Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Endometriosis: diagnosis and management.

Bibliographic Source(s)

National Guideline Alliance. Endometriosis: diagnosis and management. London (UK): National Institute for Health and Care Excellence (NICE); 2017 Sep 6. 25 p. (NICE guideline; no. 73).

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

= Poor = Fair = Good = Very Good = Excellent

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests
	Guideline Development Group Composition
YES	Multidisciplinary Group
YES	Methodologist Involvement
	Patient and Public Perspectives

	Use of a Systematic Review of Evidence
▮▮▮▮▮	Search Strategy
▮▮▮▮▮	Study Selection
▮▮▮▮▮	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
▮▮▮▮▮	Grading the Quality or Strength of Evidence
▮▮▮▮▮	Benefits and Harms of Recommendations
▮▮▮▮▮	Evidence Summary Supporting Recommendations
▮▮▮▯▯	Rating the Strength of Recommendations
▮▮▮▮▯	Specific and Unambiguous Articulation of Recommendations
▮▮▮▮▮	External Review
▮▮▮▮▮	Updating

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Guideline Alliance (NGA) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation) and is defined at the end of the "Major Recommendations" field.

Organisation of Care

Set up a managed clinical network for women with suspected or confirmed endometriosis, consisting of community services (including general practitioners [GPs], practice nurses, school nurses and sexual health services), gynaecology services and specialist endometriosis services (endometriosis centres).

Community, gynaecology and specialist endometriosis services (endometriosis centres) should:

> Provide coordinated care for women with suspected or confirmed endometriosis
> Have processes in place for prompt diagnosis and treatment of endometriosis, because delays can affect quality of life and result in disease progression.

Gynaecology Services for Women with Suspected or Confirmed Endometriosis

Gynaecology services for women with suspected or confirmed endometriosis should have access to:

- A gynaecologist with expertise in diagnosing and managing endometriosis, including training and skills in laparoscopic surgery
- A gynaecology specialist nurse with expertise in endometriosis
- A multidisciplinary pain management service
- A healthcare professional with an interest in gynaecological imaging
- Fertility services.

Specialist Endometriosis Services (Endometriosis Centres)

Specialist endometriosis services (endometriosis centres) should have access to:

- Gynaecologists with expertise in diagnosing and managing endometriosis, including advanced laparoscopic surgical skills
- A colorectal surgeon with an interest in endometriosis
- A urologist with an interest in endometriosis
- An endometriosis specialist nurse
- A multidisciplinary pain management service with expertise in pelvic pain
- A healthcare professional with specialist expertise in gynaecological imaging of endometriosis
- Advanced diagnostic facilities (for example, radiology and histopathology)
- Fertility services.

Endometriosis Information and Support

Be aware that endometriosis can be a long-term condition, and can have a significant physical, sexual, psychological and social impact. Women may have complex needs and require long-term support.

Assess the individual information and support needs of women with suspected or confirmed endometriosis, taking into account their circumstances, symptoms, priorities, desire for fertility, aspects of daily living, work and study, cultural background, and their physical, psychosexual and emotional needs.

Provide information and support for women with suspected or confirmed endometriosis, which should include:

- What endometriosis is
- Endometriosis symptoms and signs
- How endometriosis is diagnosed
- Treatment options
- Local support groups, online forums and national charities, and how to access them.

If women agree, involve their partner (and/or other family members or people important to them) and include them in discussions. For more guidance on providing information to people and involving family members and carers, see the NICE guideline on patient experience in adult NHS services .

Endometriosis Symptoms and Signs

Suspect endometriosis in women (including young women aged 17 and under) presenting with 1 or more of the following symptoms or signs:

- Chronic pelvic pain
- Period-related pain (dysmenorrhoea) affecting daily activities and quality of life
- Deep pain during or after sexual intercourse
- Period-related or cyclical gastrointestinal symptoms, in particular, painful bowel movements
- Period-related or cyclical urinary symptoms, in particular, blood in the urine or pain passing urine
- Infertility in association with 1 or more of the above.

Inform women with suspected or confirmed endometriosis that keeping a pain and symptom diary can aid discussions.

Offer an abdominal and pelvic examination to women with suspected endometriosis to identify abdominal masses and pelvic signs, such as reduced organ mobility and enlargement, tender nodularity in the posterior vaginal fornix, and visible vaginal endometriotic lesions.

If a pelvic examination is not appropriate, offer an abdominal examination to exclude abdominal masses.

Referral for Women with Suspected or Confirmed Endometriosis

Consider referring women to a gynaecology service for an ultrasound or gynaecology opinion if:

- They have severe, persistent or recurrent symptoms of endometriosis
- They have pelvic signs of endometriosis or
- Initial management is not effective, not tolerated or is contraindicated.

Refer women to a specialist endometriosis service (endometriosis centre) if they have suspected or confirmed deep endometriosis involving the bowel, bladder or ureter.

Consider referring young women (aged 17 and under) with suspected or confirmed endometriosis to a paediatric and adolescent gynaecology service, gynaecology service or specialist endometriosis service (endometriosis centre), depending on local service provision.

Diagnosing Endometriosis

Do not exclude the possibility of endometriosis if the abdominal or pelvic examination, ultrasound or magnetic resonance imaging (MRI) are normal. If clinical suspicion remains or symptoms persist, consider referral for further assessment and investigation.

Ultrasound

Consider transvaginal ultrasound:

- To investigate suspected endometriosis even if the pelvic and/or abdominal examination is normal
- To identify endometriomas and deep endometriosis involving the bowel, bladder or ureter.

If a transvaginal scan is not appropriate, consider a transabdominal ultrasound scan of the pelvis.

Serum Cancer Antigen 125 (CA125)

Do not use serum CA125 to diagnose endometriosis.

If a coincidentally reported serum CA125 level is available, be aware that:

- A raised serum CA125 (that is, 35 IU/ml or more) may be consistent with having endometriosis
- Endometriosis may be present despite a normal serum CA125 (less than 35 IU/ml).

MRI

Do not use pelvic MRI as the primary investigation to diagnose endometriosis in women with symptoms or signs suggestive of endometriosis.

Consider pelvic MRI to assess the extent of deep endometriosis involving the bowel, bladder or ureter.

Ensure that pelvic MRI scans are interpreted by a healthcare professional with specialist expertise in gynaecological imaging.

Diagnostic Laparoscopy

Also refer to "Surgical Management" and "Surgical Management if Fertility Is a Priority," below.

Consider laparoscopy to diagnose endometriosis in women with suspected endometriosis, even if the ultrasound was normal.

For women with suspected deep endometriosis involving the bowel, bladder or ureter, consider a pelvic

ultrasound or MRI before an operative laparoscopy.

During a diagnostic laparoscopy, a gynaecologist with training and skills in laparoscopic surgery for endometriosis should perform a systematic inspection of the pelvis.

During a diagnostic laparoscopy, consider taking a biopsy of suspected endometriosis:

- To confirm the diagnosis of endometriosis (be aware that a negative histological result does not exclude endometriosis)
- To exclude malignancy if an endometrioma is treated but not excised.

If a full, systematic laparoscopy is performed and is normal, explain to the woman that she does not have endometriosis, and offer alternative management.

Staging Systems

Offer endometriosis treatment according to the woman's symptoms, preferences and priorities, rather than the stage of the endometriosis.

When endometriosis is diagnosed, the gynaecologist should document a detailed description of the appearance and site of endometriosis.

Monitoring for Women with Confirmed Endometriosis

Consider outpatient follow-up (with or without examination and pelvic imaging) for women with confirmed endometriosis, particularly women who choose not to have surgery, if they have:

- Deep endometriosis involving the bowel, bladder or ureter or
- 1 or more endometrioma that is larger than 3 cm.

Pharmacological Pain Management

Analgesics

For women with endometriosis-related pain, discuss the benefits and risks of analgesics, taking into account any comorbidities and the woman's preferences.

Consider a short trial (for example, 3 months) of paracetamol or a non-steroidal anti-inflammatory drug (NSAID) alone or in combination for first-line management of endometriosis-related pain.

If a trial of paracetamol or an NSAID (alone or in combination) does not provide adequate pain relief, consider other forms of pain management and referral for further assessment.

Neuromodulators and Neuropathic Pain Treatments

For recommendations on using neuromodulators to treat neuropathic pain, see the NICE guideline on neuropathic pain .

Hormonal Treatments

Explain to women with suspected or confirmed endometriosis that hormonal treatment for endometriosis can reduce pain and has no permanent negative effect on subsequent fertility.

Offer hormonal treatment (for example, the combined oral contraceptive pill or a progestogen) to women with suspected, confirmed or recurrent endometriosis. (At the time of publication [September 2017], not all combined oral contraceptive pills or progestogens have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.)

If initial hormonal treatment for endometriosis is not effective, not tolerated or is contraindicated, refer the woman to a gynaecology service, specialist endometriosis service (endometriosis centre) or paediatric

and adolescent gynaecology service for investigation and treatment options.

Non-pharmacological Management

Advise women that the available evidence does not support the use of traditional Chinese medicine or other Chinese herbal medicines or supplements for treating endometriosis.

Surgical Management

Ask women with suspected or confirmed endometriosis about their symptoms, preferences and priorities with respect to pain and fertility, to guide surgical decision-making.

Discuss surgical management options with women with suspected or confirmed endometriosis. Discussions may include:

- What a laparoscopy involves
- That laparoscopy may include surgical treatment (with prior patient consent)
- How laparoscopic surgery could affect endometriosis symptoms
- The possible benefits and risks of laparoscopic surgery
- The possible need for further surgery (for example, for recurrent endometriosis or if complications arise)
- The possible need for further planned surgery for deep endometriosis involving the bowel, bladder or ureter.

Perform surgery for endometriosis laparoscopically unless there are contraindications.

During a laparoscopy to diagnose endometriosis, consider laparoscopic treatment of the following, if present:

- Peritoneal endometriosis not involving the bowel, bladder or ureter
- Uncomplicated ovarian endometriomas.

As an adjunct to surgery for deep endometriosis involving the bowel, bladder or ureter, consider 3 months of gonadotrophin-releasing hormone agonists before surgery. (At the time of publication [September 2017], not all gonadotrophin-releasing hormone agonists have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.)

Consider excision rather than ablation to treat endometriomas, taking into account the woman's desire for fertility and her ovarian reserve. Also see ovarian reserve testing in the NICE guideline on fertility problems.

Combination Treatments

After laparoscopic excision or ablation of endometriosis, consider hormonal treatment (with, for example, the combined oral contraceptive pill), to prolong the benefits of surgery and manage symptoms. (At the time of publication [September 2017], not all hormonal treatments [including not all combined oral contraceptive pills] have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.)

Hysterectomy in Combination with Surgical Management

If hysterectomy is indicated (for example, if the woman has adenomyosis or heavy menstrual bleeding that has not responded to other treatments), excise all visible endometriotic lesions at the time of the hysterectomy.

Perform hysterectomy (with or without oophorectomy) laparoscopically when combined with surgical

treatment of endometriosis, unless there are contraindications.

For women thinking about having a hysterectomy, discuss:

- What a hysterectomy involves and when it may be needed
- The possible benefits and risks of hysterectomy
- The possible benefits and risks of having oophorectomy at the same time
- How a hysterectomy (with or without oophorectomy) could affect endometriosis symptoms
- That hysterectomy should be combined with excision of all visible endometriotic lesions
- Endometriosis recurrence and the possible need for further surgery
- The possible benefits and risks of hormone replacement therapy after hysterectomy with oophorectomy (also see the NICE guideline on menopause).

Surgical Management if Fertility Is a Priority

The recommendations in this section should be interpreted within the context of NICE's guideline on fertility problems . The management of endometriosis-related subfertility should have multidisciplinary team involvement with input from a fertility specialist. This should include the recommended diagnostic fertility tests or preoperative tests, as well as other recommended fertility treatments such as assisted reproduction that are included in the NICE guideline on fertility problems .

Offer excision or ablation of endometriosis plus adhesiolysis for endometriosis not involving the bowel, bladder or ureter, because this improves the chance of spontaneous pregnancy.

Offer laparoscopic ovarian cystectomy with excision of the cyst wall to women with endometriomas, because this improves the chance of spontaneous pregnancy and reduces recurrence. Take into account the woman's ovarian reserve. (Also see ovarian reserve testing in the NICE guideline on fertility problems .)

Discuss the benefits and risks of laparoscopic surgery as a treatment option for women who have deep endometriosis involving the bowel, bladder or ureter and who are trying to conceive (working with a fertility specialist). Topics to discuss may include:

- Whether laparoscopic surgery may alter the chance of future pregnancy
- The possible impact on ovarian reserve (also see ovarian reserve testing in the NICE guideline on fertility problems)
- The possible impact on fertility if complications arise
- Alternatives to surgery
- Other fertility factors.

Do not offer hormonal treatment to women with endometriosis who are trying to conceive, because it does not improve spontaneous pregnancy rates.

Definitions

Strength of Recommendations

Some recommendations can be made with more certainty than others, depending on the quality of the underpinning evidence. The Committee makes a recommendation based on the trade-off between the benefits and harms of a system, process or an intervention, taking into account the quality of the underpinning evidence. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The Committee usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally the Committee uses 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The Committee uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of people, a system, process or an intervention will do more good than harm, and be cost effective. Similar forms of words (for example, 'Do not offer…') are used when the Committee is confident that an intervention will not be of benefit for most people.

Interventions That Could Be Used

The Committee uses 'consider' when confident that a system, process or an intervention will do more good than harm for most people, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the person's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the person.

Clinical Algorithm(s)

An algorithm titled "Endometriosis algorithm" is provided in the original guideline document.

A National Institute for Health and Care Excellence (NICE) pathway titled "Endometriosis overview" is provided on the NICE Web site .

Scope

Disease/Condition(s)

Endometriosis

Guideline Category

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Obstetrics and Gynecology

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Patients

Physician Assistants

Physicians

Guideline Objective(s)

- To make recommendations for the diagnosis and management of endometriosis in community services, gynaecology services and specialist endometriosis services (endometriosis centres)
- To raise awareness of the symptoms of endometriosis, and to provide clear advice on what action to take when women with signs and symptoms first present in healthcare settings
- To provide advice on the range of treatments available

Target Population

Women with confirmed or suspected endometriosis, with recurrent symptoms of endometriosis, or with asymptomatic endometriosis discovered incidentally

Note: Young women (aged 17 and under) have been identified as a subgroup needing specific consideration. Women with endometriosis occurring outside the pelvis and postmenopausal women are not covered in this guideline.

Interventions and Practices Considered

1. Organisation of care
    - Gynaecology services for women with suspected or confirmed endometriosis
    - Specialist endometriosis services (endometriosis centres)
2. Endometriosis information and support
3. Evaluation of endometriosis symptoms and signs, including abdominal and/or pelvic examination
4. Referral for women with suspected or confirmed endometriosis
5. Diagnosing endometriosis
    - Ultrasound
    - Serum cancer antigen 125 (CA125) (not recommended)
    - Magnetic resonance imaging (MRI)
    - Diagnostic laparoscopy
6. Use of staging systems
7. Monitoring for women with confirmed endometriosis
8. Pharmacological pain management
    - Analgesics
    - Neuromodulators and neuropathic pain treatments
    - Hormonal treatments
9. Non-pharmacological management (not recommended)
10. Surgical management
    - Laparoscopic surgery
    - Combination treatments
    - Hysterectomy in combination with surgical management
11. Surgical management if fertility is a priority

Major Outcomes Considered

- Pain
- Health-related quality of life
- Activities of daily living
- Complications of treatment
- Recurrence of endometriosis

- Admission to hospital
- Fertility
- Cost-effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Guideline Alliance (NGA) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Developing the Review Questions and Protocols

The 21 review questions developed for this guideline were based on the key areas identified in the guideline scope. They were drafted by the NGA and refined and validated by the Committee. The review questions were based on the following frameworks:

> Intervention reviews – using population, intervention, comparison and outcome (a patient, intervention, comparator, outcome [PICO] framework)
> Reviews of diagnostic test accuracy – using population, diagnostic test (index tests), reference standard and target condition
> Qualitative reviews – using population, area of interest and themes of interest
> Prognostic reviews – using population, presence or absence of a risk factor, and outcome. This risk factor could be endometriosis itself as in the risk for cancer review (see chapter 7 in the full guideline)

Full literature searches, critical appraisals and evidence reviews were completed for all review questions.

Searching for Evidence

Clinical Literature Search

Systematic literature searches were undertaken to identify all published clinical evidence relevant to the review questions.

Databases were searched using relevant medical subject headings, free-text terms and study type filters where appropriate. Studies published in languages other than English were not reviewed. Where possible, searches were restricted to retrieve only articles published in English. All searches were conducted in MEDLINE, EMBASE and The Cochrane Library. All searches were updated in December 2016. Any studies added to the databases after this date (even those published prior to this date) were not included unless specifically stated in the text.

Search strategies were quality assured by cross-checking reference lists of highly relevant papers, analysing search strategies in other systematic reviews and asking the group members to highlight any additional studies. The questions, the study types applied, the databases searched and the years covered can be found in Appendix E.

The titles and abstracts of records retrieved by the searches were inspected for relevance, with potentially significant publications obtained in full text. These were assessed against the inclusion criteria.

During the scoping stage, a search was conducted for guidelines and reports on websites of organisations relevant to the topic. Searching for grey literature or unpublished literature was not undertaken. Searches for electronic, ahead-of-print publications were not routinely undertaken unless indicated by the Committee. All references suggested by stakeholders at the scoping consultation were initially considered.

In terms of diagnostic test accuracy reviews (see chapter 8), 1 systematic literature search was carried out for all index tests listed in the review protocol. The resulting titles and abstracts were then sifted for all index tests generating:

- Included studies for each index test; and
- A single excluded studies list for all studies that were not included in any of the diagnostic reviews.

Reviewing Research Evidence

Types of Studies and Inclusion and Exclusion Criteria

For most intervention reviews in this guideline, parallel randomised controlled trials (RCTs) were prioritised because they are considered the most robust type of study design that could produce an unbiased estimate of the intervention effects.

For diagnostic reviews, cross-sectional, retrospective or prospective observational studies were considered for inclusion. For prognostic reviews, prospective and retrospective cohort studies were included. Case-control studies were not considered for inclusion.

In the qualitative review, studies using focus groups, or structured or semi-structured interviews were considered for inclusion. Survey data or other types of questionnaires were only included if they provided analysis from open-ended questions, but not if they reported descriptive quantitative data only.

Where data from observational studies were included, the Committee decided that the results for each outcome should be presented separately for each study and meta-analysis was not conducted.

The evidence was reviewed following the steps shown schematically in Figure 2:

- Potentially relevant studies were identified for each review question from the relevant search results by reviewing titles and abstracts. Full papers were then obtained.
- Full papers were reviewed against pre-specified inclusion and exclusion criteria to identify studies that addressed the review question in the appropriate population, as outlined in the review protocols (review protocols are included in Appendix D).

Specific Inclusions and Exclusions

In Chapter 11, where the impact of surgical or hormonal treatments on fertility are reviewed, the population was restricted to women with endometriosis who had been unsuccessfully trying to conceive and who did not have assisted reproductive treatment. The outcome that was then considered in the network meta-analysis (for a description of the methods see Section 4.4.1.1 and Chapter 12) was spontaneous pregnancy (i.e., pregnancy that was not assisted by reproductive treatment).

Young women (aged 17 and under) are a specific subgroup highlighted in the scope. Endometriosis is particularly under recognised in the group of women. The Committee therefore looked for evidence specific to this age group in each review question and reported this if the evidence was specifically reported in this way.

Adverse events were initially loosely, if at all, specified in the review protocols for hormonal treatments. After further discussion with the Committee it was agreed that 'withdrawal due to adverse events' would be the only outcome related to adverse events that should be extracted. There were several reasons for

this:

- Many of the adverse events for different classes of hormonal treatments are commonly known and recognised
- The Committee wanted to know whether the possible benefit from the treatment out-weighed the adverse events, which could only be shown by whether or not women were more likely to persist taking one type of hormone over another.
- It makes the different hormonal treatments (with often very idiosyncratic adverse events) comparable.

These outcomes were therefore used in the network meta-analysis of hormonal treatments (please see Chapter 11).

Health Economic Literature Search

Refer to Appendix K for search information for each of the health economics literature searches performed: diagnosis and treatment, timing of interventions, and consideration of economic benefits and harms of diagnostic tests.

Number of Source Documents

See Appendix F: Summary of identified studies (see the "Availability of Companion Documents" field) for information on results of literature searches and the number of included and excluded studies for each review question including economic article selection.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Overall Quality of Outcome Evidence in Grading of Recommendations Assessment, Development and Evaluation (GRADE)

Level	Description
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
Low	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
Very Low	Any estimate of effect is very uncertain.

Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National

Guideline Alliance (NGA) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Searching for Evidence

Reviewing Research Evidence

The evidence was reviewed following the steps shown schematically in Figure 2 in the full version of the guideline:

- Relevant studies were critically appraised using the appropriate checklist as specified in the NICE guidelines manual
- Key information was extracted on the study's methods, according to the factors specified in the protocols and results. These were presented in summary tables (in each review chapter) and evidence tables (in Appendix G)
- Summaries of evidence were generated by outcome (included in the relevant review chapters) and were presented in committee meetings (details of how the evidence was appraised is described in "Appraising the Quality of the Evidence," below):
    - Randomised studies: meta-analysis was carried out where appropriate and results were reported in Grading of Recommendations Assessment, Development and Evaluation (GRADE) profiles (for intervention reviews)
    - Observational studies: data were presented as a range of values in GRADE profiles
    - Prognostic studies: data were presented as a range of values, usually in terms of the relative effect as reported by the authors
    - Diagnostic studies: data were presented as measures of diagnostic test accuracy (sensitivity and specificity) and were presented in modified GRADE profiles.

Qualitative studies: each study was summarised by theme and meta-synthesis was carried out where appropriate to identify an overarching framework of themes and subthemes. These were then presented in modified GRADE-CERQual (Lewin 2015) profile, where CERQual stands for Confidence in the Evidence from Reviews of Qualitative research.

For quality assurance of study identification, either whole study selections or a sample of the study selection results were double checked by a second reviewer. This was carried out for 20% of all searches related to the network meta-analysis and were double sifted.

A sample of all evidence tables was double extracted (20% of the network meta-analysis). All drafts of reviews were checked by a second reviewer. Any discrepancies were resolved by discussion between the 2 reviewers.

Method of Combining Clinical Studies

The approaches for data synthesis that were discussed and agreed with Committee when planning reviews (protocols) are described in detail in Section 4.4 of the full version of the guideline.

Appraising the Quality of Evidence

For intervention reviews, the evidence for outcomes from the included randomised controlled trials (RCTs) and observational studies were evaluated and presented using GRADE, which was developed by the international GRADE working group. Modified GRADE assessments were also carried out for accuracy measures in diagnostic reviews. For the appraisal of the quality of the evidence from qualitative reviews an adapted GRADE-CERQual (Lewin 2015) approach was used, where CERQual stands for Confidence in the Evidence from Reviews of Qualitative research.

The software developed by the GRADE working group (GRADEpro) was used to assess the quality of each outcome, taking into account individual study quality factors and the meta-analysis results. The clinical/economic evidence profile tables include details of the quality assessment and pooled outcome

data, where appropriate, an absolute measure of intervention effect and the summary of quality of evidence for that outcome. In this table, the columns for intervention and control indicate summary measures of effect and measures of dispersion (such as mean and standard deviation or median and range) for continuous outcomes and frequency of events (n/N: the sum across studies of the number of patients with events divided by sum of the number of completers) for binary outcomes. Reporting or publication bias was only taken into consideration in the quality assessment and included in the clinical evidence profile tables if it was apparent.

The selection of outcomes for each review question was decided when each review protocol was discussed with the Committee. However, given the nature of most of the review questions included in this guideline (driven by short- or long-term outcomes), the categorisation of outcomes as critical and important did not follow the standard GRADE approach. The outcomes selected for a review question were critical for decision-making in a specific context.

The evidence for each outcome in interventional reviews was examined separately for the quality elements listed and defined in Table 3 in the full version of the guideline. Each element was graded using the quality levels listed in Table 4 in the full version of the guideline.

The main criteria considered in the rating of these elements are discussed below. Footnotes were used to describe reasons for grading a quality element as having serious or very serious limitations. The ratings for each component were summed to obtain an overall assessment for each outcome (Table 5 in the full version of the guideline).

The GRADE toolbox is designed only for RCTs and observational studies, but the Committee adapted the quality assessment elements and outcome presentation for diagnostic accuracy and qualitative studies, subject to data availability. For example, for diagnostic accuracy studies, the GRADE tables were modified to include the most appropriate measures of diagnostic accuracy (sensitivity and specificity) whereas qualitative studies were presented in summary evidence tables around themes identified or direct participants' quotations. Quality of the evidence in the qualitative reviews was assessed per study level.

Grading the Quality of Clinical Evidence

After results were pooled, the overall quality of evidence for each outcome was considered. The following procedure was adopted when using the GRADE approach:

- A quality rating was assigned based on the study design. RCTs start as high, observational studies as moderate and uncontrolled case series as low or very low
- The rating was then downgraded for the specified criteria: risk of bias (study limitations); inconsistency; indirectness; imprecision; and publication bias. These criteria are detailed in Sections 4.5.1.1 to 4.5.1.4 in the full version of the guideline. Evidence from observational studies (which had not previously been downgraded) was upgraded if there was a large magnitude of effect or a dose-response gradient, and if all plausible confounding would reduce a demonstrated effect, or suggest a spurious effect when results showed no effect.
- Each quality element considered to have 'serious' or 'very serious' issues was rated down by 1 or 2 points respectively. Value based judgements for relevant interpretation of the levels of quality elements were informed by discussion with the Committee for each review to balance consistency of approach across the guideline and clinical relevance within each review.
- The downgraded/upgraded ratings were then summed and the overall quality rating was revised, taking into account the relative contributions from the individual studies within a meta-analyses, where performed. For example, RCTs start as high and the overall quality becomes moderate, low or very low if 1, 2 or 3 points are deducted respectively
- The reasons or criteria used for downgrading were specified in the footnotes.

The details of the criteria used for each of the main quality elements are discussed further in Sections 4.5.1.1 to 4.5.1.4 in the full version of the guideline.

GRADE quality assessment was not performed for the reviews in Chapter 6 and 8 regarding monitoring and referral nor for the network meta-analysis. Quality statements were informed by assessment of risk

of bias.

Quality Assessment of Network Meta-Analysis (NMA)

For the NMAs, quality was assessed by looking at risk of bias across the included evidence (using the standard GRADE approach for this domain), as well as heterogeneity and incoherence.

The following limits of the upper 95% credible interval (CrI) for between-study standard deviation were used to assess heterogeneity for NMAs in which a random effects model was used:

Less than 0.3 – low heterogeneity
0.3 to 0.6 – moderate heterogeneity
0.6 to 0.9 – high heterogeneity
0.9 to 1.2 – very high heterogeneity.

Where significant incoherence was found it was considered to be serious when the direction of effect for both direct and indirect estimates was the same (for example, an odds ratio of greater than 1 in both the direct and indirect estimates), and very serious when the direction of effect was different (for example, an odds ratio of greater than 1 for the direct estimate but less than 1 for the indirect estimate).

For fixed-effect NMAs that did not model heterogeneity, or for networks in which incoherence could not be assessed as no closed treatment loops existed, these criteria were not considered to impact the quality of evidence.

Assessing Clinical Significance (of Intervention Effects)

The Committee assessed the evidence by outcome in order to determine if there was, or potentially was, a clinically important benefit, a clinically important harm or no clinically important difference between interventions. To facilitate this, where possible, binary outcomes were converted into absolute risk differences (ARDs) using GRADEpro software: the median control group risk across studies was used to calculate the ARD and its 95% CI from the pooled risk ratio. For continuous outcomes, the mean difference between the intervention and control arm of the trail was calculated. This was then assessed in relation to the default MID (0.5 times the median control group standard deviation).

The assessment of clinical benefit or harm, or no benefit or harm, was not based on the default minimally important difference (MID) of the relative risk, which was only used as a starting point, but on the point estimate of the absolute effect, taking into consideration the precision around this estimate.

This assessment was carried out by the Committee for each critical outcome and an evidence summary table (used in the Committee meetings, but not presented in this guideline) was produced to compile the Committee's assessments of clinical importance per outcome, alongside the evidence quality and the uncertainty in the effect estimate (imprecision). In instances where the Committee's decision differed from the default assessment, decisions were captured in the 'Linking evidence to recommendations' sections.

Assessing Clinical Significance (of Prognostic, Diagnostic or Qualitative Findings)

Absolute risk differences were not calculated for prognostic findings in this guideline. The Committee considered the size of the relative effects and whether this was large enough to constitute a sign or symptom predicting the occurrence of the selected outcome.

In a similar manner, this was carried out for diagnostic accuracy statistics to interpret how likely the size of the effect reflects a clinically meaningful association between people having a positive test and the target condition.

For themes stemming from qualitative findings, clinical importance was decided upon by the Committee taking into account the generalisability of the context from which the theme was derived and whether it was convincing enough to support or warrant a change in current practice, as well as the evidence quality.

Evidence Statements

Evidence statements are summary statements that are presented after the GRADE profiles, summarising the key features of the clinical evidence presented. The wording of the evidence statements reflects the certainty or uncertainty in the estimate of effect. The evidence statements are presented by outcome or theme and encompass the following key features of the evidence:

- The quality of the evidence (GRADE rating)
- The number of studies and the number of participants for a particular outcome
- A brief description of the participants
- An indication of the direction of effect (for example, if a treatment is clinically significant [beneficial or harmful] compared with another, or whether there is no difference between the tested treatments).

Evidence of Cost-effectiveness

The aims of the health economic input to the guideline were to inform the Committee of potential economic issues related to the diagnosis and management of endometriosis to ensure that recommendations represented a cost-effective use of healthcare resources. Health economic evaluations aim to integrate data on healthcare benefits (ideally in terms of quality-adjusted life-years [QALYs]) with the costs of different care options. In addition, the health economic input aimed to identify areas of high resource impact; recommendations which – while nevertheless cost effective – might have a large impact on CCG or Trust finances and so need special attention.

The group prioritised a single economic model on interventions where it was thought that economic considerations would be particularly important in formulating recommendations and a review of the health economic literature was undertaken. This model covered multiple review questions, as a complete health economic analysis of the treatment pathway required consideration of all possible combinations of diagnostic strategy and treatment strategy together. For economic evaluations, no standard system of grading the quality of evidence exists and included papers were assessed using the economic evaluations checklist as specified in the NICE guidelines manual.

Health economic reviews were also undertaken for review questions relating to the timing of interventions and the configurations of services. In both of these cases it was thought that the Committee may wish to make recommendations that would lead to a high resource impact, although in practice this did not occur to a substantial degree.

No economic evaluation was undertaken for questions on information and support or signs and symptoms (of endometriosis) as it was agreed with the Committee that these reviews would focus primarily on the content and quality of information which is given to patients and clinicians respectively rather than whether the provision of such information represented a cost-effective use of NHS resources, which was thought to be clinically uncontroversial. Therefore these questions were not primarily about competing alternative uses for NHS resources and therefore were not considered suitable for economic analysis.

No economic analysis was undertake for a question on staging systems. While such an economic model might be valuable in deciding on the allocation of scarce National Health Service (NHS) resources, no clinical evidence was uncovered which might populate an economic model which meant that no model could be constructed.

No economic analysis was undertaken for a question on monitoring and referral. This question was of a high health economic importance as the potential quality of life impact for misdiagnosing, for example, ovarian cancer is extremely high. However in order to perform a reasonable economic analysis on this question it would have been necessary to consider the cost-effectiveness of the treatment pathway for each possible reason to refer. Some of these pathways have existing NICE guidance but some do not, which would have required de novo modelling (taking away resources from the main health economic guideline). For this question it was agreed with the Committee that health economic input would be limited to resource impact and analysis, with a full health economic evaluation being left until all possible referral pathways had been costed in other NICE Guidelines.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Guideline Alliance (NGA) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Who Developed this Guideline?

A multidisciplinary Committee comprising healthcare professionals and researchers as well as lay members developed this guideline.

The Committee was convened by the NGA and chaired by Dr. Caroline Overton in accordance with guidance from NICE. The group met every 4 to 6 weeks during the development of the guideline.

Staff from the NGA provided methodological support and guidance for the development process. The team working on the guideline included a guideline lead, a project manager, systematic reviewers, health economists, a statistician and information scientists. They undertook systematic searches of the literature, appraised the evidence, conducted meta-analysis and cost-effectiveness analysis where appropriate and drafted the guideline in collaboration with the group.

Developing Recommendations

Over the course of the guideline development process, the Committee was presented with:

- Evidence tables of the clinical and economic evidence reviewed from the literature: all evidence tables are in Appendix H
- Summary of clinical and economic evidence and quality assessment (as presented in Chapters 4 to 11)
- Forest plots (Appendix J)
- A description of the methods and results of the cost-effectiveness analysis undertaken for the guideline (Appendix K).

Recommendations were drafted on the basis of the group's interpretation of the available evidence, taking into account the balance of benefits, harms and costs between different courses of action. This was either done formally, in an economic model, or informally. Firstly, the net benefit over harm (clinical effectiveness) was considered, focusing on the critical outcomes, although most of the reviews in the guideline were outcome driven. When this was done informally, the group took into account the clinical benefits and harms when one intervention was compared with another. The assessment of net benefit was moderated by the importance placed on the outcomes (the group's values and preferences) and the confidence the group had in the evidence (evidence quality). Secondly, the group assessed whether the net benefit justified any differences in costs.

When clinical and economic evidence was of poor quality, conflicting or absent, the group drafted recommendations based on their expert opinion. The considerations for making consensus-based recommendations include the balance between potential harms and benefits, the economic costs or implications compared with the economic benefits, current practices, recommendations made in other relevant guidelines, patient preferences and equality issues. The group also considered whether the uncertainty was sufficient to justify delaying making a recommendation to await further research, taking into account the potential harm of failing to make a clear recommendation.

The wording of recommendations was agreed by the group and focused on the following factors:

The actions healthcare professionals need to take
The information readers of the guideline need to know
The strength of the recommendation (for example, the word 'offer' was used for strong recommendations and 'consider' for weak recommendations)
The involvement of patients (and their support network if needed) in decisions about treatment and care
Consistency with NICE's standard advice on recommendations about drugs, waiting times and ineffective intervention.

The main considerations specific to each recommendation are outlined in the 'Recommendations and link to evidence' sections within each chapter of the full guideline.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

Some recommendations can be made with more certainty than others, depending on the quality of the underpinning evidence. The Committee makes a recommendation based on the trade-off between the benefits and harms of a system, process or an intervention, taking into account the quality of the underpinning evidence. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The Committee usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally the Committee uses 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The Committee uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of people, a system, process or an intervention will do more good than harm, and be cost effective. Similar forms of words (for example, 'Do not offer…') are used when the Committee is confident that an intervention will not be of benefit for most people.

Interventions That Could Be Used

The Committee uses 'consider' when confident that a system, process or an intervention will do more good than harm for most people, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the person's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the person.

Cost Analysis

Refer to the "Economic Evidence" sections statements in the full version of the guideline (see the "Availability of Companion Documents" field) for a discussion of published economic evidence for each of the guideline review questions. The full health economics report is provided in Appendix K.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

This guidance is subject to a 6-week public consultation and feedback as part of the quality assurance and peer review of the document. All comments received from registered stakeholders are responded to in turn and posted on the National Institute for Health and Care Excellence (NICE) Web site at publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The type and quality of evidence supporting each review question are described in the evidence review sections in the full version of the guideline (see the "Availability of Companion Documents" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- It is important that women with endometriosis are assessed and a diagnosis made in a timely manner, to prevent delay in effective treatment.
- Many of the hormones used to manage endometriosis-associated pain will also reduce menstrual bleeding and this may be advantageous. Similarly, the contraceptive properties of the hormones may be welcome if the woman does not wish to become pregnant at this moment in time, or unwanted if fertility is an issue.

Refer to the "Consideration of clinical benefits and harms" sections of the full version of the guideline (see the "Availability of Companion Documents" field) for details about benefits of specific interventions.

Potential Harms

- For moderate to severe pain, weak opioids such as codeine are often used but the side effects of these are often limiting; constipation in particular may aggravate endometriosis symptoms.
- None of the hormones used to manage endometriosis (or, in fact, any drug) are free of side effects, but the severity and tolerability of the side effects can vary quite significantly.
- The consequences of testing are of great importance to women and delay in diagnosis of endometriosis due to false negative results is a well-recognised issue in this population. Not having a diagnosis, or having an incorrect negative diagnosis, can cause emotional distress.

Refer to the "Consideration of clinical benefits and harms" sections of the full version of the guideline (see the "Availability of Companion Documents" field) for details about potential harms of specific interventions.

Contraindications

Contraindications

The Committee noted that laparoscopic surgery may be contraindicated for a few women for example,

those who cannot undergo procedures under anaesthetic, where there are large fibroids or where there are severe adhesions perhaps following major bowel resection, but that generally decisions regarding surgery would be based on relative harms and benefits.

Qualifying Statements

Qualifying Statements

- The recommendations in this guideline represent the view of the National Institute of Health and Care Excellence (NICE), arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.
- Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.
- Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Implementation of the Guideline

Description of Implementation Strategy

Putting This Guideline into Practice

The National Institute for Health and Care Excellence (NICE) has produced tools and resources to help put this guideline into practice (see also the "Availability of Companion Documents" field).

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

Raise awareness through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations.
Identify things staff can include in their own practice straight away.
Identify a lead with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.
Carry out a baseline assessment against the recommendations to find out whether there are gaps in current service provision.
Think about what data you need to measure improvement and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.
Develop an action plan, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.
For very big changes include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.
Implement the action plan with oversight from the lead and the project group. Big projects may also need project management support.
Review and monitor how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See the into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

Implementation Tools

Clinical Algorithm

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Identifying Information and Availability

Bibliographic Source(s)

National Guideline Alliance. Endometriosis: diagnosis and management. London (UK): National Institute for Health and Care Excellence (NICE); 2017 Sep 6. 25 p. (NICE guideline; no. 73).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017 Sep 6

Guideline Developer(s)

National Guideline Alliance - National Government Agency [Non-U.S.]

Source(s) of Funding

The National Institute for Health and Care Excellence (NICE) funds the National Guideline Alliance (NGA) and thus supported the development of this guideline.

Guideline Committee

Guideline Committee

Composition of Group That Authored the Guideline

Committee Members: Rachel Brown, General Practitioner; Dominic Byrne, Consultant Gynaecologist; Natasha Curran, Consultant in Anaesthesia and Pain Medicine; Alfred Cutner, Consultant Gynaecologist; Cathy Dean, Endometriosis Clinical Nurse Specialist; Lynda Harrison, Lay member; Jed Hawe, Consultant Obstetrician and Gynaecologist; Lyndsey Hogg, Lay member; Andrew Horne, Professor of Gynaecology and Reproductive Science; Jane Hudson-Jones, Lay member; Wendy-Rae Mitchell, Endometriosis Clinical Nurse Specialist; Caroline Overton (*Chair*), Consultant Gynaecologist; Carol Pearson, Clinical Commissioning Group Lay Member for Governance; Moji Balogun (*co-opted member*), Consultant Radiologist; Christian Becker (*co-opted member*), Associate Professor of Gynaecology and Reproductive Medicine; Mohammed Belal (*co-opted member*), Consultant Urological Surgeon; Sanjiv Manek (*co-opted member*), Consultant Gynaecological Pathologist; Natalie Lane (*co-opted member*), Clinical Psychologist (pelvic pain); Tim Rockall (*co-opted member*), Consultant Colorectal Surgeon

Financial Disclosures/Conflicts of Interest

At the start of the guideline development process all group members declared interests including consultancies, fee-paid work, shareholdings, fellowships and support from the healthcare industry. At all

subsequent group meetings, members declared arising conflicts of interest.

Members were either required to withdraw completely or for part of the discussion if their declared interest necessitated it appropriate to do so. The details of declared interests and the actions taken are shown in Appendix C (see the "Availability of Companion Documents" field).

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the National Institute for Health and Care Excellence (NICE) Web site . Also available for download in eBook and ePub formats from the NICE Web site .

Availability of Companion Documents

The following are available:

Endometriosis: diagnosis and management. Full guideline. London (UK): National Institute for Health and Care Excellence (NICE); 2017 Sep 6. 363 p. (NICE guideline; no. 73). Available from the National Institute for Health and Care Excellence (NICE) Web site .

Endometriosis: diagnosis and management. Appendices. London (UK): National Institute for Health and Care Excellence (NICE); 2017 Sep 6. (NICE guideline; no. 73). Available from the NICE Web site .

Endometriosis: diagnosis and management. Baseline assessment tool. London (UK): National Institute for Health and Care Excellence (NICE); 2017 Sep 6. (NICE guideline; no. 73). Available from the NICE Web site .

Endometriosis: diagnosis and management. Resource impact statement. London (UK): National Institute for Health and Care Excellence (NICE); 2017 Sep 6. (NICE guideline; no. 73). Available from the NICE Web site .

Hormone therapy for endometriosis symptoms: patient decision aid user guide for healthcare professionals. Implementing the NICE guideline on endometriosis (NG73). London (UK): National Institute for Health and Care Excellence (NICE); 2017 Sep. 8 p. (NICE guideline; no. 73). Available from the NICE Web site .

Developing NICE guidelines: the manual. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Oct. Available from the NICE Web site .

Patient Resources

The following are available:

Endometriosis: diagnosis and management. Information for the public. [internet]. London (UK): National Institute for Health and Care Excellence (NICE); 2017 Sep. Available from the National Institute for Health and Care Excellence (NICE) Web site .

Patient decision aid. Hormone treatment for endometriosis symptoms – what are my options? London (UK): National Institute for Health and Care Excellence (NICE); 2017 Sep. 12 p. Available from the NICE Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and

then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on October 13, 2017. The guideline developer agreed to not review the content.

This NEATS assessment was completed by ECRI Institute on October 30, 2017. The information was verified by the guideline developer on November 30, 2017.

The National Institute for Health and Care Excellence (NICE) has granted the National Guideline Clearinghouse (NGC) permission to include summaries of their clinical guidelines with the intention of disseminating and facilitating the implementation of that guidance. NICE has not yet verified this content to confirm that it accurately reflects that original NICE guidance and therefore no guarantees are given by NICE in this regard. All NICE clinical guidelines are prepared in relation to the National Health Service in England and Wales. NICE has not been involved in the development or adaptation of NICE guidance for use in any other country. The full versions of all NICE guidance can be found at www.nice.org.uk .

Copyright Statement

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

Disclaimer

NGC Disclaimer

The National Guideline Clearinghouseâ„¢ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.