

Management of Chronic Gynecologic Conditions

An Expert Panel Discussion Recap

Nonmalignant gynecological conditions, such as chronic pelvic pain resulting from endometriosis and heavy menstrual bleeding resulting from uterine fibroids, can have a substantial impact on patient quality of life. It is important that providers understand the effects of these conditions and discuss treatment options with patients.

In a recent *Contemporary OB/GYN*[®] Viewpoints video series supported by AbbVie, Ayman Al-Hendy, MD, PhD, professor and director of translational research in the Department of Obstetrics and Gynecology at the University of Chicago in Illinois, led a discussion with thought leaders about the management of chronic pelvic pain and heavy menstrual bleeding. The panel also discussed ways to improve patient-provider communications and overcome the normalization associated with nonmalignant gynecological conditions. Ahead is a recap of clinical pearls and key takeaways from the discussion.

Chronic Pelvic Pain from Endometriosis: Diagnosis and Treatment Options

In the management of endometriosis, new developments are emerging regarding patient assessment, diagnosis, and treatment initiation via telehealth. Regarding imaging, Al-Hendy said that current tools for more generalized disease have limited utility and that the gold standard historically is laparoscopic diagnosis. There is usually a vast delay in diagnosis (eg, normalization of symptoms). Moreover, there are no reliable biomarkers for endometriosis, which remains an unmet need and should have further research in the field, Al-Hendy said.

In managing individualized treatment plans, Linda Bradley, MD, a professor of surgery at the Cleveland ▶



Clinic Lerner College of Medicine at Case Western Reserve University in Ohio, noted that there are new therapeutic opportunities and that treatment should be based on symptom burden, age, and pregnancy status. “I’m very liberal when it comes to any of these things because I think you get the best buy-in when [patients are] ready for treatment instead of us pushing treatment unless there’s something. Both ureters, they’ve got hydronephrosis. They’re not urinating. They [have] poor kidney function. Not all of us in this room have seen patients with that, but in our lifetime. Cumulatively, it’s a handful of patients. I’m probably a little more patient-centric in letting people do those things,” she said.

Stacey Missmer, ScD, a professor in the Department of Obstetrics, Gynecology, and Reproductive Biology at Michigan State University’s College of Human Medicine in East Lansing, added that there are no 1-size-fits-all treatments for patients with endometriosis. “There are treatments that are absolutely life changing [and] successful for patients, and there are patients with those exact treatments who have either no benefits or have [adverse] effects that further diminish quality of life... understanding going in that this requires a dialogue and an open discussion of those priorities, [in addition to selecting] treatments for those individuals, is really important.”

When discussing treatment options with patients, Eric Surrey, MD, of the Colorado Center for Reproductive Medicine in Lone Tree, observed that it is crucial to know what a patient has been treated with before, as well as their concerns about treatment. “We have to tease out what the main goal of the patient is. I think perhaps the most important [thing] that Linda mentioned earlier is fertility versus [infertility] because the [treatment] of the patient who wants to conceive is completely different,” he said. “They’re totally different evaluation and treatment paradigms. That’s critical. The other area is [if] there’s a specific problem besides, ‘I just want my pain to go away,’ to drill down. Tell me if you had to rank the most important parts. I think that could be very helpful [as well],” he said.

Not all treatments will be good or bad for all patients, Missmer noted. “[Although] patients’ stories are extremely important, definitely take into consideration that what works for 1 person may not be the best fit for you. What didn’t work for you may



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actually be very helpful for someone else. [Regarding] social media, a general respect for meeting people where they are and respecting their experiences is very important, as well.”

When it comes to treatment options, Al-Hendy noted that first-line options have been well established. “Birth control pills [and] combination oral contraceptives traditionally have been advocated as a first-line of therapy in a cyclic fashion, or there’s some literature support with that to use it continuously.” Another agent worth pointing out is progestin, Al-Hendy noted. “We know from the basic science that endometriosis is a progesterone-resistant disease. It would make sense to, let’s say, oversaturate the system with progestin. Again, literature supports some utility and shows some benefit, at least in the short term,” Al-Hendy said.

A more recent mechanism that has been explored is gonadotropin-releasing hormone (GnRH), resulting in the development of GnRH agonists and antagonists. “For GnRH agonists, of course the mechanism of action is well known, and it would make sense to deprive endometriosis from estrogen and progestin, especially the estrogen component,” Al-Hendy said. However, long-term safety concerns limit their utility, he explained. “We cannot use them in the long term because of the severe [adverse] effects, such as bone mineral density loss and all the typical hyperestrogenic [adverse] effects.”

GnRH antagonists represent a new family of compounds in this area, and Al-Hendy noted that these agents have a rapid onset of action. “There’s no

flaring effect. It binds the receptor and starts inhibiting follicular genesis, ovarian estrogen, and progesterone production right away. You have to adjust the dose. They are available in different dose regimens, and at the high dose, you also get some of the same [adverse] effects I mentioned a second ago, the hyperestrogenic [adverse] effects.”

The role of surgery in patients with chronic pelvic pain resulting from endometriosis remains controversial, according to Surrey. In addition to the considerations of the need for surgical interventions, such as hysterectomy, Surrey noted

that recurrence rates are worth thinking about. “Recurrence rates have been well described with hysterectomy, particularly when the ovaries are left in place,” he said. “I think if you do a hysterectomy and ignore additional endometriosis in the pelvis, it is maybe not the best operation. Just taking out the uterus and ignoring the rest of the disease, particularly if the ovaries are left in situ, may not be ideal.” Finally, he observed, “There are virtually no studies looking at recurrence rates for surgical versus medical therapy and even [fewer] looking at various medical therapeutic approaches.”

The Impact and Management of Uterine Fibroids

Heavy menstrual bleeding as a result of uterine fibroids can have a significant impact on patients’ lives, which, according to Missmer, should be a focus in clinician-patient dialogues. “A critical thing around these issues [is]



making sure that we’re understanding, both in our families and communities, that life-impacting symptoms [such as] dysmenorrhea [are] preventing girls and women from conducting their lives as they wish; that is not normal,” Missmer said. “Uterine bleeding that is impacting the ability to go about one’s normal activities is not normal.” Particularly in adolescence, symptoms of uterine fibroids can be isolating, and patients may feel embarrassed to talk about it, according to Missmer.

Discussing the American College of Obstetricians and Gynecologists recommendations regarding the management of heavy menstrual bleeding with uterine fibroids, Bradley noted that history and physical exams are essential. “I think the guidelines [should] always start with our history. I think we need to look at what our best practice is, and I think physicians all over the country or all over the world have different tools that are available to them,” Dr. Bradley said. “Let’s just say that [history and physical exams are] done, and then we have imaging. Depending on size, I prefer, if it’s available, to do saline infusion sonogram,” she said. For larger uteruses, she noted, “we might want to do MRI to

look at the intracavitary lesions. A CT scan, I think, has limited use,” Bradley explained.

In managing heavy menstrual bleeding with fibroids, Al-Hendy listed medical therapeutic options, such as tranexamic acid, oral contraceptives, progestin, GnRH agonists or analogues, and GnRH antagonists. He noted that tranexamic acid may be a “good option,” but current data show a focus on ovulatory bleeding with a limited group of fibroid patients. Aside from tranexamic acid, there are many hormonal options, and fibroids are estrogen dependent and incompatible with infertility.

Al-Hendy observed that GnRH agonists cause severe hyperestrogenic status, causing the fibroid to shrink. However, he observed, serious adverse effects, such as irreversible bone loss, are possible, especially if these agents are used beyond 6 months and/or the patients has hyperestrogenic menopausal symptoms.

Surgical options should be considered for those who have failed therapy, according to Al-Hendy, and medical treatment should be tried before an invasive option. “I believe in the fibroid field, we tend to think of surgery as a first-line [therapy] because, traditionally, there [were] not a lot of good, durable, long-term treatment options,” he said.

Missmer provided an overview of the treatment algorithm based on patient choices and also discussed gaps in care for specific medical treatment. “The critical branching point is the patient’s intentions around childbearing and continued fertility. That is a definitive demarcation that sends clinicians on ►

1 path or another that has been so nicely described already," she said. "I think the critical thing around uterine preservation is that we still have emerging data in terms of short- and long-term consequences of hysterectomy and also of bilateral salpingo-oophorectomy."

Missmer added that there are some long-term implications that fall under understanding the risks. "For example, it [has] been increasingly discussed and [is] perhaps becoming more normalized for

ovary removal [in] women who [have] completed their desired childbearing when they had an endometrioma to remove the ovaries to prevent ovarian cancer. When you look at [these] data, women with endometriosis do have an increased risk of ovarian cancer, possibly driven primarily by endometriomas, [but] we don't know that definitively yet. We know that, even with that increased risk, the lifetime risk of ovarian cancer is extremely small, but the lifetime risk of cardiovascular disease is large.

The Role of Communication in the Management of Endometriosis and Uterine Fibroids

As treatment options for chronic pelvic pain and heavy menstrual bleeding continue to expand, the panelists noted that communication and building relationships with patients represent the foundation of effective care. In this regard, understanding the burden of these conditions is an essential first step. Missmer noted that embarrassment and anxiety about menstrual issues is common in individuals with these conditions, particularly in student athletes who may not want to be seen as a weak member of the team, for example. In addition to stigmas associated with these common nonmalignant gynecologic diseases, panelists explained that these conditions have an effect on social engagement and professional opportunities.

Given the difficulties regarding the stigmas of pelvic pain and heavy menstrual bleeding, the panelists noted the importance of active communication with patients and striving to understand the burden of these conditions. "We think one of the critical pieces here is to validate patients' concerns," Surrey said. Allowing patients to tell their story is essential, according to Bradley. "Storytelling in medicine is important, and, as we all learned in medical school, probably 70% to 80% of what we need to know, the patient tells us," Bradley said.

According to Surrey, communication increases the likelihood of recognizing the condition and intervening earlier. "Clearly, with any medical condition, as soon as you can intervene, the less invasive [and less



complicated] the treatment will be; it might even be very simple," he noted. "On the clinician side, there has to be time taken to elicit the information [and] validate the patient's concerns. Also, [in particular], it's not just the adolescents who may not know that this isn't normal," Surrey said.

One element of effective communication with patients is establishing expectations, according to Missmer. "Is the problem because there hasn't been any remediation or adequate remediation of the prioritized symptom that was the target of the change? Does the patient understand, and was there sufficient dialogue around the amount of time it would take?" Missmer asked. "[The problem may be that] because that primary symptom or set of symptoms this treatment was designed to tackle [has been treated,] but now they're experiencing a sense of fatigue, weight gain, weight loss, or other symptoms that weren't necessarily part of that previous discussion. [There] hasn't been a shift in importance for the patient in her quality of life."

According to Surrey, setting appropriate expectations begins at the first visit. It involves conveying to patients that they should expect improvement, but that not everyone is the same. Surrey pointed out that addressing patient goals in a realistic matter is also critical. Establishing a relationship with patients based on trust is vital for success. "The beauty of our field is [that clinicians] have a lifelong relationship with patients, particularly those [who] are in general OB/GYN. The needs will change," he said. ■