

Diagnosis of endometriosis

Guiding principles

- Use biopsychosocial framework
- Provide trauma-informed and culturally safe care
- Utilise self-reported questionnaires (e.g. RATE, CSI, PPIQ)

History

- Menstrual symptoms/pattern
- Pain history
- Previous investigations/diagnoses
- Engagement with treatment
- Family
- Sexual, reproductive and obstetric
- Gastrointestinal and urinary
- Medical and surgical
- Psychosocial
- Psychiatric
- Medication use (current and past)
- Environmental/lifestyle factors
- Factors influencing ability to manage symptoms

Consider menstrual cycle and symptom diary

Not all endometriosis-related pain or symptoms can be explained by lesions alone—consider association with central sensitisation or CPOCs

Most common symptoms:

- Pelvic pain
- Dysmenorrhoea
- Painful sexual intercourse
- Gastrointestinal/bowel symptoms
- Urinary symptoms
- Heavy menstrual bleeding
- Infertility

Non-specific symptoms:

- Non-cyclic pelvic pain
- Cyclical, non-pelvic pain
- Iron deficiency with or without anaemia
- Fatigue, sleep disturbance
- Nausea, bloating
- Low mood or anxiety
- Headaches or migraines

Suggestive clinical signs:

- Reduced pelvic organ mobility or enlargement (fixation of adnexa or adnexal mass)
- Palpable plaques, nodules, areas of thickening
- Observable vaginal endometriosis lesions
- Uterosacral ligament, pelvic or vaginal tenderness

Observations

- Vital signs
- Observe mobility, gait, positioning

Abdomen

- Inspect and palpate, assessing for:
 - Abdominal/pelvic masses
 - Uterine size
 - Colon distention
 - Tenderness and guarding

Pelvic examination

Consider individual circumstances to determine appropriateness.

May include:

- Inspection of vaginal mucosa
- Vaginal examination/palpation
- Speculum examination
- Bimanual examination
- If posterior compartment abnormal, consider rectovaginal examination

Consider pathology to screen for other aetiologies contributing to symptoms

- Urine: hCG (if childbearing age), MC&S, STIs
- Bloods: FBC, CRP, Iron studies
- Endocervical swab for PCR test for chlamydia and gonorrhoea
- Faecal: stool culture, faecal calprotectin

Use of biomarkers to diagnose endometriosis is not recommended

Pelvic imaging

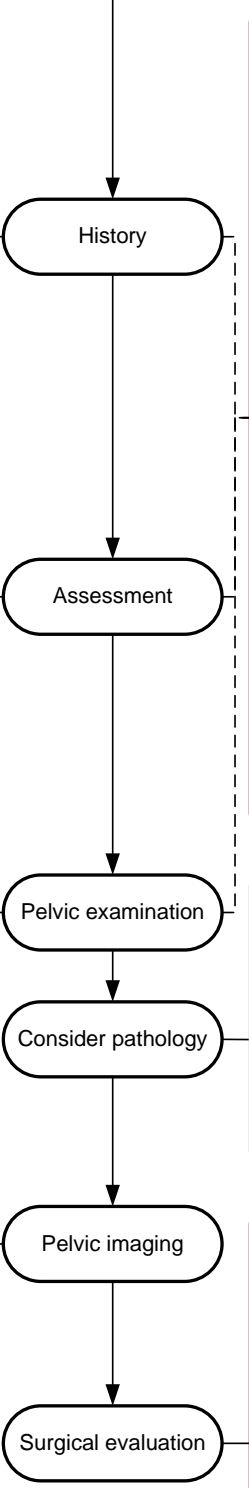
- TVS preferred
 - Where possible, refer women for an endometriosis TVS—request “endometriosis assessment” on the referral form
- MRI if TVS not available, not appropriate or DE suspected
- Transabdominal ultrasound if TVS or MRI not appropriate, unavailable or declined

Surgical evaluation

Laparoscopy is not routinely recommended for diagnostic purposes alone

- Medical management and allied health interventions can be commenced prior to laparoscopy
- Consider a laparoscopy for suspected endometriosis according to individual circumstances and goals of care
- **Refer** to gynaecologist for consultation and review
- Discuss the option of treating any visible disease if appropriate to do so

Refer to flowchart Management of endometriosis



CPOCs: chronic overlapping pain conditions; **CSI:** central sensitisation inventory; **CRP:** C-reactive protein; **DE:** deep endometriosis; **FBC:** full blood count; **hCG:** human chorionic gonadotropin; **MC&S:** microscopy, culture and sensitivity; **MRI:** magnetic resonance imaging; **PCR:** polymerase chain reaction; **PPIQ:** pelvic pain impact questionnaire; **RATE:** raising awareness tool for endometriosis; **STIs:** sexually transmitted infections; **TVS:** transvaginal ultrasound

