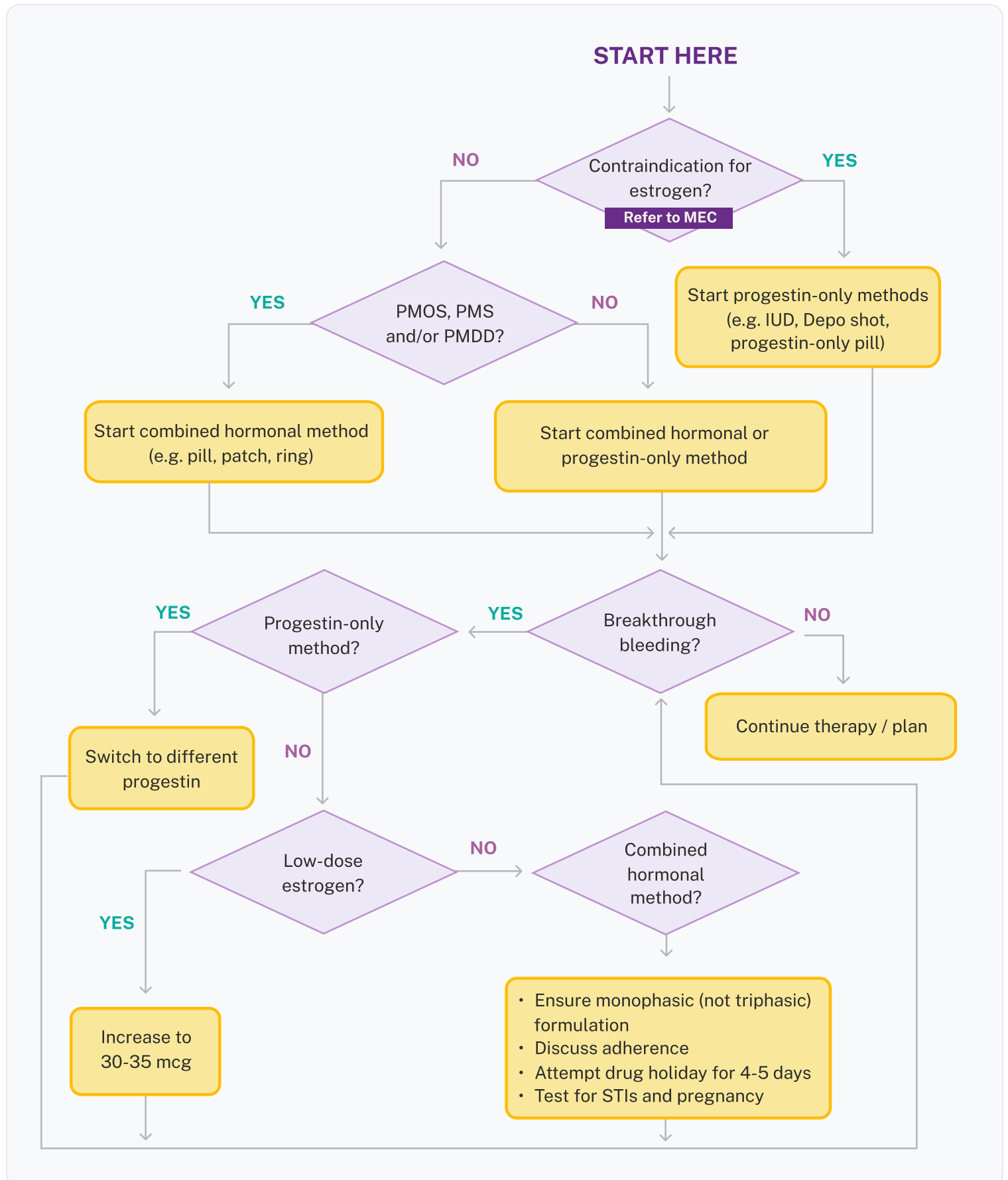


Hormone Therapy for Endometriosis



Refer to 2024 U.S. Medical Eligibility Criteria (MEC) for Contraceptive Use for information on hormone therapy options for patients with a chronic medical problem or contraindication to estrogen.

[Full Document](#)

[Summary Chart](#)

[Android App](#)

[Apple App](#)

PROGESTIN-ONLY OPTIONS

Hormonal IUD

Higher dose, such as 52 mg, more likely to induce amenorrhea.

Implant

DMPA Injection (Depo Shot)

Not recommended if interest in pregnancy in next 12 months — return of ovulation can be delayed 12–18 months.

Norethindrone

Desogestrel & Norgestimate

3rd generation progestins show superior bleeding control compared to 2nd generation (levonorgestrel and norgestrel) and 1st generation (norethindrone).

COMBINED OPTIONS

Pill

Patch

Ring

Pill and ring have **higher user satisfaction**, lower adverse effects, and **higher continuation rates** compared to the patch with extended cycle and continuous use.

CONTINUOUS OR EXTENDED CYCLE (EC) USE

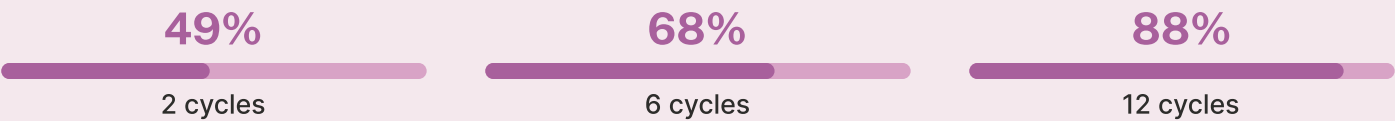
Continuous Use

Uninterrupted use without a hormone-free interval. Any pill, patch or ring can be used continuously, though some are designed specifically for this.

Extended Cycle (EC) Use

Planned hormone-free interval after more than 28 days of active hormones. EC has less breakthrough bleeding (BTB) compared to continuous use.

Amenorrhea Rates with Treatment



Counsel that breakthrough bleeding is likely early in treatment, but will decrease with time. Amenorrhea rates increase from 49% to 68% to 88% after 2, 6 and 12 cycles of treatment, respectively.

TIPS FOR DISCUSSING HORMONE THERAPY WITH PATIENTS

Inform patient that the goal of hormone therapy is to **reduce pain through amenorrhea** (stopping menstrual cycles).

Use **shared decision making** to discuss patient’s values and preferences regarding methods throughout the algorithm.

1

Set the Stage
"Not having a period can help decrease the pain you're experiencing. We usually accomplish this with hormones. Are you interested in that?"

2

Assess Priorities
"What is most important to you about the method we choose?" Prompt on pregnancy prevention, benefits beyond family planning, use and frequency, side effects and cost, if needed.

3

Reflective Listening
“That’s really helpful to hear that ----is most important to you. I can give you some extra information to help you make your decision.”

4

Respond to Concerns
“It’s really unfortunate that your friend had [issue] with that method. That can happen, but we can start at the lowest dose to hopefully prevent that while controlling your periods.”

5

Summarize & Decide
“Based on your goals and the information we reviewed about [topics discussed], what do you think is the best option for you?”

Remember to counsel patient about side effects, beyond bleeding, for the chosen method.

USE INSTRUCTIONS AND PRESCRIPTION GUIDANCE

CONTINUOUS USE
Pills
Take one tablet daily, skipping placebo week pills.
Ring
Place ring vaginally for 4 weeks, then insert new ring.
Patch
Place patch weekly onto skin.

EXTENDED CYCLE (EC) USE
Pills
Take active pill daily, skipping placebo week for 12 weeks, then stop and have a period. Restart active pills on cycle day 4–7, continue for 12 weeks, repeat.
Ring
Place ring vaginally for 4 weeks, insert new ring. Repeat for 12 weeks total, then stop and have a period. Insert new ring on cycle day 4–7, continue for 12 weeks and repeat.
Patch
Place patch weekly onto skin. Continue for 12 weeks. Place new patch on cycle day 4-7, continue to place patch weekly for 12 weeks and repeat.

ANNUAL RX
For continuous or EC use:
Pills
Dispense 112 tablets, with 4 refills
Ring
Dispense 3 rings, with 4 refills
Patches
Dispense 12 patches, with 4 refills

If the patient reports side effects related to the hormone:

- › **Avoid offering supportive care alone** — e.g. recommending antiemetic for nausea. A decrease in the hormone dose should also be considered/offered.
- › **For progestin-only pills (e.g. norethindrone)** — Dose can be reduced to as low as 0.35mcg/day -counsel patient that breakthrough bleeding (BTB) is more likely at lower dose.
- › **For combined pills** — Opt for low dose ethinyl estradiol (10-20mcg) -counsel patient that BTB is more likely at lower dose
- › **Offer switching to hormonal IUD** — Hormones are more localized and less systemic
- › **Offer prometrium 100–200 mg/day by mouth** — Note that this is not first line treatment or a form of contraception. BTB also more likely compared to other methods.