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Addressing the Multidimensional Disparities Associated with the Diagnosis and Management of Uterine Fibroids and Endometriosis

Announcer:
Welcome to CME on ReachMD. This activity, entitled “Factors That Delay Diagnosis of Uterine Fibroids and Endometriosis: The Demographic Divide” is provided by Omnia Education.

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Dr. Shulman:
Women of color are impacted disproportionately by the twin conditions of endometriosis and uterine fibroids. The disease and treatment burden in Black women is substantially greater than other racial groups, with higher rates of complications and poorer clinical outcomes.

This is CME on ReachMD, and I'm Dr. Lee Shulman.

This initiative is developed in collaboration with the Reproductive Endocrinology, Infertility, and Gynecology, or REIG, Branch of the Division of Intramural Research of the National Institute of Child Health and Human Development of the NIH. This is the primary federal entity charged with researching endometriosis, fibroids, infertility, and endocrine aspects of disease.

I'm joined today by my esteemed colleague, Dr. Linda Bradley. Dr. Bradley is professor of obstetrics, gynecology, and reproductive biology at the Cleveland Clinic Lerner College of Medicine. She is the director of the Center for Menstrual Disorders, Fibroids, and Hysteroscopic Services, and she also serves as vice chair for Diversity and Inclusion for the Cleveland Clinic Women's Health Institute. Dr. Bradley is a past president of the American Association of Gynecologic Laparoscopists, and is currently its medical director. And it's a real pleasure to welcome her today to this program.

Welcome, Linda.

Dr. Bradley:
Thanks so much, Lee. It's so wonderful to speak with you about something we're both passionate about: fibroids and endometriosis.

Dr. Shulman:
Linda, let's get started. I know you've always in the past told your audiences about the Kleenex story. Can you go over that with us?

Dr. Bradley:
I keep a box of Kleenex in my office because so often patients come with many questions, fears, concerns about readiness for hysterectomy. And the most recent story that I had was a patient coming in. I was probably her second or third opinion. She desperately wanted to be a mom. And after we unfolded her story and spoke with her, she literally started to cry. And the reason being is that she had been told that she needed a hysterectomy. And she actually asked me, “How much time” or “How long do I have?” And I said, “How long do you have for what?” And she was feeling that she would die from the fibroids, from the symptoms, that this was an urgent problem to take care of. And she just wept because she said no one had really listened to her, allowed her to speak and tell her story. And the fact that she felt unheard just led her to cry. And this happens quite often in women because they finally feel heard. And I often look over at them and say, “What are the tears for? Did I unbundle something? Did I open Pandora's box?” And many of them say the

tears are also for gratitude and for thanks for listening and letting them tell their story.

Dr. Shulman:
Why is it so important for patients and providers to understand fibroids and endometriosis?

Dr. Bradley:
Women need to know that it's common. We need to sort of debunk these words or get rid of the lexicon of tumors because they feel fearful for having fibroids. And living with pain and discomfort. So we need to let women know that it's not normal to suffer. It's not normal to miss work activities. It's not normal not to be able to want to have sex because of the fear of embarrassment of bleeding or pain. And many women have had the stories being told by their mother and grandmother of similar problems, because there may be a little bit of a genetic component to some of these disease states. But they may have grown up thinking that all women suffer. All women miss work. They've heard the stories and women have normalized pain and discomfort, and they come to believe that this is their journey. And I would say to any woman and to any patient that hears this story, and to us as doctors, that your patients should not be missing out on life, their jobs, their activities. Their quality of life can be better improved by many things that we can offer these days.

Dr. Shulman:
Linda, can you give us a bit of an overview of the demographic issues we're dealing with?

Dr. Bradley:
Women that have a uterus are prone to having fibroids, and anywhere from 60%, 70%, and some would say 80% of women would have fibroids. So the highest prevalence are among women from the African diaspora. Caucasian women have less. But it's also a disease that's seen in Hispanic women and also Asian women. So I call it an equal opportunity disease.

The biggest thing that we see among women from the African diaspora is that the disease state occurs earlier. Often fibroids are bigger, and the burden of disease, meaning quality of life and issues, are often worse. And sadly, for Black women, they often have a hysterectomy rate of 3 times that of Caucasian women.

Dr. Shulman:
And what about endometriosis?

Dr. Bradley:
The same thing with endometriosis. The prevalence of course is different, maybe 10% to 15%. And some other disease state complaints, pain, discomfort, dyspareunia, menstrual cramps, many of these symptoms can overlap. The physical exam findings and imaging findings may be different. So we as physicians need to hear the patients, listen to their stories, and then begin to determine what they actually have by a physical exam and then imaging.

Dr. Shulman:
Linda, now that we understand the importance of recognizing fibroids and endometriosis, what are the most common symptoms of these twin conditions?

Dr. Bradley:
The symptoms of fibroids and symptoms of endometriosis can overlap. However, we will see among women with fibroids that the presentation is often heavy menstrual bleeding, but it can also be bleeding every day. It could be gushing, clots, subsequent anemia. The pattern of bleeding can be quite variable. Sometimes we get called to the emergency room for urinary retention. Urgency, constipation, tenesmus, straining, hemorrhoids. But there's the bulk symptoms, the cosmetic symptoms, the potential infertility symptoms. So we have to look at everything. It's not just a single disease complaint.

For endometriosis, on the other hand, we can see more pain, cramping, pain with intercourse, sometimes constipation, sometimes hematuria, depending on if there's bladder invasion, blood in the stools. Rarely, we might see endometriosis in different organ systems. It's not common, but we might see hemoptysis. We might see blood coming from the belly button. On physical exam, we might feel a rock-hard pelvis. We may see endometriosis with nodules of sort of purple/black discoloration in the vagina. The history, again, that physical exam really will help us to determine what that patient may have.

Dr. Shulman:
There is not a day that goes by in my gynecology practice where I am not dealing with a woman who's been to several clinicians, invariably encouraged to have surgery, and in many of the cases, there's no need for such surgery.

Linda, how do you handle medical mistrust, misinformation, and individual patient preferences for surgical versus medical treatment?

Dr. Bradley:

The Journal of Internal Medicine years ago looked at a group of docs from the Mayo Clinic and just were like flies on a wall. And they find out that we interrupt our patients too soon. They come in the room, they can't even speak, and we're interrupting them. So I think much of the mistrust has been because patients have not been listened to.

So I think the first is to do no harm, but to take a great history, and then to provide information. And it's really important to be honest about what your hospital offers for services, whether it's surgical, what may it be on the hospital formulary for medications, what skill set you have as a physician and the types of newer instrumentation or collaborative services with other – like radiology. All doctors are not the same, and we don't expect them to be the same. We expect them, however, to learn and have a big knowledge base about what there is as options. Everybody can't do everything. But we do think patients deserve the knowledge base from physicians who stay mindful and learned about new developments in medicine and surgical treatments and others. So I think the mistrust comes because patients – we don't get to know them, and they don't get to know us.

Dr. Shulman:
it's a rather trite metaphor, but something I learned actually well before medical school, is you have 2 ears and 1 mouth, and that should be at least the minimal ratio for listening and speaking.

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Lee Shulman, and here with me today is Dr. Linda Bradley.

So, Linda, let's turn to those disparities in patient care. How does this important issue impact the management of fibroids and endometriosis?

Dr. Bradley:
Well, I think that disparities can be multidimensional. One can be lack of access. Depending on where you live in the South, they do not have, in many of the states, Medicaid access. I think we have to be champions for our patients and try to always start with the medications.

I've had women literally cry when I go and examine them. You know, the sense of touch, use of hands in medicine is a gift that we have. It's not just the ultrasound, but to examine a woman's belly, to do a pelvic exam. Again, I do a lot of surgery, but I also do a lot of medical treatment.

I examined a patient who had been seen an ER, heavy bleeding, IV iron, quite anemic, hemoglobin of 4, and I look back at the note and her chief complaint is heavy bleeding. No one did a pelvic exam. What did she have? A huge 6- or 7-, 8-centimeter leiomyoma that was prolapsing. I mean, that is such easy treatment for that patient.

Do we listen? Do we look? Do we touch, meaning physical examination? Do we offer the same type of radiographic imaging? You know, there's ultrasound, there's saline infusion, sonogram, there's sometimes a need for an MRI. Dedicated MRI, we have at the Cleveland Clinic for looking for endometriosis. We really work collaboratively, and as a surgeon, I want to know what's the FIGO classification, size, number, location. Help me know what I can offer this patient more minimally invasively.

Dr. Shulman:
I cannot agree with you more; too many women are still not being provided the kind of diagnostic assessment and that, I agree with you, includes hands, in fact should start with hands, and not being provided the breadth of imaging that really is needed. And not so much to avoid surgery, but to optimize clinical outcomes.

Dr. Bradley:
I think we have to also say to ourselves, when we see a woman, would my diagnosis be any different if she was a CEO's wife versus a woman who is "an essential worker" or a woman of color? So I do ask my residents, when they present a case, I begin to speak about, would this be any different? And I'm just kind of challenging them to think, would you give a different medicine? Would you order something different?

Maybe for someone who doesn't look like me, have the same resources as me, and be open to thinking about maybe there's some implicit bias in how you're making a diagnosis and offering treatment.

Dr. Shulman:
Linda, do you have any tips from a clinical perspective about how to discuss the role of GnRH antagonists in preempting knee-jerk decisions to go to surgery for both endometriosis and uterine fibroids?

Dr. Bradley:
Well, Lee, GnRH antagonists are an excellent option for women who have endometriosis, both suspected or previously diagnosed. So again, an oral regimen, quick onset of action, excellent outcomes when we ask patient questionnaires, very few side effects, and the

ability to use it for a long time. And the fact that it is also FDA-approved for the treatment of endometriosis should make patients more comfortable and physicians more apt to write prescriptions for something that is FDA-approved. So we have both disease states being covered by a novel oral treatment that patients can take very easily.

You know, I'm so happy to be at a part of my career where we truly have drugs that have been studied for fibroid use. For most of what we do in gynecology, we'd have a lot of off-label use. So I'm happy to offer patients an oral therapy, a GnRH antagonist, that acts quickly, has long half-lives, easy to take, safe, effective. And 60% of the study participants were women from the African diaspora with large fibroids.

When I read a study, I like to look at the weight, if the women were overweight, the women have low hemoglobins, they had all sizes of fibroids.

You know, we forget to say – sometimes we look at data that is – we say it's clinically significant, but who is it clinically significant to?

So these studies using the SF-36 questionnaire, which looks at 8 domains. So we care about what the patients say. They looked at hobbies, sexual activity, social embarrassment, isolation, fear, anxiety, functioning, just vitality. Emotionally, how are they feeling? These women who are on the GnRH antagonists did extremely well. They felt better, and they felt better in a short period of time. And these outcomes are sustainable over time compared to placebo.

Dr. Shulman:
Linda what's your one take-home message for our listeners?

Dr. Bradley:
You know, we learn a lot in life. So I say now when you know better, you do better. And that's a quote by one of my favorite poets, Maya Angelou. To summarize, that's listening, offering options, and staying true to understanding the patient's story.

Dr. Shulman:
For so many of our colleagues who really have not kept up to date, the evaluation and the care for women with endometriosis and fibroids has undergone an incredible change. And it really behooves all of us to stay on top of this, especially as our technology is now providing us with better interventions. And hopefully those better interventions will get to all women regardless of what community they come from.

I want to thank our audience for listening in and thank you, Linda. It was great speaking with you today.

Dr. Bradley:
It's my pleasure. Thank you.

Announcer:
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