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The Critical Role of Addressing Patient Fertility Desire in the Treatment of Uterine Fibroids and Endometriosis

Announcer:
Welcome to CME on ReachMD. This activity, entitled “The Critical Role of Addressing Patient Fertility Desire in the Treatment of Uterine Fibroids and Endometriosis” is provided by Omnia Education.

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Dr. Shulman:
Fertility preservation is a critical concern for all women of reproductive age diagnosed with endometriosis or uterine fibroids. GnRH antagonists are shifting our approach to these two conditions, and surgical trends are changing.

This is CME on ReachMD, and I'm Dr. Lee Shulman. I'm joined today by Dr. Elizabeth Stewart, a Professor at the Mayo Clinic, who is a true leader in current gynecologic trends reinforcing that less is more. I'm looking forward to our discussion today on how the surgery-only-as-indicated paradigm is changing the way we approach these complex cases.

Dr. Stewart, it's a real pleasure to be here with you today.

Dr. Stewart:
It's great speaking with you, Lee.

Dr. Shulman:
Elizabeth, let's get started. Could you provide us with a brief overview of how trends in medicine are clearly moving away from surgery as a first-line option and how this corresponds with our approach to endometriosis and uterine fibroids?

Dr. Stewart:
Yeah, I think that's a great question. We've certainly seen the move away from surgery in lots of medical fields, away from transsphenoidal surgery to use of bromocriptine agonists for pituitary adenomas and away from cardiac surgery to stent placement and even medications.

And I think we're really at a tipping point in gynecology, that when I was in training, there were women that had yearly laparoscopy for endometriosis-related pain or women who had multiple fibroid surgeries. And I think we're really seeing that there are unintended consequences to gynecologic surgery. I think gynecologists have really absorbed that lesson when it comes to removing the ovaries. And so more and more we are allowing women to keep their ovaries or even recommended that they do. But I think that concept really hasn't moved forward to trying to keep the uterus preserved and intact reproductive system. So that we really think about the uterus is an endocrine organ instead of just a reproductive organ. And so we've written fairly recently about moving beyond just reflexive and prophylactic gynecologic surgery. And I think this is critical for women with endometriosis and uterine fibroids. I think especially now that we have good medical treatments, it makes this process easier.

Dr. Shulman:

Well, I think it's true that fertility, especially in reproductive-aged women, needs to be a high priority for us clinicians when we discuss options for treating.
This is not our decision. This is our patient's decision that we need to provide information and appropriate support so that they can make an informed decision, and empower them to really take the approach that they're going to want to do to get to the clinical outcome that they truly desire.

So, Elizabeth, what is it about our approaches to uterine fibroids and endometriosis that is or should be the same or different, particularly with respect to the etiology of fertility concerns?

Dr. Stewart:
I think for both diseases, that we need to think beyond just women in their 20s and early 30s, because I think as a reproductive endocrinologist, and we have newer therapies and good pregnancy outcomes with donor eggs. Even the 40-year-old woman or the 49-year-old woman that's in your office may actually be seeking fertility.

But I think there are some key differences between uterine fibroids and endometriosis. Typically, endometriosis is a disease that affects younger women, and often it's pain that's driving decision-making. So women are often seeking relief of their pain rather than surgery to affect their reproductive organs.

With women with uterine fibroids, pain is a bigger issue than we used to think it was. Surgery becomes the treatment of choice only when other less effective treatments haven't managed the symptoms.

Dr. Shulman:
I was taught very early on that surgery for pain was likely not going to be successful, even if the pain was attributed to a particular anatomical finding, because the process of surgery in and of itself could potentially lead to other pain. Perhaps my role also as a geneticist, and providing nondirective counseling, should be something that our gynecologic colleagues should clearly consider. We really need to provide patients with accurate information and empower them to make these decisions for themselves.

Dr. Stewart:
I think now it's clearer that pain is often not in the pelvic organs at all, that it's in the brain, or it's in the nerve roots and nerve firings. So I think that that is supported by science. You're absolutely right. Working with the patient and trying to focus on her symptoms and her desires are critical.

Dr. Shulman:
So with that being said, can you delve a little deeper into your clinical approach and how you guide shared decision-making when weighing treatment options with patients?

Dr. Stewart:
Absolutely. So I think the first thing that I do when I meet with a new patient is find out what her symptoms are, what's driving her to see me, what's driving her to do something about her problem.

For example, there are women that do have heavy menstrual bleeding and may even have evidence of anemia. But that's not what's driving them to have a fibroid treatment. For them, the pressure on their bladder or the pain that they're having during their menses may be what's driving women. And so understanding exactly what symptoms they're having and what symptoms are most important to be treated is important.

I think the second thing I try to understand is where she is in her reproductive lifespan. Is she actively trying to get pregnant and maybe even infertile? Maybe she's been trying for two years, and has never even talked to a doctor about her inability to get pregnant. Maybe she wants to keep that door open, but may not choose to go in the direction of fertility, but absolutely wants a uterine-preserving option.

That I think in addition to those issues, there's a literature that suggests that women come with specific preferences. Some women would always choose a medical therapy over a surgical therapy; other women prefer interventional therapies. So I think trying to understand the underlying disease manifestations, the woman's reproductive plans and preferences, and then being able to discuss a full range of options with her. And I think the fact that we now have FDA-approved oral GnRH antagonist combinations, such as elagolix add-back therapy and relugolix combination therapy, that can give women substantial relief is really important.

Dr. Shulman:
For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Lee Shulman, and here with me today is Dr. Elizabeth Stewart.

We're turning now to ethno-racial considerations when managing endometriosis and uterine fibroids.

Elizabeth, how is the management of endometriosis and uterine fibroids impacted by ethno-racial issues? And what does this mean for

our discussions with our patients?

Dr. Stewart:
I think that the data is stronger for the disparities for women of African descent with uterine fibroids. That for Black women, uterine fibroids develop at an earlier age. And this means it has more impact on fertility and pregnancy. Black women have more concerns about having fertility-maintaining therapies and even uterine-preserving therapies if they're not seeking childbearing. That also women have more severe disease when they're of African descent.

But the good news is that the emerging data on oral GnRH antagonists combinations is that they work on severe disease just as well as they do for more modest disease.

Dr. Shulman:
Well, I think we can recognize, especially in what we've discussed here today, is that if Black women or a certain group of women are being preferentially offered surgical interventions, they're clearly getting a substandard approach to both endometriosis and uterine fibroids, given the development of GnRH antagonists. So these health disparities, clearly can play a profoundly adverse role in clinical outcomes and in long-term outcomes for women of color, for women who are not receiving the optimal approaches because of these healthcare disparities.

Women who are impacted by endometriosis tend to be, from a demographic point of view, somewhat different than women who are impacted by fibroids. Women with endometriosis can be primarily of all racial and ethnic groups, as are women with fibroids. But fibroids are clearly more common in women who are of African descent.

Obviously, the evaluation of pelvic pain mandates that we do our best to diagnose fibroids, which are done with pelvic exams and ultrasounds and perhaps other imaging. Endometriosis takes a bit more to make the diagnosis, not necessarily amenable to a specific laboratory or imaging assay, but rather a more detailed discussion of the type of pain, the symptoms that she's presenting with.

So again, I think it's important that we are able to recognize that fibroids may be more common in certain racial and ethnic groups, whereas endometriosis is not necessarily more common in a particular group, but it tends to present more commonly in women who are younger in their reproductive age.

Dr. Stewart:
I think it's also important to think about the fact that many women with both endometriosis and fibroids will have multiple interventions over their lifetime. And both women and clinicians often forget that the risk of a second surgery or a third surgery are usually substantially more than the risk of an initial surgery. So if you are needing to go in the direction of a surgical therapy, trying to time that to the time when a woman is ready to pursue pregnancy is optimal.

Dr. Shulman:
Dr. Stewart, do you have any practical tips from a clinical perspective about how to address fertility concerns with patients?

Dr. Stewart:
So I think the first practical tip is to ask. That I'm always amazed when I'm seeing a patient for a second opinion or a third opinion, and she says, “Well, gee, nobody ever asked me about what my plans for pregnancy are.” So I think asking, first of all, is the most important thing.

I think the second thing is, sometimes it's useful to clarify when a woman says, “I want fertility,” are they really saying, “I want fertility now and I'm actively trying,” versus trying to just say, “I absolutely, positively don't want a hysterectomy and I want to preserve my uterus no matter what.” So I find that there are some women who come in saying they want fertility, but really what they want is a fertility-preserving option, or in the case of fibroids, a uterine-preserving option. And again, that there may be subtle differences in what may be acceptable therapy if you're trying to get pregnant now versus you're trying to keep that door open.

I think the third thing that is really important is that both endometriosis and fibroids are diseases that are not cured by surgery, and are not necessarily even cured by hysterectomy. Certainly, there are women with endometriosis-related pain after hysterectomy. And there are women who can have fibroids implant in the pelvis as a part of the procedure. And so even after what's declared as a definitive procedure, they can have recurrent disease. So trying to minimize surgical intervention and then only employing it when you're ready to get pregnant can be the best solution for many women.

Dr. Shulman:
I continue to be amazed that the way to obtain the most optimal information about a patient in a variety of fields is not testing, it's not advanced laboratory testing, or advanced diagnostic imaging. It's sitting down and talking with the patient. And actually, for us to do less of the talking and more of the listening. And in that regard, we find out so much valuable information that is going to play a critical role

and, again, in optimizing our approach to help that woman achieve the clinical goals that she came in to see us in the first place.

Dr. Stewart:
Absolutely. I couldn't agree with you more. I think that's critical.

Dr. Shulman:
Elizabeth, before we wrap up, what's your take-home message for our audience?

Dr. Stewart:
So I think the take-home message is to talk with women about their reproductive goals and fertility goals and to listen to what they say. And now that we have effective nonsurgical therapies, there are many women that will respond to medical therapy or even minimally invasive interventional therapy. Where when you and I were training, we would have said, “Oh, just go to hysterectomy. Why not do the definitive surgery?” And I think that we're looking to relieve symptoms and optimize quality of life. And that doesn't necessarily come from surgical approaches.

Dr. Shulman:
Well, I couldn't agree with you more. I think we're going to be seeing a continuation of the wholesale progression from surgery as a first-line option for many conditions to surgery as an alternative option for those conditions, or perhaps in the future, surgery not being an option at all. And I think this is ultimately going to lead to better outcomes and, I hope, also for patients who are more satisfied with their clinical outcomes.

Dr. Stewart:
I'm in complete agreement.

Dr. Shulman:
Unfortunately, that's all the time we have today. So I want to thank our audience for listening in. And I want to thank you, Dr. Stewart, for sharing your expertise and insight. It was great speaking with you today.

Dr. Stewart:
Well, thank you for the opportunity.

Announcer:
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