ESHRE Guideline Management of women with Endometriosis

Introduction

Endometriosis is defined as the presence of endometrial-like tissue outside the uterus, which induces a chronic, inflammatory reaction. (Kennedy, et al., 2005). While some women with endometriosis can experience painful symptoms and/or infertility, others have no symptoms at all. The exact prevalence of endometriosis is unknown but estimates range from 2 to 10% of women of reproductive age, to 50% of infertile women (Eskenazi and Warner, 1997, Meuleman, et al., 2009).

Why were these guidelines produced?

The ESHRE guideline for the diagnosis and treatment of endometriosis (2005) has been a reference point for best clinical care in endometriosis for years (Kennedy, et al., 2005). Since this guideline needed updating a Guideline on the Management of Endometriosis was produced, using the methodology of the Manual for ESHRE Guideline Development published in 2009 (http://www.eshre.eu/Guidelines), with the aim of offering best practice advice on the care of women with endometriosis, including diagnosis and treatment for endometriosis-associated pain and infertility. Furthermore, information is provided on asymptomatic endometriosis, on primary and secondary prevention, on menopausal symptoms in women with a history of endometriosis and on endometriosis and malignancy.

What are similarities and differences with the previous guideline?

The current guideline development was initiated by members of the 2005 guideline development group, supplemented with advice from additional experts in the field. Key questions were formulated and patient organisations were asked which were the main problems they faced in the management of the disease. This resulted in key questions that as could be expected were not essentially different from the key questions that formed the base of the former guideline. Interestingly, a substantial part of the recommendations is also similar, indicating on the one hand a lack of recent, high quality studies in some areas and on the other hand similarities in retrieving the evidence from the literature by experts and the formal retrieving process of the evidence by a structured methodology of extensive literature searches.

However, the main difference between the two guidelines is the structured methodology, based on the Manual for ESHRE Guideline Development, including objective assessment of the literature and an extensive and transparent review by relevant stakeholders.

Methods

All details on the methodological approach of this guideline can be found on in the Manual for ESHRE guideline development (W.L.D.M. Nelen, et al, version 2009).

In short, questioning patients and clinicians resulted in 22 questions on the management of women with endometriosis that were structured in PICO format (Patient, Intervention, Comparison, Outcome). For each question the best available evidence for answering the key questions was searched in PUBMED/MEDLINE and the Cochrane library. The literature searches included studies written in English and published before January 1, 2012 or entered in PUBMED before January 1, 2012. Based on the collected evidence, and after constructing evidence tables and quality assessment, draft recommendations were written by the assigned expert guideline group member. Three two-day meetings were organised to discuss the evidence and recommendations and to reach consensus on the final formulation of the recommendations.

Strength of evidence and recommendations

For each recommendation, a grade (A-D) was assigned based on the strength of the supporting evidence (scored from 1++ to 4), based on the grading system of the Scottish Intercollegiate Guidelines Network (Scottish Intercollegiate Guidelines Network, 2010). In case of absence of evidence, the Guideline Development Group (GDG) could decide on writing good practice points (GPP), based on clinical expertise. (Table I)

After finalisation of the guideline draft, stakeholders were invited through the ESHRE newsletter (n=6000) or personal email (n=692) to review the guideline. Four hundred eighty-four comments from 61 reviewers were processed by the methodological expert (NV) and the chair of the GDG (GD) either by adapting the content of the guideline and/or by replying to the reviewer. The review process was summarized in the review report, published on the ESHRE website.

The guideline will be considered for update 4 years after publication, with an intermediate assessment of the need for updating 2 years after publication.

Conclusion

This guideline on the management of women with endometriosis is the first guideline written using the structured methodology as described in the Manual for ESHRE Guideline Development (2009), including an objective and systematic assessment of the literature and an extensive and transparent review by relevant stakeholders. A strong point is that the Guideline was refereed by many clinicians and patient organisations. Not less than 484 comments were received of which 255 indeed in some way changed the content of the Guideline. The first and foremost goal of the guideline is to provide guidance to clinicians who care for women with endometriosis. The objective was to improve on the diagnosis and treatment of endometriosis based on the available literature and, if not present, based on the opinion of members of the Guideline Development Group. Care was taken to involve women with endometriosis by explicitly asking patient organisations to come up with unsolved problems that were felt to be important. One of the most striking experiences in writing this guideline was the notion that so many key questions could either not be answered or that only little or low quality data were available. Indeed, many issues could not be resolved based on the available literature. Of the 83 recommendations almost half (32) could only be formulated as a Good Practice Point due to lack of robust data.

As a consequence, the lack of clear-cut evidence leads to many research questions. We propose that future research on clinical aspects of endometriosis should include at least: (1) The effectiveness of surgical excision of AFS/ASRM stage III-IV endometriosis in the treatment of infertility in comparison to direct referral to ART, (2) the diagnostic value of laparoscopy with or without histological verification, (3) the best way of secondary prevention of endometriosis, (4) the best management, with respect to both reproductive outcome and pain, of ovarian endometrioma and of deep endometriosis in women with active child wish, (5) the use of biomarkers for diagnosis and disease monitoring in endometriosis, (6) the benefit of anti-adhesion agents in surgery for endometriosis-associated pain, (7) the clinical management of endometriosis in adolescents, (8) the psychosocial impact of endometriosis and how this should be addressed: patient-centred care, couple-centred interventions, interventions to improve quality of life, (9) the definition of the prerequisites of centres of expertise in the management of endometriosis, and finally, (10) the achievement of an earlier diagnosis of the disease, by raising the awareness amongst primary care specialists, gastroenterologists and internal medicine specialists.

NVOG Group Endometriose is supporting this guideline.