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

The Burden of Uterine Fibroids: Exploring Physical, Cognitive, and Reproductive Impacts

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. Charles Turck.

Dr. Turck:
Welcome to *Advances in Women's Health* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss how we can address the burden of uterine fibroids is Dr. Ayman Al-Hendy. He's a Professor of Obstetrics and Gynecology and the Director of Translational Research at the University of Chicago Pritzker School of Medicine. Dr. Al-Hendy, thanks for being here today.

Dr. Al-Hendy:
Thank you so much for having me to talk about this very important topic.

Dr. Turck:
Absolutely. Well, to start us off, Dr. Al-Hendy, how can uterine fibroids affect a patient's physical and emotional wellbeing beyond heavy menstrual bleeding?

Dr. Al-Hendy:
A very important question. Uterine fibroids are the most common benign tumor of reproductive age women. Reproductive age women are roughly between 12 years old at age of menarche until the age of menopause, which is an average around 52 years. So it's a very long period of time. And the most common tumor that can affect women reproductive life in this age group is uterine fibroids. To give you a numerical context, at any point of time, the assessment suggests that there's around probably 38 to 40 million women in the US alone who are affected by symptomatic uterine fibroids. It's extremely common by the age of 50, around 70 percent of white women and about 80 percent of Black women have uterine fibroids. So it's a very common disease.

You're absolutely right—the most common symptom is heavy menstrual bleeding. But this is unfortunately just the start, because with heavy menstrual bleeding, if it goes uncorrected or uncompensated in terms of iron, etc., the patient slips into iron deficiency anemia. And iron deficiency anemia is extremely symptomatic, beyond the usual fatigue and just being tired— it's being unable to accomplish your mission or your tasks. It affects a lot of function in your daily life. Cognitive function has been documented with iron deficiency, even in the absence of anemia. So even if your hemoglobin level is normal, let's say above 11—a definition of anemia usually is when hemoglobin is less than 11, and some consider 10.5 g/dL—even if you're above that but your iron storage is depleted, your cognitive function and your intellectual function could be affected. You start to struggle remembering things in exams, maybe doing your job—especially if your job is very intellectual—beyond the physical effects and so on.

Again, beyond the bleeding, there's also the pelvic pain or pelvic discomfort. In about 15 to 20 percent of fibroid patients, the main symptom would not be heavy menstrual bleeding—it would be pelvic symptoms such as discomfort, pain, and feeling a lot of pressure and congestion. Many people lump all of these symptoms into so-called bulk symptoms. So the patient would come and complain of, let's say, constipation or urinary frequency, going to the bathroom quite frequently, waking up at night to go to the bathroom, which they didn't do before, and just feeling bloated and congested—that's also a very common symptom.

And then beyond all of these acute symptoms, fibroids can also impede the individual's ability to get pregnant. So fibroids have been associated with subfertility. And even after a pregnancy is accomplished, fibroids have been connected to miscarriages, preterm labor, and the need for cesarean section because of the abnormal position of the baby because of this tumor inside the uterus.

So when you put this all together, I think we all can agree that symptomatic uterine fibroids really compromise the quality of life of many women.

Dr. Turck:
Now, with all these impacts in mind, what are the key challenges in early detection and accurate diagnosis?

Dr. Al-Hendy:
There's a lot of normalization of symptoms. So what do I mean by that? We talked about the heavy bleeding. Well, what is the definition of heavy menstrual bleeding? Textbook definition is when the monthly menses is more than 80 mL per month. Well, again, for the average patient, that also doesn't help, because who actually counts that and measures that in that way? So a lot of women suffer from heavy menstrual bleeding without recognizing it. So that's what I mean by normalization of symptoms.

It happens in a gradual, subtle way. When we go back and take detailed history from patient with documented fibroids, they say, “Yes, indeed, I've been actually seeing these changes in my period for the last 3, 4, 5 years.” The average period of delay of diagnosis in fibroids is about 4.5 years, and that's mostly because the patient does not interact with the healthcare system during that time—not because the diagnosis is difficult, but the changes happen in a subtle way. The patient tends to normalize it. And even when the patient starts talking to her social support system, “Oh, my period is getting a little irregular or a little heavy,” there's a lot of stigma, unfortunately, in the community—I would say in all groups, but maybe particularly in minority communities—African American, Hispanic American, and so on, that, “Well, this is just part of being a woman,” or, “Everybody has that,” and things like that. So that's the reason for the delay.

But really, once the patient seeks help, an ultrasound is performed, and it's very easy to diagnose fibroids—typically by transvaginal ultrasound, which is very helpful. It tells us first if there's fibroids or not, and how many, how big each one is, and where exactly they are in the uterus, because that also can affect the treatment plan and so on.

Dr. Turck:
For those just tuning in, you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Ayman Al-Hendy about the multifaceted impact of uterine fibroids on patient’s quality of life.

So Dr. Al-Hendy, let's zero in on strategies for optimal treatment. How can we better communicate the full impact of fibroids to patients and discuss all available treatment options?

Dr. Al-Hendy:
I like to counsel my patient that there are medical treatment options and surgical treatment options. And I actually draw this on a piece of paper—a diagram of a uterus that has fibroids and so on. And I say, like any disease, we can start with medical treatment options, and if those don't achieve the desired results for the patient, or, let's say, the patient cannot use those options, we'll talk about this in some details, and then we graduate and go to the next step with more involved, more invasive treatment options, which would probably include surgery.

And I always see my patient in my scrubs, and I say, even though I'm a surgeon, it just makes sense to me that we try simple, non-invasive medical treatment options first. But most of the patients welcome that. And in fact, I see a lot of second opinion and even third opinion patients sometimes for that exact reason, because unfortunately, with some providers, they still counsel fibroid patients only about surgery—fibroid equals surgery. And like I said earlier, while this probably was acceptable 30 to 40 years ago because there was no other scientifically-based medical treatment options for fibroid, that has totally changed in the last few years.

Dr. Turck:
Now, how should we approach treatment selection for patients with symptomatic fibroids?

Dr. Al-Hendy:
In the last five to six years, there has been really major improvement in the treatment options for uterine fibroids by the introduction of this group of medication collectively called oral GnRH antagonists. Now, I think we're all quite familiar with injectable GnRH analog or GnRH agonist—things like leuprolide acetate and maybe in other countries—these are the injections that we used to use once a month or every three months to literally shut down the hypothalamic-pituitary-ovarian axis, which eventually leads to the ovary not producing estrogen and progesterone. Estrogen and progesterone are the lifeline of fibroids. So by depriving fibroids from those, the fibroids start to shrink, and the symptoms related to fibroids start to become less. And the quality of life and the patient’s general condition gets better.

The problem with these options is that estrogen is also important for other functions in the body. So even though the fibroid symptoms will get better, the patients start to suffer from menopausal symptoms, hot flushes, night sweats, and painful intercourse because of dry vagina. And also, the bones start to suffer because estrogen is also important for maintaining bone mineral density. So patients, if they

use these medications for a long time, start to lose bone mineral density, and they are at risk of things like osteoporosis.

Now, this new group of medication—things like elagolix, relugolix, and linzagolix—was a game changer. These are oral, so the compliance and the use is very simple. The patient can use them in the comfort of their homes. And also, in the same tablets of these medication during the trials, we built in adding very little amount of estrogen—enough to avoid these side effects, like hot flashes, night sweats, bone mineral density loss, etc., but not enough to allow the fibroid to grow. So we get the best of both worlds. So this is really the main improvement in the treatment options for fibroid.

Dr. Turck:
And what strategies would you say could improve equitable access to fibroid care?

Dr. Al-Hendy:
I encourage my patients to empower themselves with knowledge about the different treatment options. Things like the White Dress Foundation, the National Fibroid Foundation, and the Fibroid Project—they are all patient advocacy groups. They all aim to increase awareness of fibroid, help with early diagnosis, empower women to know all their treatment options and that there are options other than surgery, and to have good discussions with their doctors and seek patient-centered healthcare.

I see a lot of patients where the only option they are given is the surgical treatment option. And I would say there might be even some potential bias there that minority women are offered mainly surgery or only surgery because of certain assumptions and so on about the cost of medication. Again, I think the patient should empower themselves by knowing their options and engage their doctors in all of this. And that should help to hopefully level the playing field so that every patient will get the best treatment plan that suits their life.

Dr. Turck:
As we approach the end of our program, Dr. Al-Hendy, what's one takeaway you would want clinicians to keep in mind when it comes to recognizing and addressing the full impact of uterine fibroids?

Dr. Al-Hendy:
I think we should talk to the patient and listen to the patient. Allow the patient to tell us what their priority is. Is it the symptoms? Is it that they want to control their fibroid symptoms so they can achieve pregnancy? Or are they done with their fertility plans and have completed their family? All of this data and information should help with successful and satisfying interactions between the doctor and the patient. Then, the doctor then can offer the appropriate treatment options so that the patient can choose. So listen to the patient and address the patient as a whole, not just the disease or the pathology.

Dr. Turck:
With those key insights in mind, I want to thank my guest, Dr. Ayman Al-Hendy, for joining me to discuss how we can better care for patients with uterine fibroids, given the considerable impact they can have on our patients' lives. Dr. Al-Hendy was great having you on the program.

Dr. Al-Hendy:
Thank you for having me. Thank you so much.

Announcer:
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