

OPTIMIZE THE MEDICAL TREATMENT OF ENDOMETRIOSIS—USE ALL AVAILABLE MEDICATIONS

ROBERT L. BARBIERI, MD
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Dienogest as an option for endometriosis pain

For treatment of endometriosis-related pain, what about the drug dienogest and the cyclic oral contraceptive Qlaira, which contains dienogest?

Chow Kah Kiong, MBBS
Singapore

Norethindrone's conversion to ethinyl estradiol

Dr. Barbieri's editorial on the medical treatment of endometriosis is excellent! Does norethindrone acetate metabolize to ethinyl estradiol in a higher percentage when the dose is higher, or is it still 1%? We were taught that at doses of greater than 15 mg daily, norethindrone can contribute significant amounts of estrogen.

Lauren Barnes, MD
Albuquerque, New Mexico

Endometriosis is a surgical, not a medical, disease

I read with some dismay Dr. Barbieri's editorial on medical treatment of endometriosis. As a long-time disciple of the eminent Dr. David Redwine, I have dedicated my practice focus over the past 28 years to minimally invasive curative solutions to many gynecologic problems. The data on the histology, qualitative hormonal differences, and inconsistent and poor long-term response of endometriosis to traditional hormonal suppressive therapies falls strongly in favor of complete and thorough laparoscopic excision—not "biopsy"—as the only truly curative treatment, certainly not medical therapy. Endometriosis is a surgical



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disease. The experience of the dedicated few in our field who have taken the time and effort to become experts in excision (not ablation) of endometriosis bears this out.

The tragedy is that the only Current Procedural Terminology code that is usable for reimbursement is 58662. Sadly, this code was assigned a resource-based relative value scale "value" many years ago, when the operation consisted of putting a scope in the abdomen and taking a sampling biopsy (which took all of 10 minutes). Of course, we know that a prolonged, delicate procedure requiring retroperitoneal dissection, ureterolysis, excision of deeply infiltrating rectovaginal septum endometriosis, and discoid or segmental bowel resection requires the kind of surgical expertise developed only by those who put in the time and effort to get good at this type of surgery. The majority of ObGyns who have a full obstetric practice and low surgical volumes simply are not going to struggle in the operating room over the many cases that it takes to become good, and safe, at this pro-

cedure only to receive an insulting reimbursement.

It is emblematic of this travesty that many of the best minimally invasive surgery practitioners do not accept insurance or other third-party payment such as Medicaid as they would otherwise not cover their overhead.

Putting premenopausal women into a severely hypoestrogenic state with medication is cruel and, even worse, does not cure the disease.

Balanced information on surgical management should have been presented in the article. And physicians who are not capable of proper laparoscopic excision should refer the patient.

Hugo Ribot, MD
Cartersville, Georgia

Dr. Barbieri responds

I thank Drs. Chow, Barnes, and Ribot for their interest in my recent editorial on the medical treatment of endometriosis. I agree with Dr. Chow that dienogest, a synthetic progestin, is effective in the treatment of pelvic pain caused by endometriosis. In one observational study, norethindrone acetate 2.5 mg daily and dienogest 2 mg daily had similar efficacy in the treatment of pelvic pain. Dienogest treatment was associated with fewer side effects but was much more expensive than norethindrone acetate.¹ The US Food and Drug Administration has approved a combination estradiol-progestin pill (Natazia, Qlaira) as a contraceptive, and I have occasionally used this medication in my practice for women with pelvic pain caused by endometriosis. Dienogest monotherapy is not available in the United States.

Dr. Barnes reminds us that norethindrone is a substrate for the aromatase enzyme system and can be

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converted to ethinyl estradiol.² The conversion occurs at a very low rate, likely less than 0.4%.³ At a norethindrone acetate dose of 5 mg daily, aromatization would result in the production of less than 2 µg of ethinyl estradiol daily.

Dr. Ribot advocates for surgery as the primary treatment of pelvic pain caused by endometriosis. I agree with Dr. Ribot that, for severe pain caused

by deep infiltrating endometriosis, surgery is an optimal approach. However, for women with pelvic pain and Stage I endometriosis, hormonal treatment after initial surgical diagnosis and treatment reduces pain recurrence and repetitive surgical procedures.⁴

References

1. Vercellini P, Bracco B, Mosconi P, et al. Norethindrone acetate or dienogest for the treatment of

symptomatic endometriosis: a before and after study. *Fertil Steril*. 2016;105:734-743.

2. Barbieri RL, Petro Z, Canick JA, et al. Aromatization of norethindrone to ethinyl estradiol by human placental microsomes. *J Clin Endocrinol Metab*. 1983;57:299-303.
3. Chu MC, Zhang X, Gentzschlein E, et al. Formation of ethinyl estradiol in women during treatment with norethindrone acetate. *J Clin Endocrinol Metab*. 2007;92:2205-2207.
4. Soliman AM, Bonafede M, Farr AM, et al. Analysis of subsequent surgery rates among endometriosis patients who underwent surgery with and without concomitant leuprolide acetate therapy. *Curr Med Res Opin*. 2016;32:1073-1082.

Treating endometriosis pain: Not just one and done

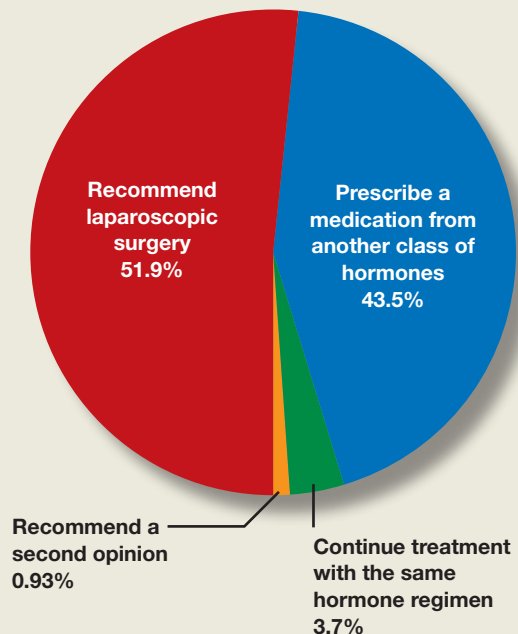
In his article, "Optimize the medical treatment of endometriosis—Use all available medications" (August 2016), OBG MANAGEMENT Editor in Chief Robert L. Barbieri, MD, discussed the various hormonal options ObGyns can prescribe for endometriosis pain when use of one drug has stopped being efficacious. Alternatives to a first-line treatment, such as continuous low-dose estrogen-progestin contraceptives, include progestin-only medications, gonadotropin-releasing hormone analogues, and androgens.

Recently, OBG MANAGEMENT posed this query to readers in a website poll: "Continued endometriosis-related pelvic pain: What's your next step?" Here's how they responded.

Poll results

More than 100 readers cast their vote:

- **51.9% (56 readers)** recommend laparoscopic surgery
- **43.5% (47 readers)** would prescribe a medication from another class of hormones
- **3.7% (4 readers)** would continue treatment with the same hormone regimen
- **0.93% (1 reader)** recommended a second opinion



To participate in the latest Poll, visit mdedge.com/obgyn

Tell us what you think!

Share your thoughts on any topic relevant to ObGyns and women's health practitioners. We will consider publishing your letter in a future issue.

Send your letter to: rbarbieri@mdedge.com

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