Endometriosis and Fertility: What's New in 2026?

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What has changed?

The 2026 NICE fertility guideline recommends a choice of IVF or up to four cycles of stimulated IUI after 2 years of unsuccessful conception in people with mild endometriosis.[1]

Management should be individualised according to five factors (**Figure 1**)[2,3].

Factors shaping the fertility pathway

1. **AGE**
   Oocyte quality • Fertility decline
2. **OVARIAN RESERVE**
   AMH • AFC • Oocyte yield
3. **TIME TRYING TO CONCEIVE**
   Longer duration • Lower conception rates
4. **ENDOMETRIOSIS**
   Altered pelvic anatomy • Impaired oocyte quality • Reduced fertility
5. **MALE FACTOR**
   Reduced sperm count • Motility • Morphology

Does surgery before IVF improve outcomes?

A 2026 systematic review and meta-analysis of **22 studies and 3,590 women** compared surgery followed by IVF/ICSI with proceeding directly to IVF/ICSI.

For women with ovarian endometriomas or deep infiltrating endometriosis, surgery before IVF/ICSI did **not significantly improve live birth or clinical pregnancy rates**.

The systematic review focused on ovarian endometriomas and deep infiltrating endometriosis, and further evidence is needed to determine whether its findings apply to minimal or mild endometriosis.



Endometriosis Fertility Pathway

WAIT
Up to 2 years in total including time already spent trying to conceive before assessment.[1]

OR

OPERATE
Consider surgery when fertility is a priority.[1]

IUI
Up to 4 cycles of stimulated IUI using gonadotrophins before IVF when appropriate.[1]

IVF
Offer IVF treatment in accordance with NICE IVF access criteria.[1]

Where does IUI fit?

NICE now recommends considering up to **4 cycles of stimulated IUI** using gonadotrophins before IVF when appropriate.[1]

The guideline committee noted that stimulated IUI may particularly be considered in patients:[2]

- without deep endometriosis
- with patent fallopian tubes
- who prefer a less invasive approach than IVF

Fertility preservation: who may benefit?

Recent evidence highlights **fertility preservation** as an important consideration, particularly in women at **risk of ovarian reserve loss**.

Factors influencing the decision include:

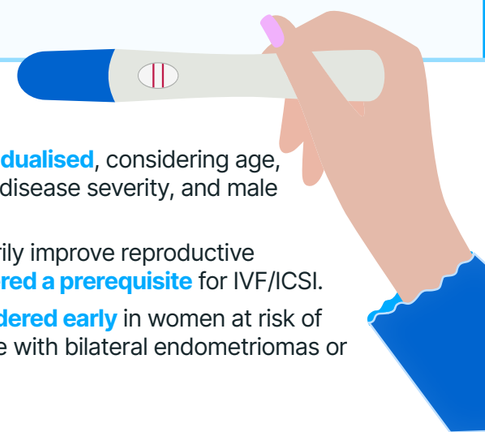
- **Age and ovarian reserve**
- **Bilateral endometriomas**
- **Previous or recurrent ovarian surgery**
- **Future reproductive plans**

Oocyte vitrification is the best-established fertility-preservation approach, although some women with reduced ovarian reserve may require more than one stimulation cycle to obtain an adequate number of oocytes.[3]



What does the evidence show?

IVF is the most cost-effective first-line fertility treatment compared with IUI, ovarian stimulation alone, or other assessed strategies.[2]



Key messages

- Fertility management should be **individualised**, considering age, ovarian reserve, duration of infertility, disease severity, and male factors.
- Surgery before IVF does not necessarily improve reproductive outcomes and **should not be considered a prerequisite** for IVF/ICSI.
- Fertility preservation should be **considered early** in women at risk of ovarian reserve loss, particularly those with bilateral endometriomas or recurrent ovarian surgery.

References:

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Abbreviations:

AFC: antral follicle count; AMH: anti-Müllerian hormone; ICSI: intracytoplasmic sperm injection; IUI: intrauterine insemination; NICE: National Institute for Health and Care Excellence.