

“TREATING POLYCYSTIC OVARY SYNDROME: START USING DUAL MEDICAL THERAPY”

ROBERT L. BARBIERI, MD
(EDITORIAL; APRIL 2017)

Weight loss and dietary management for PCOS

I enjoyed Dr. Barbieri’s editorial on polycystic ovary syndrome (PCOS), but I feel that first-line management for PCOS should be weight loss and diet modifications that include instructions on decreasing carbohydrates and insulin spikes. A 5% to 10% weight loss should produce a return of cycles. Of course, metformin and spironolactone have a place for added treatment/prevention of acne and diabetes.

Luis Linan, MD
El Paso, Texas

Metformin and progesterone for PCOS-related infertility

I have been using Beyaz and Yaz for several years in my PCOS patients for the lower androgenic activity of the drospirenone based on the same assumption and its similarity to spironolactone. I have gotten great results with metformin 1,500 mg daily and, for those who desire fertility, cycling once a month for 10 days with progesterone. My own daughter was able to conceive in just 3 months of therapy. PCOS is extremely common in our region, probably due to the high obesity rate. I saw many more cases here than I ever thought I would when I was training.

Lisa Gowan, CNM, WHNP-BC
Albany, Georgia

Check insulin levels in PCOS patients before giving metformin?

Thank you for the very nice article regarding PCOS treatment. Does Dr. Barbieri routinely check insulin

levels on patients before treating with metformin and does he require abnormal insulin levels to be present before initiating treatment? The article suggested that using the listed risk factors is sufficient. Additionally, does he perform glucose-insulin testing? If so, what is the protocol used? I have used fasting levels and 2-hour post 75-g glucose-drink testing as well. What is the best approach?

Scott A. Beckman, MD
Jasper, Indiana

Contraception and spironolactone

As usual, Dr. Barbieri has provided a thorough, concise, and practical overview on the medical management of PCOS. I would add just one small point. Another reason for using an oral estrogen-progestin pill concomitantly with spironolactone is due to the potential teratogenicity of this medication.

Bryan R. Hecht, MD
Cleveland, Ohio

Low-carb diet helps mitigate metformin side effects

Thank you for the article on PCOS. I have been treating PCOS this way for about 15 years and have been following lipids and seen dramatic improvements with that as well. I wish we as a medical community would focus on the low carbohydrate diet to help avert metformin side effects as well as treat the metabolic issues. You can get many people back on metformin by just adjusting their diet. I hope you can spread this word.

Steven Foley, MD
Lamar, Colorado

Appreciates Dr. Barbieri’s editorials

G’Day from Australia. I am a big fan of your editorials and opinions and

enjoy reading OBG MANAGEMENT. Please keep it up.

Kanapathippillai Sivanesan, MD
Brisbane, Australia

» Dr. Barbieri responds

I thank Dr. Linan, Dr. Foley, and Ms. Gowan for sharing their important insights with our readers. I agree with Dr. Linan that I should have highlighted the important guidance that women with PCOS and a body mass index (BMI) above the normal range should be encouraged to reduce their weight by 5% to 10% with diet and exercise. Dr. Foley offers a clinical pearl that a low carbohydrate diet will reduce the gastrointestinal symptoms that may occur with metformin therapy. Ms. Gowan notes that the combination of metformin plus cyclic progesterone may help to initiate more frequent ovulatory cycles in women with PCOS, thereby improving fertility. Dr. Hecht reminds us that spironolactone is a teratogen and using effective contraception can help reduce the risk of exposing a pregnancy to the medication.

Dr. Beckman raises the important clinical issue of whether it is helpful to measure insulin concentration. Measuring insulin and glucose is especially helpful in understanding the causes of hypoglycemia. An elevated insulin level at the time of an abnormally low glucose level is very worrisome. However, for women with PCOS, in whom insulin resistance is common, measuring insulin is of minimal clinical value. A normal or elevated insulin level is consistent with the diagnosis of PCOS. Assessing BMI, waist circumference, HDL-cholesterol, fasting triglyceride level, and blood pressure—components of the metabolic syndrome—are much more useful clinically. The dermatologic skin lesion

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acanthosis nigricans is also a sign consistent with insulin resistance. I do not measure insulin levels in my patients with PCOS. Metformin is a useful agent in the treatment of PCOS whether or not insulin resistance is present. Metformin may have direct actions on the ovary to reduce androgen production, in addition to its beneficial effects in the liver.

“MORE THAN ONE-THIRD OF TUMORS FOUND ON BREAST CANCER SCREENING REPRESENT OVERDIAGNOSIS”

ANDREW M. KAUNITZ, MD (MARCH 2017)

Refutes concept of overdiagnosis of breast cancer

I read with interest and serious concern the commentary and conclusions of “overdiagnosed” breast cancer. Let us revisit a few time-honored principles. Are we throwing away the valued concept of the early diagnosis of node-negative breast cancer? Is it still true that 5-year and long-term survivals are markedly better for stage I and II disease as opposed to stage III and IV disease? Is it still true that treatments designed for cure are substantially less involved, more successful, and more likely to conserve the breast and require less chemotherapy in early stage disease? Is it still true that the majority of women diagnosed with breast cancer are in the lowest risk category, ie, no family history and negative for the *BRCA* gene? If so, then who can explain the statement that “an invasive breast cancer detected by any means is overdiagnosis”? Would this imply that screening and the biopsy required to make the diagnosis was time poorly spent, the breast cancer should not be treated, and/or we should simply wait for a lump to be found by the patient deep in a large breast most likely at

that point representing advanced disease?

The last paragraph notes the current US Preventive Services Task Force (USPSTF) guidance: wait until 50 years of age to start biennial screening. If so, what do we say to women in their 40s who, through screening with mammography and/or ultrasound, were diagnosed with early node-negative invasive breast cancer? That all of that was unnecessary and would not have led to symptoms? Would extreme morbidity from advanced or recurrent disease and the horrors of treatment just to extend a few months of life qualify as a symptom to these investigators? Lax protocols are not for me, my colleagues, or patients that I know. One of the most common reasons for a lawsuit to be brought against a primary care or ObGyn provider is failure to diagnose breast cancer!

John T. Armstrong, MD
Napa, California

» Dr. Kaunitz responds

I thank Dr. Armstrong for his interest in my commentary on screening mammography and overdiagnosis. As I indicated in my commentary, I continue to recommend screening mammography for my patients, encouraging average-risk women to begin biennial screens at age 50 (consistent with USPSTF guidance), when the likelihood that tumors found with mammograms representing overdiagnosis is lower. I also indicated that I recognize that some patients prefer to begin screening at a younger age and to be screened more frequently. Dr. Armstrong’s letter refers to the “horrors of treatment” of breast cancer. From my perspective, the most “horrible” treatment is that which is administered to a woman diagnosed with a tumor destined to not cause clinical problems during her lifetime

(overdiagnosis). You also refer to a statement, “an invasive breast cancer detected by any means is overdiagnosis.” That statement does not appear in my commentary.

My commentary’s point is that overdiagnosis is common among tumors diagnosed by screening mammography, and likely explains why, in contrast with cervical cancer screening, screening mammography has failed to reduce the incidence of breast cancers presenting as advanced (metastatic) disease. Although this represents a confusing and disquieting reality for our patients, and for us their clinicians, I agree with Dr. Otis Brawley, Chief Medical and Scientific Officer of the American Cancer Society, that we must acknowledge to our patients that overdiagnosis is common, the benefits of screening have been overstated, and that some patients considered as “cured” from breast cancer have in fact been harmed by unneeded treatment.¹

Reference

1. Brawley OW. Accepting the existence of breast cancer overdiagnosis [published online ahead of print January 10, 2017]. *Ann Intern Med*. doi:10.7326/M16-2850.

“HOW AND WHEN UMBILICAL CORD GAS ANALYSIS CAN JUSTIFY YOUR OBSTETRIC MANAGEMENT”

MICHAEL G. ROSS, MD, MPH (MARCH 2017)

Cord gas analysis can be beneficial but has drawbacks

In his article, Dr. Ross makes a few statements I would like to challenge. He gives a list of indications for cord gas analysis, even with a vigorous newborn. I would suggest that doing so is not only unnecessary, but could get the delivering provider in trouble. Normal gases with a vigorous infant are not actionable, and neither are abnormal gases with a vigorous

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infant. The latter situation could, however, lower the bar for a lawsuit if any neurologic pathology is diagnosed in the child.

At our hospital, blood gas assessments generate charges of \$90 for each arterial and venous sample. The author states that gases are helpful for staff education. If that is the purpose of measuring the gases when Apgar scores are normal, then the bill for the gases should be sent to the staff, not the patient or insurance company.

The precise reason for doing cord gases is to prove you are a good doctor. If the Apgar scores are low, a healthy set of gases shows that your interventions were timely and appropriate. Normal gases prevent lawsuits in this situation.

Joe Walsh, MD
Philadelphia, Pennsylvania

>> Dr. Ross responds

I appreciate the comments of Dr. Walsh, who suggests that we should not obtain cord gases in vigorous infants due, in part, to the hospital charges. There are several reasons for the indications detailed in the article. Although normal Apgar scores would appear to negate the potential for severe metabolic acidosis, Apgar scoring accuracy has been challenged in medical legal cases. Furthermore, there may be newborn complications (eg, pre-existing hypoxic injury, intraventricular bleed) that may not be recognized immediately, yet hypoxemia and acidosis may be alleged to have contributed to the outcome. The actual cost of running a blood gas sample is far less than the \$90 hospital charges. Nevertheless, if hospital charge is a concern, I recommend that the physician obtain a cord gas sample immediately following the delivery and determine whether to run the sample after the 5-minute Apgar score is obtained.

>> **Readers periodically send in questions** for our coding specialist Melanie Witt, RN, MA. Ms. Witt is an independent coding and documentation consultant and former program manager, department of coding and nomenclature, American Congress of Obstetricians and Gynecologists.

Reader inquires about coding for McCall culdoplasty

It is difficult to know what CPT code to use for billing when my practice's physicians do a McCall culdoplasty during a vaginal or laparoscopic hysterectomy. They often do a McCall procedure when a rectocele is present. One provider said it is CPT 57283. But I read an article that said a McCall repairs an "enterocele" and code 58263 would be used if doing one during a vaginal hysterectomy. Do you have a recommendation?

Sonia Pap, CPC, COBGC
Linville/Boone, North Carolina

>> Melanie Witt responds

Preventing vaginal vault prolapse by supporting the vaginal cuff is an essential part of hysterectomy, whether abdominal or vaginal. The McCall culdoplasty procedure is performed to support the vaginal cuff at the time of a vaginal hysterectomy by attaching the uterosacral and cardinal ligaments to the peritoneal surface with suture material such that, when tied, it draws toward the midline, helping to close off the cul-de-sac. This procedure not only supports the vaginal cuff but also closes off the cul-de-sac, thus preventing the formation of an enterocele.

As such it would be considered integral to the normal vaginal hysterectomy procedure and is not separately billable. However, in some cases where

the patient has stage 1 to stage 4 uterovaginal prolapse, adjunct vaginal apex support is necessary. If the patient has this documented prior to the surgery, she will likely need more than the included uterosacral-cardinal ligament attachment to the vaginal membrane. This is where a colpopexy comes into play, and traditionally, sacrospinous fixation has been performed to accomplish this. In recent years, the uterosacral ligaments have been used instead, which is why we now have 2 codes for vaginal approach colpopexy: 57283 (uterosacral) and 57282 (sacrospinous). Both of these procedures will eliminate an existing enterocele and therefore could potentially be billed with a vaginal hysterectomy unless a more comprehensive code exists that describes the total surgery.

If the purpose of the colpopexy is to repair an existing enterocele, you would not itemize, but rather would report a vaginal hysterectomy with enterocele repair code (58263, 58270, 58292, or 58294) for that complete surgery. The codes do not specify the type of enterocele repair performed and so by definition would include "any method" including a colpopexy. You will note that the colpopexy codes 57283 and 57282 are bundled into all vaginal hysterectomy codes, and although you can use a modifier -59 to bypass this edit, you must meet the criteria for doing so. But especially, 57283 and 57282 are permanently bundled with the vaginal hysterectomy codes that include enterocele repair. Since there already exists a code that describes a vaginal hysterectomy with enterocele repair, you cannot report the modifier -59 for a separate colpopexy if the reason for doing it was to repair an enterocele. You could, however, use it if the sole reason was to do an adjunct vaginal vault repair due to documented uterovaginal prolapse.