GEM PATIENT EDUCATION CENTER

Understanding Endometriosis Surgery

Choosing the right operation, surgeon, documentation and long-term plan

Version 1.2 · September 2026

GEM POSITION: WHY LAPAROSCOPY STILL MATTERS

GEM recognizes the major advances made in expert clinical assessment, transvaginal ultrasound and MRI. These methods can identify many ovarian endometriomas and forms of deep endometriosis, but **negative imaging does not exclude endometriosis, particularly superficial peritoneal disease.** Hormonal treatment can reduce symptoms and suppress hormonal stimulation, but symptom improvement should not be interpreted as proof that established disease has disappeared. Appropriate follow-up remains important.

Diagnosis and care do not require surgery for every patient. When laparoscopy is appropriate, GEM favors planned treatment as well as assessment: inspect safely accessible surfaces, map findings, obtain pathology when appropriate, and treat visible disease within consent and safety limits. Unexpected anatomy, organ involvement or limits of consent may require a staged operation. No surgeon can guarantee that all lesions will be identified or removed.

1. When do I actually need surgery?



Not every patient with endometriosis needs surgery. The decision should consider symptoms, imaging, disease location, organ involvement, fertility goals, response or tolerance to medical treatment, and patient preference. When significant disease is suspected, GEM supports early expert surgical evaluation rather than allowing symptom suppression to become loss of appropriate follow-up.

2. How should I choose my surgeon?



Ask specifically about the surgeon's endometriosis volume and experience with endometrioma, deep disease and multi-organ involvement. Complex disease may require an endometriosis center and a multidisciplinary team.

3. What is a MIGS/endometriosis specialist?



MIGS means Minimally Invasive Gynecologic Surgery. Advanced minimally invasive training is valuable, but MIGS training alone does not automatically establish expertise in every form of endometriosis. Ask about specific endometriosis experience.

4. What should happen before surgery?



Review symptoms, examination, imaging, previous surgery and fertility goals before operating. Discuss benefits, alternatives, complications and limits of consent, including any possibility of staged treatment. Suspected bowel, bladder or ureteral disease may require other specialists.

5. Operative report, mapping and pathology



The report should describe disease location and extent, adhesions, distorted anatomy, organs involved, what was resected, what remained and why, specimens sent to pathology, and complications. Disease mapping and pathology strengthen continuity of care.

6. Photography and video documentation



GEM supports comprehensive photographic documentation and, with informed consent and appropriate privacy safeguards, preservation of the **complete unedited operative video** whenever feasible.

7. Why might disease or symptoms recur?



Endometriosis is chronic. Residual or microscopic disease may contribute to recurrence, but recurrence can also occur after apparently comprehensive surgery. Persistent symptoms may also have other causes. Reassessment should precede automatic repeat surgery.

8. When should I seek a second opinion?



Consider a second opinion before major or repeat surgery, when anatomy is complex, when bowel/bladder/ureter involvement is suspected, when fertility consequences are important, or when the proposed plan does not clearly explain what will be done.

PLAN CAREFULLY BEFORE EVERY OPERATION
SET REALISTIC GOALS. TREAT SAFELY WITH CONSENT. DOCUMENT FINDINGS.



Surgery is one option. Choice of procedure and expected benefit vary with the disease and the patient. GEM's preference for comprehensive assessment and complete unedited video is an advocacy position.

Evidence & references

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Planning and realistic goals

Surgery is not needed for every patient. Discuss benefits, alternatives, complications, fertility and limits of consent. Complexity may require other specialties or staged treatment. Recurrence does not alone prove inadequate surgery.

Documentation preference

GEM advocates detailed mapping, pathology when appropriate and complete unedited video when feasible and consented. No universal legal obligation or guarantee of complete lesion detection is asserted.

Full references

- **[S01]** ESHRE. Endometriosis guideline. 2022. Freely available
- **[S12]** Working group of ESGE, ESHRE, and WES, et al. Recommendations for the surgical treatment of endometriosis. Part 2: deep endometriosis. Hum Reprod Open. 2020;2020(1):hoaa002. doi:10.1093/hropen/hoaa002. PMID 32064361. Freely available
- **[S06]** Zakhari A, Delpero E, McKeown S, et al. Endometriosis recurrence following post-operative hormonal suppression: a systematic review and meta-analysis. Hum Reprod Update. 2021;27(1):96-107. doi:10.1093/humupd/dmaa033. PMID 33020832. Freely available

No listed institution endorses GEM.

Medical information

Do not delay care; seek emergency help for a suspected emergency.

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