Provided by AAPA American Academy of PAs The France Foundation

Out of the Shadows:

Normalizing the Management of UTERINE FIBROIDS and ENDOMETRIOSIS

1

Provided by the
American Academy of PAs
in collaboration with The France Foundation

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American Academy of PAs

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2

Steering Committee

Breann Garbas, DHSc, PA-C
Assistant Professor, UF College of Medicine
Equal Access Clinic
Gainesville, FL

Nisha McKenzie, PA-C, CSC, NCMP, IF
Women's Health Collective
Grand Rapids, MI

3

Disclosures

Activity Staff Disclosures

- The planners, reviewers, editors, staff, CME committee, and other members at the AAPA and TFF who control content have no relevant financial relationships to disclose

Faculty/Steering Committee

- Breann Garbas, DHSc, PA-C, has no relevant financial relationships to disclose
- Nisha McKenzie, PA-C, CSC, NCMP, IF, has no relevant financial relationships to disclose

4

Periods are supposed to hurt a lot; suffering is part of having a uterus.

A. True
B. False

5

It is normal to miss school or work every month because you are bleeding too heavily.

A. True
B. False

6

If my patient has excessive pain or bleeding during their period, they will need a referral to OB/GYN. Within the scope of primary care, I should not attempt to manage their care. I can't begin to manage their care myself.

A. True
B. False

7

Endometriosis and uterine fibroids are basically the same thing in presentation and how they should be medically managed.

A. True
B. False

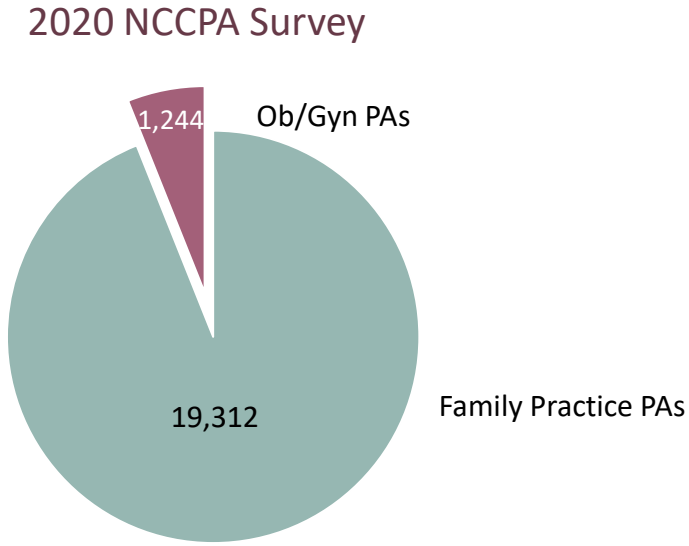
8

What You Will Gain Today

- A better understanding of the burden and quality of life impacts of endometriosis and uterine fibroids
- Improved ability to manage patients with these diseases, including use of GnRH agonists/antagonists
- Greater confidence when talking with patients about their menstrual cycle and its associated impacts

9

Why PAs?



10

Endometriosis

11

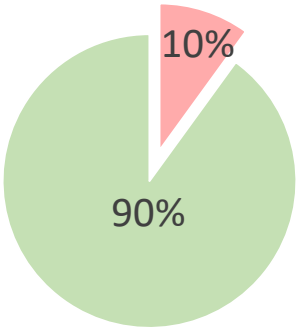
What percentage of patients with a uterus will likely experience endometriosis during their reproductive lifetime?

A. 5%
B. 10%
C. 20%
D. 40%

12

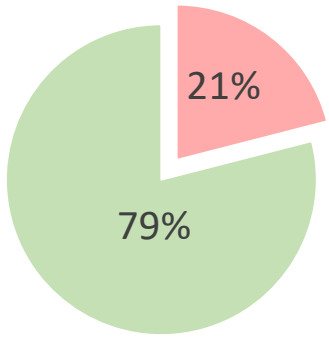
Prevalence

Endometriosis rates in women of reproductive age



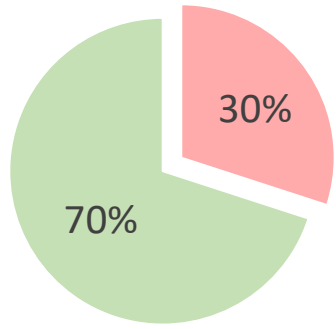
Shafrir AL. *Best Pract Res Clin Obstet Gynaecol.* 2018 Aug;51:1-15

Endometriosis rates in women presenting with chronic pelvic pain



Mowers EL. *Obstet Gynecol.* 2016 Jun;127(6):1045-1053

Endometriosis rates in women who present with infertility



Prescott J. *Hum Reprod.* 2016 Jul;31(7):1475-82

13

Impact on Quality of Life

Overall Quality of Life

Patients with endometriosis had wellness score of 51.5, normative range 70-80 for western populations

Rush G, Misajon R. *Health Care Women Int*. 2018 Mar;39(3):303-321.

Racial Disparities

Black patients less likely to be diagnosed with endometriosis and offered infertility preservation counseling

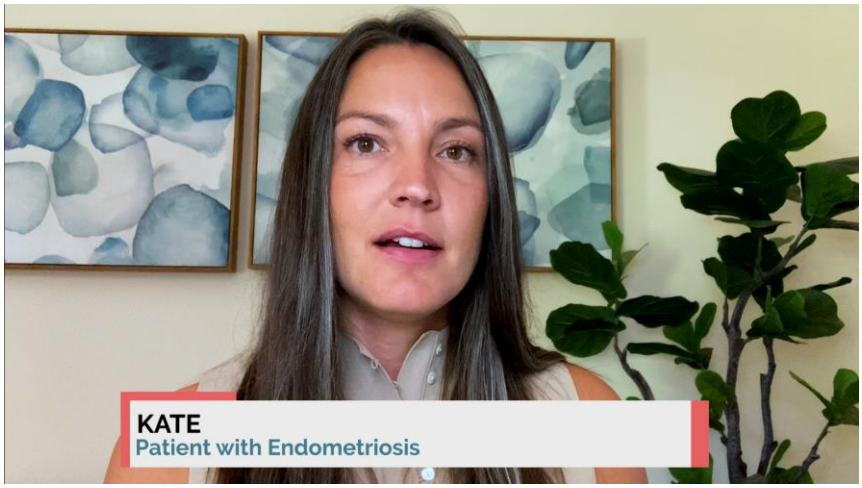
Bougie O, et al. *BJOG.* 2019 Aug;126(9):1104-1115.

Impact on Quality of Life

Time	Healthcare Costs	Fertility	Sexual Health
• ↓ Average of 6.3 work hours/week • ↓$10,177.54/year	• Annual economic burden (direct/indirect cost) in 2009 was estimated at $69.4 billion	• Patients with endometriosis have > 2 fold higher risk of infertility	• 47% of patients with endometriosis had dyspareunia[4]
Soliman AM, et al. *J Psychosom Obstet Gynaecol*. 2017;38(4):238-248.	Simoens S, et al. *Hum Reprod*. 2012;27(5):1292-1299.	Prescott J, et al. *Hum Reprod*. 2016 Jul;31(7):1475-82.	De Graaff AA, et al. *Hum Reprod*. 2013;28(10):2677-2685.

15

Quality of Life



16

Diagnosis

- Medical school training in endometriosis diagnosis (laparoscopy)
- Clinical suspicion of endometriosis

17

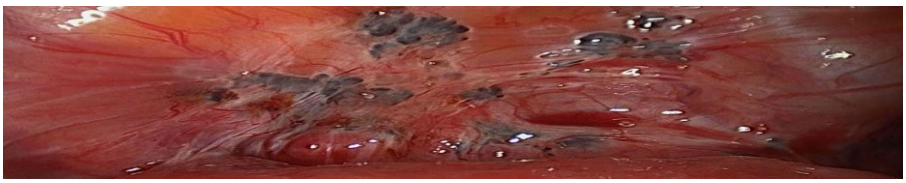
Clinical Suspicion of Endometriosis

- ✓Significant dysmenorrhea (even before menstruation)
- ✓Heavy or painful bleeding
- ✓Painful intercourse
- ✓Chronic pelvic pain (> 6 months)
- ✓Pain radiating into back or upper thighs
- ✓Bowel or urinary pain during menses
- ✓Upon physical exam
  - Fixed or retroverted uterus
  - Tender uterosacral ligaments
  - Uterosacral nodularity
  - Cul-de-sac nodularity

18

Diagnosis

- Its important to diagnose early



19

Importance of Early Diagnosis

20

Management

First-line

- Continuous Oral Contraceptive Pills (OCPs)
- Depot medroxyprogesterone acetate (DMPA) and alternatives etonogestrel implants or levonorgestrel IUD
- NSAIDs
- GnRH analogs ± add back therapy
- Norethindrone acetate

Second-line

- Aromatase inhibitors
- Laparoscopy + post surgical hormonal suppression
- Hysterectomy

21

GnRH Analogs

- Agonist versus antagonists
- Benefits of add-back therapy

	Agonists	Antagonist
Side effects	↓ bone mineral density and symptoms of hypogonadism	↓ bone mineral density and symptoms of hypogonadism
Approved for endometriosis	Buserelin, goserelin, and leuprolide	Elagolix, relugolix combination
Method of administration	Nasal spray, Injection (daily, monthly, 3-monthly)	Oral
Activity	Several weeks to respond, initial flare of symptoms common	Instant response
Limitation of usage	Generally 6 months or less with some exceptions up to 1 year	24 months or less depending on dose and hepatic function

22

Uterine Leiomyomas (fibroids)

23

Prevalence

- Increases with age during reproductive years
- By age 50
  - > 80% in African American patients with a uterus
  - 70% in White patients with a uterus

24

Symptoms of Uterine Fibroids

- ✓Bleeding (sometimes intermenstrual)
- ✓Urinary frequency/urgency
- ✓Pelvic pressure/pain
- ✓GI tract symptoms (constipation)

25

Quality of Life

Medical	Missing Work	Economic	Quality of life
• Estimated primary cause of 45% of hysterectomies	• 28% of patients reported missing work due to UF symptoms[1] • $4,600 estimated annual cost/patient[2]	• Estimated $34 billion healthcare dollars/year in US[2]	• QoL scores similar to, or more severe than those with other chronic diseases such as diabetes or breast cancer

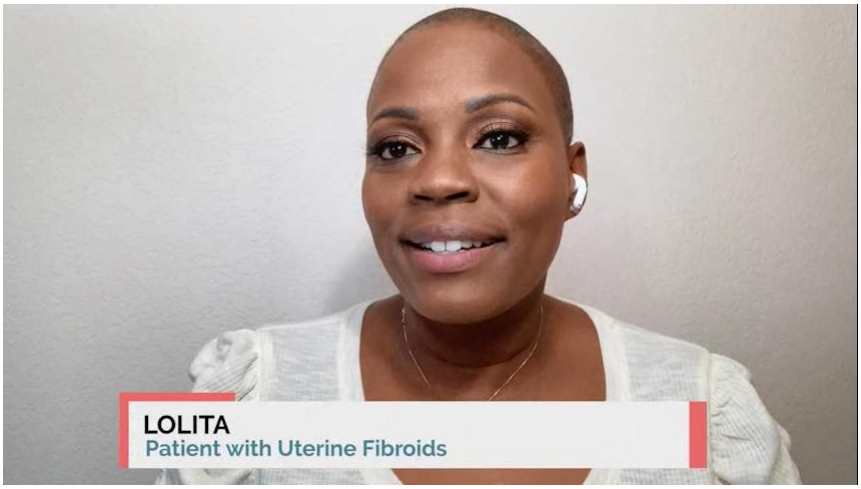
Wright JD, et al. *Obstet Gynecol.* 2013 Aug;122(2 Pt 1):233-241.

1. Borah BJ, et al. *Am J Obstet Gynecol.* 2013 Oct;209(4):319.e1-319.e20

2.Cardozo ER, et al. *Am J Obstet Gynecol.* 2012 Mar;206(3):211.e1-9.

Go VA, et al. *Am j obst gyn.* 2020 Nov 1;223(5):674-708

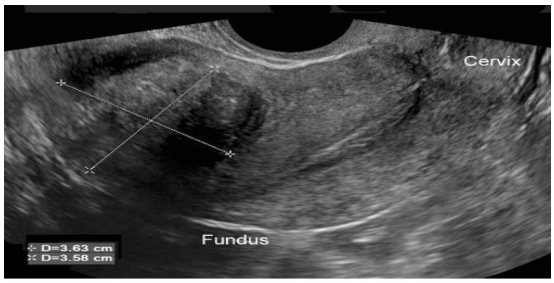
Quality of Life



27

Diagnosis of Uterine Fibroids

History and Physical → Labs → Imaging



Source: Barbara L. Hoffman, John O. Schorge, Lisa M. Halvorson, Cherine A. Hamid, Marlene M. Corton, Joseph I. Schaffer: *Williams Gynecology*, 4th Edition

28

Case Practice

Anna is a 33-year-old patient that presents with complaints of heavy bleeding during their period. Physical exam reveals uterus enlarged to 8 weeks size and irregular shape. Ultrasound demonstrates a 3 cm concentric, solid, hypoechoic mass indicating a uterine fibroid. Anna indicates she would like to have a child in the next 5 years.

29

What would be the most appropriate initial treatment for Anna?

A. Tranexamic acid
B. NSAIDs
C. GnRH antagonist with hormonal add-back therapy
D. Hysterectomy

30

Medical Management

Medical Treatment	Bleeding	Uterine Enlargement
Gonadotropic-releasing hormone antagonists with hormonal add-back therapy	X	
Levonorgestrel-releasing intrauterine devices	X	
Contraceptive steroid hormones (limited evidence in progesterone only)	X	
Tranexamic Acid	X	
Gonadotropic-releasing hormone agonists bridging to definitive	X	X

American College of Obstetricians and Gynecologists. *Obstet Gyn*. 2021 Jun 1;137(6):e100-15.

31

Surgical Management

- Uterine artery embolization
- Endometrial ablation (for myoma-related bleeding)
- MR guided ultrasound surgery
- Myolysis
- Myomectomy
- Hysterectomy

32

GnRH Antagonist Combinations: Reduction in Heavy Menstrual Bleeding

Al-Hendy A. *New Eng J Med*. 2021 Feb 18;384(7):630-42.

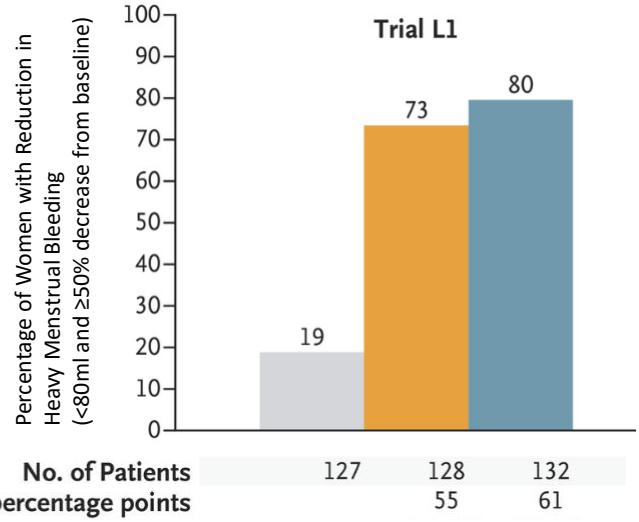
Approved GnRH antagonist combinations:

- **Relugolix, estradiol, and norethindrone combination**
- Elagolix, estradiol, and norethindrone combination

Placebo

Relugolix + estradiol + norethindrone (combination) for 24 weeks

Relugolix monotherapy for 12 week then relugolix combination for 12 weeks



33

Do You Know?

34

When using a GnRH antagonist to treat uterine fibroids, what can be done to slow the loss of bone mineral density?

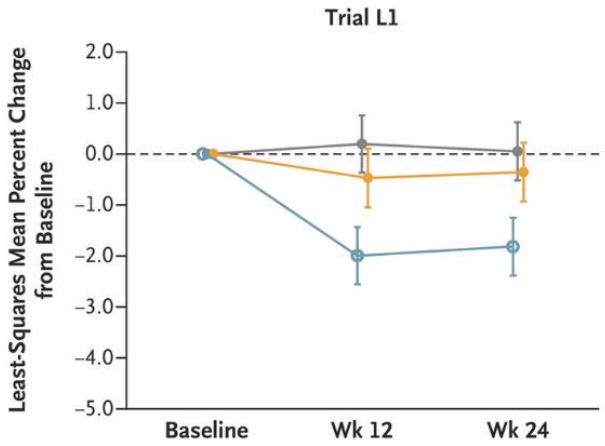
A. Add-back therapy of estradiol and/or progestin
B. Have patient increase physical activity
C. Prescribe GnRH agonists in addition to antagonist
D. There are no medical interventions to slow the side-effects of GnRH antagonists

35

Change in Bone Mineral Density

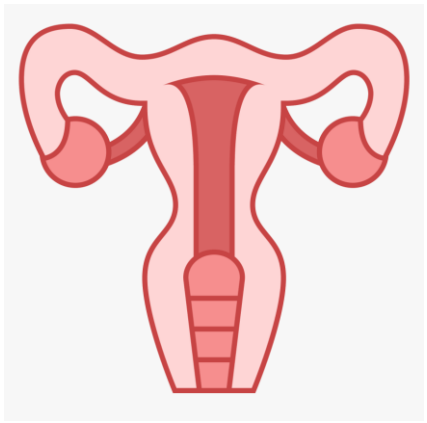
Lumbar Spine

- Placebo
- Relugolix + estradiol + norethindrone (combination) for 24 week
- Relugolix monotherapy for 12 week then relugolix combination for 12 weeks



Al-Hendy A. *New Eng J Med*. 2021 Feb 18;384(7):630-42.

Who Needs to Be Screened?



37

Case Practice

You are a primary care physician associate in a family practice. Liz is a 15-year-old patient, that comes in for a wellness check. You ask the patient how their periods are and the patient replies, “I guess ok, normal.”

38

What should you do next?

A. Ask no further questions regarding menstruation. This patient is too young to have serious menstrual complications.
B. Ask no further questions regarding menstruation, even if this patient has early endometriosis. This patient should wait to move forward with intervention until they are concerned about fertility.
C. Ask clarification questions to ascertain what “normal” means regarding menstruation and screen for menstruation irregularities. Begin treatment if discovered.
D. Do not inquire regarding menstruation. A patient will bring up problems if they exist.
E. Ask clarification questions to ascertain what “normal” means regarding menstruation and screen for menstruation irregularities. Immediately refer them to an OB/GYN if any questions/concerns arise.

39

What to Ask

- Menstrual cycle timing, duration
- Bleeding and clotting (use of pictorial bleeding chart)
- Pain and fatigue
- Pain (cycle, sex, bowel movements, and urinary)
- Infertility
- Quality of life questions (interference with daily life)

Resources:

- *Endometriosis and Uterine Fibroids Screening Guide*
- *Endometriosis and Uterine Fibroids Provider Resource Guide*

40

How to Ask

- Don’t assume
- Address earlier bias/discrimination
  - What have you been told in the past…
- Validate

41

Empower Your Patients to Become Stakeholders in Their Own Care

42

Summary

- Primary care has a unique role
- If we ask the questions, they will answer
- Reach out and make connections with other providers

43

Post-test #1: What percentage of patients with a uterus will likely experience endometriosis during their reproductive lifetime?

A. 5%
B. 10%
C. 20%
D. 40%

44

Post-test #2

Anna is a 33-year-old patient that presents with complaints of heavy bleeding during their period. Physical exam reveals uterus enlarged to 8 weeks size and irregular shape. Ultrasound demonstrates a 3 cm concentric, solid, hypoechoic mass indicating a uterine fibroid. Anna indicates she would like to have a child in the next 5 years.

What would be the most appropriate initial treatment for Anna?

A. Tranexamic acid
B. NSAIDs
C. GnRH antagonist with hormonal add-back therapy
D. Hysterectomy

46

Post-test #3: When using a GnRH antagonist to treat uterine fibroids, what can be done to slow the loss of bone mineral density?

A. Add-back therapy of estradiol and/or progestin
B. Have patient increase physical activity
C. Prescribe GnRH agonists in addition to antagonist
D. There are no medical interventions to slow the side-effects of GnRH antagonists

47

Posttest #4

You are a primary care physician associate in a family practice. Liz is a 15-year-old patient, that comes in for a wellness check. You ask the patient how their periods are and the patient replies, “I guess ok, normal.”

48

What should you do next?

A. Ask no further questions regarding menstruation. This patient is too young to have serious menstrual complications.
B. Ask no further questions regarding menstruation, even if this patient has early endometriosis. This patient should wait to move forward with intervention until they are concerned about fertility.
C. Ask clarification questions to ascertain what “normal” means regarding menstruation and screen for menstruation irregularities. Begin treatment if discovered.
D. Do not inquire regarding menstruation. A patient will bring up problems if they exist.
E. Ask clarification questions to ascertain what “normal” means regarding menstruation and screen for menstruation irregularities. Immediately refer them to an OB/GYN if any questions/concerns arise.

49

Questions?

50