

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/advances-in-womens-health/breaking-barriers-improving-access-and-outcomes-in-endometriosis-care/35627/>

ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Breaking Barriers: Improving Access and Outcomes in Endometriosis 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. Brian McDonough.

Dr. McDonough:

This is *Advances in Women's Health* on ReachMD. I'm Dr. Brian McDonough, and joining me to discuss how we can address barriers to endometriosis care is Dr. Hugh Taylor. He is the Anita O'Keeffe Young Professor and Chair of Obstetrics, Gynecology, and Reproductive Sciences at Yale School of Medicine. Dr. Taylor, thanks for being here.

Dr. Taylor:

Well, thank you. Dr. McDonough. Thank you for having me.

Dr. McDonough:

Well, Dr. Taylor, let's dive right in. What are the most common hurdles faced when getting patients with endometriosis started on treatment?

Dr. Taylor:

Well, we know there's a long delay in getting patients diagnosed. I think that's the biggest barrier—recognizing that they have endometriosis. We need to think about anybody who comes in with pelvic pain that's entrained to their menstrual cycle, that occurs predominantly at the time of menses—i.e. dysmenorrhea—most of them will have endometriosis, especially if that pain progresses over time and it's a chronic condition where that progresses—most likely endometriosis. And we need to recognize it as such, clinically diagnose it, and begin treatment.

In the old days, we used to rely on surgery to diagnose endometriosis. Someone didn't have endometriosis until they had a laparoscopy that proved it. Unfortunately, that created a tremendous delay in getting people in for treatment. You had to have fairly significant pain and disease before one would want to undergo a surgery. So it really delayed and created a huge barrier.

So listen to patients, listen to their complaints—predominantly the dysmenorrhea that's progressive and getting worse over time—diagnose endometriosis clinically, and begin treatment. And most patients are very appreciative that you've taken their symptoms seriously. You've finally given them some answers to why they're having this pain, and they're thankful to get therapy.

Dr. McDonough:

Now, if we zero in on potential challenges with insurance, how can we streamline the prior authorization and approval process? I know that can be complicated.

Dr. Taylor:

It is challenging and frustrating for physicians to take time out to deal with that prior authorization process. I think there are a few things that are key—recognize which medications frequently need prior authorization. Some of the newer GnRH antagonists that are frequently used for endometriosis care today often are screened and require prior authorization.

I find it very helpful to, upfront, have the information about what's been tried in the past and the clear diagnosis of endometriosis, the pain indication, and that they failed traditional first-line therapy, such as an oral contraceptive pill. Patients very frequently fail on oral contraceptive pills, so this is a common occurrence. But having all that information handy and available is usually all it takes to get that

prior authorization.

Dr. McDonough:

And when it comes to affordability, how can we proactively educate patients about financial assistance programs?

Dr. Taylor:

There are some. Some of the companies have financial assistance programs—the manufacturers if insurance doesn't cover these medications for the more expensive ones. And the other thing to think about is using some less expensive alternatives when the patient does respond to them. Sometimes there are more affordable options available. Again, the GnRH antagonists these days are the more expensive medications, but often somebody will respond to a progestin. If they don't respond to a progestin, androgens. Danazol is an old-fashioned treatment that's been used for a long time. It has some other side effects, but sometimes you have to weigh the side effects with affordability. You can put all that together to give the patient some real options.

Dr. McDonough:

Those just tuning in you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Dr. Hugh Taylor about navigating access challenges in endometriosis care.

So Dr. Taylor, if we continue to explore how we can help address barriers to treatment access, what role does patient advocacy play in ensuring timely and effective care?

Dr. Taylor:

Yeah, I think that plays a big role. Patients are often their own best advocates when they relate their story to someone who is considering a prior authorization. Often, that makes all the difference in the world—the type of side effects or symptoms they've had on other medications, the severe nature of their pain, the idea that they can avoid a surgery, and that this could be very much life altering for them to get approval of these medications.

Dr. McDonough:

And what are some of the best practices for ensuring continuity of care and minimizing treatment interruptions?

Dr. Taylor:

I think it's important to make sure you check in with your patients frequently and early on in the treatment process. When I start someone on a first-line medical therapy for endometriosis—and most commonly that's in the United States an oral contraceptive—there are a lot of side effects from these, including breakthrough bleeding, mood changes, bloating, and breast tenderness. I check in with them after about six to eight weeks to see if they're having any side effects or make sure it's effective at reducing the pain. If it's not, we need to move on to something else fairly quickly.

Typically, the second-line therapy is a GnRH antagonist these days. And if they're having side effects or if they're not getting pain relief, I move quickly to the next. They get frustrated if they aren't seeing a response and may disappear from your practice and not get proper care that they need, or they may prematurely have a surgery done when you may be able to control this very well with medical therapy without the need for a surgery.

I think it's also important to make sure you see them well before the next prescription is due so that if it does need a prior authorization, you have time to do that and there's not a gap in availability of their medication. And also, with some of these GnRH antagonists, the FDA has imposed a two-year limit. If the patient really needs it, you want to consider it beyond that two-year limit, and you might want to start thinking about seeing the patient early and starting that prior authorization or appeal very early on in the process so there's no gap in medication.

Dr. McDonough:

As we approach the end of our program, Dr. Taylor, do you have any key takeaways you'd like to share with our audience? I know one thing that there's concern about is the fact that sometimes people can have symptoms of endometriosis, these women are suffering, and it could go on for years before diagnosis is made or treatment is started.

Dr. Taylor:

I think it's so important to listen to our patients. Pelvic pain is a tough one, or dysmenorrhea in particular—pain with menses—that's the only pain we as human beings would ever accept as a normal pain that someone should have. And how do you quantify it? It's somewhat subjective. How do you know if your menstrual cramps are too much or worse than someone else's? Most of my patients who I see with endometriosis, when they first started complaining of dysmenorrhea, were told, "Oh, that's just menstrual cramps. Everybody has them." And it isn't until they're really quite disabled that it gets recognized. We need to listen to our patients, and we need to take that very seriously. If somebody has menstrual cramps, dysmenorrhea, that really interrupts their day, they should consider the

diagnosis of endometriosis.

The other thing we know is that there are many other symptoms associated with endometriosis that aren't always linked together. Endometriosis inflames the whole peritoneal cavity. It can lead to dysuria, bowel problems, and abdominal distention, which is common in women with endometriosis. And many of my patients have had their colonoscopy before they get the diagnosis of endometriosis. If it's just around the time of menses, those symptoms associated with some dysmenorrhea, it's usually just the endometriosis. Similarly, anxiety and depression are much more common in women with endometriosis. Think about it all as part of one big picture, and not necessarily that they have multiple diagnoses that you need to chase down and treat. Focus on the one diagnosis: endometriosis. Anybody with cyclic pelvic pain that progresses over time is very likely to have endometriosis.

I always start with first-line medical therapy and go on to another medical therapy if that doesn't work. But it's important that many of these women will not need surgery, and having them on medical therapy, you could stop the pain, stop progression of the disease, preserve their anatomy, preserve their fertility, and avoid surgery. Now, of course, there'll be some patients who fail medical therapy. If they have adhesions or fibrosis or damage that is not amenable to medical therapy, they'll still be patients who need surgery. But I would never use surgery as a first-line treatment, and I don't use surgery as a diagnostic tool. I clinically diagnose endometriosis and will save surgery for those who've failed first- and second-line medical therapy.

Dr. McDonough:

With those final thoughts in mind, I want to thank my guest, Dr. Hugh Taylor, for joining me to discuss how we can improve access to endometriosis care. Dr. Taylor, it was great having you on the program.

Dr. Taylor:

Thanks for having me. Appreciate it.

Announcer:

This episode of *Advances in Women's Health* was sponsored by Sumitomo Pharma. To access this and other episodes in our series, visit *Advances in Women's Health* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!