RECENT TRENDS IN MEDICAL MANAGEMENT OF PAIN IN ENDOMETRIOSIS - DR. KANTHI BANSAL

"Endometriosis should be viewed as a chronic disease that requires a life-long management plan with the goal of maximizing the use of medical treatment and avoiding repeated surgical procedures".

Medical treatment can be given as first line treatment, for Pain, Infertility, Recurrence, After surgery to reduce recurrence ,When surgery is not possible or refused .Medical treatment includes NSAIDs, OC Pills, Danazol, Progestogens, Antiprogesterone, Gestrinone, Prostaglandins, Aromatase Inhibitors, GnRH-agonist and GnRH-agonist with add back therapy. Most commonly used molecules for pain management are Progestins, Dienogest & GnRH- agonist. Progestins inhibit FSH & LH secretion by negative feedback & suppress ovarian function & causes atrophy of endometrial implants. Includes Oral MPA 50 – 100 mg/day, IM depot MPA – 150mg IM q3 months and LNG IUS.LNG IUS gives 85 – 95% - significant reduction in pain to patient, particularly promising for rectovaginal endometriosis.

Dienogest the miracle molecule is the first line of pain management, is given as post operative adjuvant, for RV endometriosis pain relief, as secondary prevention , recurrence & adenomyosis. It acts on both Central Nervous system & locally. Dienogest is the only low-dose progestin that has been shown to be equally effective as GnRH-agonists, with a favorable safety and tolerability profile, allowing for long-term use in endometriosis. 2 mg daily is well tolerated and effective as optimal dose in endometriosis. Treatment compliance during the long-term study was high as 98% and Patient satisfaction with dienogest: 88.9%.

Ormeloxifene is given weekly for very good control of bleeding and pain.

Cabergoline is now tried in euprolactinemic individuals with endometriosis because it has antiangiogenic actions.

Aromatase inhibitors are used in pain management; Letrozole is given in dose of 2.5 mgms for 6 months.

GnRH agonist acts on Hypothamus, suppresses the ovaries, increases apoptosis and decreases angigogenesis. GnRH-Agonists are available as depot preparations, which have to be administered at 1-3 monthly intervals to achieve pituitary suppression.

GnRH agonists initially induces an increase of the levels of gonadotrophins and estradiol(Flare up) which can be avoided by starting agonist in the midluteal phase or pretreatment with progesterone or oral contraceptives for several weeks prior to administration or Co treatment with an GnRH antagonist for the first week after the administration. Studies showed proven pain relief in 80-90% of women and extended relief when employed for 6 months or more. Long term used of GnRH agonist leads to bone marrow demineralization & osteoporosis. To prevent these complications, low dose estrogen & Progestrone or Tibilone 2.5 mg is given.