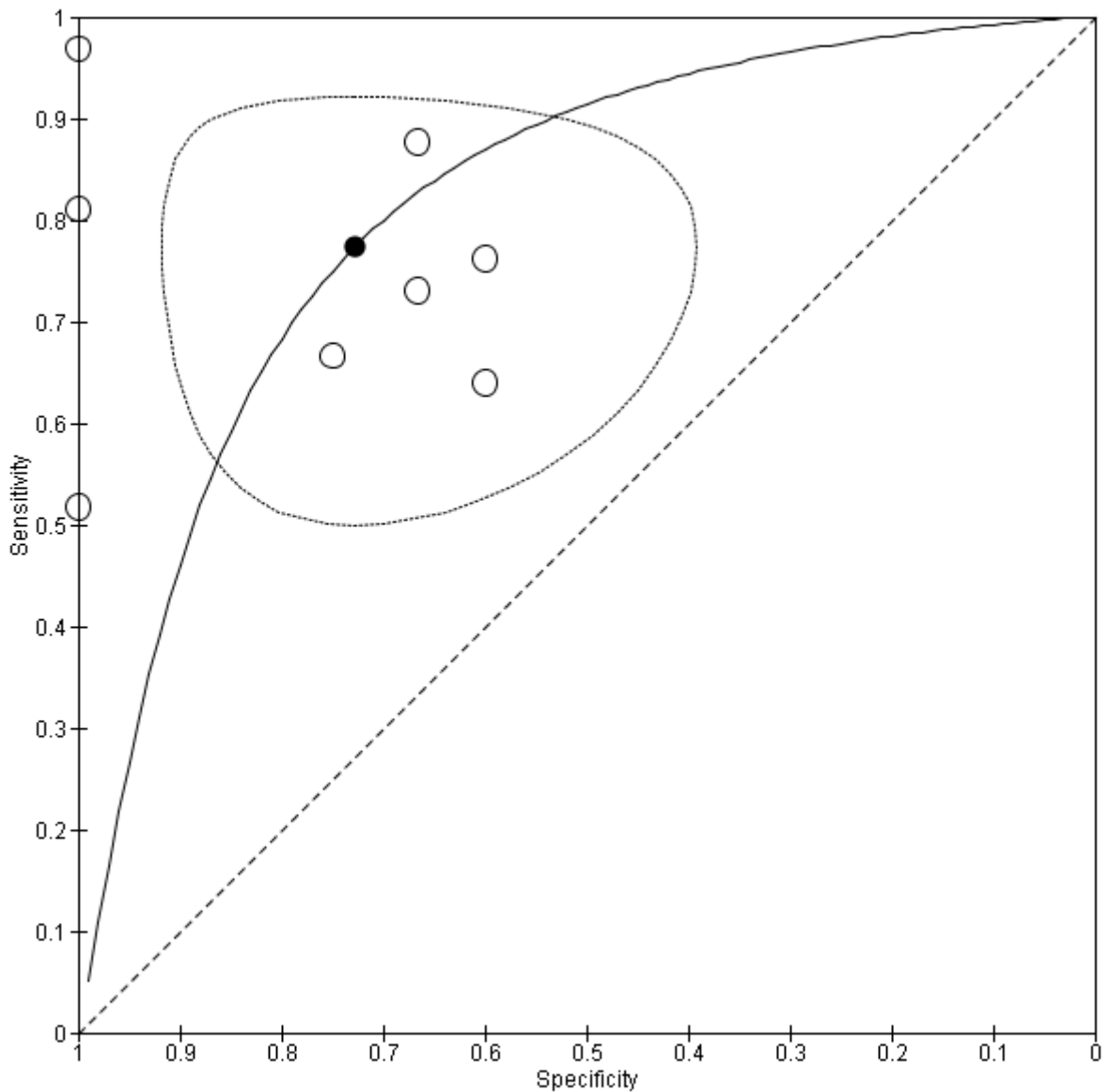
## I.10 Diagnosis – MRI

### I.103 Pelvic endometriosis

**Figure 63: Forest plot of MRI detection of pelvic endometriosis**

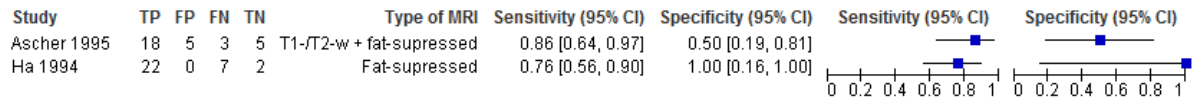


**Figure 64: Summary ROC plot of MRI for detection of pelvic endometriosis**

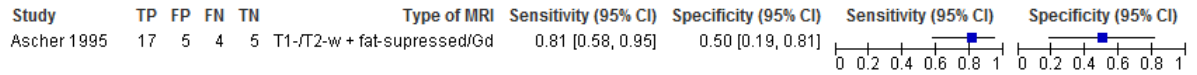


*Pooled sensitivity and specificity: 77% (62 to 88) and 72% (53 to 87)*

**Figure 65: Forest plot of MRI detection of pelvic endometriosis (fat-suppressed MRI)**

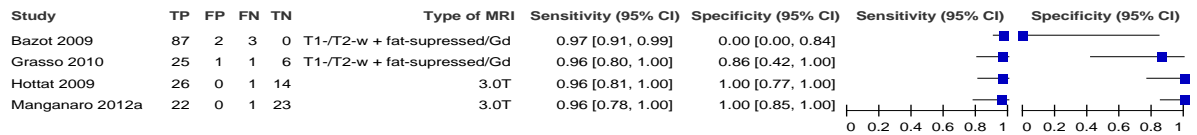


**Figure 66: Forest plot of MRI detection of pelvic endometriosis (fat-suppressed/Gd MRI)**

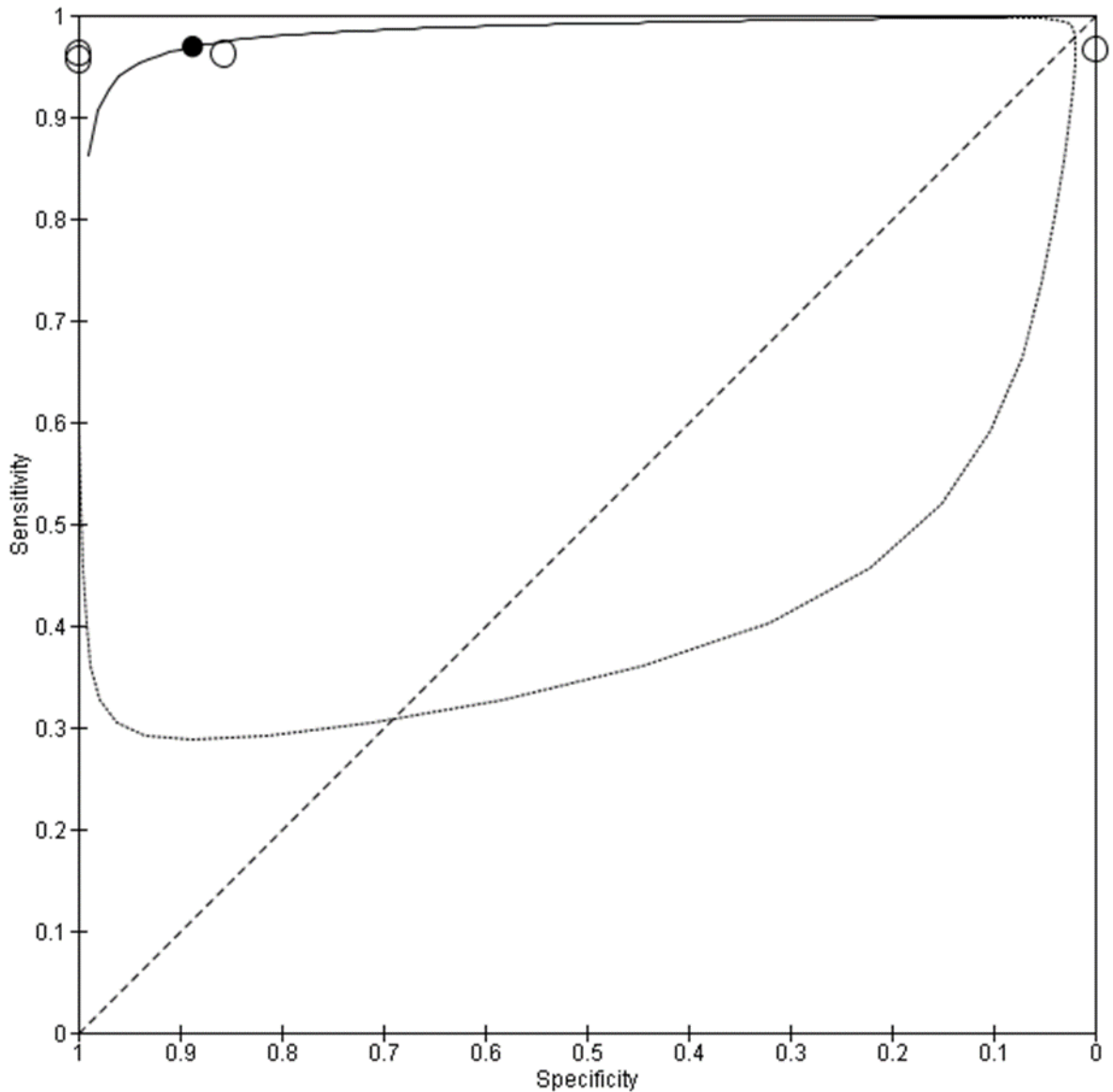


## I.10.2 DIE, posterior and anterior DIE

**Figure 67: Forest plot of MRI for detection of DIE**

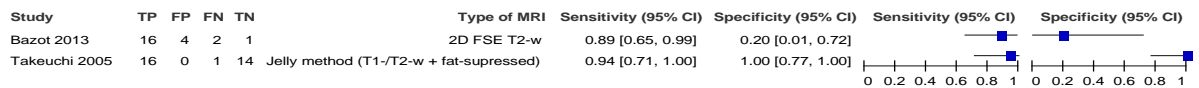


**Figure 68: Summary ROC plot of MRI for detection of DIE**

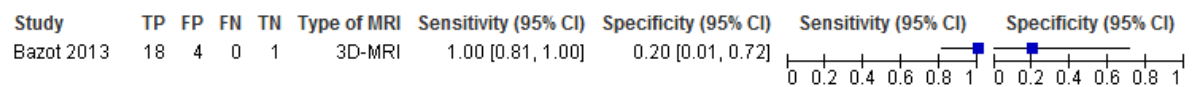


*Pooled sensitivity and specificity: 96% (90 to 99) and 86% (54 to 98)*

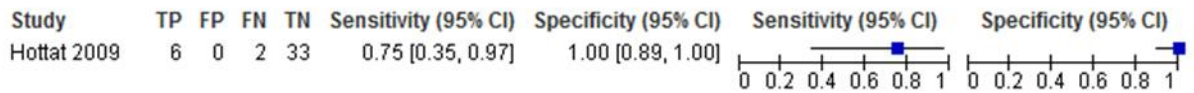
**Figure 69: Forest plot of MRI for detection of posterior DIE (2D and fat-suppressed MRI)**



**Figure 70: Forest plot of MRI for detection of posterior DIE (3D MRI)**

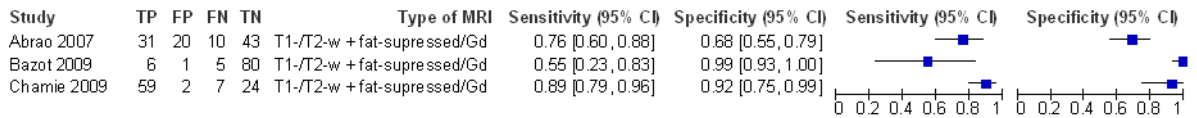


**Figure 71: Forest plot of MRI for detection of anterior endometriosis**

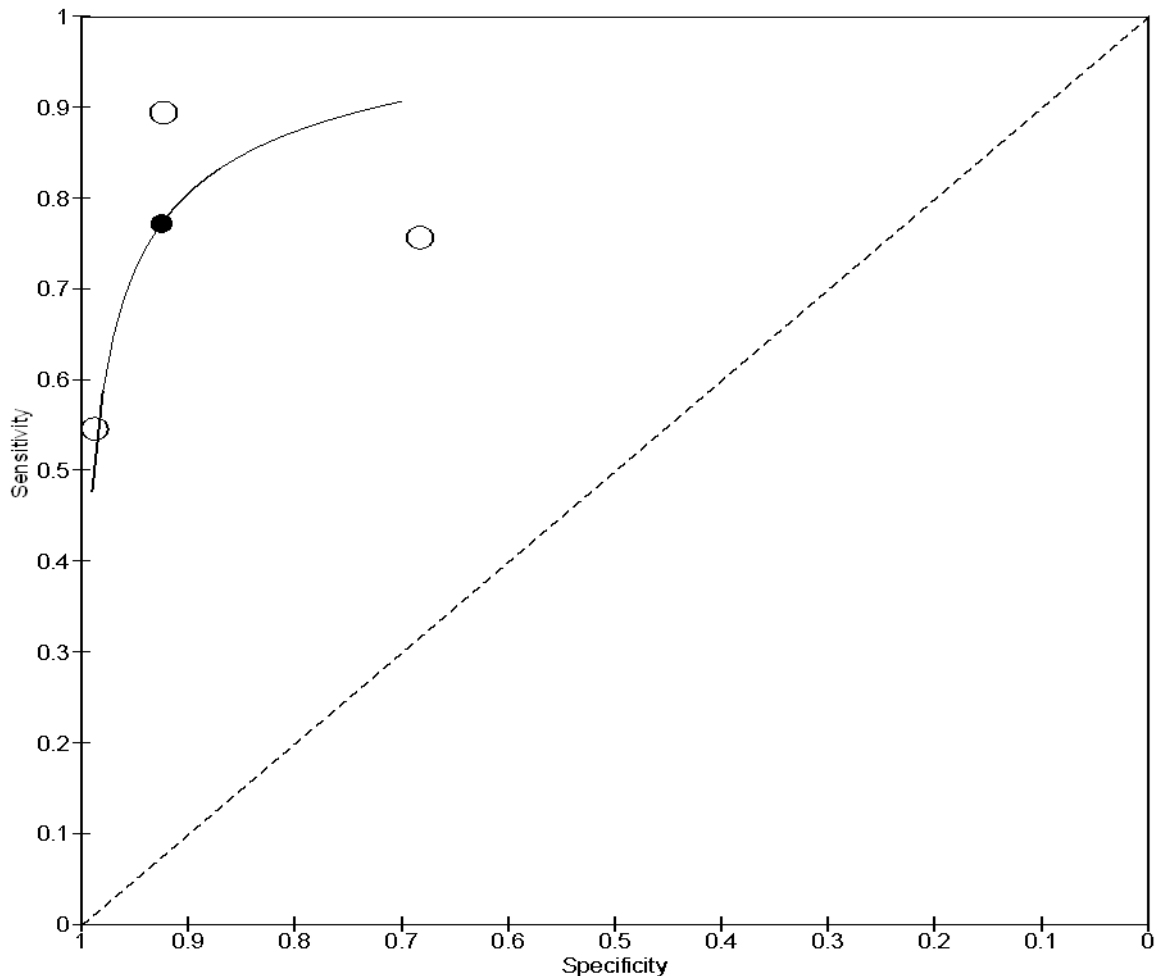


### I.10.3 Rectovaginal endometriosis

**Figure 72: Forest plot of MRI for detection of RVS endometriosis**



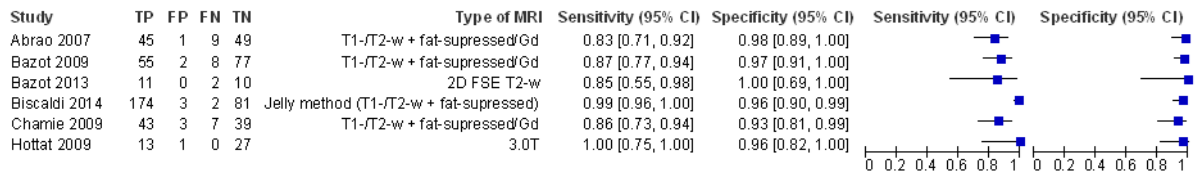
**Figure 73: Summary ROC plot of MRI for detection of RVS endometriosis**



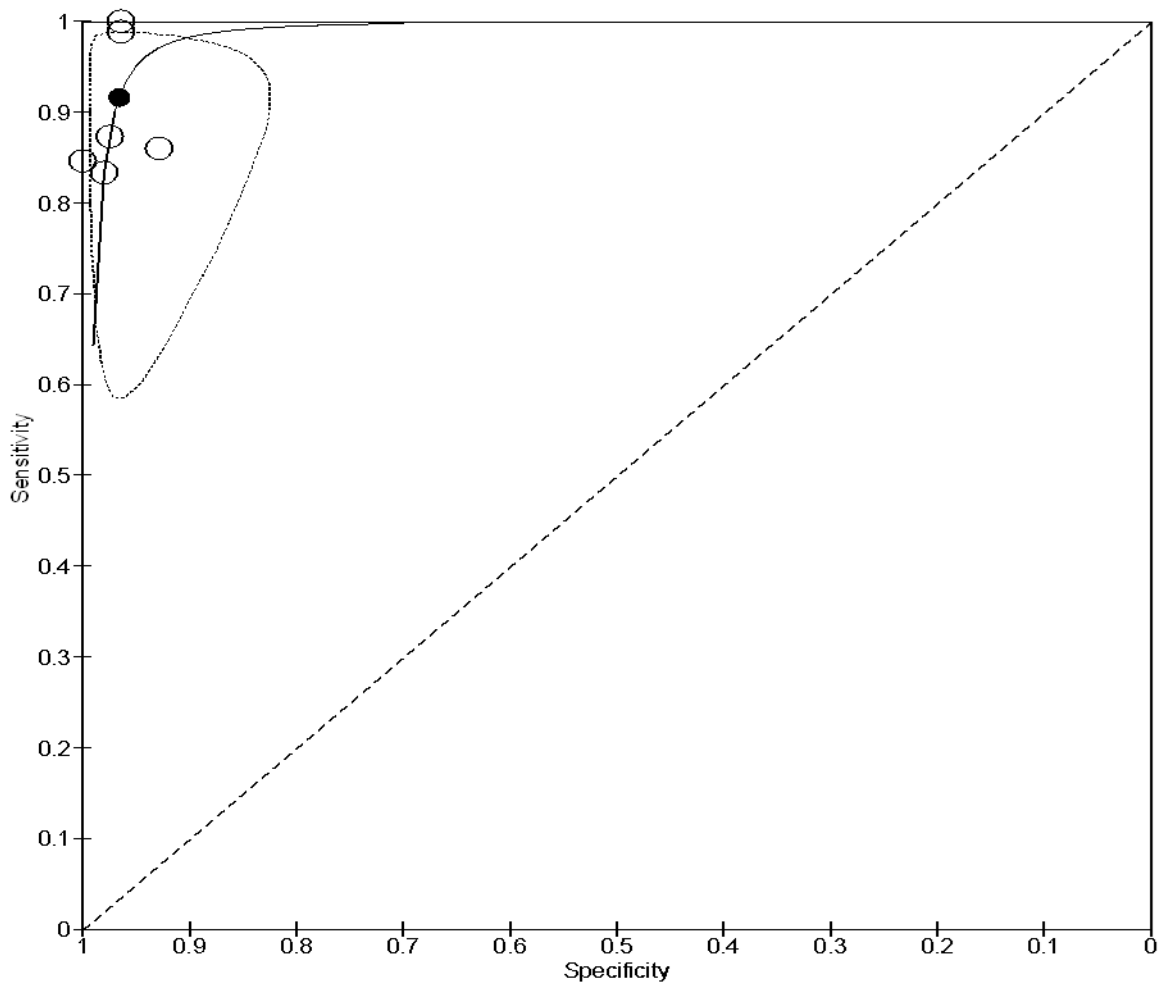
Pooled sensitivity and specificity: 75% (35 to 95) and 88% (43 to 99)

### I.10.4 Rectosigmoid endometriosis

**Figure 74: Forest plot for MRI for detection of rectosigmoid endometriosis**

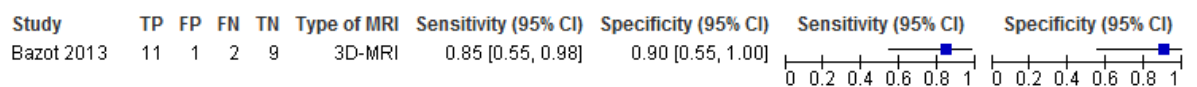


**Figure 75: Summary ROC plot of MRI for detection of rectosigmoid endometriosis**



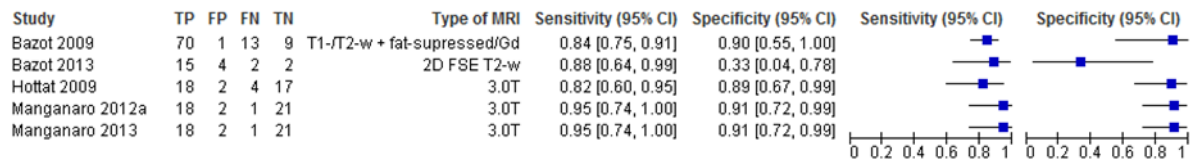
Pooled sensitivity and specificity: 91% (79 to 97) and 96% (92 to 99)

**Figure 76: Forest plots for MRI for detection of rectosigmoid endometriosis (3D MRI)**

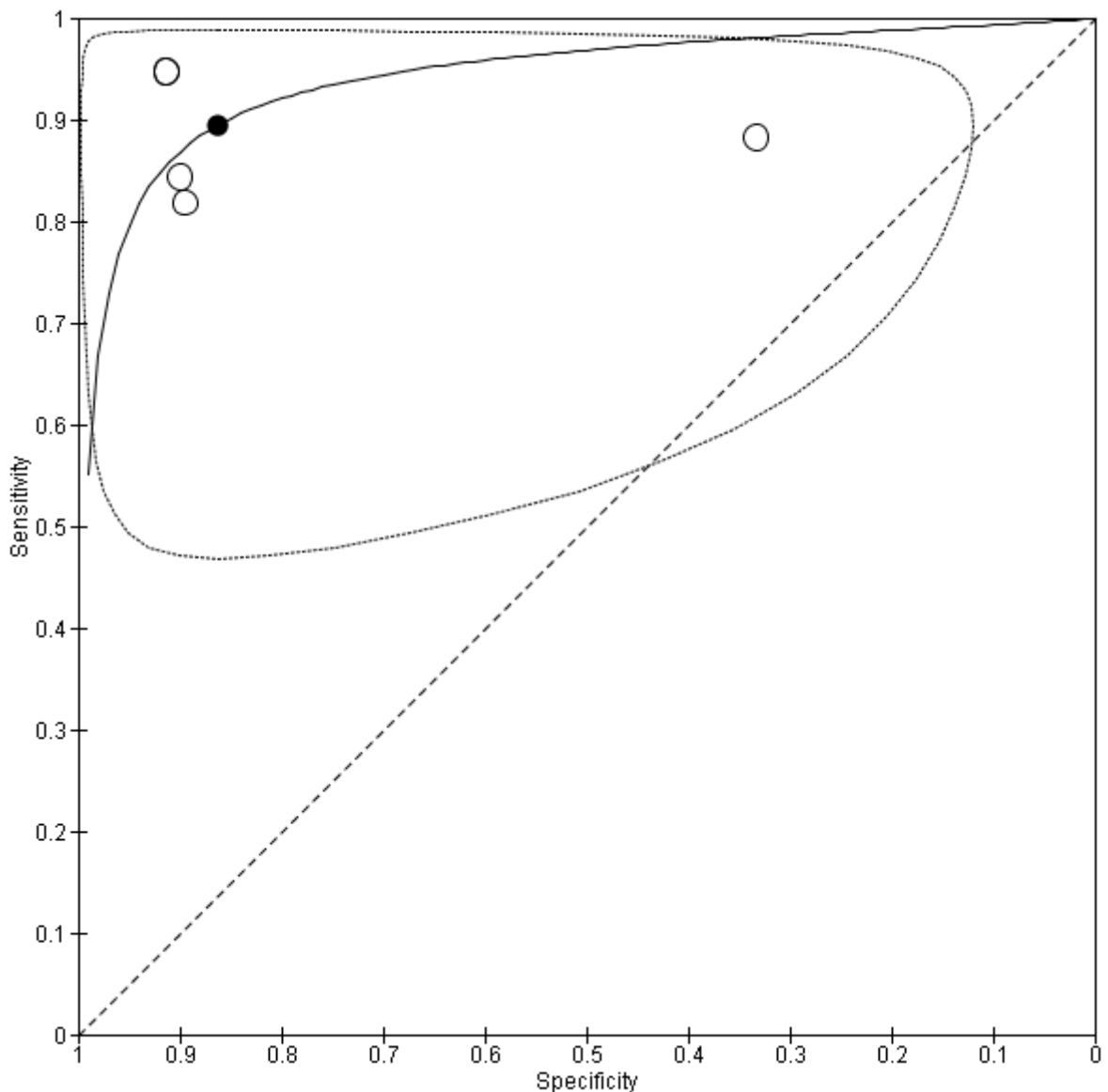


### I.10.5 Uterosacral ligament endometriosis

**Figure 77: Forest plot of MRI for detection of USL involvement by endometriosis**



**Figure 78: Summary ROC plot of MRI for detection of UCL involvement endometriosis**



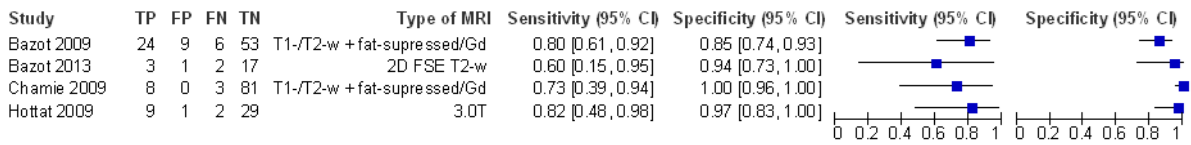
*Pooled sensitivity and specificity: 88% (77 to 96) and 84% (62 to 96)*

**Figure 79: Forest plot of MRI for detection of USL involvement by endometriosis (3D MRI)**

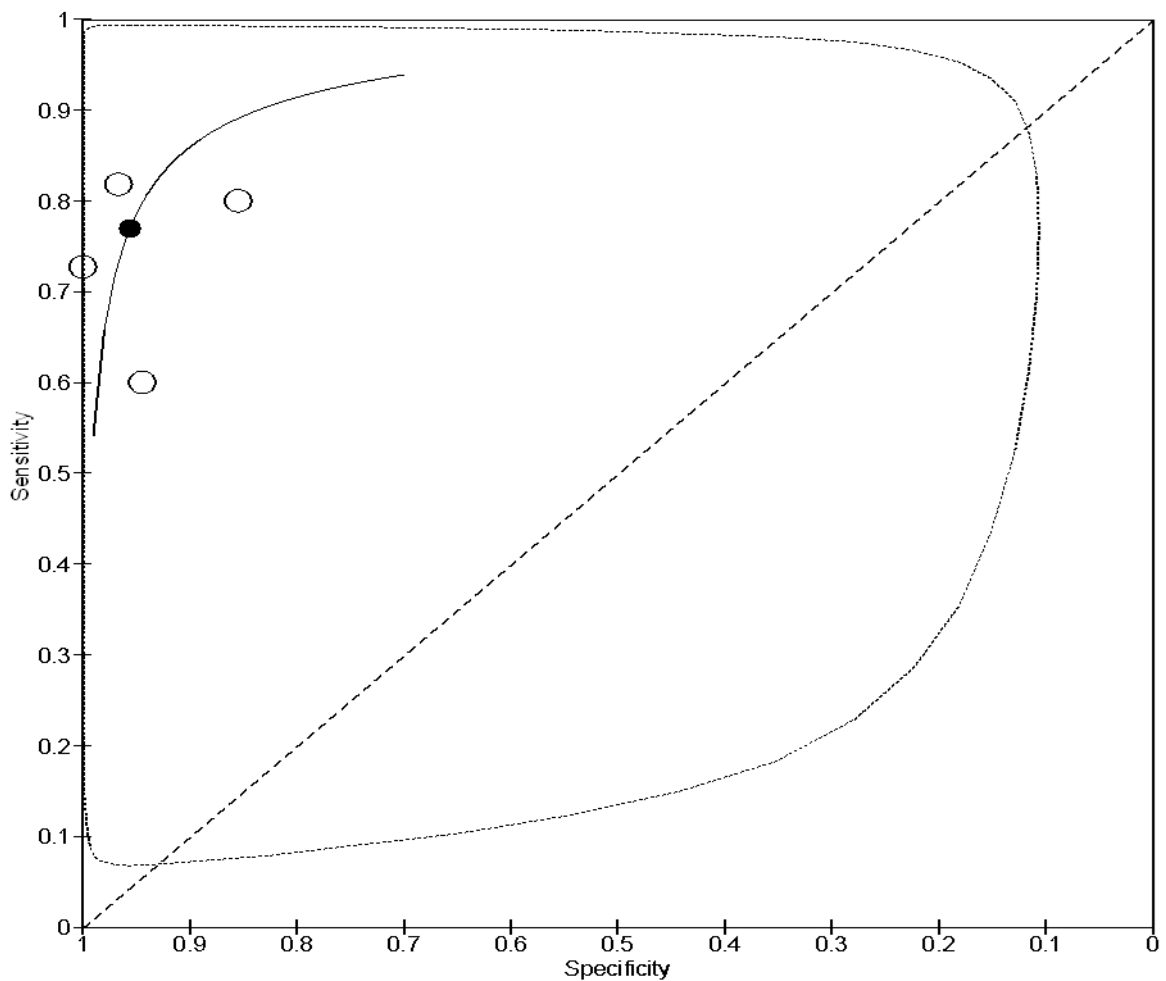


### I.10.6 Vaginal wall involvement by endometriosis

**Figure 80: Forest plot of MRI for detection of vaginal wall involvement by endometriosis**



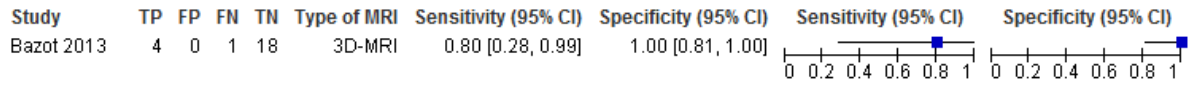
**Figure 81: Summary ROC plot of MRI for detection of vaginal wall involvement of endometriosis**



Pooled sensitivity and specificity: 75% (50 to 92) and 94% (83 to 99)

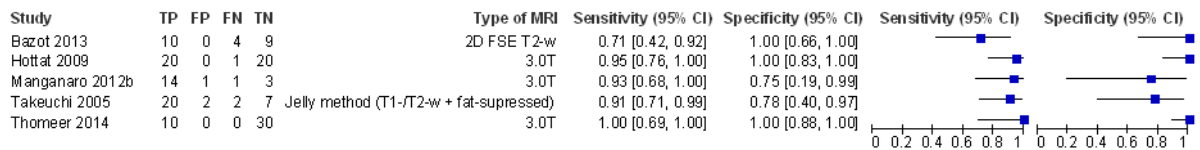


**Figure 82: Forest plot of MRI for detection of vaginal wall involvement by endometriosis (3D MRI)**

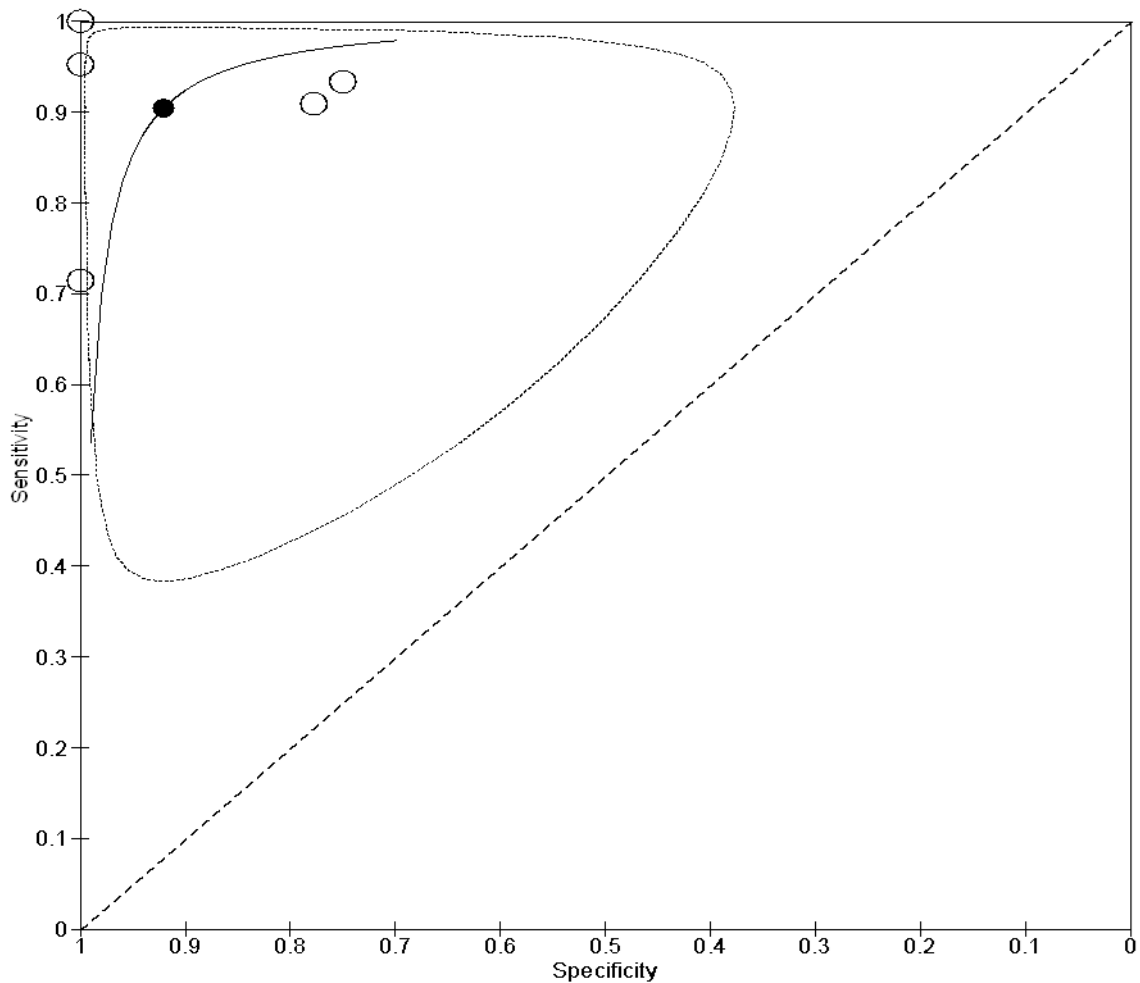


**I.10.7 Pouch of Douglas endometriosis**

**Figure 83: Forest plot of MRI for detection of POD obliteration by endometriosis**

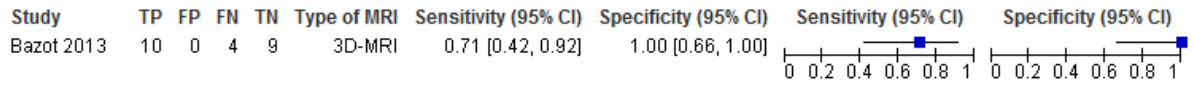


**Figure 84: Summary ROC plot of MRI for detection of POD obliteration by endometriosis**



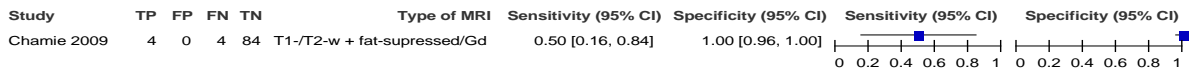
Pooled sensitivity and specificity: 89% (75 to 97) and 91% (76 to 98)

**Figure 85: Forest plot of MRI for detection of POD obliteration by endometriosis (3D MRI)**



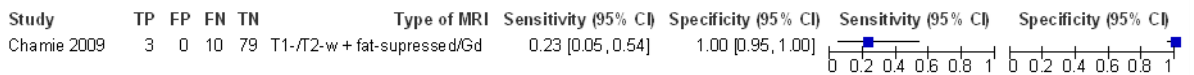
### I.10.8 Ureteral endometriosis

**Figure 10: Forest plots of MRI for detection of ureteral endometriosis**



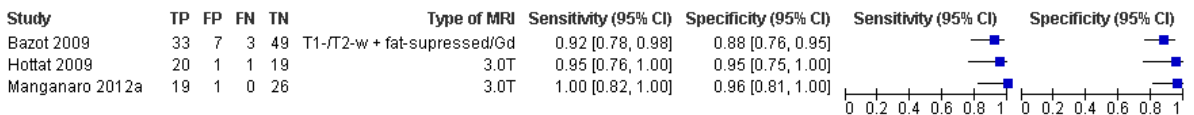
### I.10.9 Bladder endometriosis

**Figure 86: Forest plot of MRI for detection of bladder endometriosis**

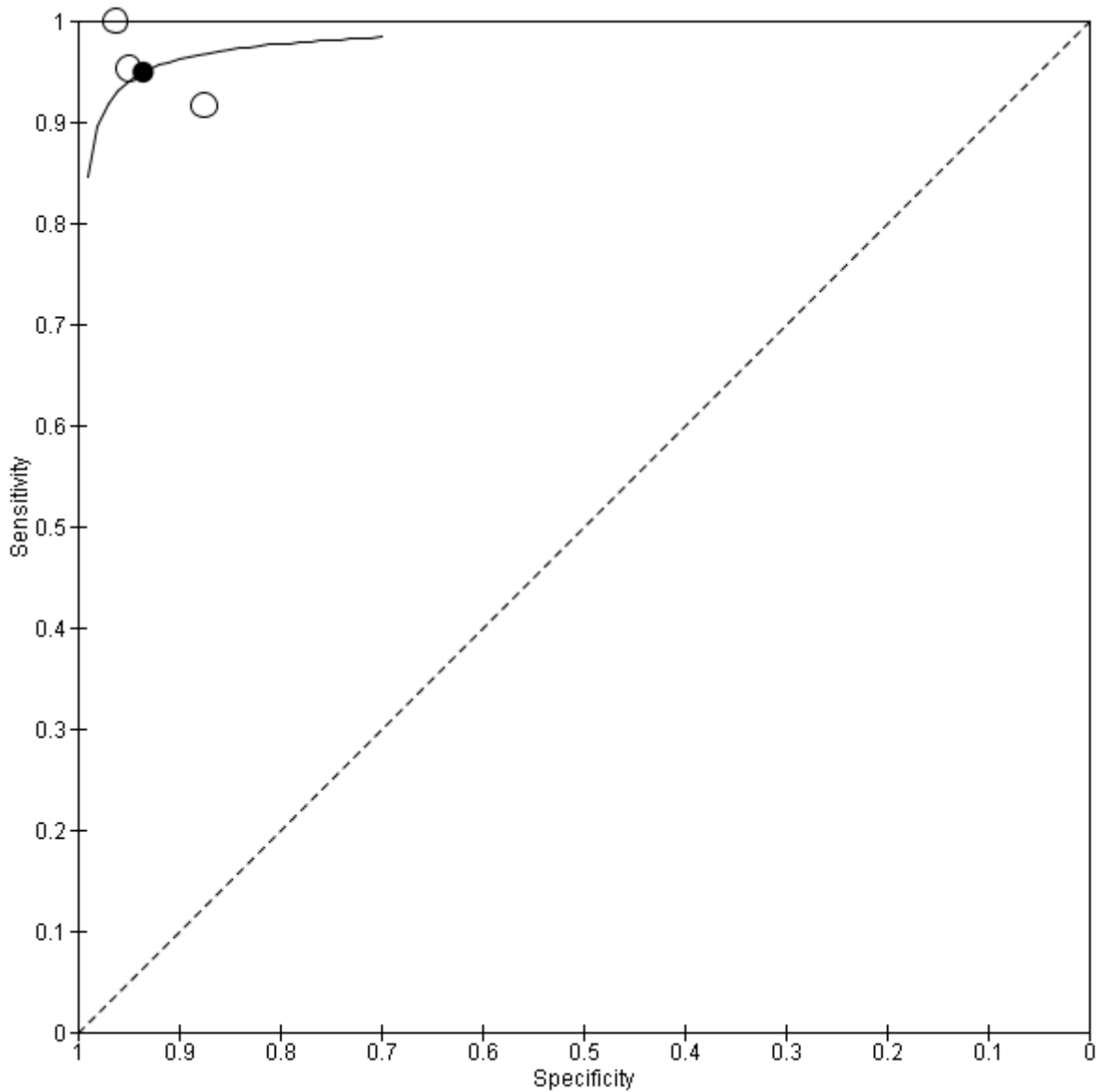


### I.10.10 Ovarian endometriosis

**Figure 87: Forest plot of MRI for detection of ovarian endometriosis**



**Figure 88: Summary ROC plot of MRI for detection of ovarian endometriosis**



1

2

### **I.13 Diagnosis – Surgical diagnosis with or without histological confirmation**

4

5 Not applicable

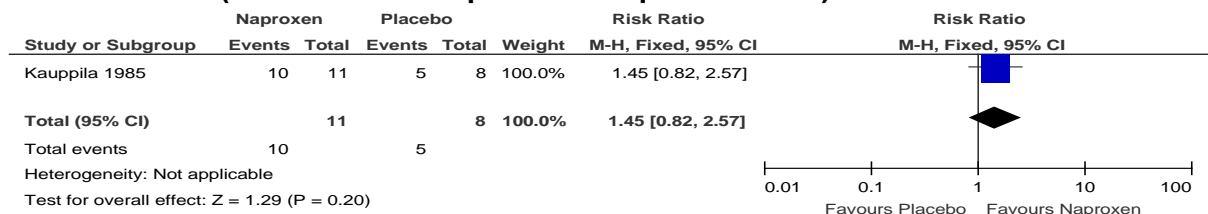
### **I.12 Staging Systems**

7 No evidence found

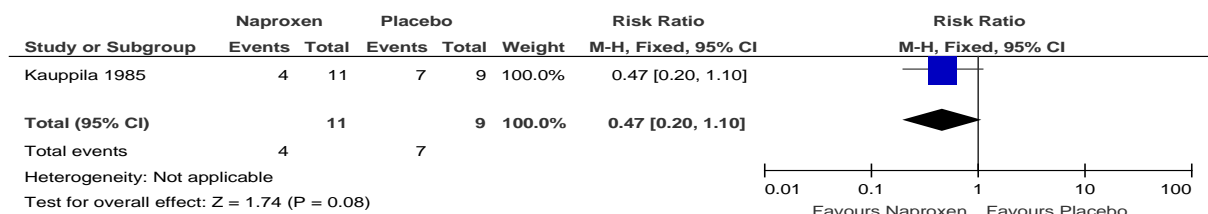
## I.13 Pharmacological management – Analgesics

### I.1321 Non-steroidal anti-inflammatory drugs (NSAIDs) versus placebo

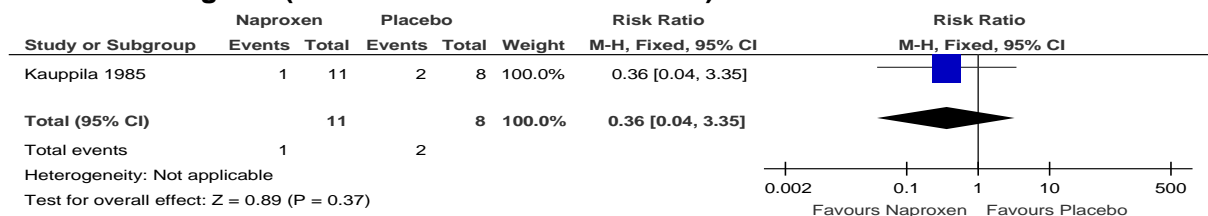
**Figure 89: NSAIDs vs PLACEBO in women with endometriosis for overall pain relief (measured with 3 point scale questionnaire)**



**Figure 90: NSAIDs vs PLACEBO in women with endometriosis for unintended effects**



**Figure 91: NSAIDs vs PLACEBO in women with endometriosis for supplementary analgesia (additional medication needed)**



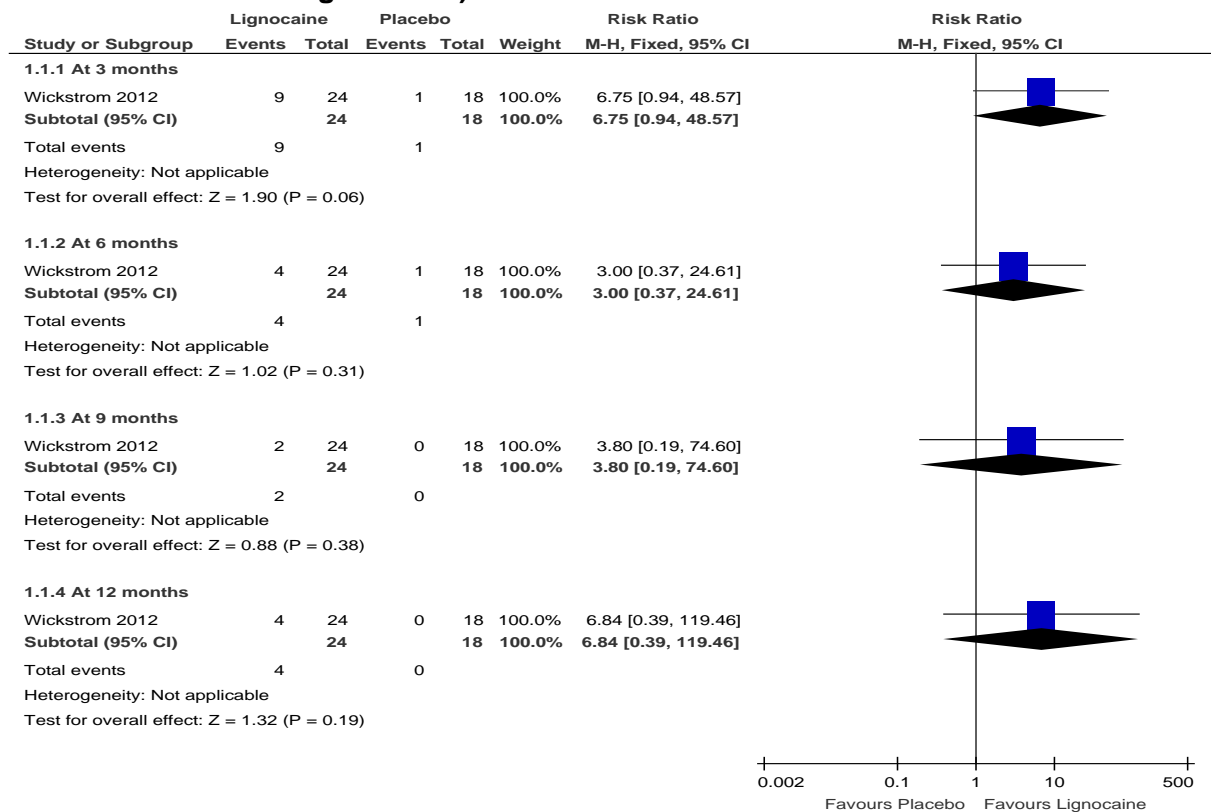
3

4

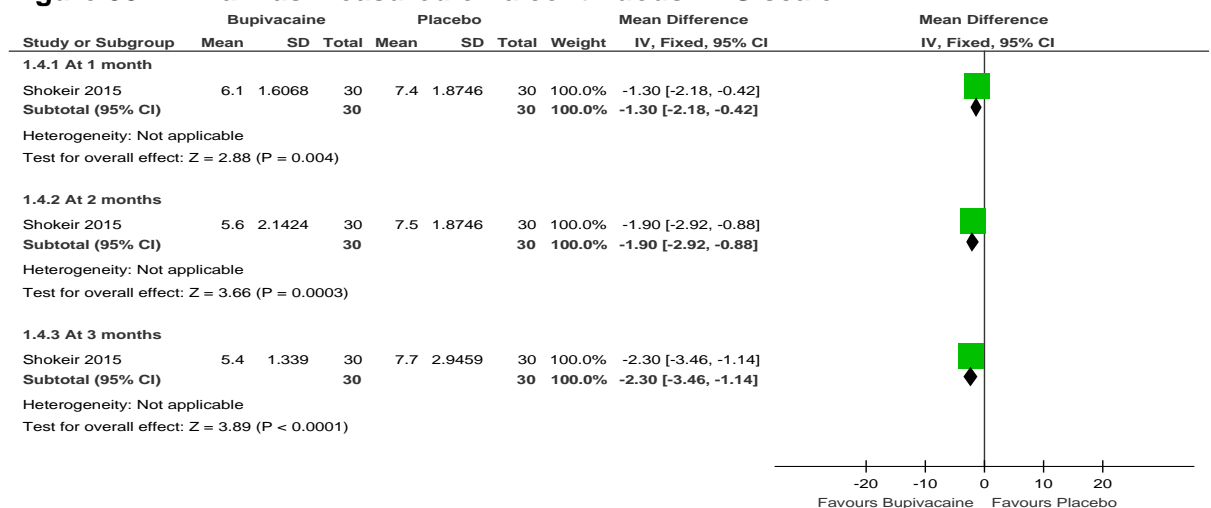
## I.14 Pharmacological management – Neuromodulators

### I.1421 Neuromodulator (perturbation of local anaesthetic) vs. placebo

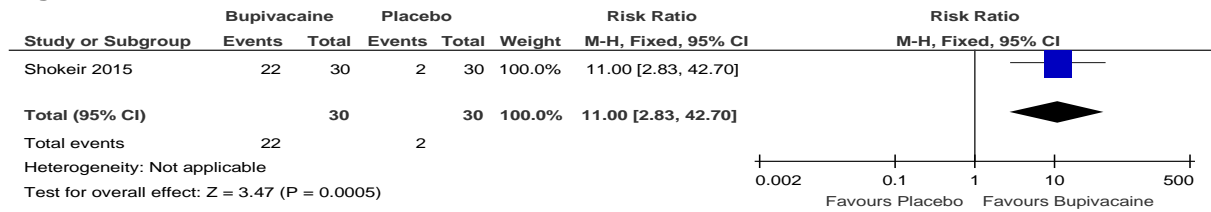
**Figure 92: Pain score as measured as a rate of participants improving ( $\geq 50\%$  on a Visual Analogue Score)**



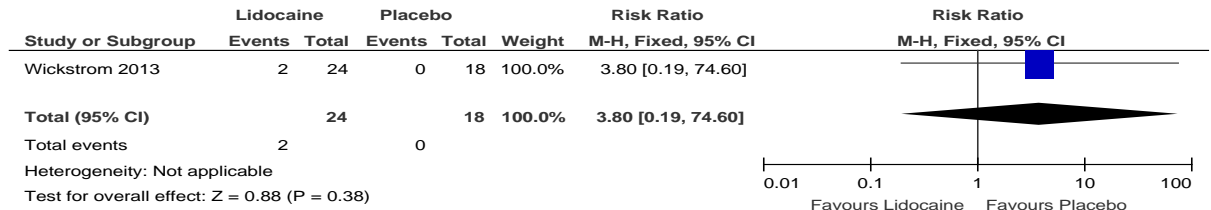
**Figure 93: Pain as measured on a continuous VAS scale**



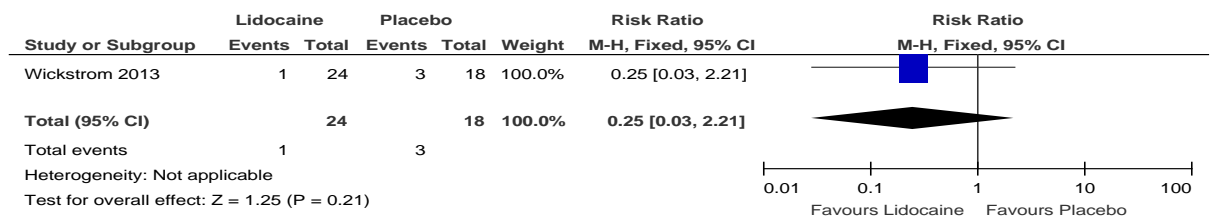
**Figure 94: Rate of women satisfied with treatment at 3 months**



**Figure 95: Recurrence at 12 months**



**Figure 96: Rate of women with escalating pain and need for other therapies at 12 months**



1

## I.15 Pharmacological management – Hormonal medical treatments

3

### I.15# Comparison 1: GnRH agonists versus no treatment

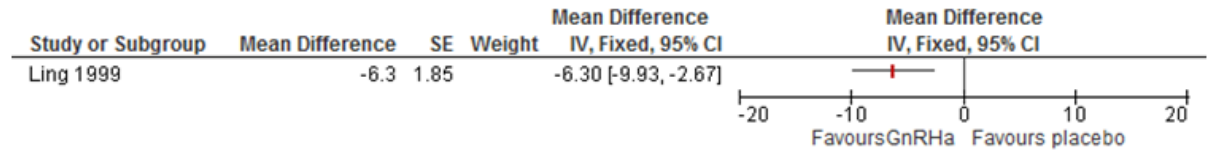
**Figure 97: Outcome: Dysmenorrhoea relief at 12 months (VAS)**



Scale: 0 (no pain), 1 to 4 (mild), 5 to 7 (moderate), 8 to 10 (severe)

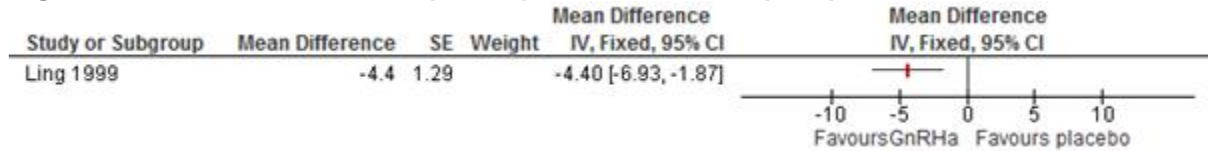
**I.15.2 Comparison 2: GnRH agonists versus placebo**

**Figure 98: Outcome: Mean dysmenorrhoea at 12 weeks (VAS)**



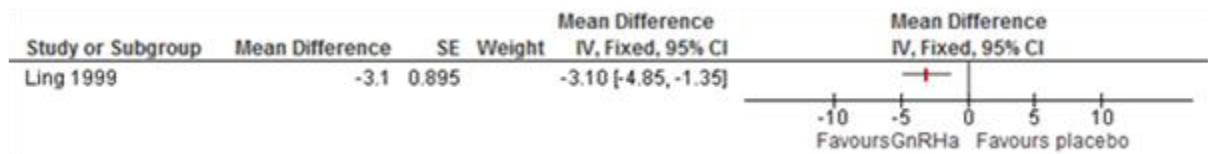
Scale: 11 point VAS

**Figure 99: Outcome: Mean pelvic pain at 12 weeks (VAS)**



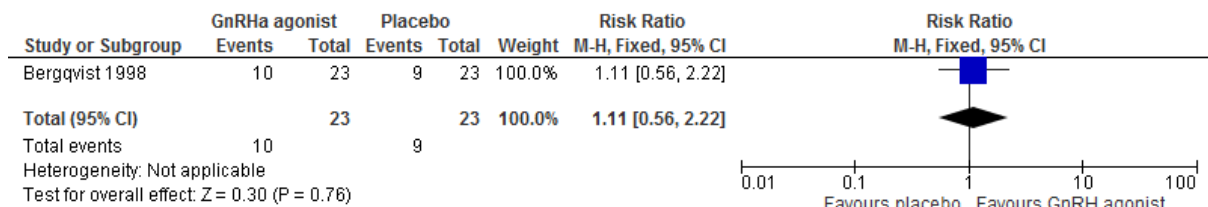
Scale: 11 point VAS

**Figure 100: Outcome: Mean deep dyspareunia at 12 weeks (VAS)**



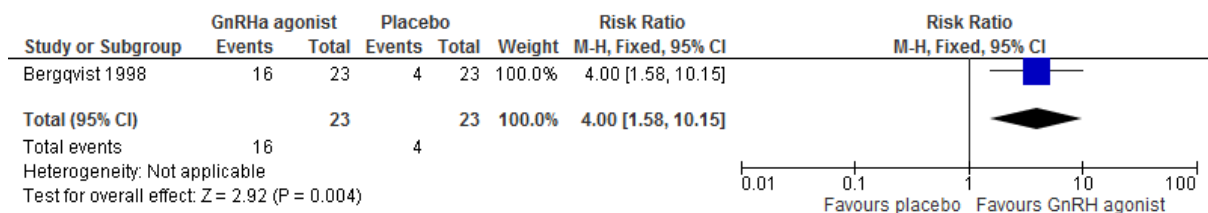
Scale: 11 point VAS

**Figure 101: Outcome: Dyspareunia cessation at 6 months**



Scale: 10 point VAS

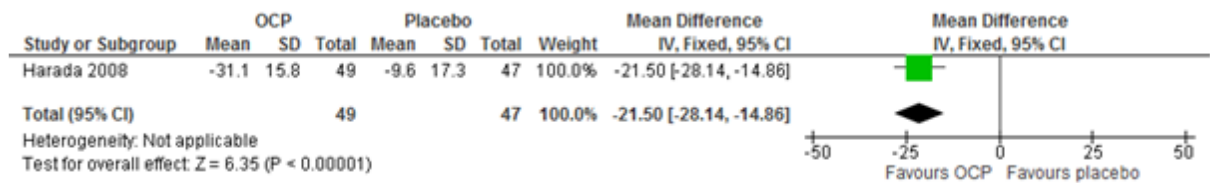
**Figure 102: Outcome: Pelvic tenderness cessation at 6 months**



2 Scale: 10 point VAS

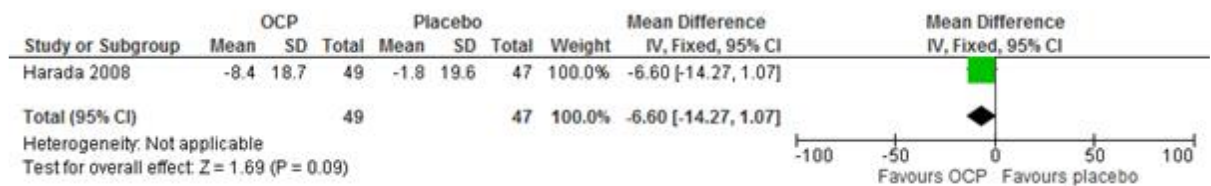
### I.15.3 Comparison 3: Combined oral contraceptive pill versus placebo

Figure 103: Outcome: Dysmenorrhoea (VAS)



Scale: VAS assumed scale 0 to 100

Figure 104: Outcome: Non-menstrual pelvic pain score (VAS)



Scale: VAS assumed scale 0 to 100

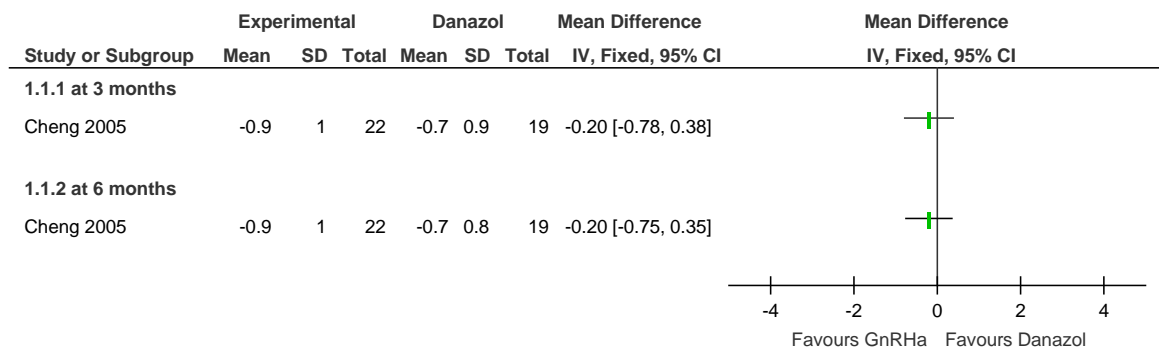
Figure 105: Outcome: Induration



2 Based on physician examination

### I.15.4 Comparison 4: GnRH agonists versus danazol

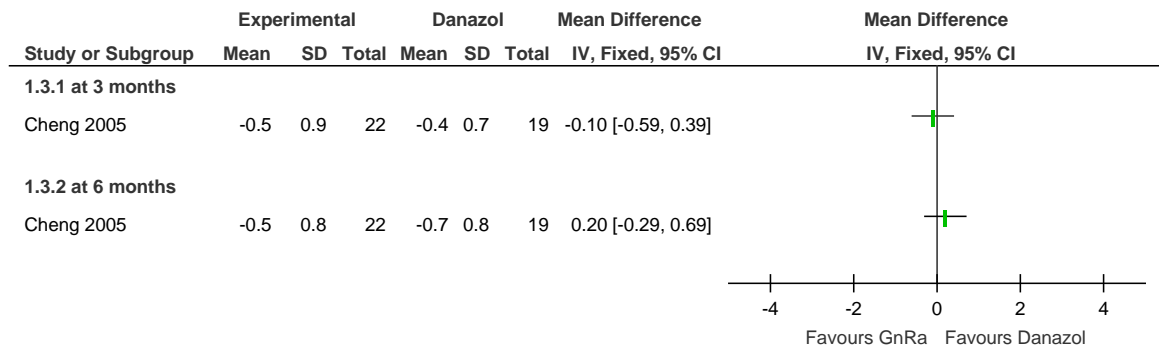
Figure 106: Outcome: pelvic tenderness



Total symptom severity score (TSSS), scale not defined

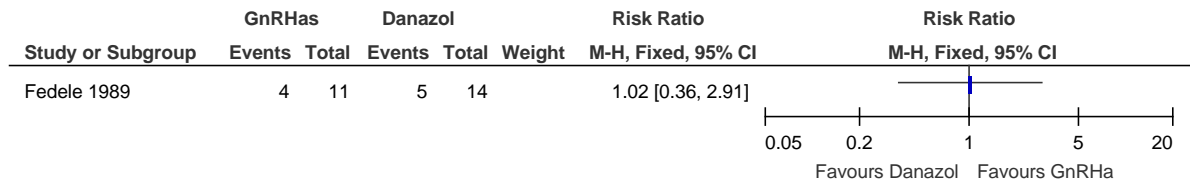


**Figure 107: Outcome: pelvic induration**



Total symptom severity score (TSSS), scale not defined

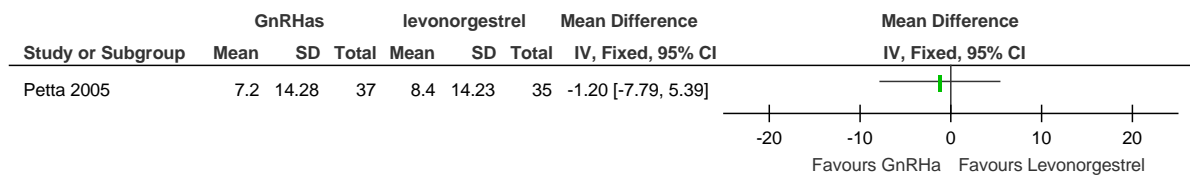
**Figure 108: Outcome: patients requiring surgery because of reappearance of symptoms and positive findings at pelvic examination at 6 months**



**I.15.5 Comparison 5: GnRH agonists versus levonorgestrel-releasing intrauterine system**

2

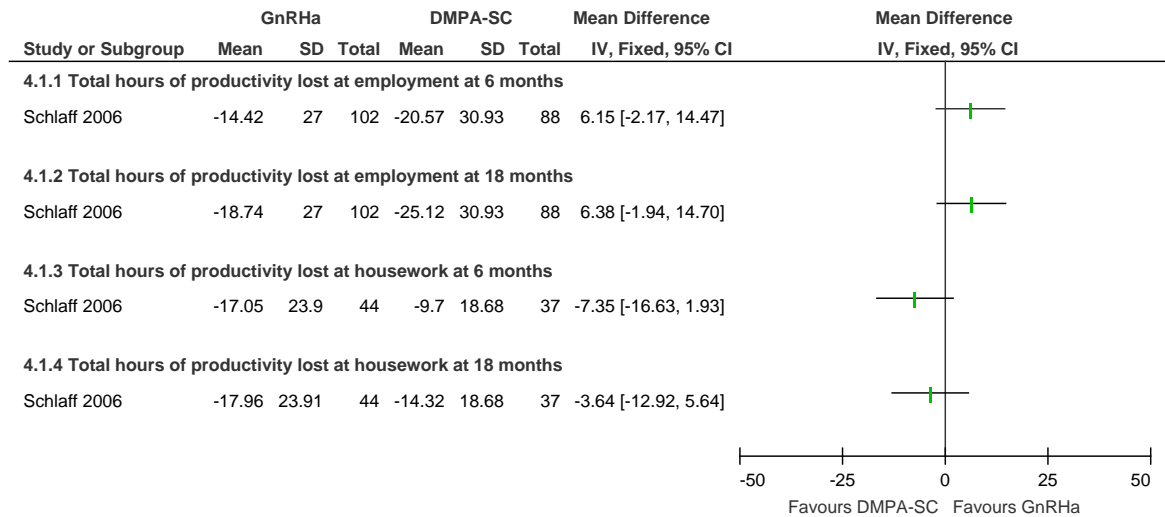
**Figure 109: Outcome: Psychological well-being at 6 months**



Psychological Well-Being Index Questionnaire which consisted of 22 self-administered items, rated on a 6-point scale

**I.15.6 Comparison 6: GnRH agonists versus DMPA-SC**

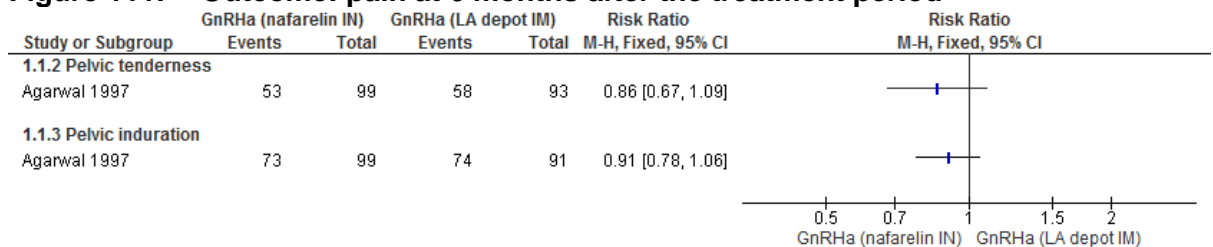
**Figure 110: Outcome: effect on daily activities - mean hours of productivity lost at employment and housework from baseline to follow-up**



Scale: mean number of work and housework hours lost

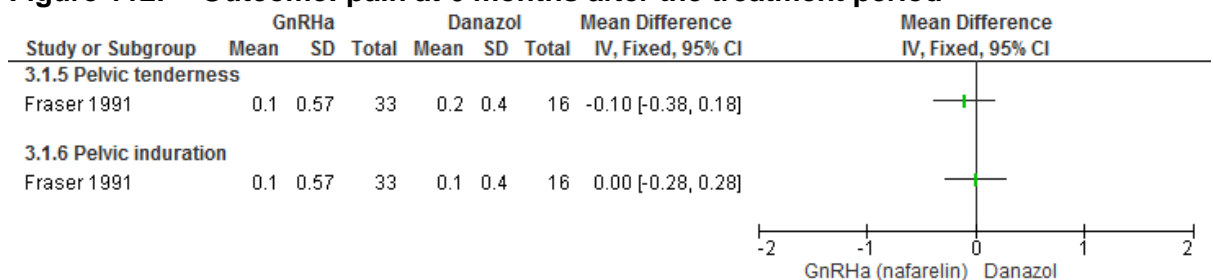
**I.15.7 Comparison 7: GnRH agonist 1 + placebo versus GnRH agonist 2 + placebo**

**Figure 111: Outcome: pain at 6 months after the treatment period**



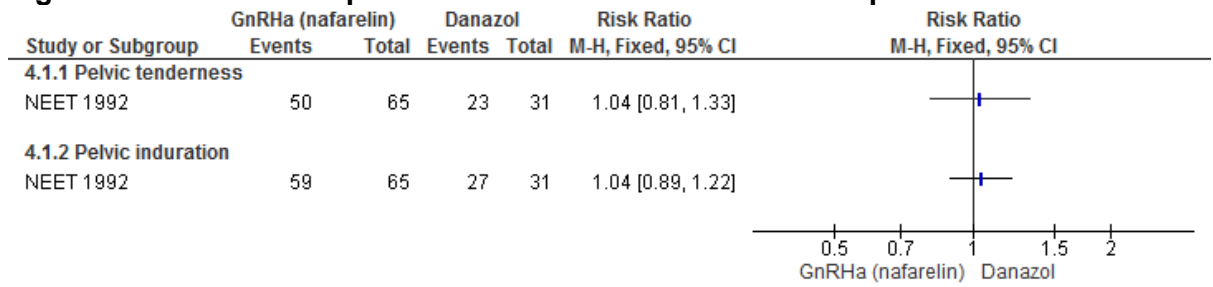
**I.15.8 Comparison 9: GnRH agonist + placebo versus Danazol + placebo**

**Figure 112: Outcome: pain at 6 months after the treatment period**

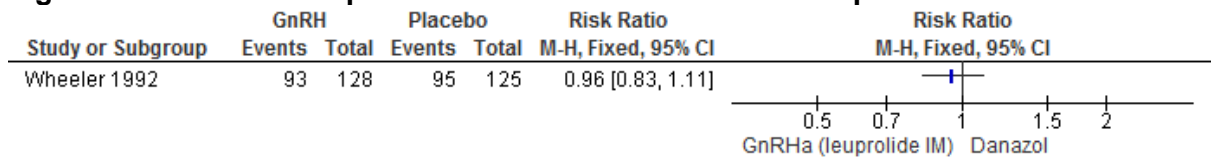


Measured with: 4-point numerical scale: 0=none; 1=mild; 2=moderate; 3=severe.

**Figure 113: Outcome: pain at 12 months after the treatment period**

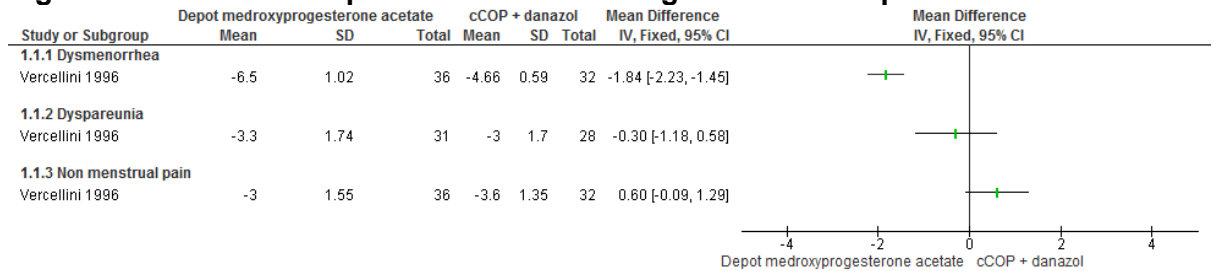


**Figure 114: Outcome: pain at 6 months after the treatment period**



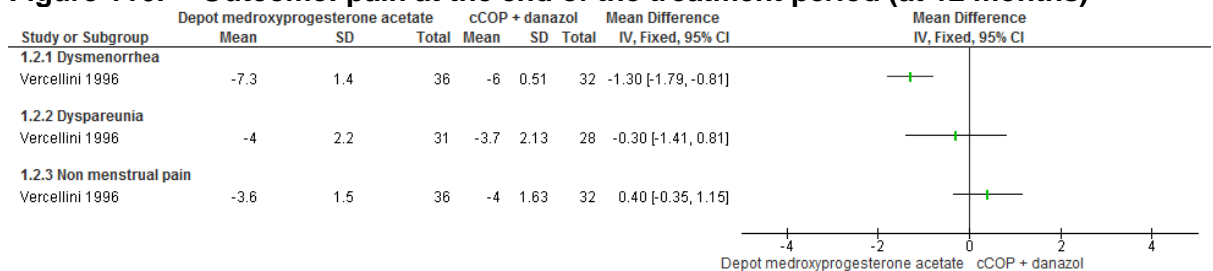
**I.15.9 Comparison 10: Depot medroxyprogesterone acetate versus cOCP + danazol**

**Figure 115: Outcome: pain at 6 months during the treatment period**



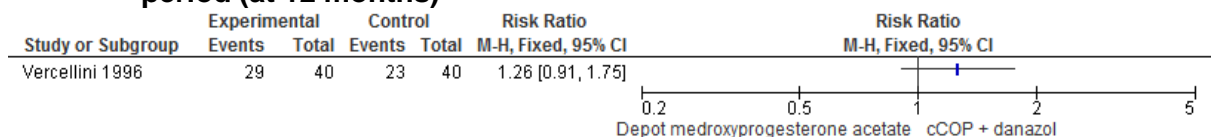
Scale: a 10 cm VAS where 0 = absence of pain, >0-5 = mild pain, >5-8 = moderate pain, >8-10 = unbearable pain

**Figure 116: Outcome: pain at the end of the treatment period (at 12 months)**



Scale: a 10 cm VAS where 0 = absence of pain, >0-5 = mild pain, >5-8 = moderate pain, >8-10 = unbearable pain

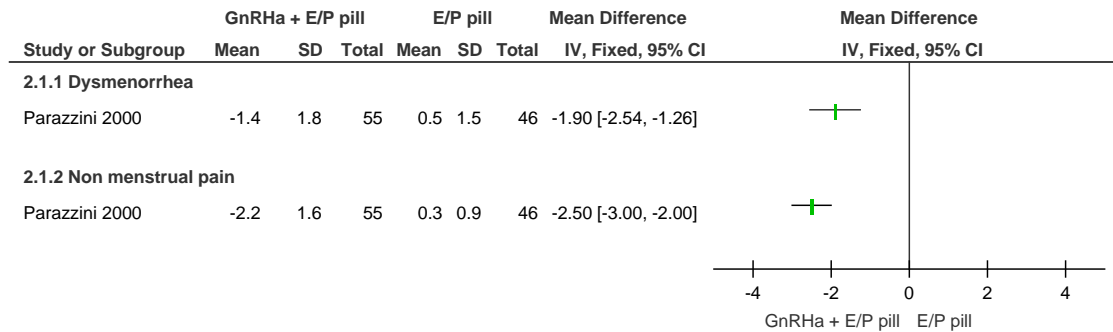
**Figure 117: Outcome: patient satisfaction with treatment at the end of the treatment period (at 12 months)**



Very satisfied/satisfied with treatment

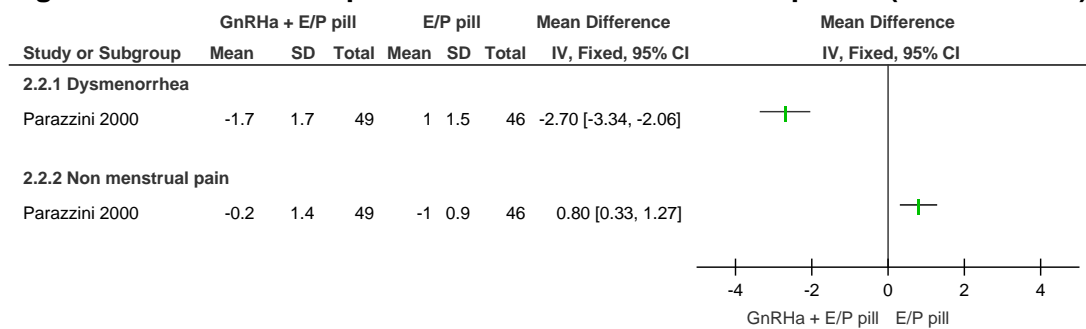
### I.15.10 Comparison 11: GnRH agonist + E/P pill versus E/P pill

**Figure 118: Outcome: pain at 8 months during the treatment period**



Scale: a 10-point VAS where 0 = the absence of pain, 10 = unbearable pain

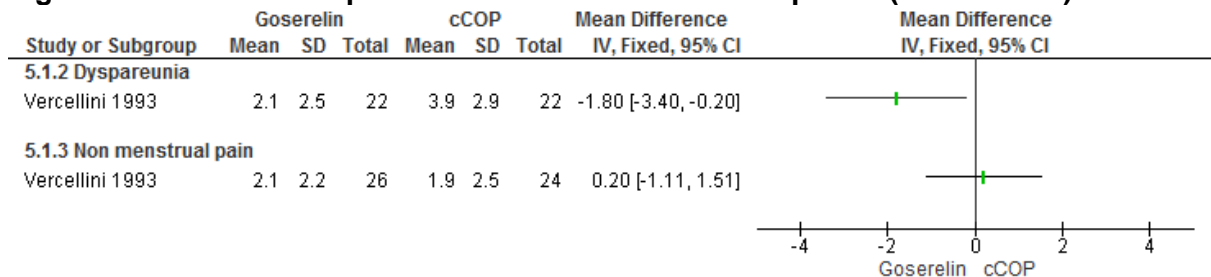
**Figure 119: Outcome: pain at the end of the treatment period (at 12 months)**



Scale: a 10-point VAS where 0 = the absence of pain, 10 = unbearable pain

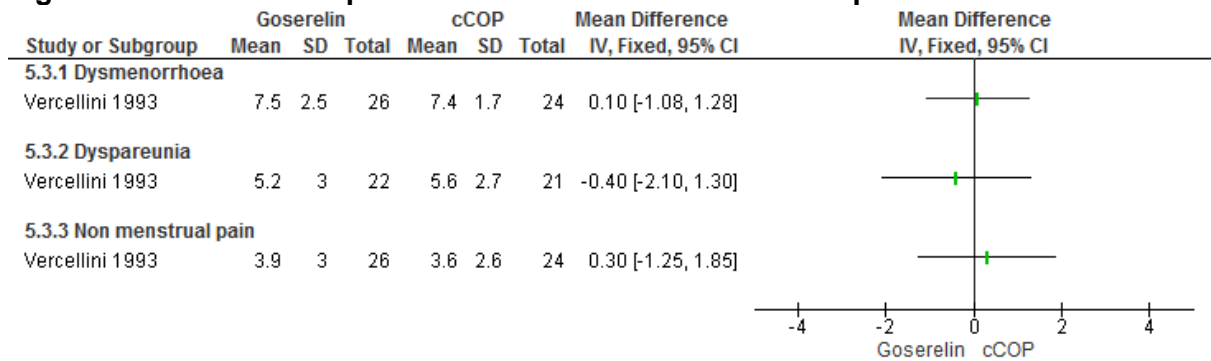
### I.15.11 Comparison 12: GnRH agonist versus cOCP

**Figure 120: Outcome: pain at the end of the treatment period (at 6 months)**



Scale: a 10-point VAS where 0 = the absence of pain, 1-5 = mild pain, 6-7 = moderate pain, 8-10 = unbearable pain

**Figure 121: Outcome: pain at 6 months after the treatment period**



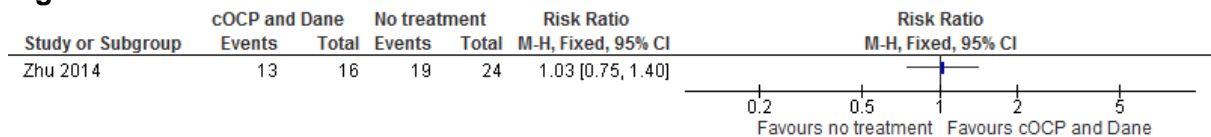
Scale: a 10-point VAS where 0 = the absence of pain, 1-5 = mild pain, 6-7 = moderate pain, 8-10 = unbearable pain

1

## I.16 Non-pharmacological management

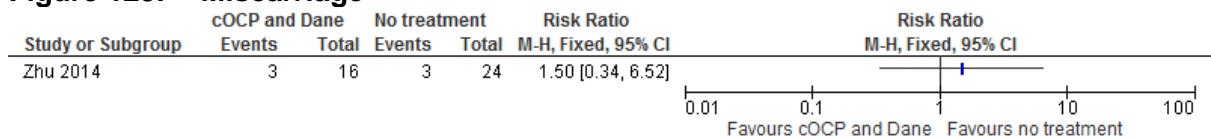
### I.16.1 cOCP and Dan'e (Chinese Herbal Medicine) versus No treatment

**Figure 122: Live birth**



Women in both groups had surgery. Subsequently women in the intervention group received a cOCP for 63 days after surgery and Dan'e Chinese Herbal Medicine daily for the latter 30 days of treatment. Outcome was assessed at 12 months after treatment ended.

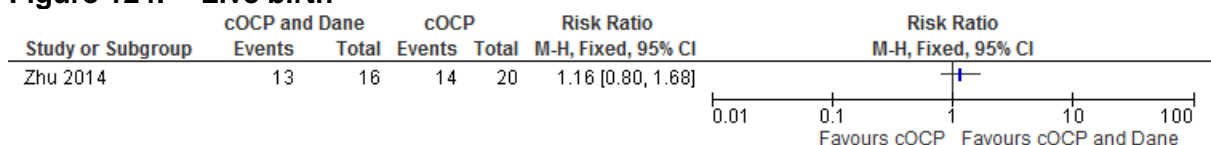
**Figure 123: Miscarriage**



Women in both groups had surgery. Subsequently women in the intervention group received a cOCP for 63 days after surgery and Dan'e Chinese Herbal Medicine daily for the latter 30 days of treatment. Outcome was assessed at 12 months after treatment ended.

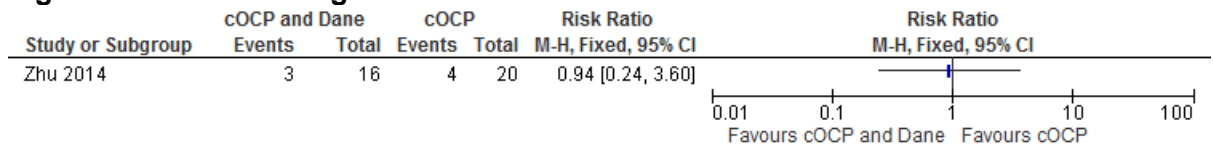
### I.16.2 cOCP and Dan'e (Chinese Herbal Medicine) versus cOCP

**Figure 124: Live birth**



Women in both groups had surgery. Subsequently women in the intervention group received a cOCP for 63 days after surgery and Dan'e Chinese Herbal Medicine daily for the latter 30 days of treatment. Women in the control group received a cOCP for 63 days after surgery alone. Outcome was assessed at 12 months after treatment ended.

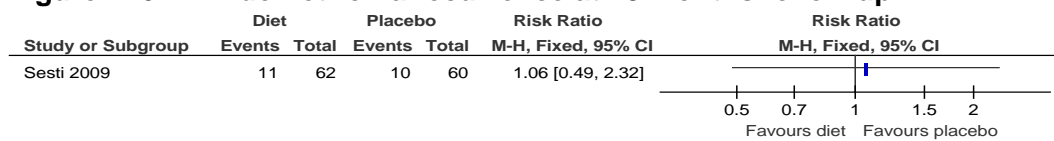
**Figure 125: Miscarriage**



Women in both groups had surgery. Subsequently women in the intervention group received a cOCP for 63 days after surgery and Dan's Chinese Herbal Medicine daily for the latter 30 days of treatment. Women in the control group received a cOCP for 63 days after surgery alone. Outcome was assessed at 12 months after treatment ended.

### I.16.3 Diet versus placebo

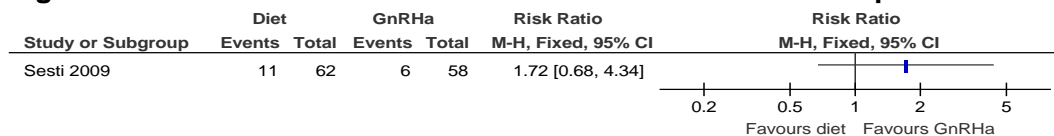
**Figure 126: Endometrioma recurrence at 18 months follow up**



Recurrence defined as presence of endometrioma >20mm diameter

### I.16.4 Diet versus GnRH analogues

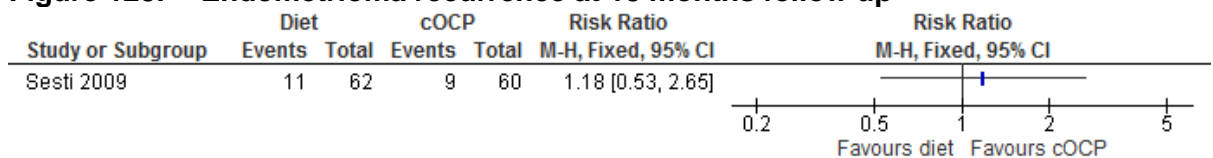
**Figure 127: Endometrioma recurrence at 18 months follow up**



Recurrence defined as presence of endometrioma >20mm diameter

### I.16.5 Diet versus cOCP

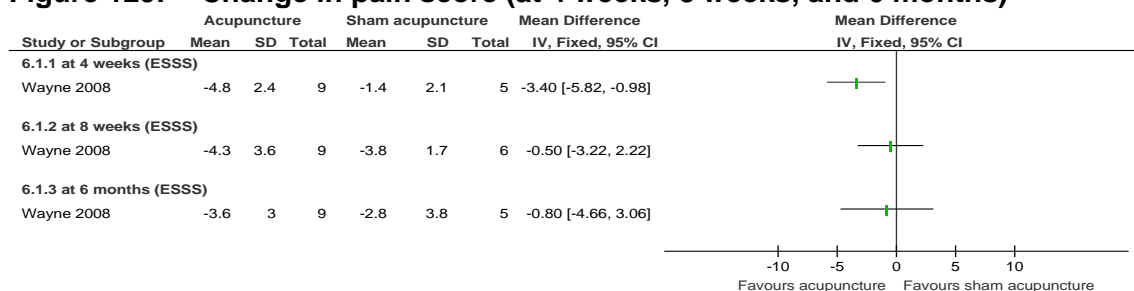
**Figure 128: Endometrioma recurrence at 18 months follow up**



Recurrence defined as presence of endometrioma >20mm diameter

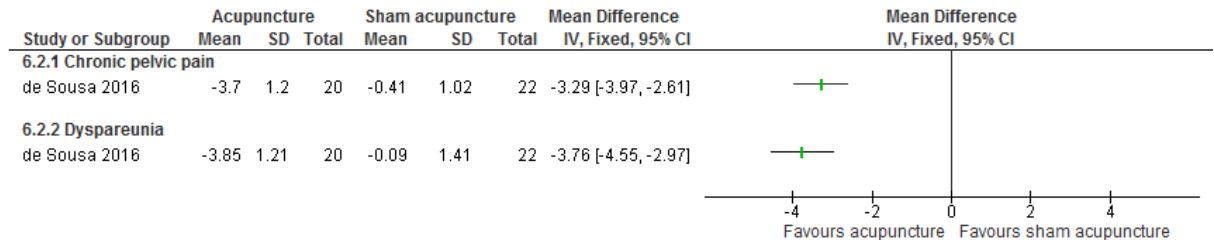
### I.16.6 Acupuncture versus sham acupuncture

**Figure 129: Change in pain score (at 4 weeks, 8 weeks, and 6 months)**



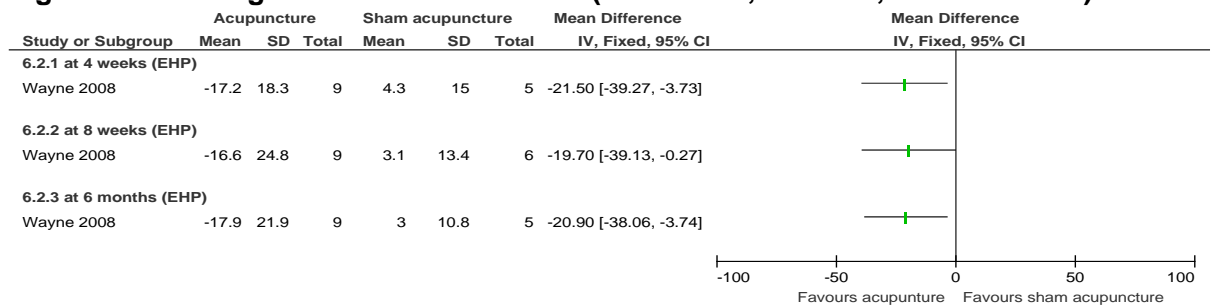
Rated with a numerical analogue scale of 0-10. Treatment duration was 8 weeks, therefore first two time points were measured whilst on treatment, and the final time point was during follow-up.

**Figure 130: Change (from baseline) in chronic pelvic pain and dyspareunia in the last 2 months**



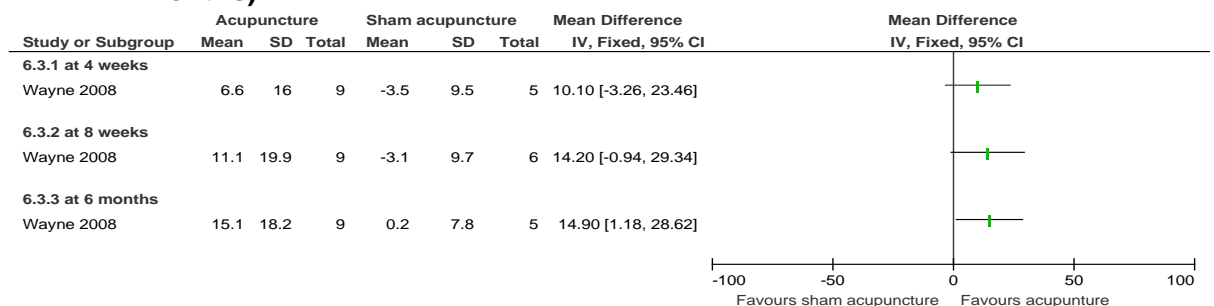
Visual analogue scale (VAS, 0-10)

**Figure 131: Change in EHP-30 total score (at 4 weeks, 8 weeks, and 6 months)**



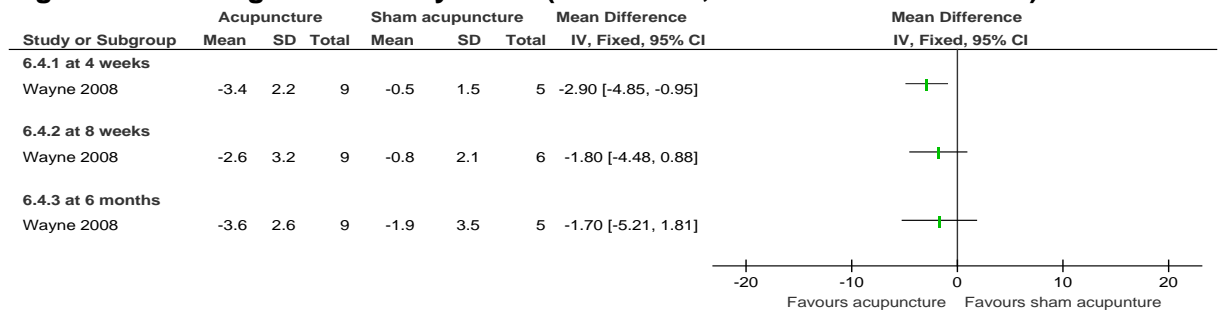
Rated on a scale of 0-100, lower scores represent better health related quality of life. Treatment duration was 8 weeks, therefore first two time points were measured whilst on treatment, and the final time point was during follow-up.

**Figure 132: Change in Pediatric Quality of Life total score (at 4 weeks, 8 weeks, and 6 months)**



Rated on a scale of 0-100, higher scores represent better health related quality of life. Treatment duration was 8 weeks, therefore first two time points were measured whilst on treatment, and the final time point was during follow-up.

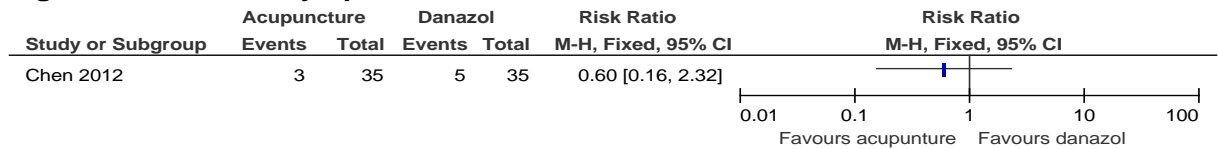
**Figure 133: Change in 3-activity score (at 4 weeks, 8 weeks and 6 months)**



Rated on a scale of 0-10, higher scores represent more difficulty with performing the activities. Treatment duration was 8 weeks, therefore first two time points were measured whilst on treatment, and the final time point was during follow-up.

### I.16.7 Acupuncture versus Danazol

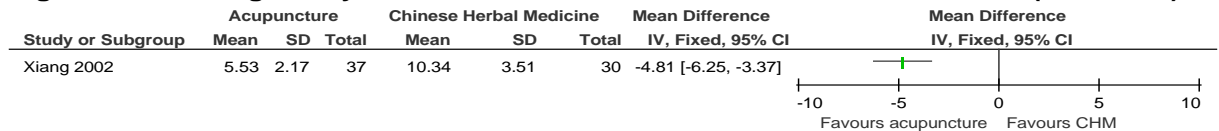
**Figure 134: Cure of symptoms at 6 months**



Cure defined as complete relief of pain and other symptoms after medication, and no relapse in the next three menstrual cycles. Treatment duration was three months, follow up was a further three-months.

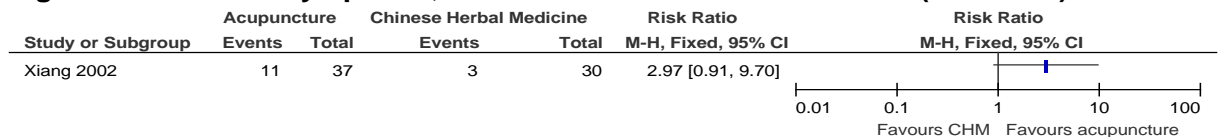
### I.16.8 Acupuncture versus Chinese Herbal Medicine

**Figure 135: Change in dysmenorrhoea, measured at the end of treatment (3 months)**



Rating scale ranges from 5-15. Mild dysmenorrhoea scores 5-7, moderate scores 8-12 and severe scores 13-15

**Figure 136: Cure of symptoms, measured at the end of treatment (3 months)**

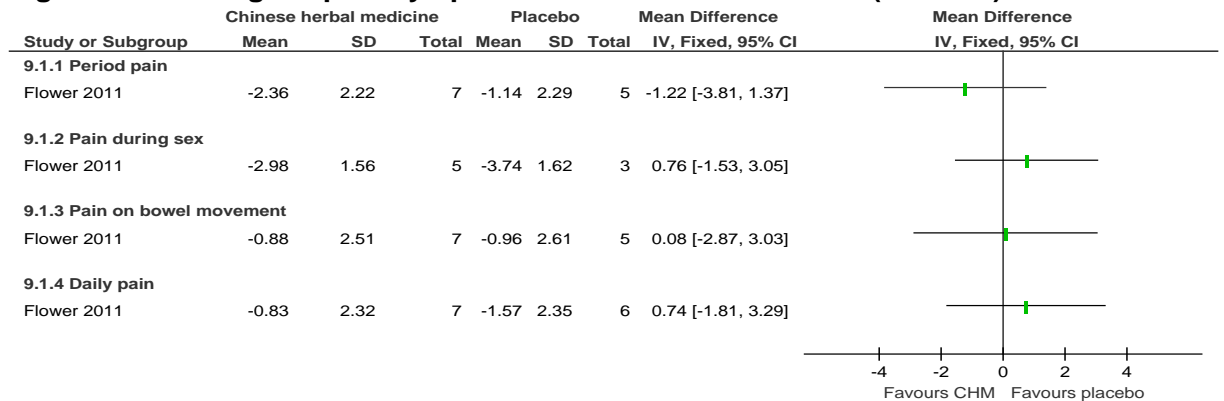


Cure symptoms defined „in accordance with Guideline for Clinical Research on New Chinese Drugs for Treatment of Pelvic Endometriosis“.



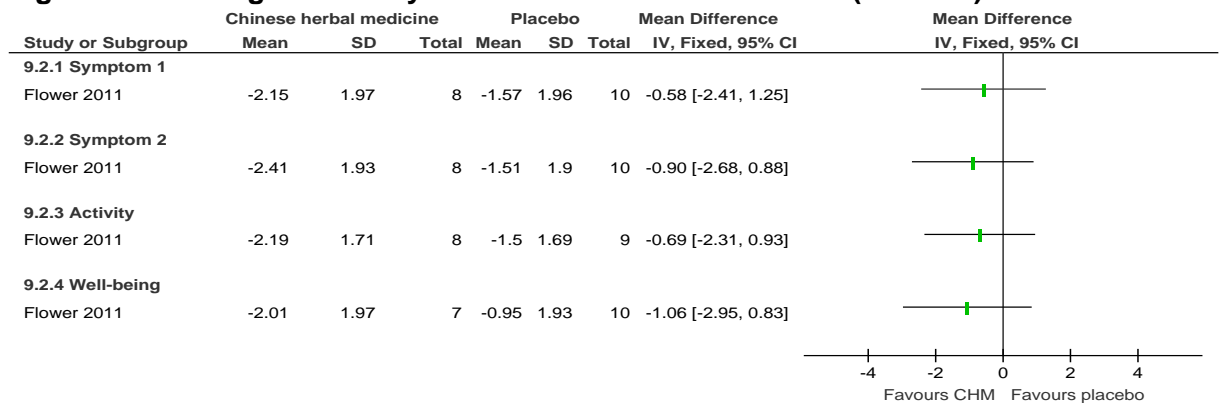
### I.16.9 Chinese Herbal Medicine versus Placebo

**Figure 137: Change in pain symptoms at the end of treatment (week 16)**



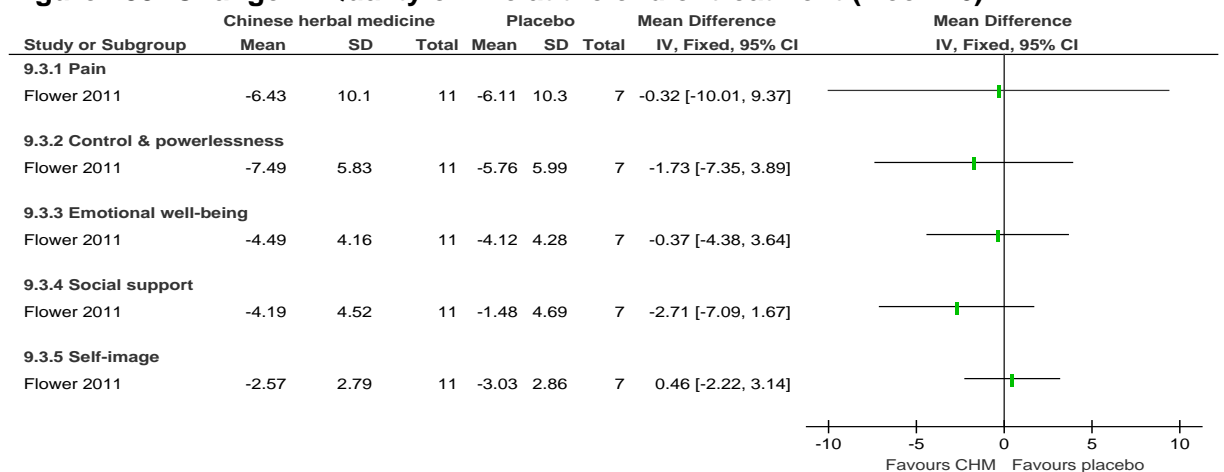
*Pain symptoms measured with Visual Analogue Scale of 0-10*

**Figure 138: Change in Quality of Life at the end of treatment (week 16)**



*Scores measured with 7-point Likert scale. Participants were asked to identify 2 symptoms that bothered them the most, and an activity that was restricted by endometriosis.*

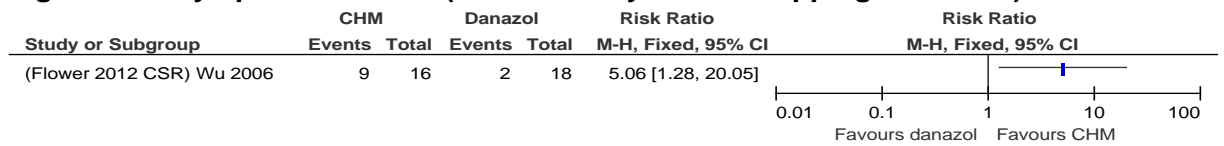
**Figure 139: Change in Quality of Life at the end of treatment (week 16)**



*Quality of life assessed with the Endometriosis Health Profile-30. Scores range from 0-100 for the subscales.*

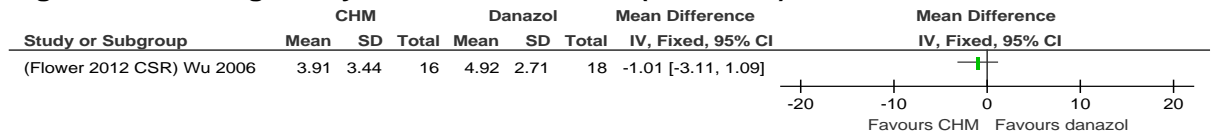
### I.16.10 Chinese Herbal Medicine (oral) versus Danazol

**Figure 140: Symptomatic relief (within three years of stopping treatment)**



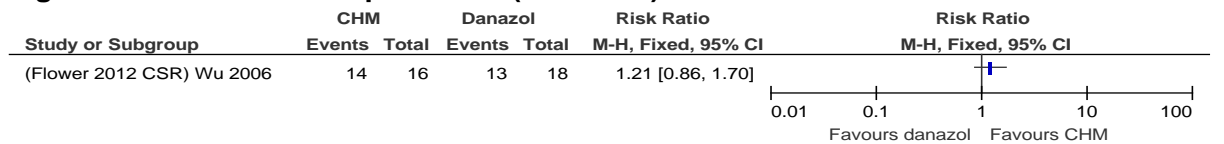
Symptomatic relief defined as complete resolution of all symptoms and signs, and included pregnancy (where desired) within 3 years of stopping treatment

**Figure 141: Change in dysmenorrhoea score (3 months)**



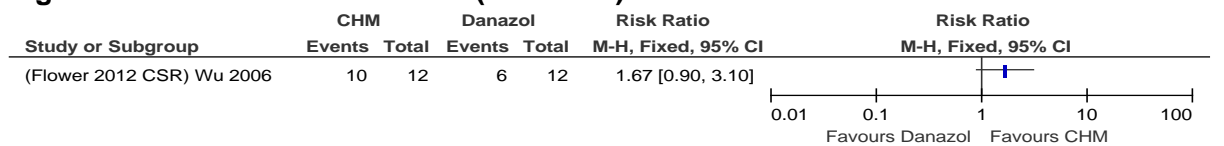
Scale not defined

**Figure 142: Lumbosacral pain relief (3 months)**



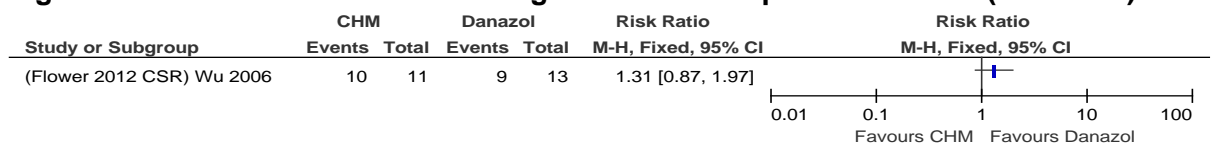
Symptomatic relief defined as complete resolution of all symptoms and signs.

**Figure 143: Rectal irritation relief (3 months)**



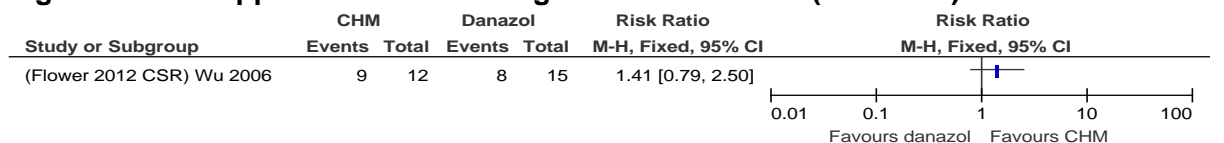
Symptomatic relief defined as complete resolution of all symptoms and signs

**Figure 144: Relief of tenderness of vaginal nodules in posterior fornix (3 months)**



Symptomatic relief defined as complete resolution of all symptoms and signs

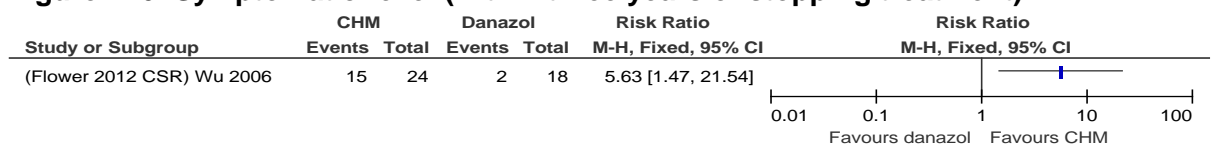
**Figure 145: Disappearance or shrinkage of adnexal mass (3 months)**



Definition of "shrinkage" is not reported

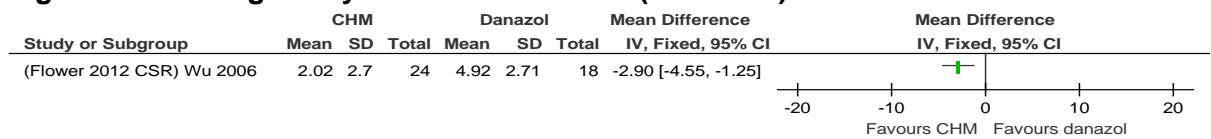
### I.16.11 Chinese Herbal Medicine (oral and enema) versus Danazol

**Figure 146: Symptomatic relief (within three years of stopping treatment)**



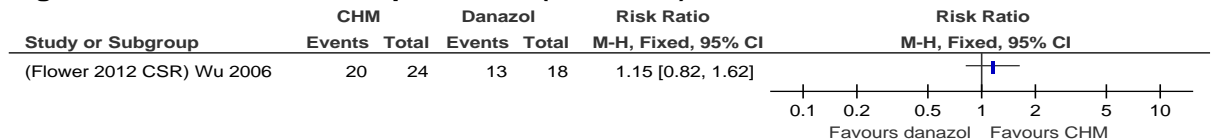
*Symptomatic relief defined as complete resolution of all symptoms and signs, and included pregnancy (where desired) within 3 years of stopping treatment*

**Figure 147: Change in dysmenorrhoea score (3 months)**



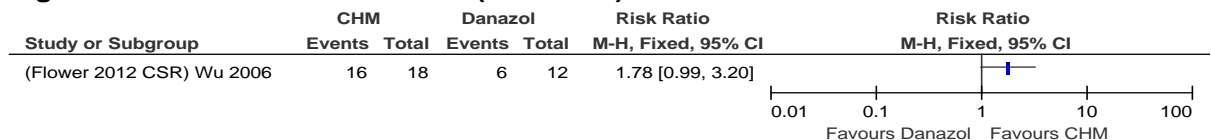
*Scale not defined*

**Figure 148: Lumbosacral pain relief (3 months)**



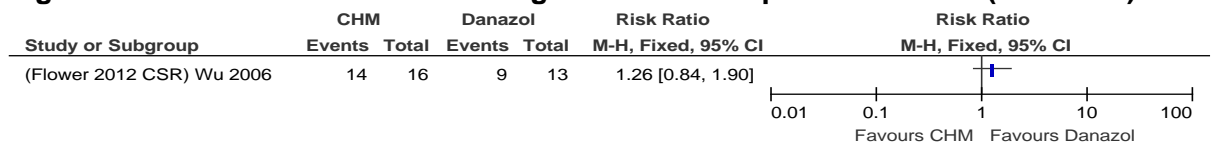
*Symptomatic relief defined as complete resolution of all symptoms and signs.*

**Figure 149: Rectal irritation relief (3 months)**



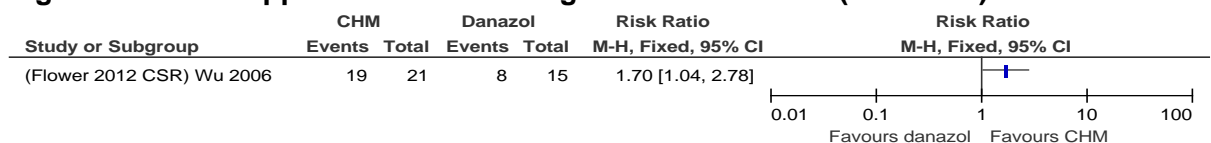
*Relief defined as complete resolution of all symptoms and signs*

**Figure 150: Relief of tenderness of vaginal nodules in posterior fornix (3 months)**



*Symptomatic relief defined as complete resolution of all symptoms and signs*

**Figure 151: Disappearance or shrinkage of adnexal mass (3 months)**

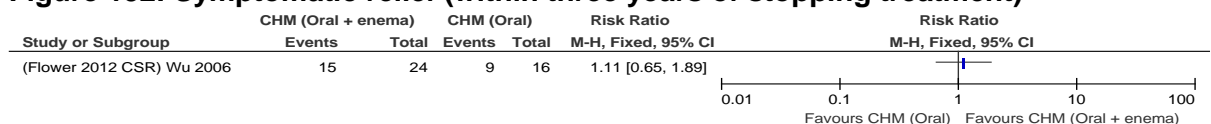


*Definition of "shrinkage" is not reported*

## I.16.12 Chinese Herbal Medicine (oral and enema) versus Chinese Herbal Medicine (oral)

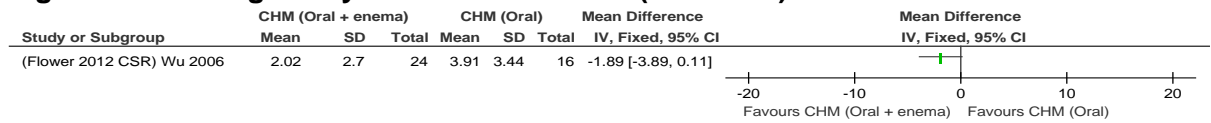
2

**Figure 152: Symptomatic relief (within three years of stopping treatment)**



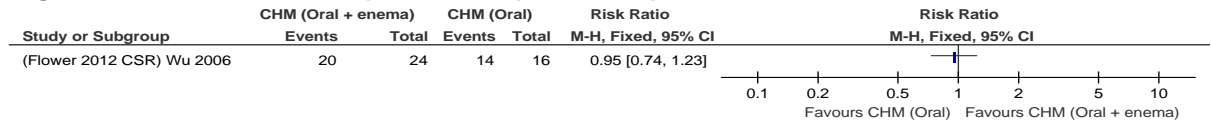
*Symptomatic relief defined as complete resolution of all symptoms and signs, and included pregnancy (where desired) within 3 years of stopping treatment.*

**Figure 153: Change in dysmenorrhoea score (3 months)**



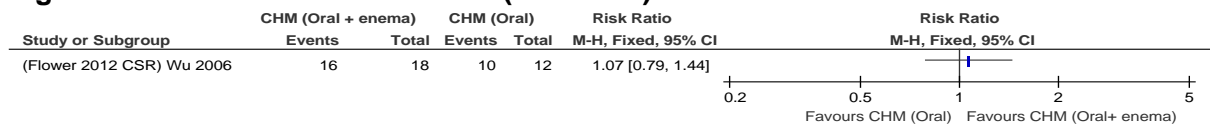
Scale not defined

**Figure 154: Lumbosacral pain relief (3 months)**



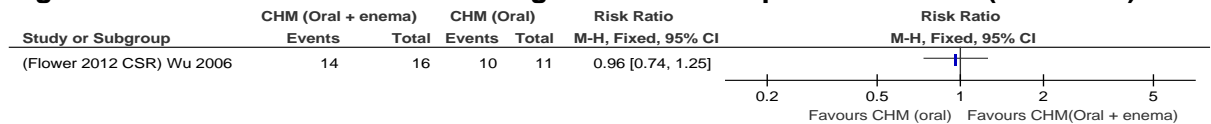
Symptomatic relief defined as complete resolution of all symptoms and signs.

**Figure 155: Rectal irritation relief (3 months)**



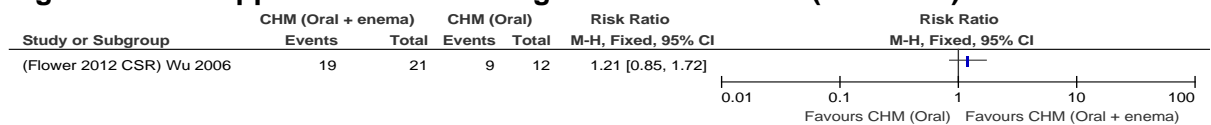
Symptomatic relief defined as complete resolution of all symptoms and signs.

**Figure 156: Relief of tenderness of vaginal nodules in posterior fornix (3 months)**



Symptomatic relief defined as complete resolution of all symptoms and signs.

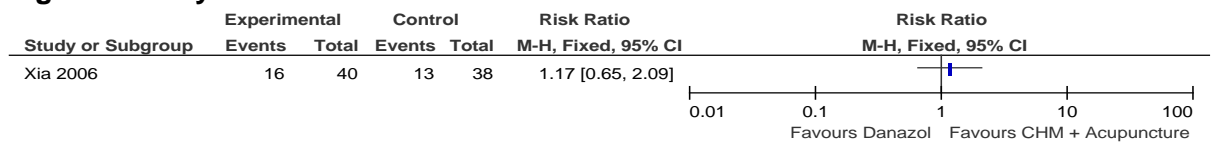
**Figure 157: Disappearance or shrinkage of adnexal mass (3 months)**



Definition of "shrinkage" is not reported

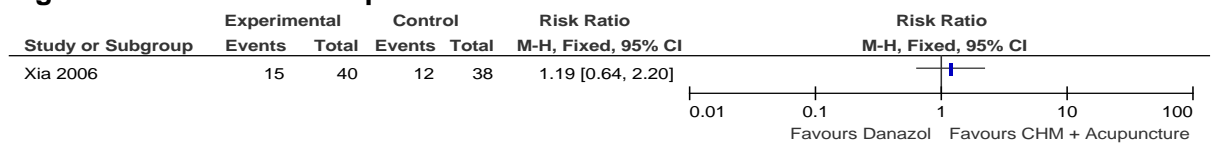
### I.16.13 Chinese Herbal Medicine and Acupuncture versus Danazol

**Figure 158: Dysmenorrhoea**



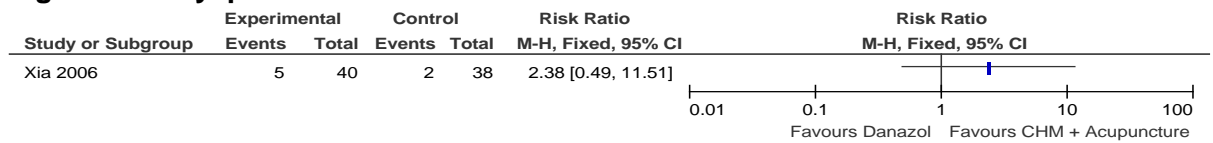
Outcome is cessation of signs and symptoms

**Figure 159: Lumbosacral pain**



Outcome is cessation of signs and symptoms

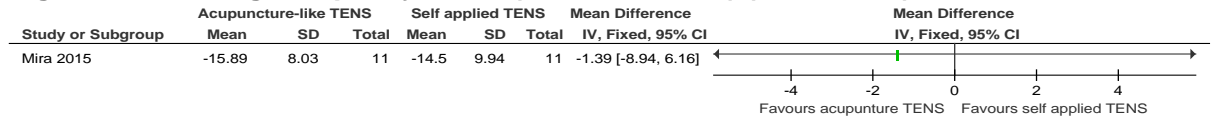
**Figure 160: Dyspareunia**



Outcome is cessation of signs and symptoms

## I.16.14 Acupuncture TENS versus self-applied TENS

**Figure 161: Change in quality of life (EHP-30 scores) (at 8 weeks)**



Scores range from 0-100

2

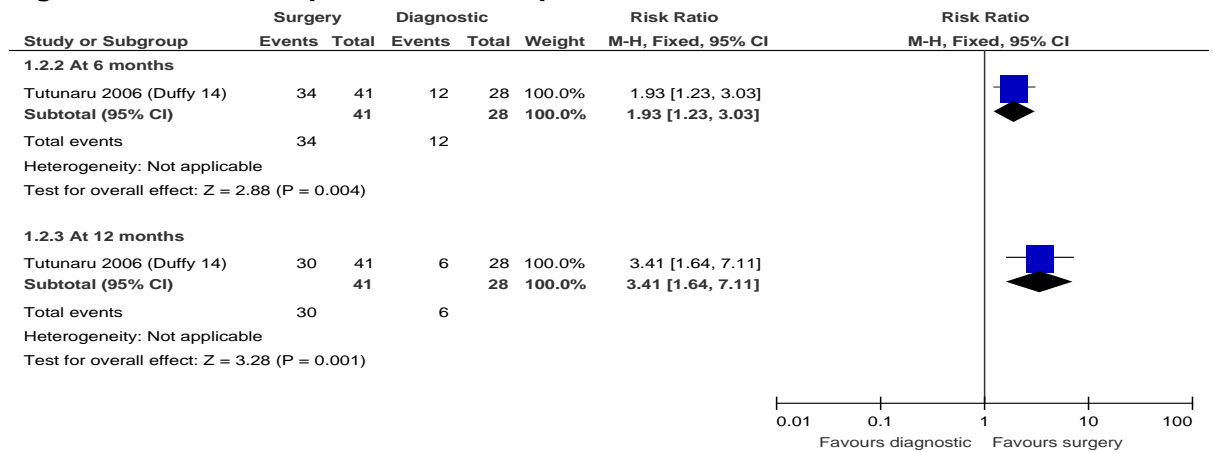
3

## I.17 Surgical management

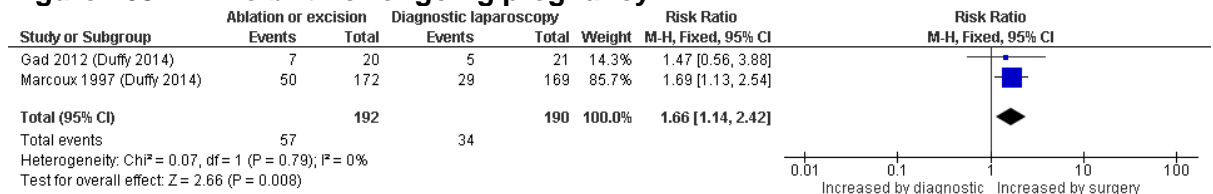
### I.17.5 Laparoscopic treatment (excision or ablation) versus diagnostic laparoscopy for endometriosis

6

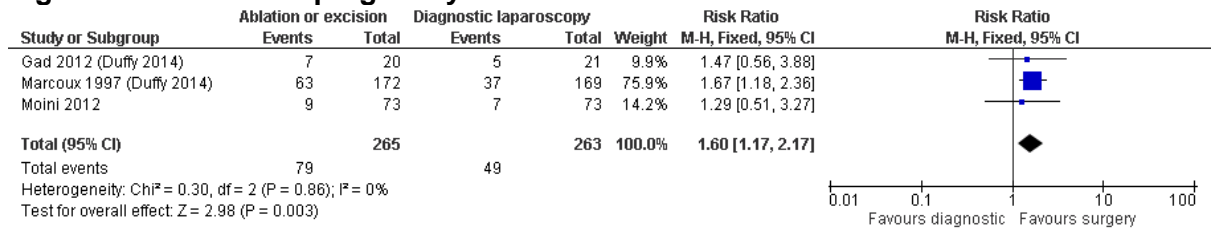
**Figure 162: Overall pain better or improved**



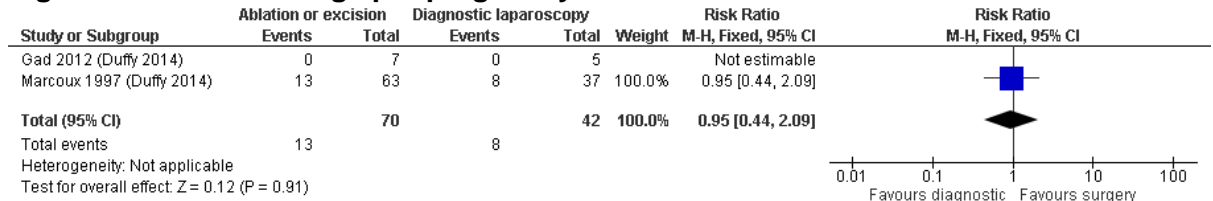
**Figure 163: Live birth or ongoing pregnancy**



**Figure 164: Clinical pregnancy**

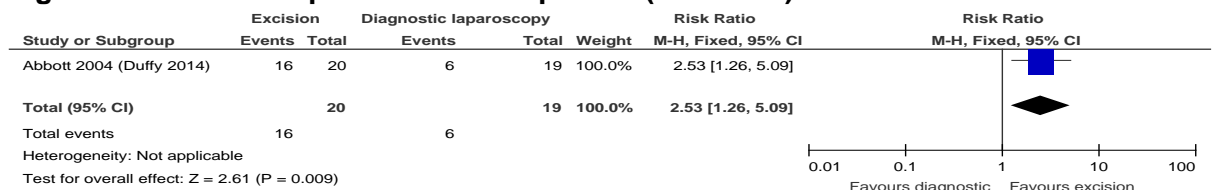


**Figure 165: Miscarriage per pregnancy**

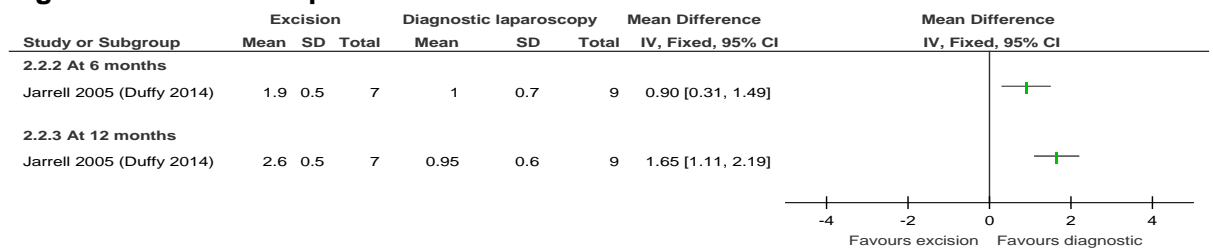


## I.17.2 Excision versus diagnostic laparoscopy for endometriosis

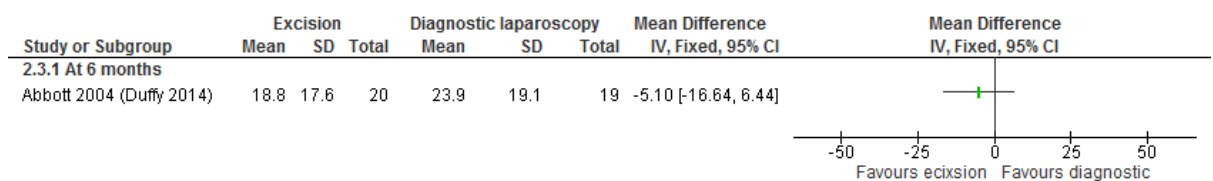
**Figure 166: Overall pain better or improved (6 months)**



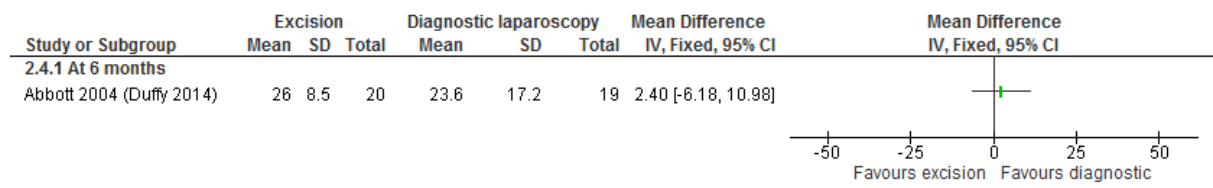
**Figure 167: Overall pain score**



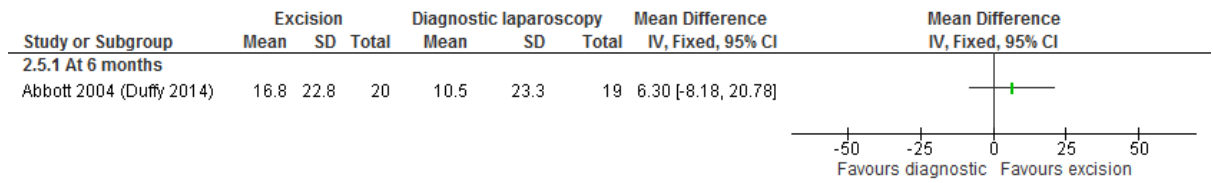
**Figure 168: Pelvic pain score**



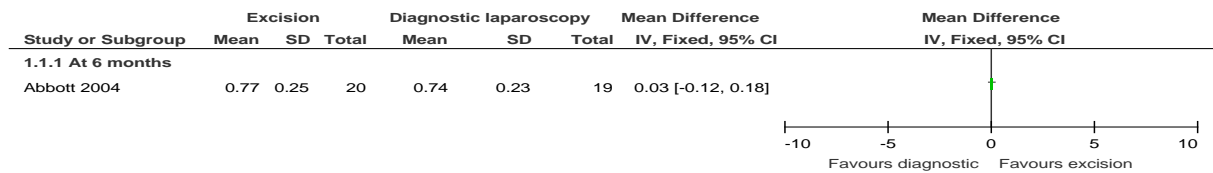
**Figure 169: Dysmenorrhea pain score**



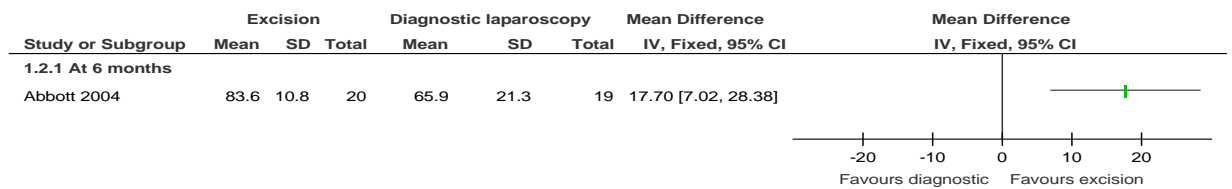
**Figure 170: Dyspareunia pain score**



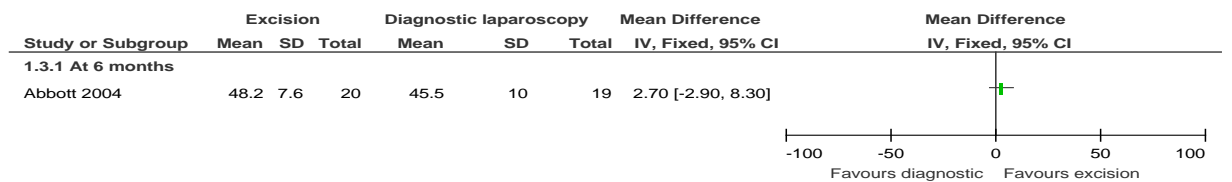
**Figure 171: Quality of life – EQ-5D index summary score**



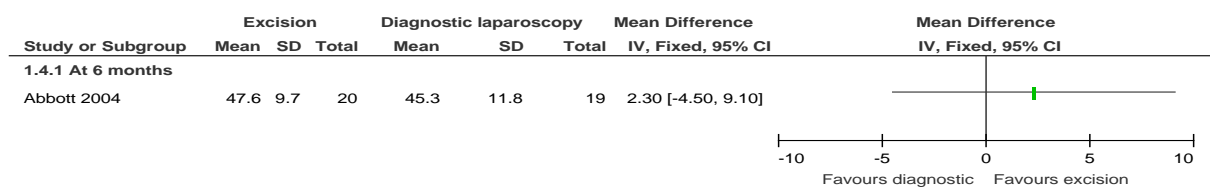
**Figure 172: Quality of life – EQ-5D VAS summary score**



**Figure 173: Quality of life – SF-12 Physical component**



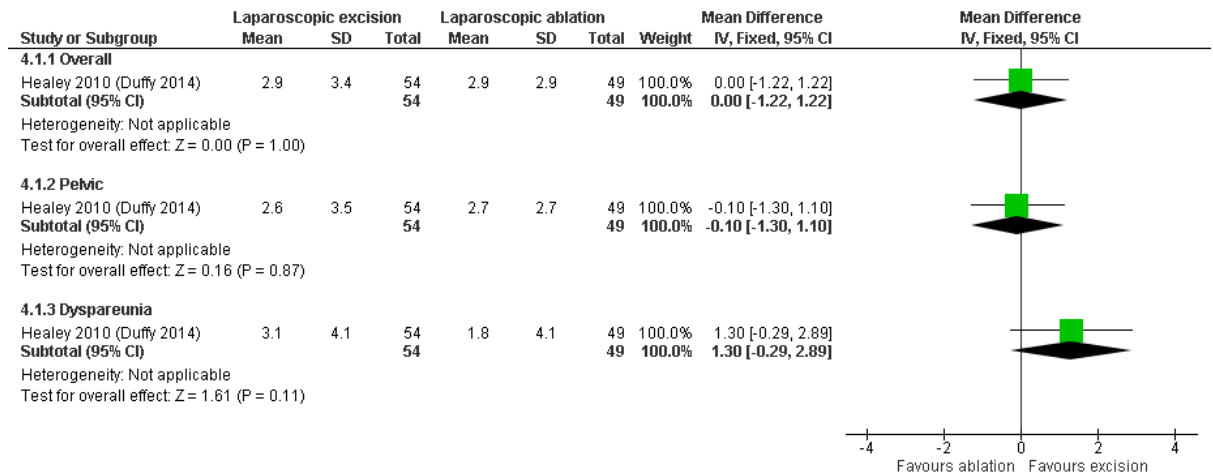
**Figure 174: Quality of life – SF12 Mental component**



**I.17.3 Excisional surgery versus ablative surgery for endometriosis**

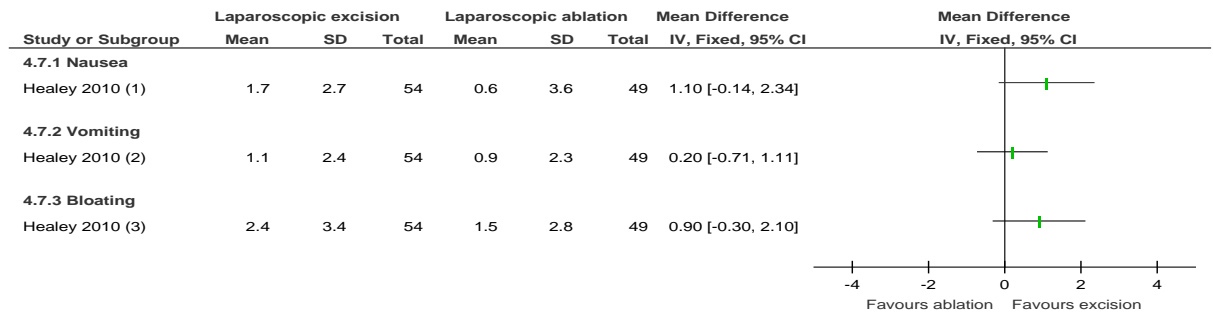
**2 Figure 175: Pain score (improvement in VAS at 12 months)**





1

2 **Figure 176: Unintended effects (improvement in VAS score by 12 months after**  
3 **operation - nausea, vomiting and bloating)**



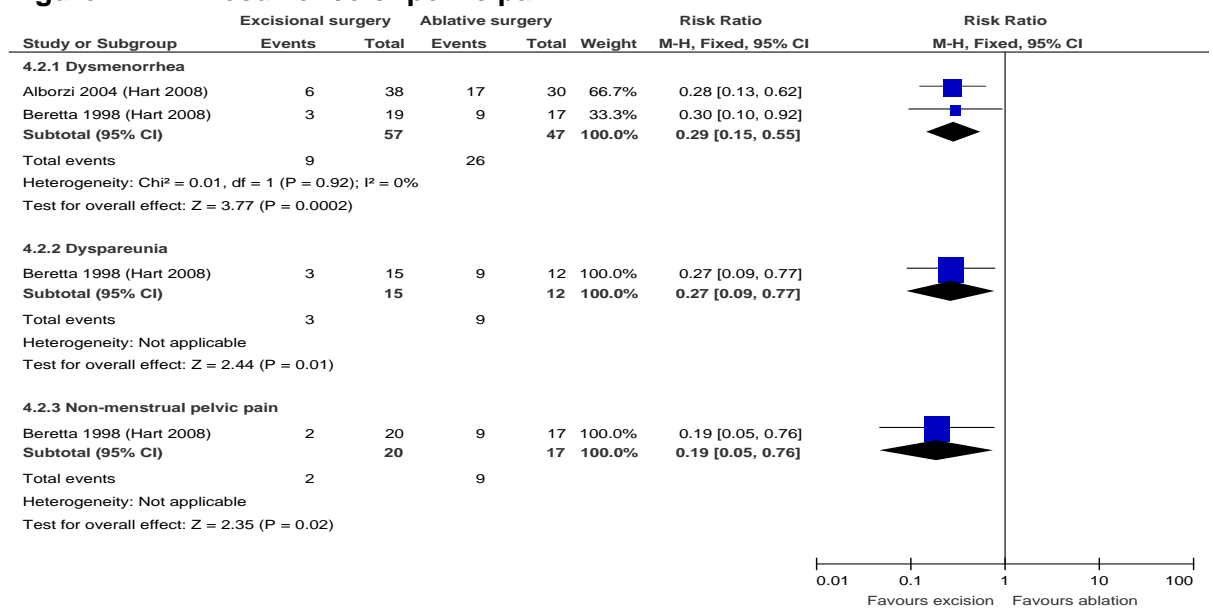
Footnotes

- (1) Outcome not reported in Duffy 2014
- (2) Outcome not reported in Duffy 2014
- (3) Outcome not reported in Duffy 2014

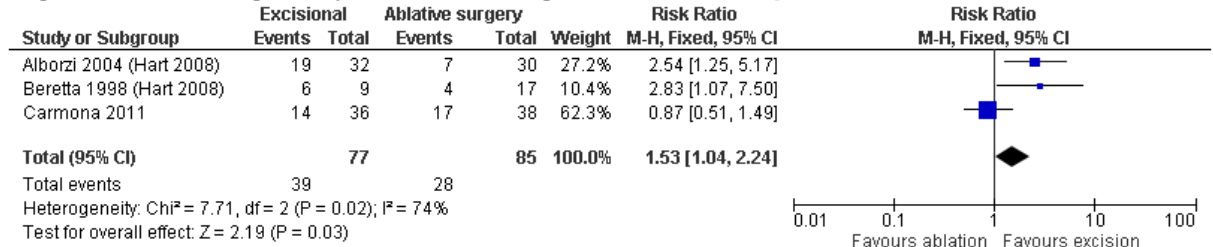
4

**I.1754 Excisional surgery versus ablative surgery for endometrioma**

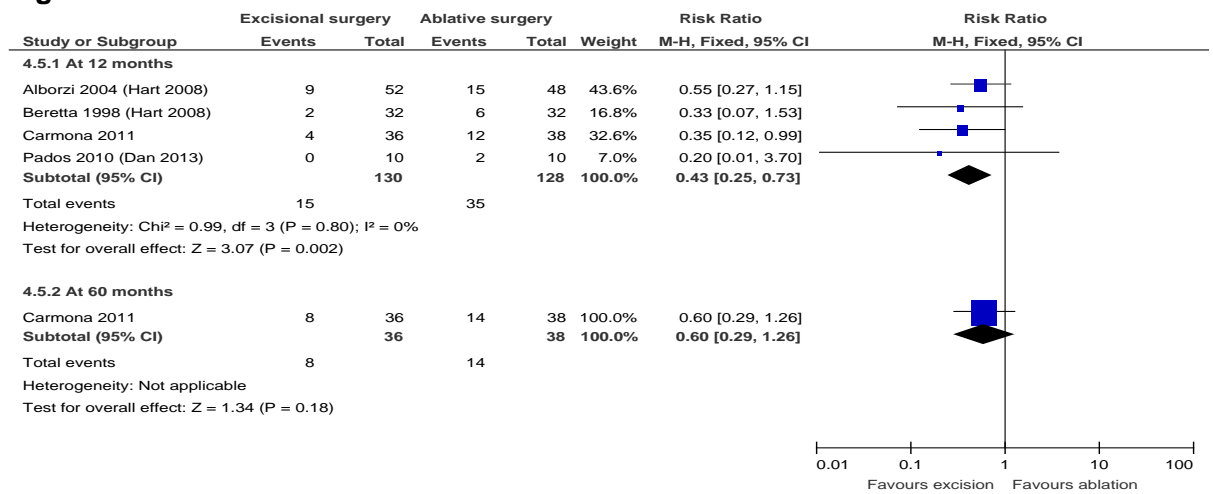
**Figure 177: Recurrence of pelvic pain**



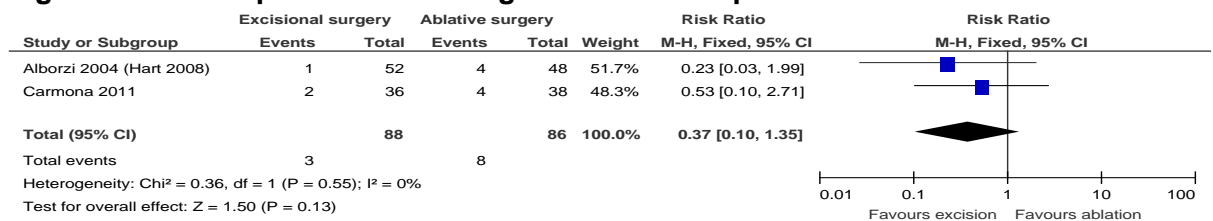
**Figure 178: Pregnancy rate after surgical treatment up to 60 months**



**Figure 179: Recurrence of endometrioma**

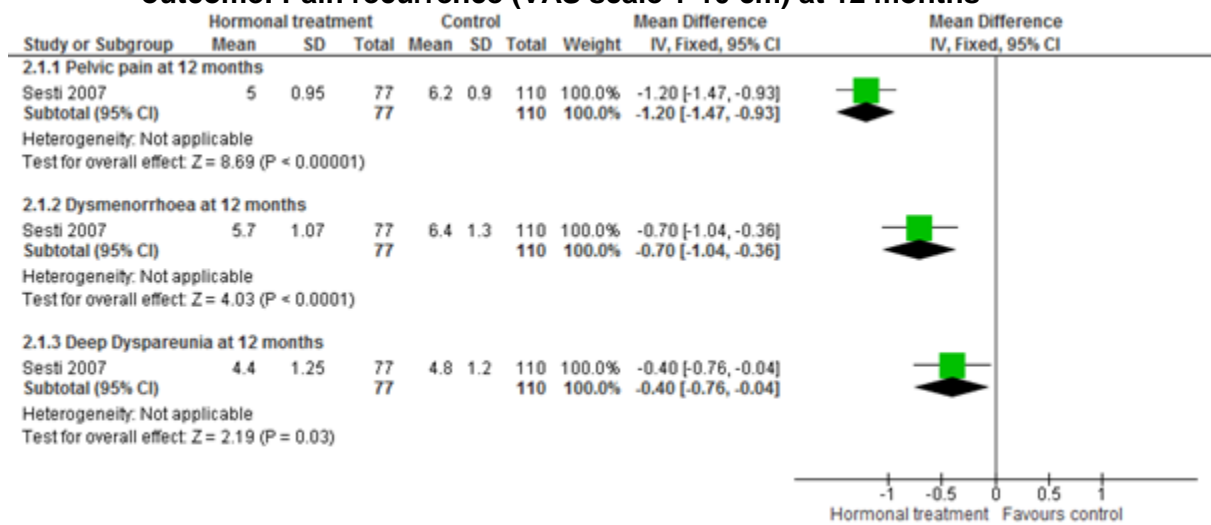


**Figure 180: Reoperation after surgical treatment up to 60 months**

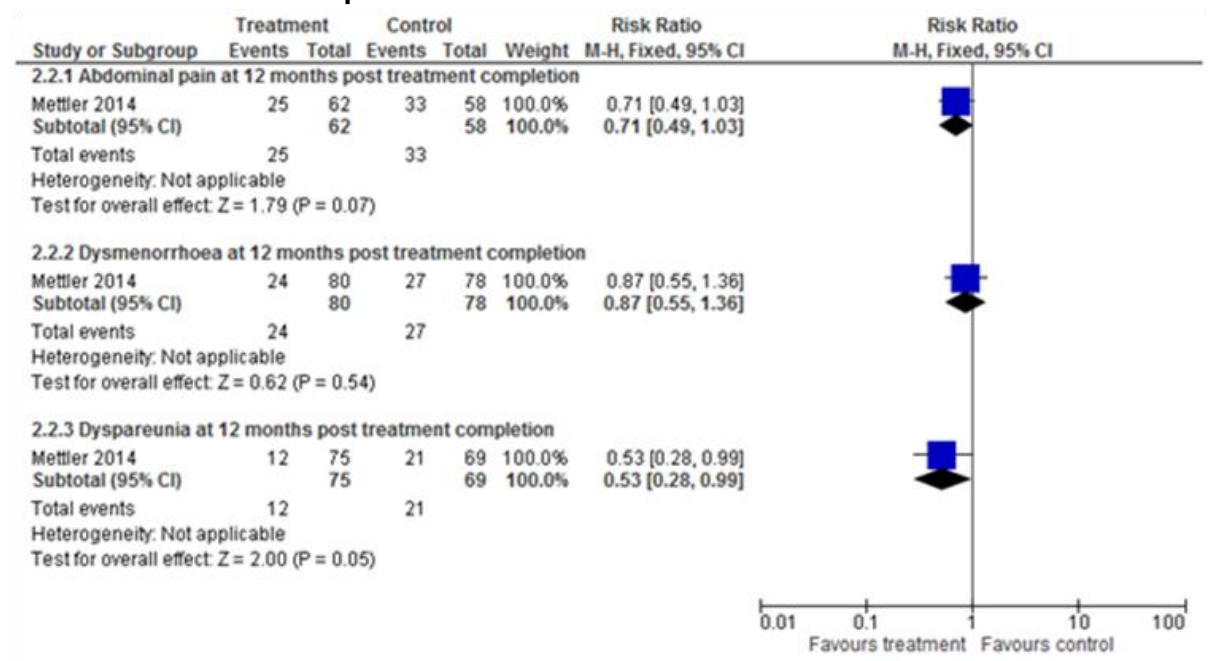


### I.17.5 Combined surgical and hormonal management of endometriosis

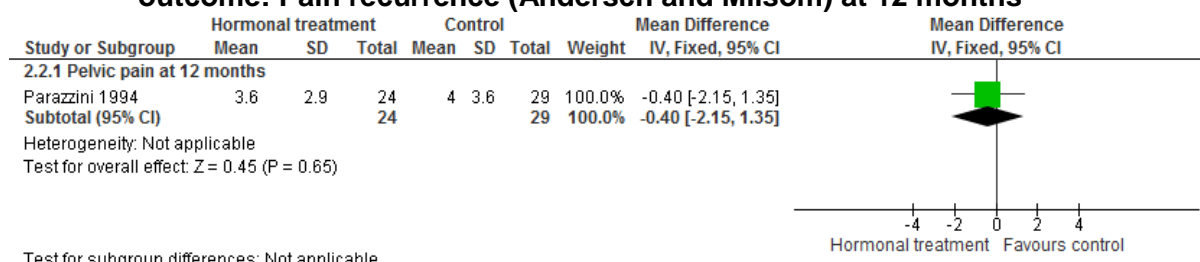
**Figure 181: Post-surgical hormonal therapy versus placebo or no treatment, outcome: Pain recurrence (VAS scale 1-10 cm) at 12 months**



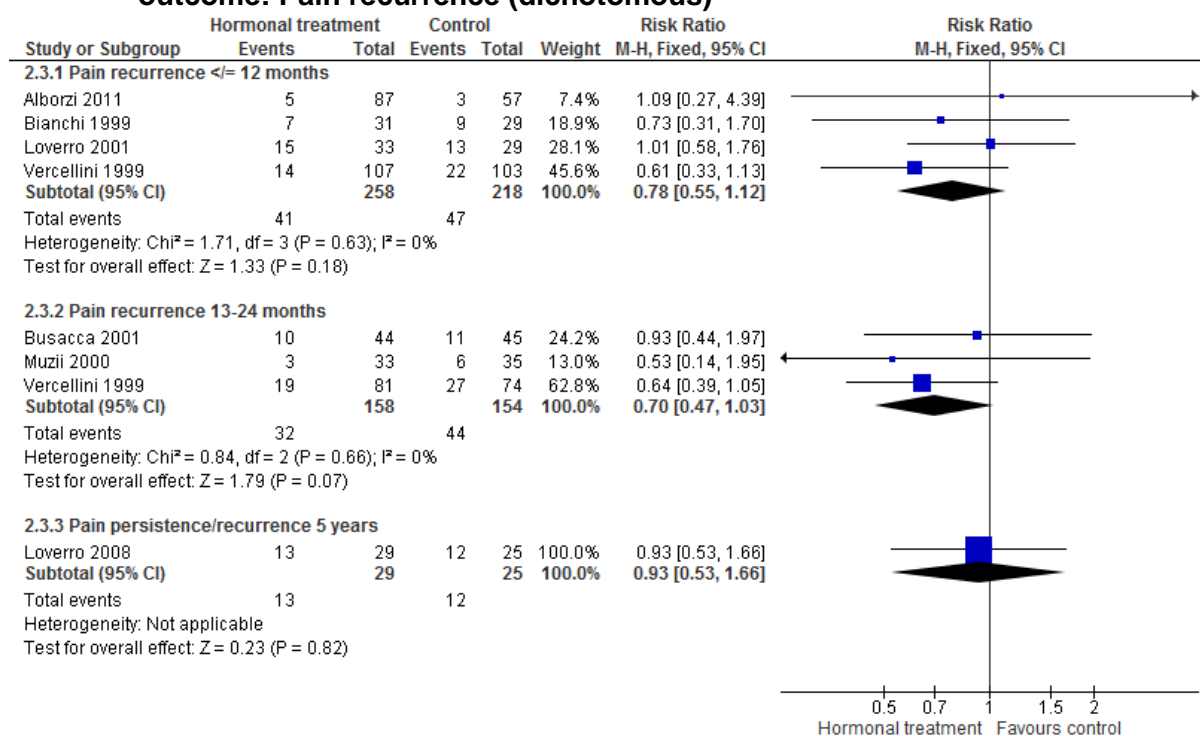
**Figure 182: Post-surgical hormonal therapy versus placebo or no treatment, outcome: Pain recurrence (questionnaire based) at 12 months post treatment completion**



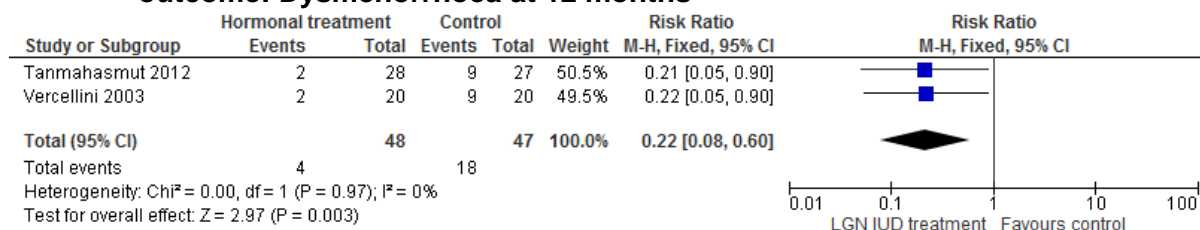
**Figure 183: Post-surgical hormonal therapy versus placebo or no treatment, outcome: Pain recurrence (Andersch and Milsom) at 12 months**



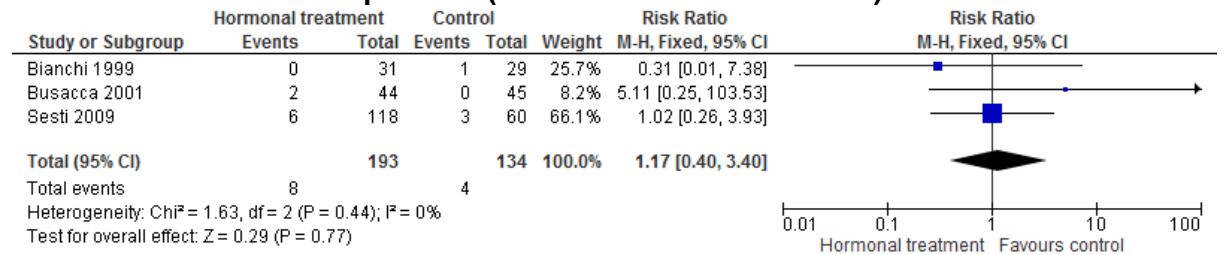
**Figure 184: Post-surgical hormonal therapy versus placebo or no treatment, outcome: Pain recurrence (dichotomous)**



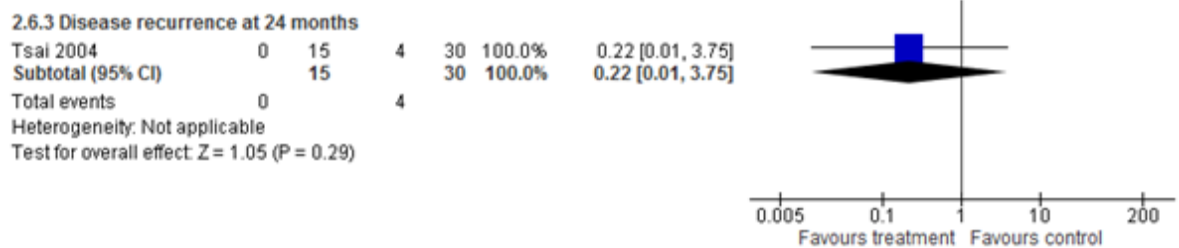
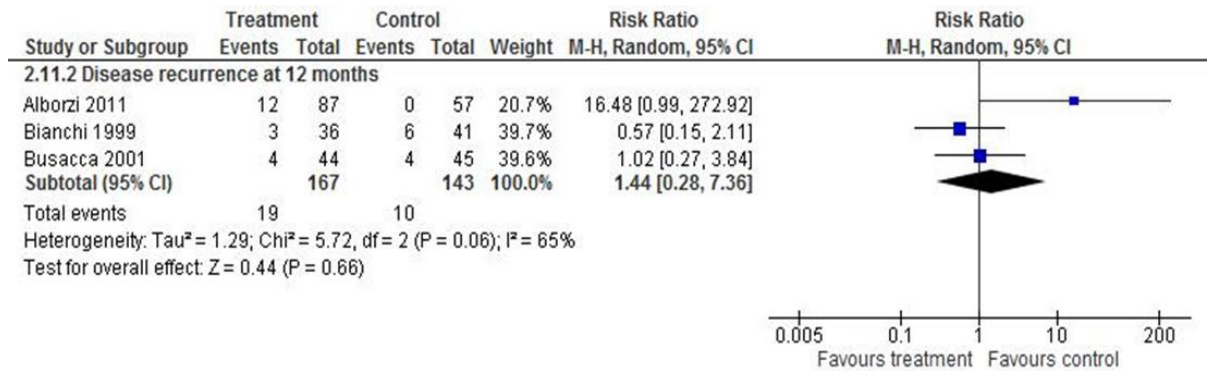
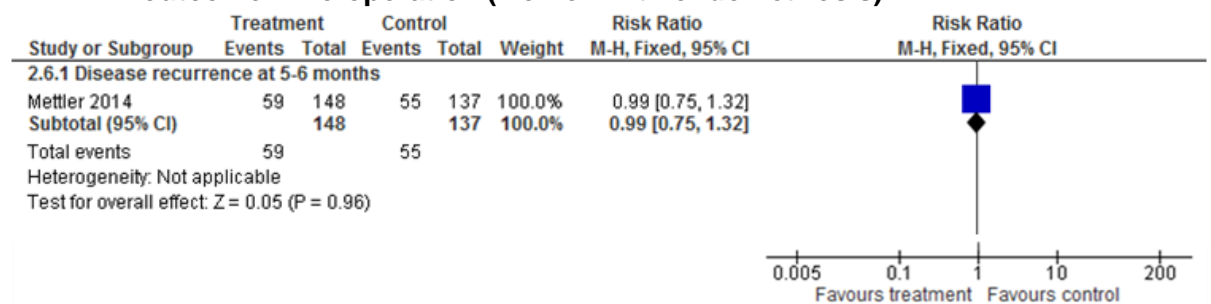
**Figure 185: Post-surgical hormonal therapy versus placebo or no treatment, outcome: Dysmenorrhoea at 12 months**



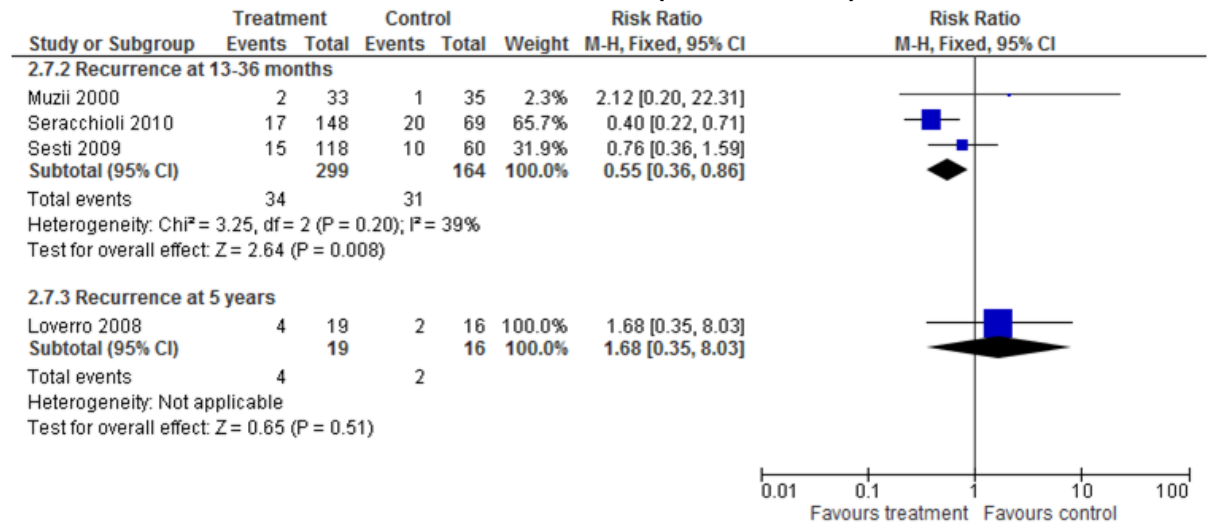
**Figure 186: Post-surgical hormonal therapy versus placebo or no treatment, outcome: Re-operation (women with endometriosis)**



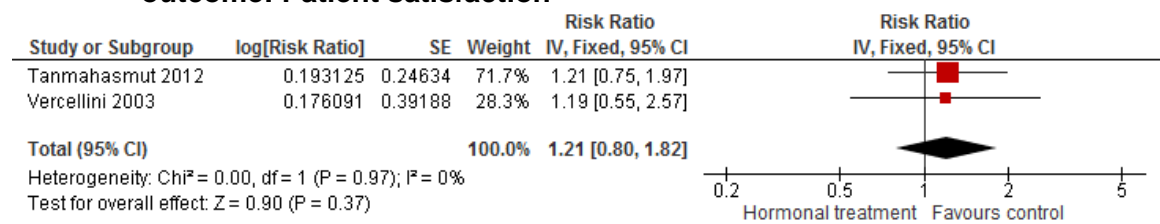
**Figure 187: Post-surgical hormonal therapy versus placebo or no treatment, outcome: Re-operation (women with endometriosis)**



**Figure 188: Post-surgical hormonal therapy versus placebo or no treatment, outcome: Endometrioma recurrence (dichotomous)**



**Figure 189: Post-surgical hormonal therapy versus placebo or no treatment, outcome: Patient satisfaction**

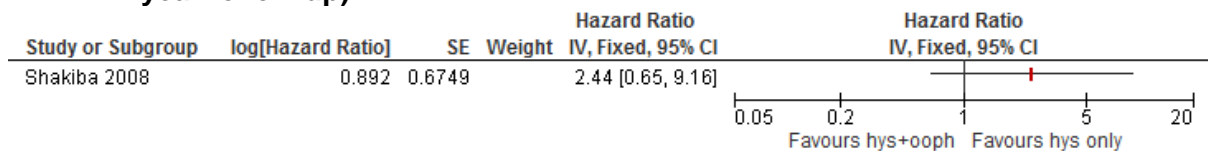


1

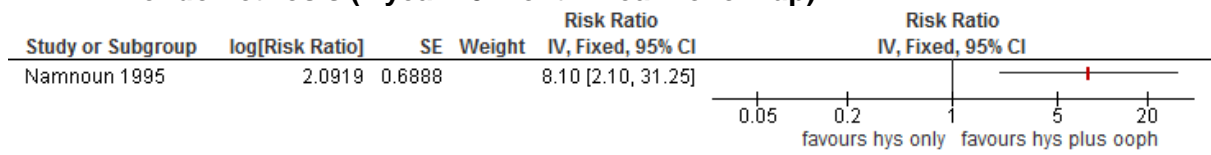
2

## I.18 Hysterectomy with or without oophorectomy

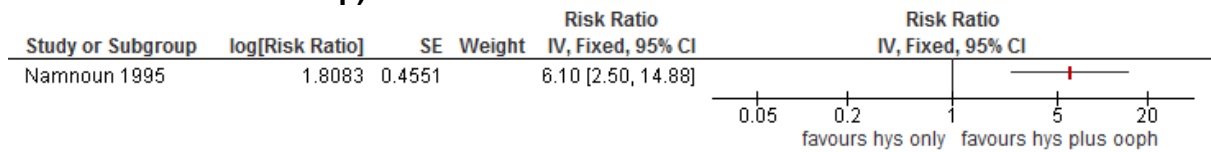
**Figure 190: Hysterectomy versus hysterectomy with or without oophorectomy for the outcome of reoperation-free survival in women with endometriosis (7 year follow-up)**



**Figure 191: Hysterectomy with oophorectomy versus hysterectomy with ovarian conservation for the outcome of risk of reoperation in women with endometriosis (4 year 10 month mean follow-up)**



**Figure 192: Hysterectomy with oophorectomy versus hysterectomy with ovarian conservation for the outcome of risk of pain recurrence (4 year 10 month mean follow-up)**



1

## I.19 Management strategies to improve spontaneous pregnancy rates

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## Appendix J: GRADE tables

### J.1 Specialist services

No evidence found

### J.2 Timing of interventions: association between duration of symptoms before laparoscopy and treatment outcomes

No evidence found

### J.3 Signs and symptoms of endometriosis (monitoring and referral)

Not applicable

### J.4 Information and support

Not applicable

### J.5 Risk of reproductive cancer

Not applicable

### J.6 Diagnosis – Ultrasound

Table 1: Clinical evidence profile: Pelvic endometriosis

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	5	1222	Serious risk of bias <sup>2</sup>	Very serious inconsistency <sup>3</sup>	No serious indirectness	Very serious imprecision <sup>4</sup>	⊕⊕⊕⊕ Very low

<sup>1</sup> Includes TVUS, tg-TVUS and TVUS kissing ovaries sign



2 2 studies did not use a consecutive or random sample, 1 study did not avoid inappropriate exclusions and 1 study did not include all patients in the analysis; unclear whether 1 study avoided inappropriate exclusions; unclear whether in 4 studies the reference standard results were interpreted without knowledge of the results of the index test. In 1 study there was high/unclear applicability concern in terms of population in so called “two-gate” design studies (according to Nisenblat 2016 Cochrane systematic review, a “two-gate” design study includes participants sampled from distinct populations with respect to clinical presentation; the same study includes participants with a clinical suspicion of having the target condition (e.g. women with pelvic pain) and also participants in whom the target condition is not suspected (e.g. women admitted for tubal ligation). “Two-gate” studies were included only where all cases and controls belonged to the same population with respect to the reference standard)

3 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

4 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

**Table 2: Clinical evidence profile: Bowel endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Index test
Ultrasound <sup>1</sup>	3	314	Very serious risk of bias <sup>3</sup>	No serious inconsistency	No serious indirectness	Very serious imprecision <sup>4</sup>	⊕⊕⊕⊕ Very low
Ultrasound <sup>2</sup>	2	171	Very serious risk of bias <sup>5</sup>	Serious inconsistency <sup>6</sup>	No serious indirectness	Serious imprecision <sup>7</sup>	⊕⊕⊕⊕ Very low

1 Includes TVUS, RWC-TVUS and TVUS-BP

2 Includes TRUS

3 2 studies did not use a consecutive or random sample, 1 study did not include all patients in the analysis, 2 studies did not avoid inappropriate exclusions and 2 studies were not blinded; unclear whether 1 study avoided inappropriate exclusions; unclear whether in 1 study the reference standard results were interpreted without knowledge of the results of the index test

4 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

5 1 study did not use a consecutive or random sample, 1 study did not include all patients in the analysis and 1 study was not blinded; unclear whether in 1 study the reference standard results were interpreted without knowledge of the results of the index test; unclear whether 1 study avoided inappropriate exclusions, whether the index test results were interpreted without knowledge of the results of the reference standard and whether there was an appropriate interval between index test and reference standard

6 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

7 Confidence interval for sensitivity in one study ranged from 47% to 100%

**Table 5: Clinical evidence profile: DIE**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	3	282	Seriuos risk of bias <sup>2</sup>	Serious inconsistency <sup>3</sup>	No serious indirectness	Very serious imprecision <sup>4</sup>	⊕⊕⊕⊕ Very low

1 Includes TVUS, TVUS-BP and 3D-TVUS

2 1 study did not use a consecutive or random sample and one study did not include all patients in the analysis; unclear if 1 study avoided inappropriate exclusions

3 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

4 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

**Table 3: Clinical evidence profile: Posterior DIE**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	7	853	Serious risk of bias <sup>3</sup>	Very serious inconsistency <sup>4</sup>	No serious indirectness	Serious imprecision <sup>5</sup>	⊕⊕⊕⊖ Very low
Ultrasound <sup>2</sup>	2	248	Very serious risk of bias <sup>6</sup>	No serious inconsistency	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Very low

1 Includes TVUS, tg-TVUS and SVG

2 Includes SVG and 3D-TVUS

3 2 studies did not use a consecutive or random sample, 3 studies did not include all patients in the analysis and 3 studies were not blinded; unclear whether 3 studies avoided inappropriate exclusions; unclear whether in 2 studies the reference standard results were interpreted without knowledge of the results of the index test; unclear whether in 1 study there was an appropriate interval between index test and reference standard

4 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

5 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

6 1 study did not use a consecutive or random sample, 1 study did not include all patients in the analysis and both studies were not blinded; unclear whether 1 study avoided inappropriate exclusions; unclear whether in 1 study there was an appropriate interval between index test and reference standard

**Table 4: Clinical evidence profile: Anterior DIE**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	1	88	Serious risk of bias <sup>1</sup>	N/A	No serious indirectness	No serious imprecision	Low

1 Includes TVUS

2 Unclear whether the study avoided inappropriate exclusions and whether the reference standard results were interpreted without knowledge of the results of the index test

**Table 6: Clinical evidence profile: Rectovaginal endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	10	983	Serious risk of bias <sup>4</sup>	Very serious inconsistency <sup>5</sup>	No serious indirectness	Very serious imprecision <sup>6</sup>	⊕⊕⊕⊖ Very low
Ultrasound <sup>2</sup>	1	90	Serious risk of bias <sup>7</sup>	N/A	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Low
Ultrasound <sup>3</sup>	2	232	Very serious risk of bias <sup>8</sup>	Serious inconsistency <sup>9</sup>	No serious indirectness	Serious imprecision <sup>10</sup>	⊕⊕⊕⊖ Very low

1 Includes TVUS, TVUS-BP, tg-TVUS, introital 3D-US and SVG

2 Includes RWC-TVUS

3 Includes TRUS

4 4 studies did not use a consecutive or random sample, 2 studies did not include all patients in in the analysis and 3 studies were not blinded; unclear whether 4 studies avoided inappropriate exclusions; unclear whether in 6 studies the reference standard results were interpreted without knowledge of the results of the index test  
5 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals  
6 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis  
7 Study did not use a consecutive or random sample; unclear whether the study avoided inappropriate exclusions and whether the reference standard results were interpreted without knowledge of the results of the index test  
8 1 study did not use a consecutive or random sample and was not blinded; unclear whether 1 study avoided inappropriate exclusions  
9 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals  
10 Confidence interval for sensitivity in one study ranged from 2% to 52%

**Table 7: Clinical evidence profile: Rectosigmoid endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	14	1615	Serious risk of bias <sup>4</sup>	Serious inconsistency <sup>5</sup>	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Very low
Ultrasound <sup>2</sup>	1	202	Very serious risk of bias <sup>6</sup>	N/A	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Low
Ultrasound <sup>3</sup>	4	330	Very serious risk of bias <sup>7</sup>	Serious inconsistency <sup>5</sup>	No serious indirectness	Very serious imprecision <sup>9</sup>	⊕⊕⊕⊖ Very low

1 Includes TVUS, TVUS-BP, tg-TVUS, RWC-TVUS and SVG

2 Includes 3D-TVUS

3 includes TRUS

4 4 studies did not use a consecutive or random sample, 3 studies did not include all patients in the analysis and 8 studies were not blinded; unclear whether 5 studies avoided inappropriate exclusions; unclear whether in 5 studies the reference standard results were interpreted without knowledge of the results of the index test; unclear whether in 1 study there was an appropriate interval between index test and reference standard

5 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

6 Not all patients included in the analysis and study was not blinded

7 1 study did not use a consecutive or random sample, 1 study did not avoid inappropriate exclusions and 3 studies were not blinded; unclear whether in 1 study there was an appropriate interval between index test and reference standard

8 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

**Table 8: Clinical evidence profile: Uterosacral ligament endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	7	714	Serious risk of bias <sup>3</sup>	Very serious inconsistency <sup>4</sup>	No serious indirectness	Serious imprecision <sup>5</sup>	⊕⊕⊕⊖ Very low
Ultrasound <sup>2</sup>	2	232	Very serious risk of bias <sup>6</sup>	Serious inconsistency <sup>7</sup>	No serious indirectness	Serious imprecision <sup>8</sup>	⊕⊕⊕⊖ Very low

1 Includes TVUS, tg-TVUS, TVUS-BP and SVG

2 Includes TRUS

3 3 studies did not use a consecutive or random sample, 2 studies did not include all patients in the analysis and 2 were not blinded; unclear whether 4 studies avoided inappropriate exclusions; unclear whether in 4 studies the reference standard results were interpreted without knowledge of the results of the index test

4 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

5 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

6 1 study did not use a consecutive or random sample and was not blinded; unclear if another study avoided inappropriate exclusions and whether the reference standard results were interpreted without knowledge of the results of the index test

7 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

8 Confidence interval for sensitivity in one study ranged from 44% to 97% and specificity from 14% to 79%

**Table 9: Clinical evidence profile: Vaginal wall involvement by endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	6	679	Serious risk of bias <sup>3</sup>	Very serious inconsistency <sup>4</sup>	No serious indirectness	Serious imprecision <sup>5</sup>	⊕⊕⊕⊖ Very low
Ultrasound <sup>2</sup>	2	232	Very serious risk of bias <sup>6</sup>	Very serious inconsistency <sup>4</sup>	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Very low

1 Includes TVUS, TVUS-BP, tg-TVUS and SVG

2 Includes TRUS

3 2 studies did not use a consecutive or random sample, 2 studies did not include all patients in the analysis and 3 studies were not blinded; unclear whether 3 studies avoided inappropriate exclusions; unclear whether in 3 studies the reference standard results were interpreted without knowledge of the results of the index test

4 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

5 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

6 1 study did not use a consecutive or random sample and was not blinded; unclear whether 1 study avoided inappropriate exclusions and whether the reference standard results were interpreted without knowledge of the results of the index test

7 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

**Table 10: Clinical evidence profile: Pouch of Douglas endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	6	755	Very serious risk of bias <sup>2</sup>	No serious inconsistency	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Very low

1 Includes TVUS, TVUS-BP and SVG+TVUS-BP

2 3 studies did not use a consecutive or random sample, 2 studies did not include all patients in the analysis and 4 studies were not blinded; unclear whether 2 studies avoided inappropriate exclusions; unclear whether in 1 study the reference standard results were interpreted without knowledge of the results of the index test

**Table 12: Clinical evidence profile: Bladder endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	5	383	Very serious risk of bias <sup>2</sup>	Very serious inconsistency <sup>3</sup>	No serious indirectness	Very serious imprecision <sup>4</sup>	⊕⊕⊕⊖ Very low

*1 Includes TVUS, TVUS-BP, tg-TVUS, 3D-TVUS and SVG+TVUS-BP*

*2 3 studies did not use a consecutive or random sample, 2 studies did not include all patients in the analysis and 4 studies were not blinded; unclear whether 3 studies avoided inappropriate exclusions; unclear whether in 1 study the reference standard results were interpreted without knowledge of the results of the index test*

*3 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals*

*4 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis*

**Table 13: Clinical evidence profile: Ovarian endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Ultrasound <sup>1</sup>	9	1066	Serious risk of bias <sup>3</sup>	No serious inconsistency	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Low
Ultrasound <sup>2</sup>	1	92	Serious risk of bias <sup>4</sup>	N/A	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Low

*1 Includes TVUS, TVUS-BP and tg-TVUS*

*2 Includes TRUS*

*3 2 studies did not use a consecutive or random sample, 3 studies did not include all patients in the analysis and 3 studies were not blinded; unclear whether 2 studies avoided inappropriate exclusions; unclear whether in 1 study the index test results interpreted without knowledge of the results of the reference standard and whether in 4 studies the reference standard results were interpreted without knowledge of the results of the index test*

*4 unclear whether the study avoided inappropriate exclusions and whether the reference standard results were interpreted without knowledge of the results of the index test*

## J.7 Diagnosis – Biomarkers: CA-125

**Table 5: Clinical evidence profile: endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
CA-125 (>=35 U/ml)	24	2491	Very serious risk of bias <sup>1</sup>	Serious inconsistency <sup>2</sup>	No serious indirectness	No serious imprecision <sup>3</sup>	⊕⊕⊕⊖ Very low

*1 5 studies did not use a consecutive or random sample, 10 studies did not pre-specify the threshold used and 5 studies did not include all patients in the analysis; unclear whether in 12 studies a consecutive or random sample of patients was used; unclear whether 3 studies avoided inappropriate exclusions; unclear whether in 13 studies the index test results were interpreted without knowledge of the results of the reference standard and whether in 4 studies the reference standard results were interpreted without*

knowledge of the results of the index test; unclear whether in 10 studies the reference standard was likely to correctly classify the target condition. In 8 studies there was high/unclear applicability concern in terms of population in so called “two-gate” design studies (according to Nisenblat 2016 Cochrane systematic review, a “two-gate” design study includes participants sampled from distinct populations with respect to clinical presentation; the same study includes participants with a clinical suspicion of having the target condition (e.g. women with pelvic pain) and also participants in whom the target condition is not suspected (e.g. women admitted for tubal ligation). “Two-gate” studies were included only where all cases and controls belonged to the same population with respect to the reference standard)

2 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

3 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

**Table 6: Clinical evidence profile: endometrioma**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
CA-125 (>=35 U/ml)	1	101	Serious risk of bias <sup>1</sup>	N/A	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Moderate

<sup>1</sup> Unclear whether the index test result was interpreted without knowledge of the results of the reference standard

## J.8 Diagnosis - Biomarkers: HE-4

**Table 7: Clinical evidence profile: endometriosis/endometrioma**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
HE-4	1	68	Very serious risk of bias <sup>1</sup>	N/A	No serious indirectness	No serious imprecision	⊕⊖⊖⊖ Very low

<sup>1</sup> not blinded; unclear whether a consecutive or random sample was used, whether inappropriate exclusions were avoided and whether there was an appropriate interval between index test and reference standard

## J.9 Diagnosis - Biomarkers: Nerve fibre marker Protein Gene Product 9.5 (PGP 9.5)

**Table 8: Clinical evidence profile**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
PGP 9.5	8	429	High risk of bias <sup>1</sup>	Serious inconsistency <sup>2</sup>	No serious indirectness	Serious imprecision <sup>3</sup>	⊕⊖⊖⊖ Very low

<sup>1</sup> 5 studies did not use a consecutive or random sample, 1 study did not pre-specified the threshold used and 1 study did not include all patients in the analysis; unclear whether in 1 study a consecutive or random sample of patients was used; unclear whether 2 studies were blinded. In 3 studies there was high/unclear applicability concern in

terms of population in so called “two-gate” design studies (according to Gupta 2016 Cochrane systematic review, a “two-gate” design study includes participants sampled from distinct populations with respect to clinical presentation; the same study includes participants with a clinical suspicion of having the target condition (e.g. women with pelvic pain) and also participants in whom the target condition is not suspected (e.g. women admitted for tubal ligation). “Two-gate” studies were included only where all cases and controls belonged to the same population with respect to the reference standard)

2 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

3 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

## J.10 Diagnosis – MRI

**Table 9: Clinical evidence profile: Pelvic endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	8	333	Serious risk of bias <sup>4</sup>	Serious inconsistency <sup>5</sup>	No serious indirectness	Serious imprecision <sup>6</sup>	⊕⊖⊖⊖ Very low
MRI <sup>2</sup>	2	62	Very serious risk of bias <sup>7</sup>	Serious inconsistency <sup>5</sup>	No serious indirectness	Serious imprecision <sup>8</sup>	⊕⊖⊖⊖ Very low
MRI <sup>3</sup>	1	31	Very serious risk of bias <sup>9</sup>	N/A	No serious indirectness	Serious imprecision <sup>10</sup>	⊕⊖⊖⊖ Very low

1 Includes conventional (T1-/T2-w), T1-w+fat-suppressed, T-1/T2-w + fat-suppressed/Gd and 3.0T MRI

2 Includes T1-/T2-w + fat-suppressed and fat-suppressed MRI

3 Includes T-1/T2-w + fat-suppressed/Gd MRI

4 4 studies did not use a consecutive or random sample and 2 studies did not include all patients in the analysis; unclear whether in 2 studies a consecutive or random sample of patients was used; unclear whether 6 studies avoided inappropriate exclusions; unclear whether in 2 studies the reference standard was likely to correctly classify the target condition; unclear whether in 5 studies the index test results was interpreted without knowledge of the results of the reference standard or the reference standard results were interpreted without knowledge of the results of the index test

5 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

6 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

7 Both studies did not use a consecutive or random sample and 1 study did not include all patients in the analysis; unclear whether both studies avoided inappropriate exclusions; unclear whether in both studies the reference standard was likely to correctly classify the target condition; unclear whether on 1 study the reference standard results were interpreted without knowledge of the results of the index test

8 Confidence interval for specificity in one study ranged from 16% to 100%

9 No consecutive or random sample used and not all patient included in the analysis; unclear whether inappropriate exclusions were avoided; unclear whether the reference standard was likely to correctly classify the target condition

10 Confidence interval for specificity ranged from 19% to 81%

**Table 5: Clinical evidence profile: DIE**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	4	212	Serious risk of bias <sup>2</sup>	Serious inconsistency <sup>3</sup>	No serious indirectness	Very serious imprecision <sup>4</sup>	⊕⊕⊕⊕ Very low

1 Includes T-1/T2-w + fat-suppressed/Gd and 3.0T MRI

2 2 studies did not use a consecutive or random sample and one study did not include all patients in the analysis; unclear whether 2 studies avoided inappropriate exclusions; unclear whether in 1 study the reference standard was likely to correctly classify the target condition; unclear whether in 2 studies the reference standard results were interpreted without knowledge of the results of the index test

3 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

4 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

**Table 10: Clinical evidence profile: Posterior DIE**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	2	54	Very serious risk of bias <sup>3</sup>	Serious inconsistency <sup>4</sup>	No serious indirectness	Serious imprecision <sup>5</sup>	⊕⊕⊕⊕ Very low
MRI <sup>2</sup>	1	23	Very serious risk of bias <sup>6</sup>	N/A	No serious indirectness	Serious imprecision <sup>7</sup>	⊕⊕⊕⊕ Very low

1 Includes Jelly method (T1-/T2-w + fat-suppressed) and 2D FSE T2-w MRI

2 Includes 3D MRI

3 1 study did not use a consecutive or random sample and 1 study did not include all patients in the analysis; unclear whether both studies avoided inappropriate exclusions; unclear whether in 1 study there was an appropriate interval between index test and reference standard; unclear whether in 1 study the reference standard results were interpreted without knowledge of the results of the index test

4 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

5 Confidence interval for specificity in one study ranged from 1% to 72%

6 Not all patients were included in the analysis; unclear whether inappropriate exclusions were avoided and whether the reference standard results were interpreted without knowledge of the results of the index test

7 Confidence interval for specificity ranged from 2% to 72%

**Table 11: Clinical evidence profile: Anterior DIE**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	1	106	Serious risk of bias <sup>2</sup>	N/A	No serious indirectness	Serious imprecision <sup>3</sup>	⊕⊕⊕⊕ Very low

1 Includes 3.0T MRI

1 Not all patients included in the analysis

2 Confidence interval for sensitivity ranged from 35% to 97%



**Table 6: Clinical evidence profile: Rectovaginal endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	3	288	Very serious risk of bias <sup>2</sup>	Serious inconsistency <sup>3</sup>	No serious indirectness	Very serious imprecision <sup>4</sup>	⊕⊕⊕⊖ Very low

1 Includes T-1/T2-w + fat-suppressed/Gd MRI

2 1 study did not use a consecutive or random sample and 1 study was not blinded; unclear whether 1 study avoided inappropriate exclusions; unclear whether in 1 study there was an appropriate interval between index test and reference standard; unclear whether in 2 studies the reference standard results were interpreted without knowledge of the results of the index test

3 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

4 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

**Table 7: Clinical evidence profile: Rectosigmoid endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	6	662	Very serious risk of bias <sup>3</sup>	No serious inconsistency	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Very low
MRI <sup>2</sup>	1	23	Very serious risk of bias <sup>4</sup>	N/A	No serious indirectness	No serious imprecision	⊕⊕⊕⊖ Very low

1 Includes T-1/T2-w + fat-suppressed/Gd, 2D FSE T2-w, jelly method (T1-/T2-w + fat-suppressed) and 3.0T MRI

2 Includes 3D MRI

3 2 studies did not use a consecutive or random sample, 2 studies did not include all patients in the analysis, 2 studies were not blinded; unclear whether 1 study avoided inappropriate exclusions; unclear whether in 1 study there was an appropriate interval between index test and reference standard; unclear whether in 3 studies the reference standard results were interpreted without knowledge of the results of the index test

4 Not all patients included in the analysis; unclear whether the study avoided inappropriate exclusions; unclear whether the reference standard results were interpreted without knowledge of the results of the index test

**Table 8: Clinical evidence profile: Uterosacral ligament endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	5	241	Serious risk of bias <sup>3</sup>	Serious inconsistency <sup>4</sup>	No serious indirectness	Very serious imprecision <sup>5</sup>	⊕⊕⊕⊖ Very low
MRI <sup>2</sup>	1	23	Very serious risk of bias <sup>6</sup>	N/A	No serious indirectness	Serious imprecision <sup>7</sup>	⊕⊕⊕⊖ Very low

1 Includes T-1/T2-w + fat-suppressed/Gd, 2D FSE T2-w and 3.0T MRI

2 Includes 3D MRI

3 2 studies did not use a consecutive or random sample and 2 studies did not include all patients in the analysis; unclear whether 3 studies avoided inappropriate exclusions; unclear whether in 1 study the reference standard was likely to correctly classify the target condition; unclear whether in 4 studies the reference standard results were interpreted without knowledge of the results of the index test

4 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

5 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

6 Not all patients included in the analysis; unclear whether the study avoided inappropriate exclusions; unclear whether the reference standard results interpreted without knowledge of the results of the index test

7 Confidence interval for specificity ranged from 0.4% to 78%

**Table 9: Clinical evidence profile: Vaginal wall involvement by endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	4	248	Very serious risk of bias <sup>3</sup>	Serious inconsistency <sup>4</sup>	No serious indirectness	Very serious imprecision <sup>5</sup>	⊕⊕⊕⊖ Very low
MRI <sup>2</sup>	1	23	Very serious risk of bias <sup>6</sup>	N/A	No serious indirectness	Serious imprecision <sup>7</sup>	⊕⊕⊕⊖ Very low

1 Includes T-1/T2-w + fat-suppressed/Gd, 2D FSE T2-w and 3.0T MRI

2 Includes 3D MRI

3 1 study did not use a consecutive or random sample and 2 studies did not include all patients in the analysis; unclear whether 2 studies avoided inappropriate exclusions; unclear whether in 1 study there was an appropriate interval between index test and reference standard; unclear whether in 3 studies the reference standard results were interpreted without knowledge of the results of the index test

4 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

5 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

6 Not all patients included in the analysis; unclear whether the study avoided inappropriate exclusions; unclear whether the reference standard results interpreted without knowledge of the results of the index test

7 Confidence interval for sensitivity ranged from 28% to 99%

**Table 10: Clinical evidence profile: Pouch of Douglas endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	5	154	Serious risk of bias <sup>3</sup>	Serious inconsistency <sup>4</sup>	No serious indirectness	Serious imprecision <sup>5</sup>	⊕⊕⊕⊖ Very low
MRI <sup>2</sup>	1	23	Very serious risk of bias <sup>6</sup>	N/A	No serious indirectness	Serious imprecision <sup>7</sup>	⊕⊕⊕⊖ Very low

1 Includes Jelly method (T1-/T2-w + fat-suppressed), 2D FSE T2-w and 3.0T MRI

2 Includes 3D MRI

3 1 study did not use a consecutive or random sample and 2 studies did not include all patients in the analysis; unclear whether 2 studies avoided inappropriate exclusions; unclear whether in 1 study the reference standard was likely to correctly classify the target condition; unclear whether in 1 study there was an appropriate interval between index test and reference standard; unclear whether in 2 studies the reference standard results were interpreted without knowledge of the results of the index test

4 Inconsistency was assessed by inspection of the sensitivity and specificity forest plots across studies, using the point estimates and confidence intervals

5 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

6 Not all patients included in the analysis; unclear whether the study avoided inappropriate exclusions; unclear whether the reference standard results interpreted without knowledge of the results of the index test

7 Confidence interval for sensitivity ranged from 42% to 92%

**Table 11: Clinical evidence profile: Ureteral endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	1	92	Very serious risk of bias <sup>2</sup>	N/A	No serious indirectness	Serious imprecision <sup>3</sup>	⊕⊖⊖⊖ Very low

1 Includes T1-/T2-w + fat-suppressed/Gd MRI

2 No consecutive or random sample used; unclear whether there was an appropriate interval between index test and reference standard; unclear whether the reference standard results interpreted without knowledge of the results of the index test

3 Confidence interval for sensitivity ranged from 16% to 84%

**Table 12: Clinical evidence profile: Bladder endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	1	92	Very serious risk of bias <sup>2</sup>	N/A	No serious indirectness	Serious imprecision <sup>3</sup>	⊕⊖⊖⊖ Very low

1 Includes T1-/T2-w + fat-suppressed/Gd MRI

2 No consecutive or random sample used; unclear whether there was an appropriate interval between index test and reference standard; unclear whether the reference standard results interpreted without knowledge of the results of the index test

3 Confidence interval for sensitivity ranged from 5% to 54%

**Table 13: Clinical evidence profile: Ovarian endometriosis**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
MRI <sup>1</sup>	3	179	Serious risk of bias <sup>2</sup>	No serious inconsistency	No serious indirectness	Very serious imprecision <sup>3</sup>	⊕⊖⊖⊖ Very low

1 Includes T1-/T2-w + fat-suppressed/Gd and 3.0T MRI

2 1 study did not use a consecutive or random sample and another study did not include all patients in the analysis; unclear whether 1 study avoided inappropriate exclusions; unclear whether in 1 study the reference standard was likely to correctly classify the target condition; unclear whether in 2 studies the reference standard results were interpreted without knowledge of the results of the index test

3 The judgment of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis

## J.11 Diagnosis – Surgilac diagnosis with or without histological confirmation

Not applicable

## J.12 Staging Systems

No evidence found

## J.13 Pharmacological management – Analgesics

Table 12: Clinical evidence profile: Analgesics versus Placebo

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Naproxen Sodium	Placebo	Relative (95% CI)	Absolute		
<b>Overall pain relief (assessed with: 3 point scale questionnaire)</b>												
1 study	randomised trial	very serious <sup>1,2,3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	10/11 (90.9%)	5/8 (62.5%)	RR 1.45 (0.82 to 2.57)*	281 more per 1000 (from 113 fewer to 981 more)	⊕⊕⊕⊕ Very low	CRITICAL
<b>Unintended effects: hypo- menorrhea, diarrhoea. Increased diuresis, headache, epigastric pain nausea, tremor and dizziness</b>												
1 study	randomised trial	very serious <sup>1,3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	4/11 (36.4%)	7/9 (77.8%)	RR 0.47 (0.2 to 1.1)*	412 fewer per 1000 (from 622 fewer to	⊕⊕⊕⊕ Very low	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Naproxen Sodium	Placebo	Relative (95% CI)	Absolute		
										78 more)		
Supplementary analgesia needed												
1 study	randomised trial	very serious <sup>1,3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	1/11 (9.1%)	2/8 (25%)	RR 0.36 (0.04 to 3.35)*	160 fewer per 1000 (from 240 fewer to 587 more)	⊕⊖⊖⊖ Very low	CRITICAL

CI: confidence interval; RR: Risk ratio; OR: Odds ratio

\*analysis carried out by NGA technical team

1 Unclear sequence generation, allocation concealment and selective reporting

2 Invalidated tool used for pain assessment

3 n=24 randomised, n=20 analysed (19 for overall pain relief and supplementary analgesia needed), no clear exclusion criteria hence high risk of selection bias

4 Wide confidence interval

## J.14 Pharmacological management – Neuromodulators

Table 13: GRADE evidence profile for local anaesthetic (pertubation) versus placebo

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Local anaesthetic	placebo	Relative (95% CI)	Absolute		
<b>Pain score - VAS &gt;50% improved - At 3 months</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	9/24 (37.5%)	1/18 (5.6%)	RR 6.75 (0.94 to 48.57)	319 more per 1000 (from 3 fewer to 1000 more)	⊕⊕⊖⊖ Low	CRITICAL
<b>Pain score - VAS &gt;50% improved - At 6 months</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	4/24 (16.7%)	1/18 (5.6%)	RR 3 (0.37 to 24.61)	111 more per 1000 (from 35 fewer to 1000 more)	⊕⊖⊖⊖ Very low	CRITICAL
<b>Pain score - VAS &gt;50% improved - At 9 months</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	2/24 (8.3%)	0/18 (0%)	Peto OR 6.01 (0.35 to	80 more per 1000 (from	⊕⊖⊖⊖ Very low	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Local anaesthetic	placebo	Relative (95% CI)	Absolute		
									102.42) <sup>4</sup>	50 fewer to 220 more) <sup>4</sup>		
<b>Pain score - VAS &gt;50% improved - At 12 months</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	4/24 (16.7%)	0/18 (0%)	Peto OR 6.81 (0.84 to 51.68) <sup>4</sup>	170 more per 1000 (from 0 more to 333 more) <sup>4</sup>	⊕⊕⊕⊖ Very low	CRITICAL
<b>Pain - VAS continuous - At 1 month (Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>5</sup>	none	30	30	-	MD 1.3 lower (2.18 to 0.42 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Pain - VAS continuous - At 2 months (Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	30	30	-	MD 1.9 lower (2.92 to 0.88 lower)	⊕⊕⊕⊕ High	CRITICAL
<b>Pain - VAS continuous - At 3 months (Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	30	30	-	MD 2.3 lower (3.46	⊕⊕⊕⊕ High	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Local anaesthetic	placebo	Relative (95% CI)	Absolute		
										to 1.14 lower)		
<b>Rate of satisfaction with treatment at 3 months</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	22/30 (73.3%)	2/30 (6.7%)	RR 11 (2.83 to 42.7)	667 more per 1000 (from 122 more to 1000 more)	⊕⊕⊕⊕ High	IMPORTANT
<b>Recurrence at 12 months</b>												
1	randomised trials	very serious <sup>6</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	2/24 (8.3%)	0/18 (0%)	Peto OR 6.01 (0.35 to 102.42) <sup>4</sup>	80 more per 1000 (from 50 fewer to 220 more) <sup>4</sup>	⊕⊖⊖⊖ Very low	IMPORTANT
<b>Escalating pain with need for other therapies at 12 months</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	1/24 (4.2%)	3/18 (16.7%)	RR 0.25 (0.03 to 2.21)	125 fewer per 1000 (from 162 fewer	⊕⊖⊖⊖ Very low	IMPORTANT



Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Local anaesthetic	placebo	Relative (95% CI)	Absolute		
										to 202 more)		

CI: confidence interval; RR: risk ratio; OR: odds ratio; Peto OR: Peto odds ratio; MD: mean difference

1 The patient flow is a little unclear and there is a difference in results using two types of analyses. The categorisation of the pain scale favours the treatment group and there are conflicting results with another pain outcome used in the same trial.

2 The confidence interval is large ranging from no effect to effect favouring the treatment.

3 The confidence interval for this outcome ranges from an effect favouring placebo to an effect favouring the treatment. There is therefore too much uncertainty around this effect.

4 Due to zero events in the control group Peto Odds ratio were used rather than Risk Ratios because this method performs well when events are very rare (Bradburn 2007). This means that the risk difference is reported with confidence intervals.

5 The confidence interval ranged from a high effect to no appreciable benefit.

6 No explanation was provided

## J.15 Pharmacological management – Hormonal medical treatments

Table 14: Clinical evidence profile: Comparison 1: GnRH agonist versus no treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist	No treatment	Relative (95% CI)	Absolute		
<b>Dysmenorrhea relief at 12 months (assessed with: VAS, 0 (no pain), 1 to 4 (mild), 5 to 7 (moderate), 8 to 10 (severe))</b>												
1	randomised trials	very serious	no serious inconsistency	serious <sup>1</sup>	serious <sup>2</sup>	none	11/19 (57.9%)	3/16 (18.8%)	RR 3.09 (1.04 to 9.18)	392 more per 1000 (from 7	⊕⊖⊖⊖ Very low	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist	No treatment	Relative (95% CI)	Absolute		
										more to 1000 more)		

CI: confidence interval; RR: risk ratio; VAS: Visual Analog Scale  
 1 The main symptom of the study population was not pain (infertility)  
 2 Confidence interval crosses one threshold

**Table 15: Clinical evidence profile: Comparison 2: GnRH agonist versus placebo**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist	Placebo	Relative (95% CI)	Absolute		
<b>Mean dysmenorrhoea at week 12 (measured with: an 11 point VAS; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	44	44	-	MD 6.30 lower (9.93 to 2.67 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Mean pelvic pain at week 12 (measured with: an 11 point VAS; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	44	44	-	MD 4.4 lower (6.93 to 1.87 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Mean deep dyspareunia at week 12 (measured with: an 11 point VAS; Better indicated by lower values)</b>												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist	Placebo	Relative (95% CI)	Absolute		
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	31	30	-	MD 3.1 lower (4.85 to 1.35 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Dyspareunia cessation at 6 months</b>												
1	randomised trials	Serious <sup>2</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	16/23	4/23	RR 4 (1.58 to 10.15)	522 more per 1000 (from 101 more to 1000 more)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Pelvic tenderness cessation at 6 months</b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	10/23 (43.5%)	9/23 (39.1%)	RR 1.11 (0.56 to 2.22)	43 more per 1000 (from 172 fewer to 477 more)	⊕⊖⊖⊖ Very low	CRITICAL

CI: confidence interval; MD: mean difference; RR: risk ratio; VAS: Visual Analog Scale

1 Outcomes measured immediately after treatment period are of less clinical relevance than sustained post-treatment effects

2 No details provided regarding sequence generation and allocation concealment (unclear risk)

3 Confidence intervals for estimate are very wide crossing two thresholds

**Table 16: Clinical evidence profile: Comparison 3: Combined oral contraceptive pill versus placebo**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral contraceptive	Placebo	Relative (95% CI)	Absolute		
<b>Dysmenorrhoea (measured with: VAS (not defined, assumed 0 to 100))</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	49	47	-	MD 21.5 lower (28.14 to 14.86 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Nonmenstrual pelvic pain (measured: with VAS (not defined, assumed 0 to 100))</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	49	47	-	MD 6.6 lower (14.27 lower to 1.07 higher)	⊕⊕⊕⊖ Low	CRITICAL
<b>Induration (physical examination)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	11/49 (22.4%)	19/47 (40.4%)	RR 0.56 (0.3 to 1.04)	178 fewer per 1000 (from 283 fewer to 16 more)	⊕⊕⊕⊖ Low	CRITICAL

CI: confidence interval; MD: mean difference; RR: risk ratio; VAS: Visual Analog Scale

1 Short duration of treatment is of limited relevance to clinical practice

2 Confidence interval crosses one threshold

**Table 17: Clinical evidence profile Comparison 1: GnRH agonist versus danazol**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRHa versus danazol	Danazol	Relative (95% CI)	Absolute		
<b>Pelvic tenderness at 3 months (assessed with TSSS, scale not defined, assumed better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>1</sup>	none	22	19	-	MD 0.2 lower (0.78 lower to 0.38 higher)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Pelvic tenderness at 6 months (assessed with TSSS, scale not defined, assumed better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>1</sup>	none	22	19	-	MD 0.2 lower (0.75 lower to 0.35 higher)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Pelvic induration at 3 months (assessed with TSSS, scale not defined, assumed better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	22	19	-	MD 0.1 lower (0.59 lower to 0.39 higher)	⊕⊕⊖⊖ Low	CRITICAL
<b>Pelvic induration at 6 months (assessed with TSSS, scale not defined, assumed better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>1</sup>	none	22	19	-	MD 0.2 higher (0.29 lower to 0.69 higher)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Patients requiring surgery because of reappearance of symptoms and positive findings at pelvic examination at &gt;12 months post treatment</b>												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRHa versus danazol	Dana zol	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>1</sup>	none	4/11 (36.4%)	5/14 (35.7%)	RR 1.02 (0.36 to 2.91)	7 more per 1000 (from 229 fewer to 682 more)	⊕⊕⊕⊖ Moderate	IMPORTANT
<b>QoL (assessed with: Psychological General Well-Being Index plus a modification of Part II of the Nottingham Health Profile)</b>												
1	randomised trials	very serious <sup>3</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>4</sup>	none	0/111 (0%)	0/58 (0%)	Not estimable	-	⊕⊕⊖⊖ Low	CRITICAL

CI: confidence interval; RR: relative risk; MD: mean difference; TSSS: Total Symptom Severity Scale; QoL: quality of life

1 Confidence interval crosses one threshold

2 Confidence interval crosses two thresholds

3 Reporting bias, i.e. not possible to assess imprecision as only descriptive data reported

4 Only descriptive data reported

**Table 18: Clinical evidence profile Comparison 2: GnRH agonist versus levonorgestrel-releasing intrauterine system**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRHa versus levonorgestrel-releasing intrauterine system	Levonorgestrel-releasing intrauterine system	Relative (95% CI)	Absolute		
<b>QoL at 6 months (assessed with: PGWB scale 0 – 110, better indicated by higher values)</b>												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRHa versus levonorgestrel-releasing intrauterine system	Levonorgestrel-releasing intrauterine system	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>1</sup>	none	37	35	-	MD 1.2 lower (7.79 lower to 5.39 higher)	⊕⊕⊕⊖ Moderate	CRITICAL

CI: confidence interval; MD: mean difference; QoL: quality of life; PGWBI: Psychological Well-Being index questionnaire  
1 Confidence interval crosses one threshold

**Table 19: Clinical evidence profile Comparison 3: GnRH agonist versus DMPA-SC**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH a (leuprolide IM)	DMPA (SC)	Relative (95% CI)	Absolute		
<b>Effect on daily activities (assessed by mean number of hours of productivity lost at employment at 6 months)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	102	88	-	MD 6.15 higher (2.17 lower to 14.47 higher)	⊕⊕⊕⊕ High	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH a (leuprolide IM)	DMP A (SC)	Relative (95% CI)	Absolute		
<b>Effect on daily activities (assessed by mean number of hours of productivity lost at employment at 18 months)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	102	88	-	MD 6.38 higher (1.94 lower to 14.7 higher)	⊕⊕⊕⊕ High	IMPORTANT
<b>Effect on daily activities (assessed by mean number of hours of productivity lost at housework at 6 months)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>1</sup>	none	44	37	-	MD 7.35 lower (16.63 lower to 1.93 higher)	⊕⊕⊕⊖ Moderate	IMPORTANT
<b>Effect on daily activities (assessed by mean number of hours of productivity lost at housework at 18 months)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>1</sup>	none	44	37	-	MD 3.64 lower (12.92 lower to 5.64 higher)	⊕⊕⊕⊖ Moderate	IMPORTANT

CI: confidence interval; DMPS: depot medroxyprogesterone acetate; IM: intramuscular; MD: mean difference; SC: subcutaneous  
1 Confidence interval crosses one threshold



**Table 20: Clinical evidence profile Comparison 1: GnRH agonist 1 + placebo versus GnRH agonist 2 + placebo**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (nafarelin IN) + placebo IM	GnRH agonist (LA depot IM) + placebo NS	Relative (95% CI)	Absolute		
<b>Relief of painful symptoms - Pelvic tenderness (follow-up 6 months<sup>1</sup>)</b>												
	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	53/99 (53.5%)	58/93 (62.4%)	RR 0.86 (0.67 to 1.09)	87 fewer per 1000 (from 206 fewer to 56 more)	⊕⊕⊖⊖ Low	CRITICAL
<b>Relief of painful symptoms - Pelvic induration (follow-up 6 months<sup>1</sup>)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	73/99 (73.7%)	74/91 (81.3%)	not pooled	not pooled	⊕⊕⊖⊖ Low	CRITICAL

CI: confidence interval; IM: intramuscular; IN: intranasal; LA: leuprorelide acetate; NS: nasal spray; RR: risk ratio

<sup>1</sup> Assessed after the end of treatment period

<sup>2</sup> Quality of evidence was downgraded by 2 points owing to very serious imprecision: confidence interval crosses two default thresholds

**Table 21: Comparison 2: GnRH agonist + placebo versus Progesterin + placebo**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (nafarelin) IN + placebo tables	Progesterin + placebo	Relative (95% CI)	Absolute		
<b>Paid working life (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment)); measured with: Nottingham Health Profile; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate an improvement in the nafarelin group, but not in the MPA group (p=0.06)	MD 0 higher (0 to 0 higher)	⊕⊕⊕⊕ Very low	CRITICAL
<b>Household work (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment)); measured with: Nottingham Health Profile; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference between groups in household work score (data not shown)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL
<b>Vacation life (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment)); measured with: Nottingham Health Profile; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference between	not pooled	⊕⊕⊕⊕ Very low	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (nafarelin) IN + placebo	Progestin + placebo	Relative (95% CI)	Absolute		
									groups in vacation life score (p=0.72)			
<b>Leisure (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment); measured with: Nottingham Health Profile; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference between groups in leisure score (p=0.93)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL
<b>Sexual life (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment); measured with: Nottingham Health Profile; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference between groups in sexual life score (p=0.90)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL
<b>Disturbed sleep (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment); measured with: Goldberg's General Health Q; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference	not pooled	⊕⊕⊕⊕ Very low	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (nafarelin) IN + placebo tables	Progestin + placebo	Relative (95% CI)	Absolute		
									between groups in sleep disturbance (difficulties of falling asleep, early waking and nightmares) score (p=0.19)			
<b>Anxiety-depression (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment); measured with: Goldberg's General Health Q; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference between groups in anxiety-depression score (p=0.20)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL
<b>Motivation (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment); measured with: Coping wheel, ISSI &amp; demands, control &amp; support Q; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference between groups in	not pooled	⊕⊕⊕⊕ Very low	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (nafarelin) IN + placebo tables	Progestin + placebo	Relative (95% CI)	Absolute		
									motivation score (p=0.41)			
<b>Emotional balance (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment)); measured with: Coping wheel, ISSI &amp; demands, control &amp; support Q; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>3</sup>	none	17	13	The results indicate no significant difference between groups in emotional balance score (p=0.44)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL
<b>Structure (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment)); measured with: Coping wheel, ISSI &amp; demands, control &amp; support Q; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>3</sup>	none	17	13	The results indicate no significant difference between groups in structure score (p=0.41)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL
<b>Coping (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment)); measured with: Coping wheel, ISSI &amp; demands, control &amp; support Q; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference	not pooled	⊕⊕⊕⊕ Very low	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (nafarelin) IN + placebo tables	Progestin + placebo	Relative (95% CI)	Absolute		
									between groups in coping score (p=0.39)			
<b>Psychological work demands (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment); measured with: Coping wheel, ISSI &amp; demands, control &amp; support Q; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference between groups in psychological work demands score (p=0.51)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL
<b>Intellectual discretion at work (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment); measured with: Coping wheel, ISSI &amp; demands, control &amp; support Q; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none <sup>3</sup>	17	13	The results indicate no significant difference between groups in Intellectual discretion at work score (p=0.95)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL
<b>Authority over decisions at work (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment); measured with: Coping wheel, ISSI &amp; demands, control &amp; support Q; Better indicated by lower values)</b>												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (nafarelin) IN + placebo	Progestin + placebo	Relative (95% CI)	Absolute		
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference between groups in “authority over decisions at work” score (p=0.39)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL
<b>Social support at work (follow-up - at 6 months (at the end of treatment) and 12 months (6 months after the end of the treatment)); measured with: Coping wheel, ISSI &amp; demands, control &amp; support Q; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	non calculable <sup>2</sup>	none	17	13	The results indicate no significant difference between groups in “social support at work” score (p=0.68)	not pooled	⊕⊕⊕⊕ Very low	CRITICAL

CI: confidence interval; IN: intranasal; MD: mean difference, Q: questionnaire

1 The quality of the evidence was downgraded of 2 points because of the high risk of reporting bias (i.e. not possible to access imprecision as only descriptive data reported) and the potential risk of detection bias (no details were given about randomization and allocation concealment methods)

2 Only descriptive data reported, no sufficient details given to assess the minimally important difference threshold and the imprecision

**Table 22: Clinical evidence profile Comparison 3: GnRH agonist + placebo versus Danazol + placebo**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (nafarelin) + danazol placebo	Danazol + nafarelin placebo NS	Relative (95% CI)	Absolute		
<b>Relief of painful symptoms - Pelvic tenderness (follow-up 6 months<sup>1</sup>; measured with: 4-point numerical scale: 0=none; 1=mild; 2=moderate; 3=severe; Better indicated by lower values)</b>												
1	randomised trials	Serious <sup>2</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	33	16	-	MD 0.1 lower (0.38 lower to 0.18 higher)	⊕⊖⊖⊖ Very low	CRITICAL
<b>Relief of painful symptoms - Pelvic induration (follow-up 6 months<sup>1</sup>; measured with: 4-point numerical scale: 0=none; 1=mild; 2=moderate; 3=severe; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	33	16	-	MD 0 higher (0.28 lower to 0.28 higher)	⊕⊖⊖⊖ Very low	CRITICAL

CI: confidence interval; MD: mean difference; NS: nasal spray

1 Assessed after the end of the treatment period

2 Quality of evidence was downgraded by 1 point owing to unclear risk of selection bias (no details given about allocation concealment methods)

3 Quality of evidence was further downgraded by 2 points owing to very serious imprecision: confidence interval crosses two default thresholds



**Table 23: Clinical evidence profile Comparison 3: GnRH agonist + placebo versus Danazol + placebo**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (nafarelin IS) + oral placebo TDS	Danazol + placebo nasal spray	Relative (95% CI)	Absolute		
<b>Relief of painful symptoms - Pelvic tenderness (follow-up 12 months<sup>1</sup>)</b>												
1	randomised trials	Serious <sup>2</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	50/65 (76.9%)	23/31 (74.2%)	RR 1.04 (0.81 to 1.33)	30 more per 1000 (from 141 fewer to 245 more)	⊕⊖⊖⊖ Very low	CRITICAL
<b>Relief of painful symptoms - Pelvic induration (follow-up 12 months<sup>1</sup>)</b>												
1	randomised trials	Serious <sup>2</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	59/65 (90.8%)	27/31 (87.1%)	RR 1.04 (0.89 to 1.22)	35 more per 1000 (from 96 fewer to 192 more)	⊕⊖⊖⊖ Very low	CRITICAL

CI: confidence interval; RR: risk ratio

<sup>1</sup> Assessed after the end of the treatment period

<sup>2</sup> Quality of evidence was downgraded by 1 point owing to unclear risk of selection bias (no details about allocation concealment method and unclear description of the allocation concealment procedure)

<sup>3</sup> Quality of evidence was downgraded by 2 points owing to very serious imprecision: confidence interval crosses two default thresholds

**Table 24: Clinical evidence profile Comparison 3: GnRH agonist + placebo versus Danazol + placebo**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist (leuprolide IM) + placebo OD PO	Danazol OD PO + placebo IM	Relative (95% CI)	Absolute		
<b>Relief of painful symptoms - Pelvic tenderness (follow-up 6 months)<sup>1</sup></b>												
1	randomised trials	Serious <sup>2</sup>	no serious inconsistency	no serious indirectness	Serious <sup>2,3</sup>	none	93/128 (72.7%)	95/125 (76%)	RR 0.96 (0.83 to 1.11)	30 fewer per 1000 (from 129 fewer to 84 more)	⊕⊕⊕⊕ Very low	CRITICAL

CI: confidence interval; IM: intramuscular; RR: risk ratio

1 Assessed after the end of treatment period

2 Quality of evidence was downgraded by 1 point owing to unclear risk of detection bias (no details were given about randomization and allocation concealment methods)

3 Quality of evidence was further downgraded by 1 point owing to serious imprecision: confidence intervals crosses one default threshold and p is higher than 0.1

**Table 25: Clinical evidence profile Comparison 1: Depot medroxyprogesterone acetate versus cCOP + danazol**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Depot medroxyprogesterone acetate	cCOP + desogestrel	Relative (95% CI)	Absolute		
<b>Pain at 6 months during treatment period - Dysmenorrhea (10 cm VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	36	32	-	MD 1.84 lower (2.23 to 1.45 lower)	⊕⊕⊕⊕ Moderate	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Depot medroxyprogesterone acetate	cCOP + desogestrel	Relative (95% CI)	Absolute		
<b>Pain at 6 months during treatment period - Dyspareunia (10 cm VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	31	28	-	MD 0.3 lower (1.18 lower to 0.58 higher)	⊕⊕⊕⊖ Low	CRITICAL
<b>Pain at 6 months during treatment period - Non menstrual pain (10 cm VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	36	32	-	MD 0.6 higher (0.09 lower to 1.29 higher)	⊕⊕⊕⊖ Low	CRITICAL
<b>Pain at the end of treatment period (12 months) - Dysmenorrhea (10 cm VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	36	32	-	MD 1.3 lower (1.79 to 0.81 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Pain at the end of treatment period (12 months) - Dyspareunia (10 cm VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	31	28	-	MD 0.3 lower (1.41 lower to 0.81 higher)	⊕⊕⊕⊖ Low	CRITICAL
<b>Pain at the end of the treatment period (12 months) - Non menstrual pain (10 cm VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	36	32	-	MD 0.4 higher (0.35 lower to 1.15 higher)	⊕⊕⊕⊖ Very low	CRITICAL
<b>Patient satisfaction with treatment at the end of treatment period (12 months) (very satisfied/satisfied)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	29/40 (72.5%)	23/40 (57.5%)	RR 1.26 (0.91 to 1.75)	149 more per 1000 (from 52 fewer to 431 more)	⊕⊕⊕⊖ Low	IMPORTANT

CI: confidence interval; MD: mean difference; RR: relative risk; VAS: Visual Analog Scale  
1 'Open label', subjects not blinded  
2 Confidence interval crosses one default threshold  
3 Confidence interval crosses two default thresholds

**Table 26: Clinical evidence profile Comparison 2: GnRH agonist + E/P pill versus E/P pill**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GnRH agonist + E/P pill	E/P pill	Relative (95% CI)	Absolute		
<b>Pain at 8 months during treatment period - Dysmenorrhea (10-point VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	55	46	-	MD 1.9 lower (2.54 to 1.26 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Pain at 8 months during treatment period - Non menstrual pain (10-point VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	55	46	-	MD 2.5 lower (3 to 2 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Pain at the end of treatment period (12 months) - Dysmenorrhea (10-point VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	49	46	-	MD 2.7 lower (3.34 to 2.06 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Pain at the end of treatment period (12 months) - Non menstrual pain (10-point VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	49	46	-	MD 0.8 higher (0.33 to 1.27 higher)	⊕⊕⊖⊖ Low	CRITICAL

CI: confidence interval; E/P: oestrogen plus progestogen; MD: mean difference; VAS: Visual Analog Scale

1 No blinding of study participants, investigators or assessors reported  
2 Confidence interval crosses one default threshold

**Table 27: Clinical evidence profile Comparison 3: GnRH agonist versus cCOP**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Goserelin	cCOP	Relative (95% CI)	Absolute		
<b>Pain at the end of treatment period (6 months) - Dyspareunia (10-point VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	22	22	-	MD 1.8 lower (3.4 to 0.2 lower)	⊕⊕⊖⊖ Low	CRITICAL
<b>Pain at the end of treatment period (6 months) - Non menstrual pain (10-point VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	26	24	-	MD 0.2 higher (1.11 lower to 1.51 higher)	⊕⊕⊖⊖ Low	CRITICAL
<b>Pain at 6 months after treatment period - Dysmenorrhoea (10-point VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	26	24	-	MD 0.1 higher (1.08 lower to 1.28 higher)	⊕⊖⊖⊖ Very low	CRITICAL
<b>Pain at 6 after treatment period - Dyspareunia (10-point VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	22	21	-	MD 0.4 lower (2.1 lower to 1.3 higher)	⊕⊕⊖⊖ Low	CRITICAL
<b>Pain at 6 months after treatment period - Non menstrual pain (10-point VAS: better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	26	24	-	MD 0.3 higher (1.25 lower to 1.85 higher)	⊕⊕⊖⊖ Low	CRITICAL

CI: confidence interval; cCOP: combined oral contraceptive pill; MD: mean difference; VAS: Visual Analog Scale

1 No blinding of participants, investigators or assessors reported

2 Confidence interval crosses one default threshold  
3 Confidence interval crosses two default thresholds

## J.16 Non-pharmacological management

**Table 28: Clinical evidence profile: Comparison 1: cOCP and Dan'e compared to no treatment for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	cOCP and Dane	No treatment	Relative (95% CI)	Absolute		
<b>Live birth (denominator pregnancy) – at 12 months after treatment completion</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>1</sup>	none	13/16 (81.3%)	19/24 (79.2%)	RR 1.03 (0.75 to 1.4)	24 more per 1000 (from 198 fewer to 317 more)	⊕⊕⊖⊖ Low	IMPORTANT
<b>Miscarriage (denominator pregnancy) - at 12 months after treatment completion</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>1</sup>	none	3/16 (18.8%)	3/24 (12.5%)	RR 1.5 (0.34 to 6.52)	62 more per 1000 (from 82 fewer to 690 more)	⊕⊕⊖⊖ Low	IMPORTANT

CI: confidence interval; RR: risk ratio; cOCP: combined oral contraceptive pill  
1 Confidence interval for estimate is very wide crossing two thresholds

**Table 29: Clinical evidence profile: Comparison 2: cOCP and Dan'e compared to cOCP for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	cOCP and Dane	cOCP	Relative (95% CI)	Absolute		

Live birth (denominator pregnancy) – at 12 months after treatment completion												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	13/16 (81.3%)	14/20 (70%)	RR 1.16 (0.8 to 1.68)	112 more per 1000 (from 140 fewer to 476 more)	⊕⊕⊕⊖ Moderate	IMPORTANT
Miscarriage (denominator pregnancy) – at 12 months after treatment completion												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>1</sup>	none	3/16 (18.8%)	4/20 (20%)	RR 0.94 (0.24 to 3.6)	12 fewer per 1000 (from 152 fewer to 520 more)	⊕⊕⊖⊖ Low	IMPORTANT

CI: confidence interval; RR: Risk ratio; cOCP: combined oral contraceptive pill

1 Confidence interval for estimate is very wide crossing two thresholds

2 Confidence interval for estimate is very wide crossing one threshold

**Table 30: Clinical evidence profile: Comparison 3: Diet compared to Placebo for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Diet	Placebo	Relative (95% CI)	Absolute		
Endometrioma recurrence <sup>1</sup> - at 18 months												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	11/62 (17.7%)	10/60 (16.7%)	RR 1.06 (0.49 to 2.32)	10 more per 1000 (from 85 fewer to 220 more)	⊕⊕⊖⊖ Low	IMPORTANT

1 The recurrence of endometrioma was defined as the presence of cyst, detected by transvaginal ultrasonography, with a pattern suggesting an endometrioma more than 20 mm in diameter.

2 Confidence interval for estimate is very wide crossing two thresholds

**Table 31: Clinical evidence profile: Comparison 4: Diet compared to GnRHs for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
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No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Diet	GnRHa	Relative (95% CI)	Absolute		
<b>Endometrioma recurrence<sup>1</sup> - at 18 months</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	11/62 (17.7%)	6/58 (10.3%)	RR 1.72 (0.68 to 4.34)	74 more per 1000 (from 33 fewer to 346 more)	⊕⊕⊖⊖	IMPORTANT

CI: confidence interval; RR: Risk ratio

1 The recurrence of endometrioma was defined as the presence of cyst, detected by transvaginal ultrasonography, with a pattern suggesting an endometrioma more than 20 mm in diameter.

2 Confidence interval for estimate is very wide crossing two thresholds

**Table 32: Clinical evidence profile: Comparison 5: Diet compared to cOCP for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Diet	cOCP	Relative (95% CI)	Absolute		
<b>Endometrioma recurrence<sup>1</sup> - at 18 months</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	11/62 (17.7%)	9/60 (15%)	RR 1.18 (0.53 to 2.65)	27 more per 1000 (from 71 fewer to 248 more)	⊕⊕⊖⊖	IMPORTANT

CI: confidence interval; RR: Risk ratio; cOCP: combined oral contraceptive pill

1 The recurrence of endometrioma was defined as the presence of cyst, detected by transvaginal ultrasonography, with a pattern suggesting an endometrioma more than 20 mm in diameter.

2 Confidence interval for estimate is very wide crossing two thresholds

**Table 33: Comparison 6: Acupuncture compared to Sham acupuncture for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture	Sham acupuncture	Relative (95% CI)	Absolute		



Change (from baseline) in pain in last 4 weeks - at 4 weeks (ESSS) (Better indicated by lower values)												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	9	5	-	MD 3.4 lower (5.82 to 0.98 lower)	⊕⊕⊕⊖ Low	CRITICAL
Change (from baseline) in pain in last 4 weeks - at 8 weeks (ESSS) (Better indicated by lower values)												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	9	6	-	MD 0.5 lower (3.22 lower to 2.22 higher)	⊕⊖⊖⊖ Very low	CRITICAL
Change (from baseline) in pain in last 2 months - Chronic pelvic pain (Better indicated by lower values)												
1	randomised trials	serious <sup>6</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	20	22	-	MD 3.29 lower (3.97 to 2.61 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
Change (from baseline) in pain in last 2 months - Dyspareunia (Better indicated by lower values)												
1	randomised trials	serious <sup>6</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	20	22	-	MD 3.76 lower (4.55 to 2.97 lower)	⊕⊕⊕⊖ Moderate	CRITICAL
Change (from baseline) in pain in last 4 weeks - at 6 months (ESSS) (Better indicated by lower values)												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	9	5	-	MD 0.8 lower (4.66 lower to 3.06 higher)	⊕⊖⊖⊖ Very low	CRITICAL
Change (from baseline) in QoL (EHP Total score) - at 4 weeks (EHP) (Better indicated by lower values)												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	9	5	-	MD 21.5 lower (39.27 to 3.73 lower)	⊕⊕⊕⊖ Low	CRITICAL

<b>Change (from baseline) in QoL (EHP Total score) - at 8 weeks (EHP) (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	9	6	-	MD 19.7 lower (38.7 to 0.7 lower)	⊕⊕⊕⊖ Low	CRITICAL
<b>Change (from baseline) in QoL (EHP Total score) - at 6 months (EHP) (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	9	5	-	MD 20.9 lower (37.57 to 4.23 lower)	⊕⊕⊕⊖ Low	CRITICAL
<b>Change (from baseline) in QoL (Paediatric QoL Inventory Total score)<sup>1</sup> - at 4 weeks (Better indicated by higher values)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	9	5	-	MD 10.1 higher (3.26 lower to 23.46 higher)	⊕⊕⊕⊖ Low	CRITICAL
<b>Change (from baseline) in QoL (Paediatric QoL Inventory Total score)<sup>1</sup> - at 8 weeks (Better indicated by higher values)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	9	6	-	MD 14.2 higher (0.94 lower to 29.34 higher)	⊕⊕⊕⊖ Low	CRITICAL
<b>Change (from baseline) in QoL (Paediatric QoL Inventory Total score)<sup>1</sup> - at 6 months (Better indicated by higher values)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	9	5	-	MD 14.9 higher (1.18 to 28.62 higher)	⊕⊕⊕⊖ Low	CRITICAL
<b>Change (from baseline) in activities of daily living (3 activity score)<sup>2</sup> - at 4 weeks (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	9	5	-	MD 2.9 lower (4.85 to 0.95 lower)	⊕⊖⊖⊖ Very low	IMPORTANT

Change (from baseline) in activities of daily living (3 activity score) <sup>2</sup> - at 8 weeks (Better indicated by lower values)												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	8	6	-	MD 1.8 lower (4.48 lower to 0.88 higher)	⊕⊕⊕⊖ Low	IMPORTANT
Change (from baseline) in activities of daily living (3 activity score) <sup>2</sup> - at 6 months (Better indicated by lower values)												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	9	5	-	MD 1.7 lower (5.21 lower to 1.81 higher)	⊕⊖⊖⊖ Very low	IMPORTANT

Ci: confidence interval; MD: mean difference; ESSS: Endometriosis Symptom Severity Scale (0-10); EHP: Endometriosis Health Profile-30 (subscales range 0-100)

<sup>1</sup> Paediatric QoL Inventory Total score (subscales range 0-100)

<sup>2</sup> Activity scale scores range 0-10

<sup>3</sup> Due to dropouts

<sup>4</sup> Confidence interval for estimate is very wide crossing one threshold

<sup>5</sup> Confidence interval for estimate is very wide crossing two thresholds

<sup>6</sup> The quality of the evidence was downgraded because of the unclear risk of attrition bias (no details provided in the text), unclear risk of detection bias

**Table 34: Clinical evidence profile: Comparison 7: Acupuncture compared to Danazol for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture	Danazol	Relative (95% CI)	Absolute		
<b>Cure of symptoms</b>												
<b><sup>1</sup> - after 3 cycles of menstruation</b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	3/35 (8.6%)	5/35 (14.3%)	RR 0.6 (0.16 to 2.32)	57 fewer per 1000 (from 120 fewer to 189 more)	⊕⊖⊖⊖ Very low	IMPORTANT

CI: confidence interval; RR: Risk ratio

<sup>1</sup> Defined as complete relief of pain and other symptoms after medication and no relapse in the next 3 menstrual cycles

<sup>2</sup> No blinding

<sup>3</sup> Confidence interval for estimate is very wide crossing two thresholds

**Table 35: Clinical evidence profile: Comparison 8: Acupuncture compared to Chinese herbal medicine for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture	Chinese herbal medicine	Relative (95% CI)	Absolute		
<b>Dysmenorrhea (scale 0-15) - after 3 cycles of menstruation (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup> <sup>2</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	37	30	-	MD 4.81 lower (6.25 to 3.37 lower)	⊕⊕⊕⊕ Very low	CRITICAL
<b>Cure of symptoms<sup>1</sup> - after 3 cycles of menstruation</b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	Serious <sup>4</sup>	none	11/37 (29.7%)	3/30 (10%)	RR 2.97 (0.91 to 9.7)	197 more per 1000 (from 9 fewer to 870 more)	⊕⊕⊕⊕ Low	IMPORTANT

CI: confidence interval; MD: mean difference

1 Defined according Guideline for Clinical Research on New Chinese Drugs for Treatment of Pelvic Endometriosis

2 No blinding

3 Confidence interval for estimate is very wide crossing two thresholds

4 Confidence interval for estimate is very wide crossing one threshold

**Table 36: Clinical evidence profile: Comparison 9: Chinese herbal medicine compared to Placebo for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Chinese herbal medicine	Placebo	Relative (95% CI)	Absolute		
<b>Change (from baseline) in pain (VAS) at week 16 - Period pain (not defined)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	7	5	-	MD 1.22 lower (3.81 lower to	⊕⊕⊕⊕ Very low	CRITICAL

											1.37 higher)		
<b>Change (from baseline) in pain (VAS) at week 16 - Pain during sex (not defined)</b>													
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	5	3	-		MD 0.76 higher (1.53 lower to 3.05 higher)	⊕⊕⊕⊕ Very low	CRITICAL
<b>Change (from baseline) in pain (VAS) at week 16 - Pain on bowel movement (not defined)</b>													
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	7	5	-		MD 0.08 higher (2.87 lower to 3.03 higher)	⊕⊕⊕⊕ Very low	CRITICAL
<b>Change (from baseline) in pain (VAS) at week 16 - Daily pain (not defined)</b>													
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	7	6	-		MD 0.74 higher (1.81 lower to 3.29 higher)	⊕⊕⊕⊕ Very low	CRITICAL
<b>Change (from baseline) in patient assessed QoL (MYMOP) at week 16 - Symptom 1 (Better indicated by lower values)</b>													
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	8	10	-		MD 0.58 lower (2.41 lower to 1.25 higher)	⊕⊕⊕⊕ Very low	IMPORTANT
<b>Change (from baseline) in patient assessed QoL (MYMOP) at week 16 - Symptom 2 (Better indicated by lower values)</b>													
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	8	10	-		MD 0.9 lower (2.68 lower to 0.88 higher)	⊕⊕⊕⊕ Low	IMPORTANT
<b>Change (from baseline) in patient assessed QoL (MYMOP) at week 16 - Activity (Better indicated by lower values)</b>													

1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	8	9	-	MD 0.69 lower (2.31 lower to 0.93 higher)	⊕⊖⊖⊖ Very low	IMPORTANT
<b>Change (from baseline) in patient assessed QoL (MYMOP) at week 16 - Well-being (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	7	10	-	MD 1.06 lower (2.95 lower to 0.83 higher)	⊕⊕⊖⊖ Low	IMPORTANT
<b>Change (from baseline) in QoL (EHP 30) at week 16 - Pain (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	11	7	-	MD 0.32 lower (10.01 lower to 9.37 higher)	⊕⊖⊖⊖ Very low	CRITICAL
<b>Change (from baseline) in QoL (EHP 30) at week 16 - Control &amp; powerlessness (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	11	7	-	MD 1.73 lower (7.35 lower to 3.89 higher)	⊕⊖⊖⊖ Very low	IMPORTANT
<b>Change (from baseline) in QoL (EHP 30) at week 16 - Emotional well-being (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	11	7	-	MD 0.37 lower (4.38 lower to 3.64 higher)	⊕⊖⊖⊖ Very low	IMPORTANT
<b>Change (from baseline) in QoL (EHP 30) at week 16 - Social support (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	11	7	-	MD 2.71 lower (7.09	⊕⊕⊖⊖ Low	IMPORTANT

											lower to 1.67 higher)		
<b>Change (from baseline) in QoL (EHP 30) at week 16 - Self-image (Better indicated by lower values)</b>													
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	11	7	-		MD 0.46 higher (2.22 lower to 3.14 higher)	⊕⊕⊕⊕ Very low	IMPORTANT

CI: confidence interval; MD: mean difference; MYMOP: Measure Your own Medical Outcomes Profile (1-7-point Likert scale); QoL: quality of life

1 Due to drop outs

2 Confidence interval for estimate is very wide crossing two thresholds

3 Confidence interval for estimate is very wide crossing one threshold

**Table 37: Clinical evidence profile: Comparison 10: Chinese herbal medicine (oral) compared to Danazol for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Chinese herbal medicine (oral)	Danazol	Relative (95% CI)	Absolute		
<b>Symptomatic relief<sup>1</sup></b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	serious indirectness <sup>3</sup>	no serious imprecision	none	9/16 (56.3%)	2/18 (11.1%)	RR 5.06 (1.28 to 20.05)	451 more per 1000 (from 31 more to 1000 more)	⊕⊕⊕⊕ Low	IMPORTANT
<b>Dysmenorrhea score (Better indicated by lower values) – at the end of 3 months treatment</b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	16	18	-	MD 1.01 lower (3.11 lower to 1.09 higher)	⊕⊕⊕⊕ Low	CRITICAL
<b>Lumbosacral pain relief (Better indicated by lower values) – at the end of 3 months treatment</b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	14/16 (87.5%)	13/18 (72.2%)	RR 1.21 (0.86 to 1.7)	152 more per 1000 (from 101 fewer to 506 more)	⊕⊕⊕⊕ Low	CRITICAL

Rectal irritation relief (Better indicated by lower values) – at the end of 3 months treatment												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	10/12 (83.3%)	6/12 (50%)	RR 1.67 (0.9 to 3.1)	335 more per 1000 (from 50 fewer to 1000 more)	⊕⊕⊖⊖	CRITICAL
Tenderness of vaginal nodules in posterior fornix – at the end of 3 months treatment												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	10/11 (90.9%)	9/13 (69.2%)	RR 1.31 (0.87 to 1.97)	215 more per 1000 (from 90 fewer to 672 more)	⊕⊕⊖⊖	IMPORTANT
Adnexal masses disappearance or shrinkage – at the end of 3 months treatment												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	9/12 (75%)	8/15 (53.3%)	RR 1.41 (0.79 to 2.5)	219 more per 1000 (from 112 fewer to 800 more)	⊕⊖⊖⊖	IMPORTANT

CI: confidence interval; RR: Risk ratio; MD: mean difference

1 Defined as a complete resolution of all symptoms and signs and included pregnancy, when desired, within three years of stopping treatment

1 Not clear if blinding was performed

3 Although the outcome is defined, it is wide encompassing different symptoms and signs

4 Confidence interval for estimate is very wide crossing one threshold

5 Confidence interval for estimate is very wide crossing two thresholds

**Table 38: Clinical evidence profile: Comparison 11: Chinese herbal medicine (oral + enema) compared to Danazol for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Chinese herbal medicine (oral + enema)	Danzol	Relative (95% CI)	Absolute		
Symptomatic relief <sup>1</sup>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	serious indirectness <sup>3</sup>	no serious imprecision	none	15/24 (62.5%)	2/18 (11.1%)	RR 5.62 (1.47 to 21.54)	513 more per 1000 (from 52 more to 1000 more)	⊕⊕⊖⊖	IMPORTANT



Dysmenorrhea score (Better indicated by lower values) - at the end of 3 months treatment												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	24	18	-	MD 2.9 lower (4.55 to 1.25 lower)	⊕⊕⊖⊖ Low	CRITICAL
Lumbosacral pain relief (Better indicated by lower values) - at the end of 3 months treatment												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	20/24 (83.3%)	13/18 (72.2%)	RR 1.15 (0.82 to 1.62)	108 more per 1000 (from 130 fewer to 448 more)	⊕⊕⊖⊖ Low	CRITICAL
Rectal irritation relief (Better indicated by lower values) - at the end of 3 months treatment												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	16/18 (88.9%)	6/12 (50%)	RR 1.78 (0.99 to 3.2)	390 more per 1000 (from 5 fewer to 1000 more)	⊕⊕⊖⊖ Low	CRITICAL
Tenderness of vaginal nodules in posterior fornix - at the end of 3 months treatment												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	14/16 (87.5%)	9/13 (69.2%)	RR 1.26 (0.84 to 1.9)	180 more per 1000 (from 111 fewer to 623 more)	⊕⊕⊖⊖ Low	IMPORTANT
Adnexal masses disappearance or shrinkage - at the end of 3 months treatment												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	19/21 (90.5%)	8/15 (53.3%)	RR 1.7 (1.04 to 2.78)	373 more per 1000 (from 21 more to 949 more)	⊕⊕⊖⊖ Low	IMPORTANT

CI: confidence interval; RR: Risk ratio; MD: mean difference; CSR: Cochrane systematic review

1 Defined as a complete resolution of all symptoms and signs and included pregnancy, when desired, within three years of stopping treatment

2 Not clear if blinding was performed

3 Although the outcome is defined, it is wide, encompassing different symptoms and signs.

4 Confidence interval for estimate is very wide crossing one threshold

**Table 39: Clinical evidence profile: Comparison 12: Chinese herbal medicine (oral+ enema) compared to Chinese herbal medicine (oral) for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Chinese herbal medicine (oral+ enema)	Chinese herbal medicine (oral)	Relative (95% CI)	Absolute		
<b>Symptomatic relief<sup>1</sup></b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	serious indirectness <sup>3</sup>	very serious <sup>4</sup>	none	15/24 (62.5%)	9/16 (56.3%)	RR 1.11 (0.65 to 1.89)	62 more per 1000 (from 197 fewer to 501 more)	⊕⊕⊕⊕ Very low	IMPORTANT
<b>Dysmenorrhea score (Better indicated by lower values) - at the end of 3 months treatment</b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	Serious <sup>5</sup>	none	24	16	-	MD 1.89 lower (3.89 lower to 0.11 higher)	⊕⊕⊕⊕ Low	CRITICAL
<b>Lumbosacral pain relief (Better indicated by lower values) - at the end of 3 months treatment</b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>5</sup>	none	20/24 (83.3%)	14/16 (87.5%)	RR 0.95 (0.74 to 1.23)	44 fewer per 1000 (from 227 fewer to 201 more)	⊕⊕⊕⊕ Low	CRITICAL
<b>Rectal irritation relief (Better indicated by lower values) - at the end of 3 months treatment</b>												
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	very serious <sup>4</sup>	none	16/18 (88.9%)	10/12 (83.3%)	RR 1.07 (0.79 to 1.44)	58 more per 1000 (from 175	⊕⊕⊕⊕ Very low	IMPORTANT

										fewer to 367 more)			
<b>Tenderness of vaginal nodules in posterior fornix - at the end of 3 months treatment</b>													
1	randomised trials	serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>5</sup>	none	14/16 (87.5%)	10/11 (90.9%)	RR 0.96 (0.74 to 1.25)	36 fewer per 1000 (from 236 fewer to 227 more)	⊕⊕⊖⊖	Low	IMPORTANT
<b>Adnexal masses disappearance or shrinkage - at the end of 3 months treatment</b>													
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>4</sup>	none	19/21 (90.5%)	9/12 (75%)	RR 1.21 (0.85 to 1.72)	158 more per 1000 (from 112 fewer to 540 more)	⊕⊕⊖⊖	Low	IMPORTANT

CI: confidence interval; RR: Risk ratio; MD: mean difference; CSR: Cochrane systematic review

1 Defined as a complete resolution of all symptoms and signs and included pregnancy, when desired, within three years of stopping treatment

2 Not clear if blinding was performed

3 Although the outcome is defined, it is wide, encompassing different symptoms and signs

4 Confidence interval for estimate is very wide crossing two thresholds

5 Confidence interval for estimate is very wide crossing one threshold

**Table 40: Clinical evidence profile: Comparison 13: Chinese herbal medicine and Acupuncture compared to Danazol for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Chinese herbal medicine and Acupuncture	Danazol	Relative (95% CI)	Absolute		

<b>Dysmenorrhea (cessation) - at the end of 3 months treatment</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	16/40 (40%)	13/38 (34.2%)	RR 1.17 (0.65 to 2.09)	58 more per 1000 (from 120 fewer to 373 more)	⊕⊕⊕⊕ Very low	CRITICAL
<b>Lumbosacral pain (cessation) - at the end of 3 months treatment</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	15/40 (37.5%)	12/38 (31.6%)	RR 1.19 (0.64 to 2.2)	60 more per 1000 (from 114 fewer to 379 more)	⊕⊕⊕⊕ Very low	CRITICAL
<b>Dyspareunia (cessation) - at the end of 3 months treatment</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	5/40 (12.5%)	2/38 (5.3%)	RR 2.38 (0.49 to 11.51)	73 more per 1000 (from 27 fewer to 553 more)	⊕⊕⊕⊕ Very low	CRITICAL

CI: confidence interval; RR: Risk ratio

1 No blinding

2 Confidence interval for estimate is very wide crossing two thresholds

**Table 41: Clinical evidence profile: Comparison 14: Acupuncture TENS compared to Self-applied TENS for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture TENS	Self-applied TENS	Relative (95% CI)	Absolute		
<b>Change (from baseline) in QoL (EHP-30 Total score) - after 8 weeks (Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>2</sup>	none	11	11	-	MD 1.39 lower (8.94 lower to 6.16 higher)	⊕⊕⊕⊕ Very low	CRITICAL

CI: confidence interval; MD: mean difference; EHP-30: Endometriosis Health Profile-30

1 No blinding

2 Confidence interval for estimate is very wide crossing two thresholds

## J.17 Surgical management

### J.17.1 Laparoscopic treatment (excision or ablation) versus diagnostic laparoscopy

Table 42: Clinical evidence profile: Laparoscopic treatment (excision or ablation) versus diagnostic laparoscopy for endometriosis

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Laparoscopic treatment (excision or ablation) versus diagnostic laparoscopy	Control	Relative (95% CI)	Absolute		
<b>Overall pain better or improved - At 6 months</b>												
1	randomised trials	very serious <sup>1,2</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	34/41 (82.9%)	12/28 (42.9%)	RR 1.93 (1.23 to 3.03)	399 more per 1000 (from 99 more to 870 more)	⊕⊕⊕⊕ Very low	CRITICAL
<b>Overall pain better or improved - At 12 months</b>												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Laparoscopic treatment (excision or ablation) versus diagnostic laparoscopy	Control	Relative (95% CI)	Absolute		
1	randomised trials	very serious <sup>1,2</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	30/41 (73.2%)	6/28 (21.4%)	RR 3.41 (1.64 to 7.11)	516 more per 1000 (from 137 more to 1000 more)	⊕⊕⊕⊖ Low	CRITICAL
<b>Live birth or ongoing pregnancy</b>												
2	randomised trials	very serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	57/192 (29.7%)	34/190 (17.9%)	RR 1.66 (1.14 to 2.42)	135 more per 1000 (from 29 more to 291 more)	⊕⊖⊖⊖ Very low	IMPORTANT
<b>Clinical pregnancy</b>												
3	randomised trials	very serious <sup>4</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	79/265 (29.8%)	49/263 (18.6%)	RR 1.6 (1.17)	131 more per 1000	⊕⊖⊖⊖ Very low	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Laparoscopic treatment (excision or ablation) versus diagnostic laparoscopy	Control	Relative (95% CI)	Absolute		
									to 2.17)	(from 37 more to 256 more)		
<b>Miscarriage per pregnancy</b>												
2	randomised trials	serious <sup>5</sup>	no serious inconsistency	no serious indirectness	very serious <sup>4</sup>	none	13/70 (18.6%)	8/42 (19%)	RR 0.95 (0.44 to 2.09)	5 fewer per 1000 (from 60 fewer to 118 more)	⊕⊕⊕⊕ Very low	IMPORTANT

CI: confidence interval; RR: risk ratio

1 Unclear if selective reporting

2 Evidence was downgraded by two due to performance bias (blinding of participants and personnel and attrition bias (incomplete outcome data)

3 Evidence was downgraded by one due to serious imprecision as 95%CI crossed one default MID

4 No blinding of participants and personnel and incomplete outcome data

## J.17.2 Laparoscopic excision versus diagnostic laparoscopy

**Table 43: Excision versus diagnostic laparoscopy for endometriosis**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Excision	Control, diagnostic laparoscopy	Relative (95% CI)	Absolute		
<b>Overall pain better or improved (6 months) (follow-up six months)</b>												
1	randomised trials	no serious risk of bias <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	16/20 (80%)	6/19 (31.6%)	RR 2.53 (1.26 to 5.09)	483 more per 1000 (from 82 more to 1000 more)	⊕⊕⊕⊕ High	CRITICAL
<b>Overall pain score - At 6 months (follow-up six months; Better indicated by lower values)</b>												
1	randomised trials	very serious <sup>2</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	1.9 (0.5) N=7	1.9 (0.7) N=9	-	MD 0.90 (from 0.31 to 1.49)	⊕⊕⊕⊖ Very low	CRITICAL
<b>Overall pain score - At 12 months (follow-up 12 months; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	no serious imprecision <sup>5</sup>	none	2.6 (0.5) N=7	0.95 (0.6) N=9	-	MD 1.65 (from 1.11 to 2.19)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Pelvic pain scores - At 6 months (follow-up six months; Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	18.8 (17.6) N=20	23.9 (19.1) N=19	-	-5.10 (from -16.64 to 6.44)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Dysmenorrhea pain score - At 6 months (follow-up six months; Better indicated by lower values)</b>												



Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Excision	Control, diagnostic laparoscopy	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	26 (8.5) N=20	23.6 (17.2) N=19	-	MD 2.40 (from -6.18 to 10.98)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Dyspareunia pain score - At 6 months (follow-up six months; Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	16.8 (22.8) N=20	10.5 (23.3) N=19	-	MD 6.30 (from -8.18 to 20.78)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>EQ-5D index summary - At 6 months (higher scores indicate better overall health)</b>												
1	randomised trial	no serious risk of bias <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	20	19	-	MD 0.03 (from 0.12 to 0.18)	⊕⊕⊕⊖ Low	CRITICAL
<b>EQ-5D VAS summary - At 6 months (higher scores indicate better health state)</b>												
1	randomised trial	no serious risk of bias <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	20	19	-	MD 17.7 (from 7.02 to 28.38)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>SF-12 physical component score - At 6 months (higher scores indicate better self-reported health)</b>												
1	randomised trial	no serious risk of bias <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>3</sup>	none	20	19	-	MD 2.7 (from 2.9 to 8.3)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>SF-12 physical component score - At 6 months (higher scores indicate better self-reported health)</b>												
1	randomised trial	no serious	no serious inconsistency	no serious	serious <sup>3</sup>	None	20	19	-	MD 2.3 (from	⊕⊕⊕⊖ Moderate	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Excision	Control, diagnostic laparoscopy	Relative (95% CI)	Absolute		
		risk of bias <sup>1</sup>		indirectness						4.5 to 9.1)		

CI: confidence interval; RR: relative risk; MD: mean difference

1 Unclear if selective reporting

2 Evidence was downgraded by two due to performance bias (blinding of participants and personnel and attrition bias (incomplete outcome data)

3 Evidence was downgraded by one due to serious imprecision as 95%CI crossed one default MID

4 No blinding of participants and personnel and incomplete outcome data

5 Evidence was downgraded by two due to very serious imprecision as 95%CI crossed two default MIDs

### J.17.3 Laparoscopic excision versus laparoscopic ablation

Table 44: Laparoscopic excisional surgery versus ablative surgery for endometriosis and endometrioma

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Excisional surgery versus ablative surgery	Control	Relative (95% CI)	Absolute		
<b>Endometriosis</b>												
<b>Pain score (reduction in VAS at 12 months) - Overall (a higher score indicates greater pain intensity)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	2.9 (3.4);N=54	2.9 (2.9);N=49	-	MD 0 higher (1.22 lower to 1.22 higher)	⊕⊕⊖⊖ Low	CRITICAL
<b>Pain score (reduction in VAS at 12 months) - Pelvic (a higher score indicates greater pain intensity)</b>												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Excisional surgery versus ablative surgery	Control	Relative (95% CI)	Absolute		
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	2.6 (3.5); N=54	2.9 (2.9);N=49	-	MD 0.1 lower (1.3 lower to 1.1 higher)	⊕⊕⊕⊖ Low	CRITICAL
<b>Pain score (reduction in VAS at 12 months) - Dyspareunia (a higher score indicates greater pain intensity)</b>												
1	randomised trials	very serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	3.1 (4.1); N=54	1.8 (4.1);N=49	-	MD 1.3 higher (0.29 lower to 2.89 higher)	⊕⊖⊖⊖ Very low	CRITICAL
<b>Unintended effects (reduction from VAS score by 12 months after operation (nausea, vomiting) - Nausea (a higher score indicates greater pain intensity)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	1.7 (2.7); N=54	0.6 (3.6);N=49	-	MD 1.1 higher (0.14 lower to 2.34 higher)	⊕⊕⊕⊖ Low	IMPORTANT
<b>Unintended effects (reduction from VAS score by 12 months after operation (nausea, vomiting) - Vomiting (a higher score indicates greater pain intensity)</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	no serious	none	1.1 (2.4); N=54	0.9 (2.3);N=49	-	MD 0.2 higher	⊕⊕⊕⊖ Moderate	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Excisional surgery versus ablative surgery	Control	Relative (95% CI)	Absolute		
					imprecision					(0.71 lower to 1.11 higher)		
<b>Unintended effects (reduction from VAS score by 12 months after operation (nausea, vomiting) - Bloating (a higher score indicates greater pain intensity))</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	2.4 (3.4); N=54	1.5 (2.8); N=49	-	MD 0.9 higher (0.3 lower to 2.1 higher)	⊕⊕⊕⊖ Low	IMPORTANT
<b>Endometrioma</b>												
<b>Recurrence of pelvic pain - Dysmenorrhea</b>												
2	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	9/57 (15.8%)	26/47 (55.3%) 54.8%	RR 0.29 (0.15 to 0.55)	389 fewer per 1000 (from 247 fewer to 466 fewer)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Recurrence of pelvic pain - Non-menstrual pelvic pain</b>												
1	randomised trials	serious <sup>3</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	2/20 (10%)	9/17 (52.9%)	RR 0.19 (0.05)	428 fewer per 1000	⊕⊕⊕⊖ Low	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Excisional surgery versus ablative surgery	Control	Relative (95% CI)	Absolute		
									to 0.76)	(from 127 fewer to 503 fewer)		
<b>Pregnancy rate up to 60 months after surgical treatment</b>												
3	randomised trials	no serious risk of bias <sup>4</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	39/77 (50.6%)	28/85 (32.9%) 23.3%	RR 1.53 (1.04 to 2.24)	123 more per 1000 (from 9 more to 289 more)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Recurrence of endometrioma - At 12 months</b>												
4	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	15/130 (11.5%)	35/128 (27.3%)	RR 0.43 (0.25 to 0.73)	146 fewer per 1000 (from 69 fewer to 192 fewer)	⊕⊕⊕⊕ High	IMPORTANT
<b>Recurrence of endometrioma - At 60 months</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	8/36 (22.2%)	14/38 (36.8%)	RR 0.6 (0.29 to 1.26)	147 fewer per 1000 (from	⊕⊕⊖⊖ Low	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Excisional surgery versus ablative surgery	Control	Relative (95% CI)	Absolute		
										261 fewer to 96 more)		
<b>Reoperation after surgical treatment up to 60 months follow-up</b>												
2	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	3/88 (3.4%)	8/86 (9.3%)	RR 0.37 (0.1 to 1.35)	59 fewer per 1000 (from 85 fewer to 33 more)	⊕⊖⊖⊖ Very low	IMPORTANT

CI: confidence interval; RR: relative risk; MD: mean difference

1 Evidence was downgraded by two due to performance lack of blinding and attrition bias.

2 Evidence was downgraded by one due to serious imprecision as 95%CI crossed one default MID

3 Evidence was downgraded by one due to lack of blinding.

4 Taking into account weighting in a meta-analysis and the likely contribution from each component, evidence was downgraded by one due to lack of blinding.

5 Evidence was downgraded by two due to very serious imprecision as 95%CI crossed two default MIDs

J.17.4 Combined surgical and hormonal management of endometriosis

Table 5: Clinical evidence profile: Comparison: Pharmacological therapy after surgery vs placebo or no pharmacological therapy after surgery

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Post-surgical pharmacological therapy versus placebo or no treatment	Control	Relative (95% CI)	Absolute		
<b>Pain recurrence (VAS) - Pelvic pain (follow-up 12 months; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	77	110	-	MD 1.2 lower (1.47 to 0.93 lower)	⊕⊕⊕ Moderate	CRITICAL
<b>Pain recurrence (VAS) - Dysmenorrhoea (follow-up 12 months; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	77	110	-	MD 0.7 lower (1.04 to 0.36 lower)	⊕⊕⊕⊕ Low	CRITICAL
<b>Pain recurrence (VAS) - Deep dyspareunia (follow-up 12 months; Better indicated by lower values)</b>												
1	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	77	110	-	MD 0.4 lower (0.76 to 0.04 lower)	⊕⊕⊕⊕ Very low	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Post-surgical pharmacological therapy versus placebo or no treatment	Control	Relative (95% CI)	Absolute		
<b>Pain recurrence (questionnaire based) - Abdominal pain at 12 months post treatment completion</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	25/62 (40.3%)	33/58 (56.9%)	RR 0.71 (0.49 to 1.03)	165 fewer per 1000 (from 290 fewer to 17 more)	⊕⊕⊖⊖ Low	CRITICAL
<b>Pain recurrence (questionnaire based) - Dysmenorrhoea at 12 months post treatment completion</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	24/80 (30%)	27/78 (34.6%)	RR 0.87 (0.55 to 1.36)	45 fewer per 1000 (from 156 fewer to 125 more)	⊕⊖⊖⊖ Very low	CRITICAL
<b>Pain recurrence (questionnaire based) - Dyspareunia at 12 months post treatment completion</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	12/75 (16%)	21/69 (30.4%)	RR 0.53 (0.28 to 0.99)	143 fewer per 1000 (from 3	⊕⊕⊖⊖ Low	CRITICAL



Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Post-surgical pharmacological therapy versus placebo or no treatment	Control	Relative (95% CI)	Absolute		
										fewer to 219 fewer)		
<b>Pain recurrence (Andersch and Milsom) - Pelvic pain (follow-up 12 months; Better indicated by lower values)</b>												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	24	29	-	MD 0.4 lower (2.15 lower to 1.35 higher)	⊕⊕⊖⊖ Low	CRITICAL
<b>Pain recurrence (dichotomous) (follow-up 12 months)</b>												
4	randomised trials	very serious <sup>5</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	41/258 (15.9%)	47/218 (21.6%)	RR 0.78 (0.55 to 1.12)	47 fewer per 1000 (from 97 more to 26 more)	⊕⊖⊖⊖ Very low	CRITICAL
<b>Pain recurrence (dichotomous) (follow-up 13-24 months)</b>												
3	randomised trials	very serious <sup>6</sup>	no serious inconsistency	no serious	serious <sup>2</sup>	none	32/158 (20.3%)	44/154 (28.6%)	RR 0.7 (0.47	86 fewer per 1000	⊕⊖⊖⊖ Very low	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Post-surgical pharmacological therapy versus placebo or no treatment	Control	Relative (95% CI)	Absolute		
				indirectness					to 1.03)	(from 151 fewer to 9 more)		
<b>Pain recurrence (dichotomous) (follow-up 60 months)</b>												
1	randomised trials	serious <sup>7</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	13/29 (44.8%)	12/25 (48%)	RR 0.93 (0.53 to 1.66)	34 fewer per 1000 (from 226 fewer to 317 more)	⊕⊕⊕⊖ Very low	CRITICAL
<b>Dysmenorrhoea (follow-up 12 months)</b>												
2	randomised trials	serious <sup>8</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	4/48 (8.3%)	18/47 (38.3%)	RR 0.22 (0.08 to 0.6)	299 fewer per 1000 (from 153 fewer to 352 fewer)	⊕⊕⊕⊖ Moderate	CRITICAL
<b>Re-operation (women with endometriosis)</b>												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Post-surgical pharmacological therapy versus placebo or no treatment	Control	Relative (95% CI)	Absolute		
3	randomised trials	serious <sup>9</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	8/193 (4.1%)	4/134 (3%)	RR 1.17 (0.4 to 3.4)	5 more per 1000 (from 18 fewer to 72 more)	⊕⊕⊕⊕ Very low	IMPORTANT
<b>Endometriosis recurrence (dichotomous) - Disease recurrence at 5-6 months (follow-up 5-6 months)</b>												
1	randomised trials	serious <sup>4</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	59/148 (39.9%)	55/137 (40.1%)	RR 0.99 (0.75 to 1.32)	4 fewer per 1000 (from 100 fewer to 128 more)	⊕⊕⊕⊕ Very low	NOT IMPORTANT
<b>Endometriosis recurrence (dichotomous) (follow-up 12 months)</b>												
3	randomised trials	very serious <sup>10</sup>	serious <sup>11</sup>	no serious indirectness	very serious <sup>3</sup>	none	19/167 (11.4%)	10/143 (7%)	RR 1.44 (0.28 to 7.36)	31 more per 1000 (from 50 fewer)	⊕⊕⊕⊕ Very low	NOT IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Post-surgical pharmacological therapy versus placebo or no treatment	Control	Relative (95% CI)	Absolute		
										to 445 more)		
<b>Endometriosis recurrence (dichotomous) (follow-up 24 months)</b>												
1	randomised trials	very serious <sup>12</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	0/15 (0%)	4/30 (13.3%)	RR 0.22 (0.01 to 3.75)	104 fewer per 1000 (from 132 fewer to 367 more)	⊕⊕⊕⊖ Very low	CRITICAL
<b>Endometrioma recurrence (dichotomous) - Recurrence at 13-36 months</b>												
3	randomised trials	serious <sup>13</sup>	no serious inconsistency <sup>14</sup>	no serious indirectness	serious <sup>2</sup>	none	34/299 (11.4%)	31/164 (18.9%)	RR 0.55 (0.36 to 0.86)	85 fewer per 1000 (from 26 fewer to 121 fewer)	⊕⊕⊕⊖ Low	NOT IMPORTANT
<b>Endometrioma recurrence (dichotomous) (follow-up 60 months)</b>												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Post-surgical pharmacological therapy versus placebo or no treatment	Control	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias <sup>7</sup>	no serious inconsistency	no serious indirectness	very serious <sup>3</sup>	none	4/19 (21.1%)	2/16 (12.5%)	RR 1.68 (0.35 to 8.03)	85 more per 1000 (from 81 fewer to 879 more)	⊕⊕⊖⊖ Low	NOT IMPORTANT
<b>Patient Satisfaction</b>												
2	randomised trials	serious <sup>8</sup>	no serious inconsistency	no serious indirectness	serious <sup>2</sup>	none	-	-	RR 1.21 (0.80 to 1.82)	-	⊕⊕⊖⊖ Low	NOT IMPORTANT

CI: confidence interval; RR: relative risk; MD: mean difference

1 Blinding: unclear risk. Placebo is not described and seems unlikely that blinding could be maintained when the interventions are depot and oral hormonal treatments

2 95% Confidence Interval crosses one imprecision threshold

3 95% Confidence Interval crosses two imprecision thresholds

4 Randomisation, Allocation concealment: unclear risk. No information provided. Blinding: High risk. No placebo used

5 Allocation concealment: unclear risk. Not mentioned in Alborzi 2011, Loverro 2001 or Bianchi 1999. Blinding: high risk. No placebo used in Alborzi 2011, Bianchi 1999 or Vercellini 1999. Incomplete data reporting: unclear risk. 22% withdrawal overall in Vercellini 1999 due to reasons other than symptom recurrence or major protocol violations (similar in each group). 18% withdrawal overall in Alborzi 2011 after randomisation due to "poor patients follow up" with reasons not reported and unequal loss across groups (11/58 letrozole group, 18/58 dipherelin group and 1/59 no treatment group)

6 Allocation concealment: unclear risk. Not mentioned in Busacca 2001 or Muzii 2000. Blinding: high risk. No placebo use in Busacca 2001, Muzii 2000 or Vercellini 1999. Incomplete data reporting: unclear risk. 22% withdrawal overall in Vercellini 1999 due to reasons other than symptom recurrence or major protocol violations (similar in each group). Other bias: unclear risk. No baseline characteristics reported in Muzii 2000

7 Allocation concealment: unclear risk. Not mentioned.

8 Blinding: unclear/high risk of performance bias. Unclear how patients were blinded to IUD presence in Tanmahasamut 2012 and Vercellini 2003 reported as an open label study with outcome assessors not blinded to treatment group (high risk of detection bias)

9 Allocation concealment: unclear risk. Not mentioned in Bianchi 1999, Busacca 2001 or Sesti 2009. Blinding: high risk. No placebo use in Bianchi 1999 or Busacca 2001.

10 Allocation concealment: unclear risk. Not mentioned in Alborzi 2011, Bianchi 1999 or Busacca 2001. Blinding: high risk. No placebo used in Alborzi 2011, Bianchi 1999 or Busacca 2001. Incomplete data reporting: unclear risk. 18% withdrawal overall in Alborzi 2011 after randomisation due to "poor patients follow up" with reasons not reported and unequal loss across groups (11/58 letrozole group, 18/58 dipherelin group and 1/59 no treatment group).

11 Using random effects model. Heterogeneity:  $Chi^2 = 5.72$ ,  $df = 2$  ( $P = 0.06$ );  $I^2 = 65\%$ . Removal of Alborzi 2011 ( $RR = 16.48$  95%CI 0.99 - 272.92) from the pooled analysis removes inconsistency (Heterogeneity:  $Chi^2 = 0.38$ ,  $df = 1$  ( $P = 0.54$ );  $I^2 = 0\%$ ) and the pooled fixed effects result for Bianchi 1999 and Busacca 2001 becomes  $RR = 0.76$  (95%CI 0.30 - 1.90)

12 Blinding: high risk. No placebo used. Incomplete data reporting: high risk. 4/15 (27%) loss to follow up in treatment group in Tsai 2004.

13 Allocation concealment: unclear risk. Not mentioned in Muzii 2000 or Sesti 2009. Blinding: unclear risk - no placebo use in Muzii 2000 or in Seracchioli 2010 (although outcome assessors were blinded to treatment group. Incomplete data reporting: unclear risk. 8% withdrawal overall in relevant treatment arms in Sesti 2009. Other bias: unclear risk. No baseline characteristics reported in Muzii 2000

14 Using fixed effects model Heterogeneity:  $Chi^2 = 3.25$ ,  $df = 2$  ( $P = 0.20$ );  $I^2 = 39\%$

## J.18 Hysterectomy with or without oophorectomy

Table 45: Clinical evidence profile: Hysterectomy only vs hysterectomy + oophorectomy

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hysterectomy without oophorectomy	Hysterectomy with oophorectomy	Relative (95% CI)	Absolute		
<b>Pain recurrence (Hysterectomy only vs hysterectomy+bilateral oophorectomy (follow-up median 4 years 10 months; assessed with: relative risks)</b>												
1	observational studies	very serious <sup>1</sup>	no serious inconsistency	serious <sup>2</sup>	No serious imprecision	none	-	-	HR 6.1 (2.5 to 14.6) <sup>3</sup>	-	⊕⊕⊕⊕ Very low	CRITICAL
<b>Re-operation (Hysterectomy only vs hysterectomy+bilateral oophorectomy (follow-up median 7 years; assessed with: Hazards ratios)</b>												
1	observational studies	Serious <sup>4</sup>	no serious inconsistency	no serious indirectness	very serious <sup>5</sup>	none	-	-	RR 2.44 (0.65 to 9.1) <sup>6</sup>	-	⊕⊕⊕⊕ Very low	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hysterectomy without oophorectomy	Hysterectomy with oophorectomy	Relative (95% CI)	Absolute		
<b>Re-operation (Hysterectomy only vs hysterectomy+ bilateral oophorectomy (follow-up median 4 years 10 months; assessed with: relative ratios)</b>												
1	observational studies	very serious <sup>1</sup>	no serious inconsistency	serious <sup>2</sup>	No serious imprecision	none	-	-	RR 8.1 (2.1 to 31.2) <sup>3</sup>	-	⊕⊕⊕⊕ Very low	IMPORTANT

CI: confidence interval; HR: hazard ratio; RR: relative risk

1 Evidence was downgraded by 2 due to study design: study was a retrospective cohort with outpatient chart review.

2 Evidence was downgraded by 1 due to indirectness: patients underwent surgeries between 1979 to 1991. Women over 45 years were excluded.

3 Adjusted for age at time of surgery (≤35 years, >35 years), stage of disease (revised AFS classification), previous medical therapy and previous surgery. None of the covariates were identified as significant confounding factors.

4 Evidence was downgraded by 1 due to outcome selection bias.

5 Evidence was downgraded by 2 due to very serious imprecision as 95% confidence interval crossed 2 default minimally important differences (MIDs).

6 Adjusted for age, stage of disease, or operative time predictive for re-operation. Age and time of surgery were considered important confounding factors, stage of disease did not have any effect on surgery-free time in any group, but stratification for multiple factors reduced the statistical power and even large differences may not reach statistical significance even though the size of the difference may be clinically important. The P value for the comparison was 0.18.

## J.19 Management strategies to improve spontaneous pregnancy rates

Not applicable

