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Cut to the Chase: Why Not Treat Endometriosis With GnRH Antagonists First?

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Al-Hendy:
This is CME on ReachMD, and I'm Dr. Ayman Al-Hendy. Here with me today is Dr. Suzie As-Sanie.

Dr. As-Sanie:
It is a pleasure to be here today, Ayman.

Dr. Al-Hendy:
And Dr. James Simon.

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

Dr. Al-Hendy:
Okay, let's get started. Jim, can you provide your point of view on the relevance of GnRH antagonists as a medical therapy for the management of endometriosis in select population of women?

Dr. Simon:
So in keeping with the FDA's labeling on the GnRH antagonists with or without add-back, I think the place of surgery has become, one, final surgery, removal of the pelvic organs in women who are done with their reproduction and really have end-stage pain and deep endometriosis. One variation on that would be the patients who have deep endometriosis and who are limited in their lives and their quality of life by severe pain. But I don't think our historic use of laparoscopy as a diagnostic technique is necessary anymore. By eliminating diagnostic laparoscopy, we reduce risk, we save money – healthcare dollars – and we can get patients under treatment earlier and reduce the progression of their disease. That approach, I think, is how I see the present and future of the GnRH antagonists in the therapeutic armamentarium. Using them both as a diagnostic tool, that is, do the patient's symptoms get better on these agents or not? And if they do, then use the agents as treatment between the diagnostic time point and the time when that patient wishes to get pregnant or when she's done with her fertility altogether. Unknowns in that setting and in the use of these agents include how long they can be utilized without inducing bone loss or other menopause-related symptoms and exactly what the optimum add-back therapies are. And then finally, can these agents also serve as contraceptives while we're using them for disease progression treatment and symptomatic relief?

Suzie, what are your thoughts?

Dr. As-Sanie:
Thank you, Jim. They were all really excellent points.

And a couple of things that I would add. I think when talking to patients, one of the most important things to point out is, is that endometriosis is considered a chronic condition that often has symptoms throughout the reproductive years. And so while surgery can often be a helpful treatment for the right patient at the right time, we really need to consider chronic medical therapy throughout the reproductive years to help manage the symptoms. We also know that endometriosis is not cured by surgery, nor is it cured by any specific type of medical therapy. And so having a treatment plan that can go through the reproductive years is incredibly important. And so in talking with patients about what their treatment options are, we know that there are a variety of medications that can suppress estrogen and therefore manage endometriosis symptoms and cause regression of lesions. But every single type of medication has a variety of different potential side effects and different efficacy for a given patient. And so while we know that across different medications most medications can be very helpful for the majority of patients, different patients have different individual experiences. And so we need to work with patients on an individual basis to find a medical treatment option for them that works for them and minimizes their side effects and maximizes the treatment efficacy over their life course.

Ayman, Jim and I have provided our thoughts on this topic. What are your thoughts?

Dr. Al-Hendy:
Well, thank you, Jim and Suzie, this was a fantastic overview. I approach patients with endometriosis as patients suffering from a chronic medical condition. I think we all can agree that endometriosis is a chronic medical disease. And actually, with the delay in diagnosis, etc., women usually get diagnosed, let's say, in their early 20s. If we approach this disease as a surgical disease, you are setting these young women for a trajectory of multiple surgeries. And by the time they are in their mid-30s, they probably had 4 or 5 laparoscopies to treat their endometriosis-related symptoms. I think we can agree, that's not typically what we would like to offer our patient with multiple surgeries. So I approach this as a medical disease. I think oral GnRH antagonists could be an excellent first-line treatment for patients with endometriosis. It's simple, it's oral, it's safe and efficacious, and the patient can use this in the comfort of their home.

Also, for couples who are pursuing pregnancy, this is a good transition, and they can stop the treatment once they are ready to pursue building a family, and there is a quick return of ovulation and fertility within around 4 to 6 weeks.

This is how I approach patients with endometriosis unless they have some contraindication and they are not good candidate for medical therapy or they definitely don't want medical therapy. And of course, it's a patient-doctor shared decision. In that case, I pursue surgery. Otherwise, my default approach to a patient with a clinical diagnosis of endometriosis is oral GnRH as the first line of treatment.

So I approach endometriosis patients just like the way we teach our students and residents and clinical fellows, like any other disease in medicine, by simple medical therapy first and then only if the patient is not a good candidate for this option or they fail that option, then we can go to more invasive options, such as laparoscopic surgery or other forms of procedures. So this is collectively how I approach my patients with endometriosis.

Suzie and Jim, I want to thank you for being part of this episode.

Dr. As-Sanie:
It was a pleasure to be here today, Ayman and Jim.

Dr. Simon:
Ayman and Suzie, it was great to be part of this program.

Dr. Al-Hendy:
This concludes our discussion on the use of oral GnRH antagonists as a first line in the medical management of endometriosis. Unfortunately, our time is up. Thank you, everyone, for listening.

Announcer:
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