

Endometriosis: GPQ

A. Organisation details

1a. Name of the GP surgery:

1b. Name of the person completing this questionnaire:

2a. Role of the person completing this questionnaire

GP

Nurse

Other (Please specify):

Please specify any additional options here...

2b. Is this patient currently registered with this practice?

Yes

No

3. STRUCTURED COMMENTARY

B. Initial presentation to the GP

1a. How did this patient first present to this GP with endometriosis? *

- At appointment at GP surgery
- Correspondence/ discharge letter from secondary care following laparoscopic diagnosis
- Correspondence from another provider (Please specify):

Please specify any additional options here...

1b. Date first presented to this GP surgery (dd/mm/yyyy):

Unknown

2a. Was this presentation prior to a formal diagnosis of endometriosis or a recurrence of disease?

- Prior to formal diagnosis Recurrence Unknown

2b. What symptoms relating to endometriosis did the patient have at the time of this presentation?

- Acyclical pelvic pain
- Bowel symptoms
- Painful periods (dysmenorrhea)
- Extra-pelvic pain
- Pain on defecation (dyschezia)
- Painful urination (dysuria) Multi-site pain
- Irregular bleeding
- Heavy menstrual bleeding
- Constipation
- Painful intercourse
- Bladder symptoms
- Absence of/Missed menstruation
- Subfertility
- Not applicable - patient did not present to this GP surgery prior to diagnosis
- Unknown
- None

Please specify any additional options here...

3. How long did the patient have any of the above listed symptoms of endometriosis, before initially seeking clinical help? (dd/mm/yyyy).

Not Applicable Unknown

Investigations completed by the General Practitioner (if presented to the GP with endometriosis symptoms prior to discharge)

4a. Was a pelvic examination performed on the patient in Primary Care?

- Yes No Unknown

4b. If answered "Yes" to [4a] then:

Did the findings of the pelvic examination alter the management of the patient?

- Yes No Unknown

**4c. If answered "Yes" to [4b] then:
If YES, please give further details:**

**5. If answered "Yes" to [4a] then:
Did you feel confident doing a pelvic examination?**

Yes No Unknown

6a. Prior to their surgical diagnosis of endometriosis, was the patient referred by this GP surgery for any imaging relating to endometriosis?

Yes No Unknown

**6b. If answered "Yes" to [6a] then:
If YES, which of the following imaging was the patient referred for?**

Trans-abdominal ultrasound Trans-vaginal ultrasound Trans-rectal ultrasound
 MRI Unknown

Please specify any additional options here...

Hormonal treatments:

7a. Were any of the following hormonal treatments prescribed to this patient by the GP for the management of endometriosis related symptoms, prior to formal diagnosis? (Answers may be multiple):

Combined oral contraceptive pill Progesterone only pill
 Contraceptive patch Mirena IUS (intrauterine system)
 Depo-Provera injection Nexplanon
 Oestrogen patch Depo-Provera injection
 No hormonal treatments were prescribed

Please specify any additional options here...

**7b. If answered "Combined oral contraceptive pill", "Progesterone only pill", "Contraceptive patch", "Mirena IUS (intrauterine system)", "Depo-Provera injection", "Nexplanon", "Oestrogen patch" or "Depo-Provera injection" to [7a] then:
If hormonal treatment(s) were prescribed by the GP, for how long prior to referral to gynaecology?**

weeks

Not Applicable Unknown

Other treatments:

8. Please list all other medications prescribed for symptoms relating to endometriosis (including any pain medication), the date they were first prescribed, and any side effects.

C. Referral to Gynaecology

1a. How was this patient first referred to a gynaecology service for treatment of their symptoms relating to endometriosis?

- GP Practice Emergency Department Unknown
 Not applicable

Please specify any additional options here...

1b. Was this first referral to a specialist (e.g., BSGE) endometriosis centre?

- Yes No Unknown

2a. Did you experience any barriers in referring this patient to the gynaecological service?

- Yes No Unknown

2b. If answered "Yes" to [2a] then:

If YES, please explain what barriers were experienced:

3. If answered "GP Practice" to [1a] then:

Was a diagnosis of suspected endometriosis or probable endometriosis made by this GP prior to referral?

- Yes No Unknown

4a. Prior to diagnosis with endometriosis, did the patient have any other symptoms that were not gynaecological?

- Yes No Unknown

4b. If answered "Yes" to [4a] then:

If YES, please state what:

4c. If answered "Yes" to [4a] then:

If YES, on reviewing the history and subsequent outpatient clinic appointments and investigations, were these symptoms due to endometriosis?

- Yes No Unknown

4d. If answered "Yes" to [4a] then:

If YES, at any time, was this patient referred to a non-gynaecological specialty pathway for management of those symptoms?

- Yes No Unknown

4e. If answered "Yes" to [4a] then:

If YES, which specialty? (Please check all that apply).

- Colorectal Gastroenterology Urology Hepatology
 Musculoskeletal Dermatology Rheumatology

Please specify any additional options here...

D. Referral to supporting services.

1. Was this patient assessed by/ referred to any of the following supporting services by the GP? (Please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Clinical psychologist | <input type="checkbox"/> Colorectal surgery |
| <input type="checkbox"/> Other surgery | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Physiotherapy specialist in pelvic pain |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Other physiotherapy |
| <input type="checkbox"/> Fertility services | <input type="checkbox"/> Endometriosis clinic |
| <input type="checkbox"/> Pain clinic | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Unknown | |

Please specify any additional options here...

2a. Was this patient referred to any other supporting services?

- Yes No Unknown

**2b. If answered "Yes" to [2a] then:
If YES, please provide details:**

E. Communication

1a. Did this GP surgery receive correspondence regarding the patient's diagnosis and/or laparoscopic surgery from the secondary care (SC)?

- Yes No Unknown

1b. If answered "Yes" to [1a] then:

If YES to Q1, did this include (Please check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Follow-up |
| <input type="checkbox"/> Plan Medications | <input type="checkbox"/> Operation findings |
| <input type="checkbox"/> Stage of patient's endometriosis | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Contact with an endometriosis specialist nurse | <input type="checkbox"/> Imaging results |
| <input type="checkbox"/> Unknown | |

Please specify any additional options here...

2a. Is there anything else you felt missing from the correspondence received?

- Yes No Unknown

2b. If answered "Yes" to [2a] then:

If YES, please provide details:

F. Follow-up

1a. Following diagnosis of endometriosis, was follow-up with primary care recommended (e.g., on the discharge summary following laparoscopy)?

- Yes No Unknown

**1b. If answered "Yes" to [1a] then:
If YES, did this follow-up happen?**

- Yes No Unknown

**1c. If answered "Yes" to [1a] then:
If YES, date of follow-up:**

- Not Applicable Unknown

2. Was the patient offered Patient Initiated Follow-Up (PIFU)?

- Yes No Unknown

3. Was the patient provided with information about endometriosis and what to do if symptoms got worse/re-occurred?

- Yes No Unknown

4a. Was any form of patient reported outcome measures collected at the follow up appointment?

- Yes No Unknown

**4b. If answered "Yes" to [4a] then:
If YES, please provide further details:**

G. Ongoing symptoms

1a. Following diagnosis of endometriosis, did the patient re-attend at this GP practice with persistent symptoms/ recurrence of the condition?

- Yes No Unknown

1b. If answered "Yes" to [1a] then:

If YES, were they re-referred to a gynaecology service?

- Yes No Unknown

1c. If answered "Yes" to [1b] then:

If YES, date of re-referral:

- Not Applicable Unknown

1d. If answered "Yes" to [1b] then:

If YES, what was the patient's pathway for re-referral to a gynaecology service? (Please check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Booking a GP appointment, referral to gynaecology | <input type="checkbox"/> Fast-track pathway |
| <input type="checkbox"/> Direct contact to specialist centre | <input type="checkbox"/> Self-referral to independent hospitals |
| <input type="checkbox"/> Pathway via community gynaecology | <input type="checkbox"/> Direct contact with gynaecology (SC) |
| <input type="checkbox"/> Contact endometriosis nurse | |
| <input type="checkbox"/> Unknown | |

Please specify any additional options here...

2. Please use the free text box below, to comment on what you think could be done to improve the patient's pathway for endometriosis treatment: