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Changing the Paradigm in the Management of Endometriosis: Moving Away From “Surgery First” to “Pharmacologic Therapy First”

Announcer:
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Dr. Al-Hendy:
This is CMD on ReachMD, and I'm Dr. Ayman Al-Hendy. I'm here today with Dr. James Simon. Welcome, Jim.

Dr. Simon:
It's a pleasure to be here with you today, Ayman.

Dr. Al-Hendy:
Great, so let's get started. Let's begin our discussion on the surgery-first paradigm change in the management of endometriosis.

Jim, is surgery always necessary to make an endometriosis diagnosis?

Dr. Simon:
Ayman, that's a great question and one that I would've answered differently 20 years ago, 10 years ago, and today. So historically, the gold standard for a diagnosis of endometriosis was laparoscopy either with or without histologic evaluation of tissues taken and thought to be endometriotic lesions. That still remains the definition used in approval of different therapies for FDA utilization and approval.

But in clinical medicine, I think there are changes afoot that have slowly progressed over the last 20 years. That historic focus on the lesion is actually quite confusing because the lesions are extraordinarily varied in their appearance on laparoscopy, often clear or microscopic, making finding them nearly impossible. So I'd rather describe endometriosis as a menstrual cycle-related chronic inflammatory systemic disorder with a constellation of complaints focused on pelvic pain.

This tends to group individuals into a category where they're more likely to get diagnosed earlier, treated earlier, thereby shortening the time to a surgical diagnosis, if that's even necessary, and preventing downstream effects of the disorder, adhesions, additional pain, etc.

Let's examine those symptoms that I talked about as the constellation suggesting, if not making, a diagnosis of endometriosis. They include persistent or worsening pelvic pain, particularly adjacent to the onset of the menstrual period; pain during the menstrual period, dysmenorrhea; increasing deep dyspareunia. And this is an important point.

So penetrative pain can occur with a variety of disorders unrelated to endometriosis, but deep pain during sex is commonly related to peritoneal disease or deep endometriosis in the cul-de-sac. This is an important distinction. Pain during defecation or dyschezia is also a very well-known and characterized symptom of deep endometriosis, and cyclic catamenial symptoms in other symptoms, bowel problems, pelvic pain, even joint symptoms can be associated with endometriosis, particularly long-standing disease. So if one were to take a patient history and find, in addition to those symptoms, infertility or pain during menses beginning in adolescence and becoming

progressive and more severe, chronic pain in other organ systems, these are suggestive of endometriosis. And then obviously any previous laparoscopic diagnosis, that nails it down quite easily. And I'd also mention, although it's a little sketchy, that a positive family history of endometriosis, while indicative, is not diagnostic, but should point one in that direction.

Finally, let's not forget the physical exam. Nodules in the cul-de-sac, a retroverted uterus. Don't forget that endometriosis in the cul-de-sac can best be palpated on rectal exam, oftentimes neglected in young women but I think important in this setting. These are all consistent with endometriosis. Obviously, an ovarian cyst or ovarian or adnexal mass, which on imaging looks to be a hemorrhagic or geographic cyst on ultrasound, as highly suggestive, small masses, uterosacral ligament nodularity and other masses in the cul-de-sac also are quite suggestive of endometriosis on exam.

Ayman, I've given you my take on the diagnostic approach. What do you think?

Dr. Al-Hendy:
So, Jim, that was a fantastic overview. I take a slightly different approach. Always think of endometriosis as a chronic medical condition, so I approach it as a medical disease, and I rely on the information I can get from the patient history and the physical exam to make a clinical diagnosis of endometriosis. For example, in the history, I look for flags that would highly suggest or be markers of endometriosis, such as infertility, dysmenorrhea in this patient as an adolescent, especially if unresponsive to NSAIDs, chronic general pain, previous laparoscopy with the diagnosis, of course, would be quite helpful, also positive family history. Endometriosis tends to run in families.

On the exam side, I do a thorough pelvic exam, looking for things like nodules in the cul-de-sac, retroverted uterus, especially if it's fixed or have limited mobility, a mass consistent possibly with an endometrioma or endometriosis. And of course, if there's an obvious external endometrioma, for example, in the umbilical region.

Of course, also, I use imaging liberally to help me in the clinical diagnosis of endometriosis. Things like transvaginal ultrasound, very good in diagnosing ovarian endometrioma, for example. MRI also is very helpful to find any small masses in other organs like the bladder and the bowel and the pelvic sidewall, and really any nodules or masses in the pelvic region.

So in closing, the approach that I described to you does not diminish the value of laparoscopy as a treatment option for those in whom medical therapy is either insufficient, nor does it minimize laparoscopy as a diagnostic tool when the clinical signs are uncertain or suggest a non-endometriosis-related pathology. But overall, I would say most of the cases, we can diagnose by clinical assessment and imaging without the need for surgery.

Thank you very much, Jim, for giving your overview and your approach for diagnosis of endometriosis. I think this is going to be very helpful to our audience, and thank you again also for participating in this episode and giving us your insight on this topic.

Dr. Simon:
It's a real pleasure to be here today, Ayman.

Dr. Al-Hendy:
Unfortunately, our time is up. Thank you, everyone, for listening and have a great rest of your day.

Announcer:
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