ENDOMETRIOSIS

RCGP LEARNING

PRESENTATION AND INITIAL ASSESSMENT

Symptoms	Examination	Refer at first presentation?
• ≥6/12 cyclical or continuous pelvic pain. • Dysmenorrhoea affecting daily activities and quality of life. • Deep dyspareunia. • Cyclical GI or urinary symptoms, in particular dysuria, haematuria or dyschezia. • Subfertility and one of the above. • Symptom diary may be useful.	• Normal examination doesn't exclude endometriosis. • Abdominal examination +/- VE and speculum. • Look for abdominal/adnexal masses, fixed and/or retroverted uterus, tender nodularity in posterior fornix or visible endometriotic lesions in vagina.	• Consider if symptoms are severe, recurrent or persistent or if there are pelvic signs. • Lower threshold if trying to conceive (as most primary care management is contraceptive and endometriosis can cause subfertility). • Consider work/study, cultural background, psychosexual and emotional needs.

INVESTIGATIONS

Transvaginal ultrasound	Investigate for differentials	Tests to avoid in primary care
• Might be normal in endometriosis. • Should be done if symptoms are severe, persistent or recurrent or if there are pelvic signs – consider even if examination is normal. • Will also pick up some differentials (fibroids, uterine myoma, ovarian cyst, malignancy of ovary or uterus).	• Recurrent UTI, interstitial cystitis or bladder cancer. • Pregnancy complications. • IBS, appendicitis, gastroenteritis, coeliac, • Malignancy – cervix, ovary, endometrium, bowel. • Primary dysmenorrhoea. • PID. • Referred pain from disc disease.	• Ca125 – if has been done coincidentally, remember that it may be raised or normal in endometriosis. • MRI.

MANAGEMENT IN PRIMARY CARE

Analgesia	Hormonal	Other issues
• 3/12 trial of paracetamol and/or NSAIDs. • If no benefit, consider other analgesia.	• Combined or progestogen only contraception e.g. pill, implant, injectable or levonorgestrel intrauterine device.	• Consider using decision aid attached to NICE guideline. • NICE advises against Chinese herbal/traditional medicines.

REFERRAL

Is a definitive diagnosis needed?	When to refer	Where to refer
• European guidelines – 'Both diagnostic laparoscopy and imaging combined with empirical treatment…can be considered in women suspected of endometriosis. There is no evidence of superiority of either approach…pros and cons should be discussed with the patient.'	• If considering endometriosis, tell patient and document if deciding not to refer, so they don't later think diagnosis was delayed. • Refer if symptoms are severe, persistent or recurrent. • Refer if initial management not effective, not tolerated, or contraindicated.	• Refer to specialist centre (find at bsge.org.uk) for endometriosis outside the pelvic cavity or involving bowel, bladder or ureter. • Specialist centres have MDT including surgery, CNS, pain management and fertility. • If ≤17 consider adolescent gynaecology.

ESHRE endometriosis guideline (2022), NICE NG73 (2017), NICE CKS (2023)