Clinical Management of Endometriosis
Tommaso Falcone, MD, and Rebecca Flyckt, MD
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Questions have been written by:
John Fischer, MD
Department of Obstetrics, Gynecology, and
Women’s Health
University of Minnesota Medical School
Minneapolis, MN

Responses have been written by:
Tommaso Falcone, MD
Obstetrics, Gynecology, and Women’s Health
Institute
Cleveland Clinic
Cleveland, OH
and
Rebecca Flyckt, MD
Obstetrics, Gynecology, and Women’s Health
Institute
Cleveland Clinic
Cleveland, OH

Question 1:

What is the overlap between endometriosis and adenomyosis? Could they be considered a variation of the same disorder, namely, abnormal implantation of endometrial tissue?

Response from Drs. Falcone and Flyckt:

Endometriosis and adenomyosis have a high degree of concordance, and many of their common symptoms overlap. Indeed, both endometriosis and adenomyosis manifest similar key differences in sex steroid hormone receptors and inflammatory mediators. However, there is increasing evidence that endometriosis and adenomyosis are not variants of the same underlying disorder, and that adenomyosis results from independent molecular pathways and signaling. Whereas deeply infiltrating endometriosis or endometriomas can be considered alternative presentations of the same underlying disease, adenomyosis should not be considered “endometriosis of the uterus.”

Question 2:

Given the strong familial association of endometriosis with a 7-fold to 10-fold increase in risk among first-degree relatives, is there a place for prophylactic continuous oral contraceptives or similar suppressive therapy in a young woman with a mother or sister with endometriosis who would like to delay, blunt, or even try to prevent the onset of endometriosis?

Response from Drs. Falcone and Flyckt:

Although combined oral contraceptive use has been associated with decreased risk of endometriosis and endometrioma formation, there are no studies specific to risk reduction for young women with first-degree family members affected by endometriosis. For women with other indications or interest in starting treatment, there may be potential additional benefit in endometriosis prevention or suppression that can inform discussions and decision-making.
Question 3:
Given the concept of central sensitization as a possible contributor to the pain associated with endometriosis, are there treatments, such as gabapentin or sacral neuromodulation, that may act to downregulate this sensitization?

Response from Drs. Falcone and Flyckt:
Sustained and effective treatment of the pain associated with endometriosis necessitates a multidimensional approach that may include both pharmacologic and minimally invasive procedures. In addition to physical therapy and trigger point injections, which address the myofascial aspects of central sensitization, treatment with gamma-Aminobutyric acid analogs and neuromodulation with transcutaneous electrical stimulation do show potential benefit in the treatment of chronic pelvic pain associated with endometriosis.4,5

Question 4:
How does the combination of hormonal suppression, such as continuous oral contraceptives, and NSAIDs compare to either continuous oral contraceptives or NSAIDs alone?

Response from Drs. Falcone and Flyckt:
Although there are no head-to-head trials to address this specific question, clinical experience suggests that the combination of continuous oral contraceptives and NSAIDs is preferable to either treatment alone, and is certainly superior to NSAIDs alone. Especially during acute pain exacerbations or recurrences, the addition of NSAIDs to medical suppressive regimens is preferable to initiating narcotics.

Question 5:
Given that treatment with gonadotropin-releasing hormone (GnRH) agonists is associated with a higher recurrence rate as well as the limited duration of treatment of only 6 months, what patient type would be best treated with this medication?

Response from Drs. Falcone and Flyckt:
Both GnRH agonists and antagonists can be used as a measure of last resort when other better-tolerated agents with lower costs have failed to achieve adequate pain relief. Agonists/antagonists can also be useful agents as a bridge to surgery.

Question 6:
Is there an optimal “debulking” of the number and size of endometriotic lesions that should be achieved with surgical treatment of endometriosis?

Response from Drs. Falcone and Flyckt:
If endometriosis surgery is being performed for pain relief, the surgeon should make every effort to remove all visible disease, as even small lesions can cause persistent pain. Optimal endometriosis excision is painstaking work, and should be undertaken by practitioners who have the training and time to achieve full excision or ablation of implants. It is our opinion that incomplete surgery may perpetuate the chronic pain experienced by endometriosis patients.
Question 7:

It seems that the role of surgery or medical treatment alone does not improve pain or fertility in patients with endometriosis. Is there evidence that combined treatment with both medical suppression and surgical treatment improves outcomes better than either therapy alone?

Response from Drs. Falcone and Flyckt:

Surgery can be highly effective in reducing endometriosis-associated pain, but must always be combined with plans for postoperative medical suppression to achieve lasting reductions in pain and prevent recurrences. Improvements in fertility achieved by surgery are minimal in comparison to assisted reproductive technology, and medical suppression with the goal of improving fertility is not effective or recommended.

References