Clinical Diagnosis and Early Medical Management for Endometriosis: Consensus for Asia

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Introduction

- The diagnosis and treatment of endometriosis has recently undergone considerable changes with an increasing focus on patient-centered care that includes more frequent clinical management, including use of questioning and imaging, and early medical treatment.[1,2]
- While this changing paradigm for non-surgical diagnosis and medical management necessitates consideration of how best to deliver patient-centered care, available guidelines and recommendations do not necessarily reflect current practice and the emerging evidence base, including within Asia.
- Therefore, this work provides consensus guidance regarding clinical diagnosis and early medical management of endometriosis within Asia.

Methods

- In 2019, clinicians with expertise in the diagnosis and treatment of endometriosis met to critically evaluate available evidence at the time, including international guidelines and consensus reports,[3-10] on clinical diagnosis and early medical management of endometriosis and their applicability to current clinical practices, with a predominant focus within Asia.
- This work is a summation of these deliberations and provides guidance regarding clinical diagnosis and early medical management of endometriosis within Asia.

Results

Guidance for clinical diagnosis

To shorten diagnostic delay, clinical diagnosis should focus on symptom recognition, which can be indicative of endometriosis without laparoscopic confirmation

- A clinical approach to diagnosis considers that endometriosis can occur without pelvic pain symptoms and that pelvic pain might be attributed to causes other than endometriosis.[2,11]
- We propose focusing on the patient history and clinical examination, which can decrease diagnostic delay especially in low resource settings.

Transvaginal sonography (TVS) is an appropriate first-line imaging approach for diagnosing pelvic endometriosis

- For some endometriosis subtypes, TVS improves accuracy when used in conjunction with symptoms, patient history, and/or physical findings.[1,12,13]
- Consideration of the appropriateness of TVS for individual patients is required. For those in whom TVS is not appropriate, use of alternative imaging approaches, such as transabdominal or transrectal sonography, should be considered.

Early empiric treatment

Management of women with a clinical presentation suggestive of endometriosis should be individualized considering their presentation and therapeutic need

- A definitive diagnosis is not required before commencing treatment in patients with pelvic pain who are not desirous of immediate pregnancy.
- The primary focus of endometriosis treatment should be the management of a patient's presenting symptoms, and treatment should be individually tailored, accounting for patient and disease-related factors and treatment-related characteristics.

Hormonal treatment is recommended to reduce endometriosis-associated pelvic pain for patients with a non-surgical endometriosis diagnosis and no immediate pregnancy desires

- Hormonal treatment for women with suspected or confirmed endometriosis can have a beneficial effect on pain and is not associated with a detrimental effect on subsequent fertility.[5]
- Of the available hormonal treatments, we consider progestin only pills to be one of the first-line treatment options for early medical management of endometriosis.

Progestins are a first-line management option for early medical treatment, with oral progestin-based therapies generally a better option compared to combined oral contraceptives (COCs) because of their safety profile

- Oral progestin-based therapies are generally a better option compared with COCs for the medical management of endometriosis, as oral progestins are not contraindicated according to patient age and smoking status and have a generally favorable tolerability profile.[14]

The selective progestin, dienogest, can be used long-term if needed and a larger evidence base supports dienogest use compared with gonadotropin-releasing hormone agonists (GnRHa) as first-line medical therapy

- Long-term follow-up for dienogest is at least 60 months in clinical studies that include patients from adolescence to women in their fifth decade.[15-23]
- A 5-year study found that dienogest (2 mg/day) reduced endometriosis-associated pelvic pain and avoided pain recurrence post-surgery, and was well tolerated with clinically manageable adverse effects.[21]

GnRHa may be considered for first-line therapy in some specific situations or as short-term therapy before dienogest and non-steroidal anti-inflammatory drugs (NSAIDs) as add-on therapy for endometriosis-associated pelvic pain

- Because the use of GnRHa in patients who have not reached maximum bone density requires careful consideration,[4,8,9] GnRHa should be considered as a first-line, short-term therapy only for carefully selected patients.
- Because of the limitations of NSAIDs (e.g., potential inhibition of ovulation, gastric ulceration and cardiovascular disease risk) and their inability to alter the disease course,[24-26] NSAIDs are generally insufficient for treatment of patients with a confirmed diagnosis of endometriosis or with symptoms other than dysmenorrhea.

Algorithm

- A consistent approach to clinical diagnosis and treatment of endometriosis is necessary to optimize patient care and outcomes. However, a validated algorithm that utilizes both clinical diagnosis and early medical therapy using contemporary treatment approaches is not available currently.
- We propose an algorithm that incorporates clinical diagnosis and early medical management for endometriosis in Asia **(Figure)**. Notably, further evaluation of such an algorithm and incorporation into routine practice will require consideration of its effect on diagnosis rates and patient outcomes.

Conclusion

- It is recommended that early clinical diagnosis and medical treatment of endometriosis should now be considered, including within Asia, to contribute to delivery of patient-centered care.
- A validated algorithm that utilizes both of these aspects of diagnosis and treatment is not available currently.
- Based on our consideration of the available evidence from recent international guidelines, consensus reports and the literature on clinical diagnosis and early medical management of endometriosis, we propose an algorithm that incorporates clinical diagnosis and early medical management for endometriosis in Asia.
- Notably, further evaluation of such an algorithm and incorporation into routine practice will require consideration of its effect on diagnosis rates and patient outcomes.

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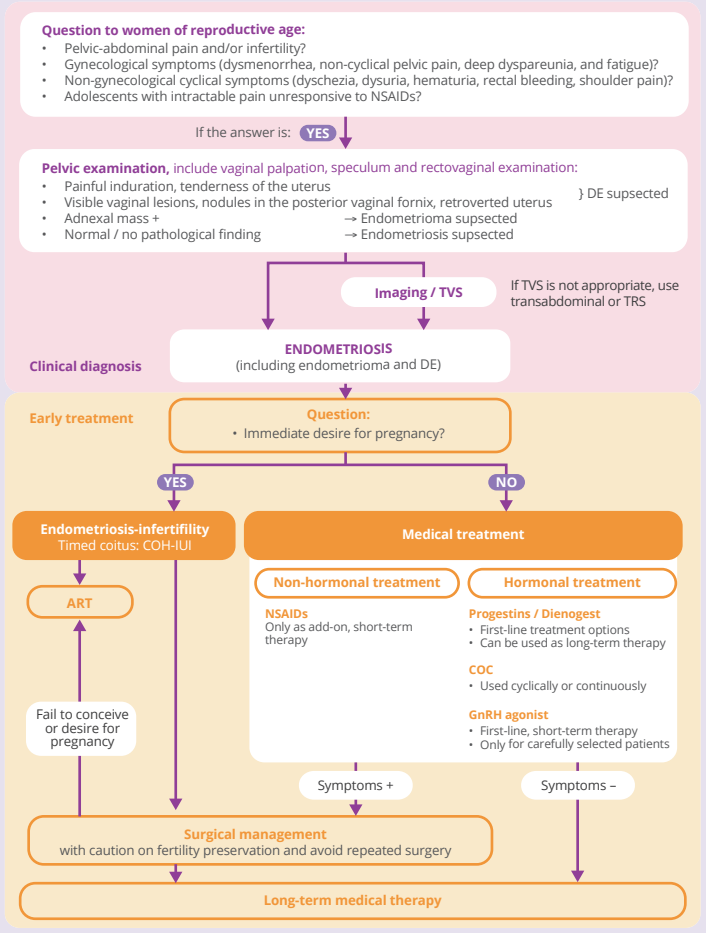
Figure. Algorithm for the clinical diagnosis and early treatment of endometriosis in Asia



ART, assisted reproductive technology; COC, combined oral contraceptive; COH, controlled ovarian hyperstimulation; DE, deep endometriosis; GnRH, gonadotropin-releasing hormone; IUI, intra-uterine insemination; NSAID, nonsteroidal anti-inflammatory drug; TRS, transrectal sonography; TVS, transvaginal sonography.

Acknowledgments: This work was supported by Bayer Inc. Medical writing services were provided by Tricia Newell, PhD, and were funded by Bayer Inc in accordance with Good Publication Practice (GPP3) guidelines (http://ismpp.org/gpp3).

Presented at the SEUD Congress 2021; Stockholm, Sweden; December 9–11, 2021

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MA-PF-WHC-SG-0006-1