Transcript Details

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A Whole-Patient Approach to Endometriosis: Closing Gaps in Care

Announcer:
You're listening to *Advances in Women's Health* on ReachMD, and this episode is sponsored by Sumitomo Pharma. Here's your host, Dr. Mary Katherine Cheeley.

Dr. Cheeley:
Welcome to *Advances in Women's Health* on ReachMD. I'm Dr. Mary Katherine Cheeley, and joining me to discuss how we can apply a whole patient approach to endometriosis management is Dr. Joseph Patruno. He's an OB/GYN at Lehigh Valley Jefferson Health Network in Pennsylvania. Dr. Patruno, thanks so much for being here today.

Dr. Patruno:
Dr. Cheeley, it's my pleasure.

Dr. Cheeley:
Alright, let's jump in and get started. Can you help me understand what the biggest gaps are in how we currently diagnose endometriosis?

Dr. Patruno:
I think one of the biggest gaps we have with this condition is it's poorly understood in terms of its natural history as well as its progression. The diagnosis is also difficult because symptoms are non-specific, and similarly to your clinical exam, often won't show anything terribly specific to say that a patient has endometriosis; therefore, it's either missed or the diagnosis is wrong in a lot of cases.

The second big challenge we have as clinicians is that we don't have any really sensitive biomarkers or non-invasive imaging, or imaging that allows us to make this diagnosis. Often, the testing that we have available to us is inconclusive. Obviously, ultrasound, CTs, and MRIs play an important role in the diagnosis of endometriosis, and it's actually quite effective with endometriomas or cysts in deep infiltrating disease, but not so good with early disease and especially peritoneal disease.

Of course, laparoscopy is probably still our gold standard, or surgically diagnosing the disease, either by seeing it, and even more ideally, by biopsying it and looking at it under a microscope. And I think this is actually one of our big gaps because the times when we should be doing this, when patients are young and early in the disease process, they may not be getting to us as gynecologic surgeons. So the fact that a surgical diagnosis is really the gold standard is obviously an underlying gap to making this diagnosis early.

Dr. Cheeley:
So you mentioned that it can be non-specific with how patients present. How does endometriosis impact patients beyond just pelvic pain or infertility?

Dr. Patruno:
I think treatment is very much dependent on whether or not a patient's primary goal is to get pregnant versus pain management. Generally, there's an evolution here of this pelvic pain that these patients experience. It starts out as the pelvic pain—often cyclic with menstrual periods, sometimes related to ovulation—and over time, you'll see that evolve to non-menstrual pain and other pain that's provoked with the most classic symptom being dyspareunia or sexual pain.

The disease very insidiously also affects through inflammation and scarring and upregulation of the nervous system—a centralized pain syndrome in a lot of these patients, especially if they've endured the disease for a while, if it hasn't been well managed, and if it hasn't been diagnosed at an early stage. So what you'll see with these patients is significant bladder and bowel dysfunction. Once again, we talked about sexual dysfunction, and that's generally a product of myofascial pain or pelvic floor dysfunction. So what may start out as pain in the lower quadrants only with your menstrual cycles quickly evolves into more global pain that involves also your vulvovaginal area. So as your pelvic floor muscles are contracting, you're seeing many somatic, autonomic, and visceral nerves being upregulated, including your pudendal nerve. So most of my patients who tend to be on the more advanced side will also have significant pelvic floor dysfunction and pudendal neuralgia.

And then finally, this chronic pain upregulation and centralization of pain leads to alterations at the level of the cortex in the brain. Patients are influenced not only physically, but it affects them emotionally. And certainly we see a correlation in patients with endometriosis with depression, anxiety, obsessive-compulsive elements, and fatigue. And a lot of this is the chicken or egg. Did the disease cause those symptoms? Or are those symptoms a coinciding comorbidity with the disease? And I'm sure it falls somewhere in between both of those things.

Dr. Cheeley:
So you describe this as a continuum for this disease. Why do you think that patients often experience diagnostic delays, which then cause a progression of the disease before we can do anything about it? And what do you think we can do to shorten that timeline?

Dr. Patruno:
Yeah, that's a great question. And just to give a little bit of foundation with this, the average age that a patient gets diagnosed with endometriosis is probably about 28. And if you think about that, patients at that juncture have probably already experienced 15 to 20 years of menstrual and reproductive life. And understanding that endometriosis is a disease that's probably fueled by estrogen and reproductive hormones, certainly during that time period, it's probably been progressing, growing, and causing symptoms. It's also been shown that patients will see eight doctors before they're appropriately diagnosed. So clearly, we're not doing a great job identifying patients with this disease and diagnosing them in a timely manner.

So going back to our last section, one of the biggest issues is the non-specific nature of the symptoms and not having access to terribly sensitive, non-invasive tests. And I think it also falls under the category of education. If you think about patients and when their endometriosis probably develops, which I propose is in their adolescents and teens to start, and progresses through their reproductive life, they're being managed by primary care doctors, family medicine, pediatricians, and emergency medicine doctors sometimes when they end up in a hospital setting because of an acute pain episode. So I think it's important to educate patients on the disease, but also our healthcare community and especially primary care providers who will be taking care of these patients at an early stage in their existence. So I think that's a big part of it.

And the other part, and I'll give a microcosm—in my practice, I'm generally fairly liberal about doing surgery on young patients, especially if they fail pain management with analgesics and basic hormonal suppressants because there is always a very high chance that those patients have endometriosis. And my goal is to first of all, diagnose it, treat it, and also prevent them from that upregulation and going on to the age of 28 or 35 or 40 before they're appropriately diagnosed with the disease.

Dr. Cheeley:
For those just tuning in, you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Mary Katherine Cheeley, and I'm speaking with Dr. Joseph Patruno about our evolving understanding of comprehensive endometriosis care.

Dr. Patruno, I want to learn some more about care strategies. How can we individualize treatment based on the patient's symptoms and their priorities that you mentioned before? Take me through how you do that.

Dr. Patruno:
Yeah, it's a great question. And once you establish the diagnosis of endometriosis, I think what's really critical is counseling. So in doing that, I take into consideration a number of things. Obviously, you have to take into consideration the patient's comorbidities and other medical problems. So their overall health and medical history are very important, their current symptoms, the extent of their disease. especially if you've established the diagnosis surgically, what their desires and expectations are, and what they think is reasonable and what their thoughts are. Then, it's a paradigm where you go off into two vectors—whether someone wants pain management as their primary goal versus getting pregnant—because they're sort of exclusive from each other.

Generally, with endometriosis, we focus on medications and surgery as our options. So first-line therapy is generally analgesics, pain management. Certainly non-steroidals are probably your best first-line treatment, and often that will work pretty well for people with mild disease, or primarily dysmenorrhea, or menstrual pain.

When patients become more advanced, I think if you are managing these patients, you need to feel comfortable using things like neuromodulators and other pain adjuncts. I think they become very important when you're dealing with other organ dysfunction and clear nerve upregulation. So in those areas, you're dealing with tricyclics, serotonin, norepinephrine, uptake inhibitors, and things like gabapentinoids, which I think are often valuable in these patients.

When we look at the hormonal side of things, the goals are suppression. And when I say suppression, I try to suppress three things: ovulation, menstruation, and also estrogen production, especially in patients who have endometriosis, once again believing that estrogen is the fuel to the fire in this disease. So generally, when we're managing patients hormonally, those are the agents that serve the best purpose.

You generally take a stepwise approach, starting with basic combined oral contraceptive pills. There's reasonable data that shows that if you use these continuously so patients can bypass their menstrual periods, they'll do quite well. Progesterone-only pills also are quite effective in my practice, and I often will put people on higher dose norethindrone as a really excellent adjunct for endometriosis care. It's been well proven in the literature. It's cheap, and it's also provides birth control, which is a nice little benefit with a lot of these things we're going to discuss.

The next line of treatments I would offer patients are generally longer-acting progestins, and they may come in the form of the levonorgestrel-containing IUD. And I'll generally focus on a higher dose as opposed to a lower dose apparatus. Levonorgestrel implants are great for suppressing ovulation and menstruation. And then finally, medroxyprogesterone is a great product for endometriosis management in that it generally will initiate amenorrhea, very effectively stop ovulation, and also, for good or bad, decrease estrogen in these patients.

Going beyond that, then you're talking about the GnRH analogs. In the past, we went with GnRH agonists in the form of leuprolide, usually. There were a couple of other products out there that were quite effective. In the last five or six years, elagolix and relugolix have become available, and these are GnRH antagonists. They're oral. They're a little bit better tolerated than leuprolide was in the past, and they're tremendously effective in my experience in managing the more brittle endometriosis patients in my practice.

So I think that summarizes most of the medical management that I would see. On the surgical side, once again, you have two vectors. You'll go in one as being conservative—generally, that's fertility sparing, and in those cases, you'll try to recreate anatomy and obviously remove any disease. Often, when you go into these patients surgically, you'll also find adhesions and other conditions and scarring related to the endometriosis itself that should be removed.

As a sidebar, there should be very few cases that you aren’t approaching a patient surgically through a minimally invasive technique. And I would say that would either be laparoscopic or robotic, depending on which of those tools you feel more comfortable with and you have at your disposal. But all the surgery should be done pretty much minimally invasively to optimize the procedure itself, but also the recovery, of course.

Definitive surgery is also an option for many of these patients. And when I say definitive, I'm referring to hysterectomy. Now, people will say, “Why do a hysterectomy if the disease is outside of the uterus?” The uterus is the endpoint for the symptoms that many of these patients feel, and they've been very much upregulated with periods. Often, there's bleeding dysfunction as well. So in many cases, a simple hysterectomy will provide significant benefit.

And of course, there's a place for other adjunctive behavioral changes or modification—things like mindfulness, yoga, Pilates, and so forth, which will serve a purpose in terms of keeping the patient more globally intact, both physically and emotionally.

Dr. Cheeley:
Talk to me about endometriosis and fibroids. Any key considerations that we should have if a patient has both conditions?

Dr. Patruno:
I actually manage these two conditions very similarly. And probably, if I were going to go into one direction with them, it would be with the GnRH analogs. Now, I mentioned elagolix and relugolix—both of those medications are indicated both for endometriosis as well as uterine fibroids. So they can be used sort of interchangeably. And I found great success in terms of managing my patients with any of those conditions—endo, adeno, or fibroids—using that particular class of medications.

For fibroids, there's a variety of conservative surgical procedures that could be considered. Generally, I reserve those for patients who do want to have fertility in the future or whose fertility has been affected by the leiomyomas. There are also some other non-surgical procedures out there, including ablations, as well as embolizations that could be used in patients with fibroids. And then finally, hysterectomy is a terribly effective procedure for people with fibroids and bleeding or adenomyosis and pain.

Dr. Cheeley:
This has been such a great discussion. I would love to thank my guest, Dr. Joseph Patruno, for joining me today to discuss the whole

patient approach for managing endometriosis. Dr. Patruno, it was lovely having you.

Dr. Patruno:
Dr. Cheeley, the pleasure was all mine. Thanks.

Announcer:
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