



Working Group „Guidelines for the Diagnosis and Treatment of Endometriosis“ of the German, Austrian, Swiss, and Czech Societies for Obstetrics and Gynecology in collaboration with the Endometriosis Research Foundation (SEF) and the European Endometriosis League (EEL)

Directing Author: Prof. U. Ulrich, M.D. (Berlin)

Members of the Working Group: O. Buchweitz, M.D. (Hamburg), R. Chvatal, M.D. (Znaim), Prof. R.-L. De Wilde, M.D. (Oldenburg), Prof. A. D. Ebert, M.D. (Berlin), B. Engl, M.D. (Bruneck), I. von Leffern, M.D. (Hamburg), Prof. R. Greb, M.D. (Dortmund), D. Haas, M.D. (Linz), G. Halis, M.D. (Berlin), Prof. J. Huckle, M.D. (Wuppertal), Prof. J. Keckstein, M.D. (Villach), Prof. M. Müller, M.D. (Bern), Prof. P. Oppelt, M.D. (Linz), S. P. Renner, M.D. (Erlangen), M. Sillem, M.D. (Mannheim), Prof. K.-W. Schweppe, M.D. (Westerstede), W. Stummvoll, M.D. † (Linz), Prof. H.-R. Tinneberg, M.D. (Gießen), F. Tuttlies, M.D. (Villach), Prof. U. Ulrich, M.D. (Berlin), Prof. L. Wildt, M.D. (Innsbruck)



These Guidelines are jointly shared by the following Scientific Societies and Organizations:

German Society for Obstetrics and Gynecology (DGGG)

- Working Group Gynecologic Endoscopy (AGE)
- Working Group Gynecologic Oncology (AGO)
- German Society for Gynecologic Endocrinology and Reproductive Medicine

German Society for Psychosomatic Obstetrics and Gynecology (DGPF)

German Society for Visceral Surgery (DGAV)

German Society for Urology

Austrian Society for Obstetrics and Gynecology (ÖGGG)

Swiss Society for Obstetrics and Gynecology (SGGG)

Czech Society for Obstetrics and Gynecology

Endometriosis Research Foundation (SEF)

European Endometriosis League (EEL)

Endometriosis Association Germany

Endometriosis Association Austria (EVA)



Statements:

- a) Endometriosis – one of the most common gynecologic diseases – is defined as the occurrence of endometrium-like cell formations outside the uterine cavity.

- b) The cardinal symptom is chronic pelvic pain. Infertility is common.



Statement:

Etiology and pathogenesis of endometriosis are not fully understood. Therefore, a causal therapy is not known to date.

Recommendation:

All staging systems known to date have their limitations. In order to ensure the international comparability of data, the use of the rASRM staging system – and in cases of deep infiltrating endometriosis the additional use of the ENZIAN classification – is recommended.



Statements:

- a) In rare cases, malignancy – usually ovarian cancer – may arise from endometriosis.

- b) Aside from this, the association of other, non-gynecologic malignancies with endometriosis has been described in the literature. The clinical significance of this observation is not understood.



Statements:

a) Indications for endoscopic diagnosis and treatment of endometriosis are as follows:

- Chronic pelvic pain,
- Destruction of organs, *and/or*
- Infertility.

b) For control of symptoms, the surgical removal of endometriotic lesions is considered as "gold standard" .

Recommendations:

In general, the diagnosis of endometriosis is to be established histologically. Hence, diagnostic laparoscopy is essential for the diagnostic work-up.



Statements:

- a) The diagnosis of peritoneal endometriosis is made laparoscopically.
- b) Treatment of choice is the laparoscopic removal of the implants.

Recommendation:

Following hormonal suppression of the ovarian function, endometriotic implants may undergo regression. For the reduction of endometriosis-associated symptoms, progestins, OCs, or GnRH analogs may be used in order to induce therapeutic amenorrhea.



Statement:

The diagnosis of ovarian endometriomas is primarily made by transvaginal ultrasound.

Recommendations:

- a) For primary treatment of ovarian endometriomas, the cyst wall should be removed surgically. Fenestration alone is considered insufficient.
- b) Endocrine drug treatment alone is neither effective in eliminating an ovarian endometrioma (and, consequently, to replace its surgical removal) – nor in compensating for incomplete surgical removal. Therefore, it is not recommended.



Statements:

a) Deep infiltrating endometriosis (DIE) is defined as involvement of the rectovaginal septum, vaginal fornix, retroperitoneum (pelvic side wall, parametrium), bowel, ureters, and urinary bladder.

b) The primary diagnosis of DIE is made clinically with rectovaginal palpation, inspection with divided specula, vaginal ultrasound, and transabdominal ultrasound of the kidneys being mandatory.



Recommendations:

- a) For treatment, complete resection of DIE should be performed. Nonetheless, compromises must be made as preservation of fertility often is imperative. Considering that the disease is benign and potentially relevant complications may occur, the extent of resection should be thoroughly discussed and agreed upon with the patient.
- b) Treatment of DIE should be carried out in specialized centers with a multidisciplinary approach (Ebert et al. 2013).
- c) If patients with DIE are to be managed conservatively – as well as pre- and postoperatively – sonographic examination of the kidneys is mandatory in order to avoid overlooking silent hydronephrosis. DIE-associated hydronephrosis is an absolute indication of appropriate diagnosis and treatment.



Statement:

The diagnosis of adenomyosis is primarily established clinically by vaginal ultrasonography and/or MRI. Most often, it is only the histological result after hysterectomy that is proving.

Recommendations:

- a) Given completion of family planning and presence of respective symptoms, hysterectomy can be recommended.
- b) If the patient opts for preservation of the uterus, a therapeutic amenorrhea may be induced, or a progestin-releasing IUD inserted .



Statements:

- a) While a causal relationship has not been resolved yet, endometriosis and infertility are often associated.

- b) For the treatment of women with both endometriosis and infertility, appropriate skills and experience in infertility surgery, as well as cooperation with centers for reproductive medicine are required.



Recommendations:

- a) In women with both infertility and endometriosis, the implants should be surgically removed for the improvement of fertility.
- b) In cases of recurrence, assisted reproductive technologies are superior to repeated surgery in terms of pregnancy rate. In repeat operations for ovarian endometriosis, the surgery-related reduction of ovarian reserve is to be considered.
- c) Postoperative treatment with GnRH analogs was ineffective in improving spontaneous pregnancy rates and is, therefore, not recommended.
- d) Any drug treatment for endometriosis alone does not improve fertility and should not be applied from a reproductive-medicine perspective.



Recommendation:

Psychosomatic aspects in the treatment of patients with endometriosis should be considered and integrated early on.



No statements, no recommendations.



Statement:

After extensive surgery – especially for deep infiltrating endometriosis, after repeat endometriosis operations, or in patients with chronic pain, there often is a need for rehabilitation.

Recommendation:

This need mentioned should be assessed, and measures of rehabilitation, or after-care, respectively, be initiated.

To cope with the physical and emotional problems that women with endometriosis may be faced with, patients should be informed about the options of self-help.