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<https://reachmd.com/programs/cme/addressing-endometriosis-your-patients-combining-individualized-treatment-options-patient-clinician-/10470/>

Released: 10/31/2018

Valid until: 10/31/2019

Time needed to complete: 15 minutes

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Addressing Endometriosis with Your Patients: Combining Individualized Treatment Options with Patient-Clinician Dialogue

Announcer:

This is CME on ReachMD! The following activity, titled *Addressing Endometriosis with Your Patients: Combining Individualized Treatment Options with Patient-Clinician Dialogue* is provided in partnership with Omnia Education and supported by an educational grant from AbbVie.

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The faculty for this activity is Dr. Stephen Cohen.

Dr. Cohen:

Hello, everybody. I'm Dr. Stephen Cohen presenting today's lecture, a small talk. I'm faculty at SUNY

Upstate Medical School and also at Albany Medical Center. My residency training was in OB/GYN at the University of Michigan.

Almost anyone providing women's health in the United States and the world knows about endometriosis, a common disease which often times is frustrating to both patients and providers in that we have limited treatments for this disease, and it plays a big role in patients' lives, a disease that affects women and creates havoc often times in their life, their personal relationships and their physical condition. We are lucky in this day and age that we now have some treatments, and we need to discuss with the patients what treatment options that they would want to use.

So, with that background as we go through, let me talk to you a little bit about endometriosis itself. It's a chronic disease of reproductive-age women. It can start as young as 14 or 15 years old and goes to menopause. It's stimulated by estrogen. We've known that for a long time. The prevalence rate is approximately 10%. Seventy to 80% of patients who present with pelvic pain once we've excluded other causes—bladder and bowel, for example—will be found to have endometriosis on laparoscopy. But often, and to nobody's fault, the diagnosis is delayed. Physicians may look at other causes for pelvic pain and may not absolutely come up with the diagnosis, and a number of women will tell us that they have suffered for a few years or many years without adequate treatment until the diagnosis is finally made. And, unfortunately, there's a high recurrence rate following either medical or surgical therapy, so that once you're treated doesn't mean that this is gone. In fact, it often times will come back, and in most cases, at least 40 to 50% of the time it recurs and more treatment options are necessary—again, either surgical or medical.

Often times, patients will self-treat with nonsteroidals, or so-called Motrin-type drugs and Celebrex and those drugs. They often self-treat themselves even before they show up in your office complaining of pain, ... And we now try to treat pharmacologically and not surgically, certainly initially for most of our patients. It's different than it was 20 to 30 years ago where almost all these women went to the operating room. So we use drugs like combined oral contraceptives. And although there have been no good studies on those drugs because they have been used for so long, they seem to work in many cases, especially those women whose pain is painful periods.

Progesterones have been used for years and decades, and those can be given either by injection or by mouth, and sometimes by IUD, and many studies have shown that they are effective in the treatment of endometriosis. But again, 10 to 20% of women don't get a relief from these drugs, and when they do, often times over their lifetime the pain comes back.

The medication that seems to be most effective against endometriosis after the patients have failed the common treatments, such as oral contraceptives or progesterone, is GnRH agonists. Those drugs in

the United States are under the trade name of Lupron Depot and Synarel. Those drugs shut down the pituitary so that the estrogen levels drop, and when estrogen drops, endometriosis and the symptoms of endometriosis improve usually dramatically. Unfortunately, these drugs have side effects, and the most common side effect is bone loss. The drug is effective but limited. Maximum length of time in general on label would be 1 year.

The newest drug out now, which was just approved about 3 months ago so it's just new to the market, is the GnRH antagonist. What this drug does is it sits on the receptors of the pituitary so that it blocks the pituitary from secreting FSH and LH, which stimulate the ovaries to produce estrogen, a very simple concept. It just blocks the secretion of the substances that will go on to stimulate estrogen production. ... Because endometriosis is stimulated by estrogen, blocking estrogen and lowering estrogen has significant effect at reducing pain. This drug, however, like other drugs that drop estrogen also affects bone loss and increases bone loss, and women develop the symptoms of menopause—even though it's reversible in this situation—and those symptoms, those side effects, those annoying side effects are hot flashes, night sweats and other less common side effects.

Surgery has been done in patients who don't get better on pharmacological treatment or in patients who recur, and also in patients who are being treated for infertility, which is another symptom that endometriosis causes, but we're focusing today on the pain area of endometriosis.

It's always important to talk to the patient, and more so with endometriosis than maybe any other women's disease, because patients react differently. Their pain is different. What they are asking you to help them with is different. So we need to listen to the patient. We always say, "Listen to the patient; she's trying to tell you something." And we need to develop a relationship of trust and teamwork, so we want to be a team and a partner, not necessarily treater and the patient's coming in as just accepting what you tell her. We want to use decision aids when appropriate, and that means we want to show them charts and structures. Some patients don't understand. When we're talking about risk percentage to them, "1% of patients may develop this type of thing" may not mean much to the patient, but if you have a chart that maybe has 100 patients on it and you color 1 in, they get a better idea what you're talking about.

We want to talk about which symptoms is she having and what is the severity of those symptoms. The potential for recurrence, we want to explain to her this is a chronic disease and not a disease like a sore throat where you improve with a short course of antibiotics. We want to know about her fertility, whether it's immediate or whether it's in the future or whether she doesn't desire fertility at all. And we want to explain to her and talk to her about cost and side effects and how these drugs are given, because each patient will have a different view of what's going to work for her and her lifestyle. We

want to describe the risks, and we want to be transparent, but we want to ask the patient what they fear and what they expect to get from the drugs. For some patients, benefits are much more important than risk. They want to not have that pain. Others fear the risk more than the benefits, and so you need to balance the patient. And often times, patients have an idea of what the risks are which is not really accurate. They have been told either by the web or by their best friend what the risks are, and sometimes you have to sit there and review the science with them and sort of alleviate some of those risks so that you can work as a team.

Endometriosis needs patient-centered care. Patients need to be involved in the decision-making, maybe more so than any other disease that we treat because it presents so variably, and that means talking to the patient and finding out, again, what she expects from the care. We still need to tell the patient what's available to her and appropriate for her. For example, a patient with osteoporosis, low bone density, may not be appropriate for some of these estrogen-lowering drugs. So we're going to tell her what's available and what she should consider and maybe even a preference order, but then we have to bring her in to make the final decision on those plans.

So let's just take a couple of examples here, and let's go on to a couple cases and look how we would work with that.

So our first case is Kiri. She's a 44-year-old patient. She's had a couple of children, so infertility was not her problem. She's taken Motrin, one of the nonsteroidals for pain, and with the clinical diagnosis of endometriosis, she actually has had a laparoscopy back in 2009, and the diagnosis has been made. And her only other surgery is a caesarean section. Her physical exam, like many, is normal, but she complains of severe painful periods. Her pain she rates as a 7/10. She doesn't have any chronic pain, and she has no pain with intercourse, but she's missing a couple days a week [sic] and it's starting to affect her job and her home life. She has no desire to become pregnant again.

Her physical exam is normal, which is often times found in patients with early-stage endometriosis, She misses work 1 or 2 days a month. She has no desire to have another child. She's fine with the 2 that she has. And she comes asking what her options are, how she can help with her menstrual pain.

So we need to know a little bit more. We need to know, for example, what was done at the time of laparoscopy and what did they find. Was she improved after the laparoscopy maybe removed some of her endometriosis, or was it just diagnostic and they just looked? Has she taken other meds besides the Motrin, meds that worked and meds that didn't work? For example, has she been on an oral contraceptive? Often times, that works for painful periods. And if she has, has she been on it continuously so that she has no periods, or has she been on it cyclically? What past medical treatments are very important to know because there's no sense in reinventing the wheel. Often times, it's just that

they have run out of drug or gone off it. We always do a pelvic exam. It's important to do that even though it's often times normal, but sometimes it shows abnormalities like nodularity or immobility of the pelvic organs, meaning scarring or adhesions. And we want to get an ultrasound; although, imaging is not usually very helpful in early-stage endometriosis.

We can then talk to her about the treatment options that she has, and Kiri's treatment options are going to be any of the pharmaceutical drugs that we've talked about earlier in this talk, including the newer drugs that are being used, not-so-new GnRH agonists, but the very-new GnRH antagonists can also be used.

So, once we present this to Kiri, we sit back and we say, "What do you think?" "What would you like to do?" "How can we help you?" "You need treatment, obviously, but we'd like to know what your opinion is." And then explore with Kiri again what she came in asking for, what her priority is and what medication she would feel comfortable taking. Once we narrow that down, we would review risks with her—bone loss, for example, if she picks a drug that may cause bone loss; clotting, for example, if she picks an oral contraceptive.

So, let's move on to case number 2, which is Aimee. Aimee is 23 years old. She's had 2 pregnancies and 1 child. She's been taking Motrin and continuous oral contraceptives, throwing out the placebo to try to eliminate her menstrual periods. Her only medical problem that she reports to us is depression, which we would probably expect in patients who have the pain that Aimee has. She did have a laparoscopy in 2015, and endometriosis was noted. She tells us that it was stage II endometriosis. And when you do your physical exam, you find out that she does have signs of endometriosis. Her uterosacral ligaments behind the uterus are thickened and hard, and the uterus doesn't move like it should move. And when you ask her what symptoms she's having, she tells you basically all of them. She's having severe painful periods, she has pain between her periods, and she has painful intercourse—8 out of 10 she tells you—and those are the problems that she's having. She does also miss 2 days of work per month, but that's not her most important problem. Her most important problem is a sexual relationship with her partner. And she's had to limit that, and she tells us, as most do, that, "He's a wonderful man and he tries to help me," but eventually things are starting to break up a little bit, and she's worried that the relationship may not last.

So, again, we have to ask the same type of questions we asked on the first case. When did the pain begin? What type of pain we know. What has been used in the past? We can guess that she's probably used other things with the severe pain. And what worked and what didn't? Does she want to have another child? She only has 1, and she tells you, yes, she does.

We do an exam—which we've done and I've reported above—and we get an ultrasound to see if we

can see anything such as endometriomas of the ovary or other problems. Often times for painful intercourse, surgery becomes a route, and especially if we know that when she had her laparoscopy they removed some endometriosis and it worked. If she says she went to an expert laparoscopist, he or she removed endometriosis and she had no pain relief, then revisiting surgery is probably not in her best interest. And we talk about the available drugs that are available. Again, Lupron agonists work well for painful intercourse, and the FDA has approved the new drug Elagolix, the GnRH antagonist, specifically for painful intercourse.

So, once again we discuss these options. We find out what might work for her, we find out what her interests are, we bring her into the decision-making, we tell her about the risks and benefits of the drug, and then we help her make her decision. So, endometriosis is not just, “Here is a prescription, go home, you’ll be better.” Endometriosis is really... You need to be involved with the patient, and usually her family, and you need to find out what their interests are and what needs to be done. And if we do that, we do very well.

Unfortunately, as life would have it in the medical world in this day and age, our visit time gets shorter and shorter; it makes it more and more difficult. But in the end you may need to bring these patients back and spend a little extra time with them so that when they walk out, they don’t say, “He didn’t even...” or, “She didn’t even listen to me. That’s not what I wanted. That’s not my problem.” You want her to walk out and say, “Boy, he—” or “—she really listened. This is the first person I’ve talked to in a long time that heard what I said and is going to do what I want.”

This is Dr. Stephen Cohen. Thank you for listening. I hope that we added a little bit to your treatment of endometriosis. And good day.

Announcer:

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