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

• Describe the multiple symptoms of endometriosis and its varied presentation among patients including pelvic pain mapping

• Collaborate with patients to make a more timely clinical diagnosis of endometriosis and refer patients to specialists if needed

• Include patients’ symptoms, preferences, and values to identify and select the best available treatment options for management of endometriosis symptoms and disease
Faculty Information

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Background

• Common disease

• Often times frustrating to both patients and providers
  – Limited treatments
  – Plays a big role in patients’ lives

• Affects women’s personal relationships and physical condition

• Need to discuss treatment options with patients
Endometriosis

- Chronic disease of reproductive age women
- Stimulated by estrogen
- 10% prevalence
- 70-80% of women who present with pain/infertility (after other causes excluded)
- Diagnosis often delayed
- High recurrence rate following medical/surgical treatment
Current Treatment Options

• NSAIDs

• Combined oral contraceptives
  – Often self-treat before seeing their physician
  – Treat pharmacologically, not surgically, at least initially for most patients
  – Evolved over the years from all patients being sent to the OR
  – Works in many cases, especially women who experience painful periods
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• Progesterone (oral; injectable; IUS)
  – Administered by injection or by mouth
  – Studies show effective in treating endometriosis for 80-90% of patients
Current Treatment Options (con’t)

• Modified testosterone

• GnRH agonists (injectable; nasal)
  • Most effective after the patient has failed the common treatments
  • Shut down the pituitary causing estrogen levels drop; symptoms of endometriosis usually improve dramatically
  • Do have side effects, most common is bone loss
  • Effective but limited; max. length on label is approximately one year
Antagonist Effect: Elagolix Binds Competitively to the GnRH Receptor\textsuperscript{1,2}

- Competes with endogenous GnRH for GnRH receptor occupancy in the anterior pituitary and blocks receptors upon binding, so fewer receptors are activated\textsuperscript{1}
- Suppresses LH and FSH in a dose-dependent manner\textsuperscript{1}
  - LH and FSH suppression begins within hours of administration\textsuperscript{*} and is reversible upon discontinuation\textsuperscript{1}
- Leads to decreased serum levels of the ovarian sex hormones estradiol and progesterone\textsuperscript{1}

FSH: follicle-stimulating hormone; GnRH: Gonadotropin-releasing hormone; LH: luteinizing hormone

\textsuperscript{1} Ng J, Chwalisz K, Carter DC, Klein DC, J Clin Endocrinol Metab. 2017;102(5):1683-1691.
Patient Centered Care

• General
  – Listen to patient attentively: goals, fears, experiences
  – Develop relationship of trust and teamwork
  – Use decision aids when appropriate
Patient Centered Care (con’t)

• Treatment risk and benefits
  – Explain goals of therapy
  – Personalize treatment selection
    • Management plans should consider
      – Symptom severity
      – Potential for recurrence
      – Desire for fertility
      – Other considerations: cost, side effects, and route of administration
    – Describe risks that are common, including feared risks
    – Monitor for tolerance, compliance, persistence and effectiveness
Patient Cases
Case #1: Kiri

- Age 44
- G2P2002
- Med history: Motrin
- Medical history: negative
- Surgical history:
  - C-section x 1
  - Laparoscopy 2009
- Physical exam: normal
- c/o severe dysmenorrhea (7/10)
- Missing work 1-2 days per month
- No desire for fertility
Case #1 Kiri Discussion

• What more do we need to know:
  – Operative findings/excision or ablation/any pain lessening and recurrence
  – History:
    • When did pain recur?
    • Same type of pain?
    • Current meds for pain?
    • Effecting relationships?
  – Past medical treatments?
    • Effective or ineffective
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    - Effective or ineffective
  - Exam and ultrasound findings
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  - Past medical treatments?
    - Effective or ineffective
  - Exam and ultrasound findings
  - Patient’s desires:
    - Surgical vs. medical
    - Medical: injectable/intrauterine/oral
Case #2: Aimee

- Age 23
- G2P1001
- Current med history: Motrin/Continuous COC’s
- Medical history: depression
- Surgical history:
  - Laparoscopy 2015
- Physical exam: thickened uterosacral ligaments; decreased mobility
- c/o severe dysmenorrhea (7/10) and dyspareunia (8/10)
- Missing work 2 days per month
Case #2 Aimee Discussion

• What more do we need to know:
  – Operative findings/excision or ablation/any pain lessening and recurrence
  – History:
    • When did pain recur?
    • Same type of pain?
    • Current meds for pain?
    • Effecting relationships?
  – Past medical treatments?
    • Effective or ineffective
  – Desire for maintaining fertility
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  - Exam and ultrasound findings
  - Patient’s desires:
    - Surgical vs. medical
    - Medical: injectable/intrauterine/oral
Conclusions

• Physicians need to spend a bit more time with endometriosis patients and really listen to them

• The goal is for these patients to feel that they are being heard and that they work together on their treatment approach