RANZCOG Australian Living Evidence Guideline: Endometriosis

RANZCOG's **Australian Living Evidence Guideline: Endometriosis** was released in May 2025, replacing the 2021 guideline. It is particularly relevant to family physicians/GPs because it explicitly shifts much of **recognition, initial investigation and first-line treatment into primary care**, rather than treating laparoscopy or specialist review as prerequisites to management.

Dr. Paul Tervit, Aug 2026

Practical summary for family physicians

Area	RANZCOG guidance	Role of the family physician
Recognition	Suspect endometriosis from the **clinical history**, including cyclical/non-cyclical pelvic pain, dysmenorrhoea and associated bowel, urinary, sexual and fertility symptoms. Family history is relevant.	**GP recognition is pivotal to reducing diagnostic delay.** Characterise pain, menstrual symptoms, dyspareunia, bowel/bladder symptoms, fertility intentions and impact on work/study/QoL. A short symptom diary can help.
Examination	Offer abdominal and, where appropriate, pelvic examination. Findings can include tenderness, reduced organ mobility or nodularity. **A normal examination does not exclude endometriosis.**	Examine where clinically appropriate while recognising that neither normal examination nor mild findings should halt investigation when the history is convincing.
Initial imaging	**Transvaginal ultrasound is the first-line investigation** for people with suggestive symptoms, even when examination is normal. Pelvic MRI is an alternative where TVUS is inappropriate; MRI is particularly useful when deep disease is suspected.	GPs can initiate imaging rather than waiting for gynaecology. Ideally use imaging providers with expertise in gynaecological/endometriosis imaging.
Normal ultrasound	A negative ultrasound **does not exclude superficial peritoneal endometriosis**.	This is an important primary-care message: don't dismiss a compelling clinical syndrome because the ultrasound is normal. Persistent symptoms despite treatment warrant further assessment/referral.
Other tests	CT is **not** recommended as the primary investigation. **CA-125 is not recommended for diagnosis** because of inadequate diagnostic performance.	Avoid unnecessary biomarkers/CT as attempts to "rule out" endometriosis.
Analgesia	A short trial of an **NSAID ± paracetamol** is reasonable unless contraindicated. Opioids, if required for acute pain, should be at the minimum effective dose for a limited period.	Initiate and review analgesia, but avoid allowing escalating analgesic therapy to substitute for disease-directed treatment and multidisciplinary pain management.
Hormonal treatment	For suspected **or diagnosed** endometriosis in someone not currently trying to conceive, offer first-line hormonal therapy: **combined hormonal contraception or a progestogen** (oral, injection, implant or IUD), using shared decision-making.	**Treatment does not need to await surgical confirmation.** This is arguably the most important change for primary care: GPs can initiate hormonal suppression while diagnostic evaluation proceeds.
Review	Review first-line treatment at approximately **3 months** for efficacy and tolerability. If ineffective/intolerable, another first-line option/formulation can be trialled for another 3 months.	GP provides longitudinal therapeutic trials and assesses response rather than automatically referring after the first treatment fails.
Fertility	Hormonal suppression should **not** be prescribed as endometriosis treatment to someone actively trying to conceive.	Establish reproductive intentions early. Fertility concerns or delay are reasons to consider specialist referral.

Area	RANZCOG guidance	Role of the family physician
When to refer	Refer when initial treatment is ineffective, intolerable or contraindicated; symptoms are severe/persistent/recurrent; examination findings persist despite treatment; imaging suggests **endometrioma or deep endometriosis**; or there are ongoing fertility concerns.	GP remains the coordinator but escalates appropriately. Deep bowel, bladder or ureteric disease should ideally go to a gynaecologist/endometriosis service with appropriate surgical expertise.
Chronic disease model	Endometriosis should be managed using a **biopsychosocial, multidisciplinary approach**, potentially involving pelvic physiotherapy, psychology, pain services, fertility services and gynaecology.	The family physician is well placed to be the **long-term coordinator of care**, including psychological wellbeing, sexual health, pelvic-floor dysfunction, chronic pain and reproductive goals.

The key message for general practice

The guideline effectively moves away from the traditional pathway of **"suspect endometriosis → refer to gynaecology → laparoscopy → then treat."**

Instead, the primary-care pathway is closer to:

Recognise clinically → examine appropriately → organise TVUS → start first-line analgesia/hormonal treatment → review response → coordinate multidisciplinary care → refer selectively.

Importantly, **laparoscopy is no longer required before a patient can be treated as having suspected endometriosis**. RANZCOG recommends considering diagnostic laparoscopy, preferably after a treatment trial, when clinically appropriate—even where ultrasound/MRI is normal—but this sits downstream of substantial primary-care management.

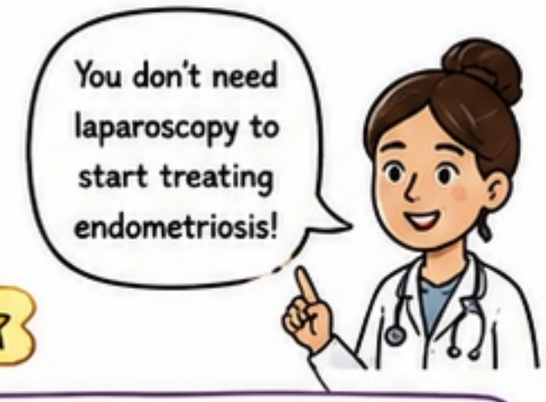
So, from a family-medicine perspective, the major conceptual change is that **endometriosis is increasingly a chronic condition that can be actively diagnosed and managed in primary care, with gynaecology providing escalation rather than necessarily being the entry point to treatment**. RANZCOG itself describes primary care as the usual entry point and notes that some patients can be diagnosed and managed there.

One caveat for NZ practice: this is currently an **Australian** living guideline; RANZCOG stated in November 2025 that work was underway to adapt it for the Aotearoa New Zealand context.

ENDOMETRIOSIS

Recognition, investigation and first-line management in primary care

Key guidance from the RANZCOG Australian Living Evidence Guideline (2025)



WHAT IS ENDOMETRIOSIS?

Chronic, estrogen-dependent condition where endometrial-like tissue is found outside the uterus.

Common symptoms:

- Dysmenorrhoea (often severe)
- Chronic pelvic pain (cyclical or non-cyclical)
- Deep dyspareunia
- Bowel symptoms (pain, bloating, diarrhoea/constipation)
- Urinary symptoms (painful bladder, frequency)
- Infertility
- Fatigue, impact on mood and QoL

Consider family history of endometriosis.

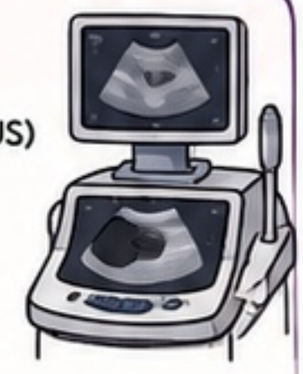
1. RECOGNISE CLINICALLY

- History is key – examination can be normal.
- Characterise pain & menstrual pattern
- Ask about bowel, urinary, sexual and fertility symptoms
- Assess impact on work/study and quality of life
- Use a symptom diary if helpful

2. EXAMINE APPROPRIATELY

- Abdominal ± pelvic exam as appropriate
- May find tenderness, reduced organ mobility or nodularity
- A normal examination does NOT exclude endometriosis.

3. INITIAL INVESTIGATIONS



First-line: Transvaginal ultrasound (TVUS) for all with suggestive symptoms.

- Even if examination is normal
- Use providers with expertise in gynaecological/endometriosis imaging

Normal TVUS does NOT exclude superficial peritoneal endometriosis.

Alternative: Pelvic MRI if TVUS is inappropriate or if deep disease is suspected.

NOT recommended:

- CT scan as primary investigation
- CA-125 blood test for diagnosis (inadequate diagnostic performance)

4. FIRST-LINE MANAGEMENT IN PRIMARY CARE

A. ANALGESIA

- Trial of NSAID ± paracetamol unless contraindicated.
- If opioids needed for acute severe pain, use minimum effective dose for the shortest time possible.

Manage pain, but don't let analgesics replace disease-directed treatment and multidisciplinary care.

B. HORMONAL TREATMENT
(for those NOT trying to conceive)

Offer first-line hormonal therapy:

- Combined hormonal contraception OR
- Progestogen (oral, injection, implant or IUD)

Treatment can start for SUSPECTED endometriosis.

You do NOT need surgical confirmation to commence treatment.

C. REVIEW & TRIALS

- Review at ~3 months for efficacy and tolerability.
- If ineffective or intolerable, trial a different first-line option/formulation for another 3 months.

D. FERTILITY

Hormonal suppression is NOT recommended for those actively trying to conceive.

Establish reproductive intentions early.

5. WHEN TO REFER

Refer to a gynaecologist / multidisciplinary endometriosis service when:

- First-line treatment is ineffective, intolerable or contraindicated
- Symptoms are severe, persistent or recurrent
- Examination findings persist despite treatment
- Imaging suggests endometrioma or deep endometriosis
- Fertility concerns or delay
- Diagnostic uncertainty or complex comorbidity
- Suspected deep disease involving bowel, bladder or ureter (refer to appropriate expertise)

Consider diagnostic laparoscopy (preferably after a treatment trial) when clinically appropriate – even if ultrasound/MRI is normal.

6. CHRONIC DISEASE – MULTIDISCIPLINARY CARE

A biopsychosocial approach improves outcomes.

Address mental health, sexual health, pelvic-floor dysfunction, chronic pain and reproductive goals.

KEY TAKE-HOME MESSAGES

- GPs are the usual entry point.
- You can diagnose, investigate and start treating in primary care.
- Normal examination or ultrasound does NOT exclude endometriosis.
- Treat early, review well, coordinate long-term care.

EARLY RECOGNITION + EVIDENCE-BASED MANAGEMENT + MULTIDISCIPLINARY CARE = BETTER OUTCOMES

RANZCOG Australian Living Evidence Guideline: Endometriosis (2025) | RACGP-endorsed