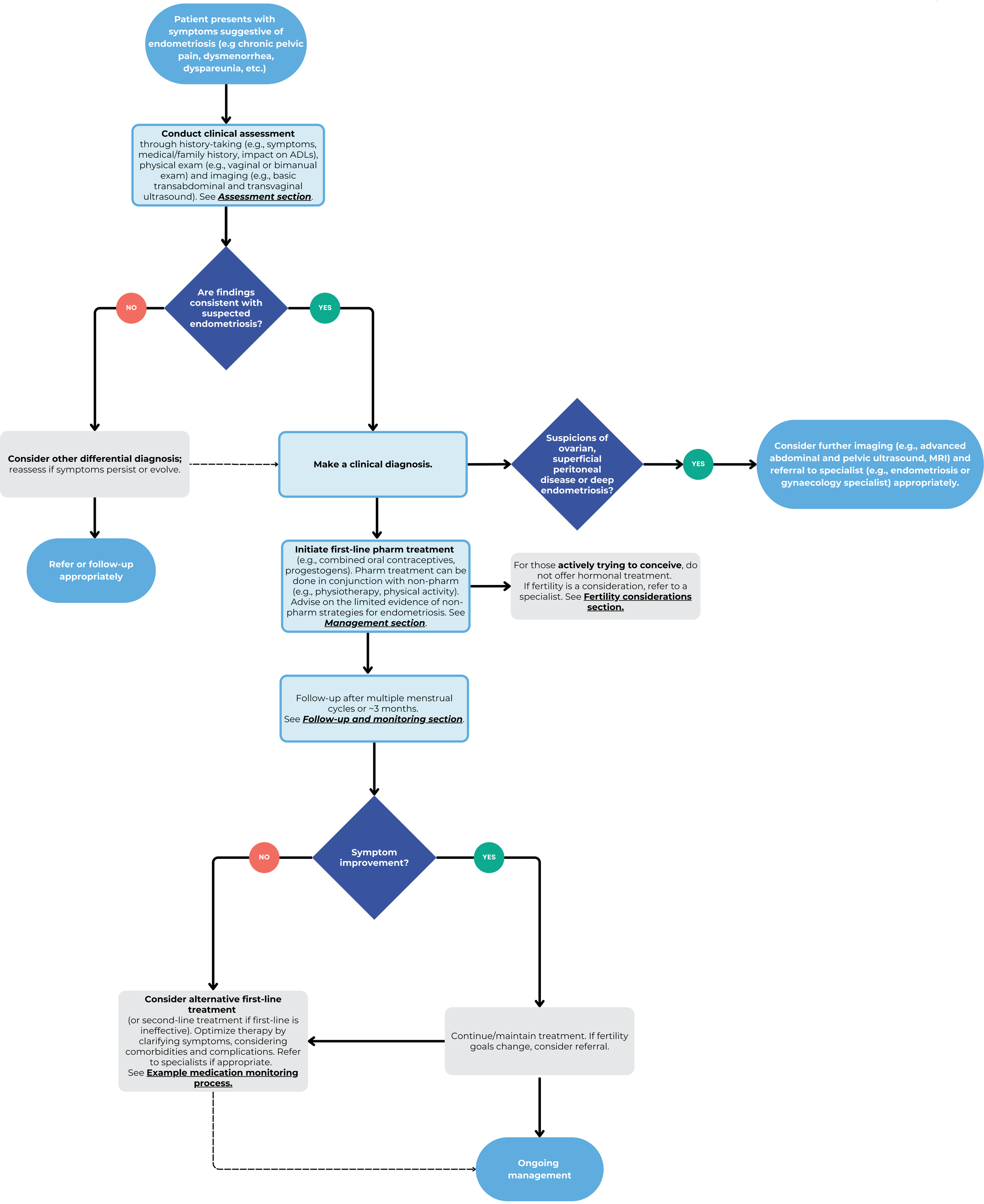
Patient presents with symptoms suggestive of endometriosis (e.g chronic pelvic pain, dysmenorrhea, dyspareunia, etc.)
Conduct clinical assessment through history-taking (e.g., symptoms, medical/family history, impact on ADLs), physical exam (e.g., vaginal or bimanual exam) and imaging (e.g., basic transabdominal and transvaginal ultrasound). See Assessment section.
Are findings consistent with suspected endometriosis?
NO
YES
Consider other differential diagnosis; reassess if symptoms persist or evolve.
Refer or follow-up appropriately
Make a clinical diagnosis.
Suspicions of ovarian, superficial peritoneal disease or deep endometriosis?
YES
Consider further imaging (e.g., advanced abdominal and pelvic ultrasound, MRI) and referral to specialist (e.g., endometriosis or gynaecology specialist) appropriately.
Initiate first-line pharm treatment (e.g., combined oral contraceptives, progestogens). Pharm treatment can be done in conjunction with non-pharm (e.g., physiotherapy, physical activity). Advise on the limited evidence of non-pharm strategies for endometriosis. See Management section.
For those actively trying to conceive, do not offer hormonal treatment. If fertility is a consideration, refer to a specialist. See Fertility considerations section.
Follow-up after multiple menstrual cycles or ~3 months. See Follow-up and monitoring section.
Symptom improvement?
NO
YES
Consider alternative first-line treatment (or second-line treatment if first-line is ineffective). Optimize therapy by clarifying symptoms, considering comorbidities and complications. Refer to specialists if appropriate. See Example medication monitoring process.
Continue/maintain treatment. If fertility goals change, consider referral.
Ongoing management