LETTERS

Physician questions incontinence statistics


Managing urinary incontinence: an expanding role for Ob/Gyns

In "Managing urinary incontinence: an expanding role for Ob/Gyns" [December], Alan Garely, MD, tells us of the millions and millions of women who suffer from incontinence. I am 69 years old and have been in practice in the same place for 36 years. Most of my patients are more than 40 years old. I have asked every patient in my care for the past 20+ years whether she is incontinent. The majority say no.

After I read the article, I decided to keep a list of the patients I saw. Of 32 women, 25 had no complaints of incontinence, and the remaining 7 had insignificant incontinence. Granted, this may not be an entirely valid sample, but is the estimate of "more than 20 million American women who suffer from some form of urinary incontinence" reproducible using strict scientific methods? Furthermore, nothing positive comes from denigrating ourselves for not curing incontinence that is either minor or misdiagnosed.

James Honig, MD
Rockledge, Fla

DR. GARELY RESPONDS:

Dr. Honig makes some good points. He questions the estimate of 20 million urinary incontinence sufferers in the U.S. I, too, find myself questioning this number and am not really sure if it encompasses women who have had only 1 episode or who are always incontinent.

However, according to the census bureau, there are approximately 41 million women over 50. In Dr. Honig's small sample size, 22% suffered from some form of incontinence. Apply this percentage to all women over 50, and there would be roughly 10 million women with complaints of incontinence. If we include women of all ages, this number could easily reach 15 million. No, I don't think "strict scientific methods" were used, but somebody out there is buying close to $2 billion worth of overactive bladder drugs and spending countless billions on adult diapers.

The bottom line: Urinary leakage is embarrassing. Experience has shown us if you don't ask, patients may not tell. My goal was simply to help gynecologists develop a strategy that would be easy to apply to their practices.

Vaginal breech delivery challenged

The debate over "The term breech: vaginal or cesarean delivery?" [January] should be moot. Although Alex Vidaeff, MD, and Edward Yeomans, MD, argue for vaginal delivery, no one in his or her right mind would opt for this mode of delivery unless forced to because the baby is falling out.

The only physicians willing to consider it either are academicians who practice in tertiary university settings with a cadre of residents or physicians with access to 24-hour, in-house anesthesia and cesarean section capabilities. Most important, they are supported by hefty liability insurance policies and a phalanx of hospital attorneys willing to wage war on their behalf when something goes wrong.

Change the tort system, and I might consider doing vaginal breeches again. Or maybe not. I can do a cesarean in 30 minutes and have a healthy baby and a happy mother with minimal morbidity.

The alternative: I can sweat for several hours waiting for the mother to deliver, tying up several other people in the delivery room, all the while realizing that any purported cost savings would be immediately wiped out by a multimillion-dollar judgment when something goes wrong.

I don't care what the literature says. The only outcomes that matter are my own.

David Rivera, MD
Lombard, Ill

DRS. VIDAEFF AND YEOMANS RESPOND:

We appreciate Dr. Rivera's comments, but unlike him, we do care what the literature says. Our article was prompted by what we perceive

as a lack of debate following such an important study as the Term Breech Trial. Cognizant of the radical impact the trial's results may have on the future of our specialty, we wanted to stimulate scientific and clinical dialogue concerning the practical applicability of its conclusions.

Are there increased nutritional needs with OCs and HRT?

I am interested in obtaining more information about the nutritional needs of women who take exogenous estrogen, i.e., oral contraceptives (OCs) and hormone replacement therapy (HRT).

James Gordon, MD
Chesterfield, Mo

KARIN MICHELS, SCD, MSC, MPH, RESPONDS:

The only consistently found effect of exogenous hormone use on nutritional status is a disturbance of the vitamin B_6 (pyridoxine) metabolism by OCs.[1,2] This finding was largely based on studies of OCs with high estrogen content.

It is not clear whether the newer low-dose OCs may have less of an impact on vitamin B_6 status than the higher-dose preparations.[3] Therefore, until additional studies can be performed, vitamin B_6 supplementation is recommended in women who take OCs.

Editor's note: Dr. Michels is assistant professor of obstetrics, gynecology, and reproductive biology at Harvard Medical School and Brigham and Women's Hospital in Boston, Mass.

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3. van der Vange N, van der Berg H, Kloosterboer HJ, Haspels AA. Effects of seven low-dose combined contraceptives on vitamin B_6 status. *Contraception.* 1989;40:377-384.

Weighing when to report bad outcomes to insurance carriers

In Ken Heland's Medicolegal Consult column [December], he stated that medical malpractice insurance companies should be notified of all bad outcomes or potential claims.

While I thought his comments were valuable, physicians should be aware that many insurance carriers will enter any report a clinician gives them concerning a bad outcome as a "claim" or "incident," even if no legal notice of a lawsuit or intent of a lawsuit is present. This claim will then permanently show up in a physician's record with the malpractice insurance company.

Reporting all bad outcomes prior to legally being required to do so is an open invitation to increased premiums or cancellation of coverage. Therefore, I would like to argue that it is better to err on the side of caution and report only those cases in which there is a credible threat of litigation.

Byron G. Darby, MD
Austin, Tex

MR. HELAND RESPONDS:

Most malpractice insurance carriers can distinguish between a "bad outcome" and an actual claim. Certainly a physician who reports an excessive number of bad outcomes will be at higher risk for termination or a higher rate. Insurance underwriters will think that he or she is an accident waiting to happen, whether or not the bad outcomes result in claims.

Some companies want all "incidents" to be reported; others prefer to focus on actual claims. Obtain a written letter from your insurance carrier as to its specific policy.

Absent a written policy, always report cases with a likelihood of permanent disability, as well as cases of unexpected death. Only report temporary disability cases or those that can be corrected by subsequent surgery when the extent of the temporary disability was quite painful and severe and the medical costs were high. In my opinion, these are the types of cases that are most likely to lead to litigation, and reporting them to your insurance company at the time of the incident might give you and the carrier the tools to help manage the case in order to avoid a claim.