The "ins" and outs of trocar insertion

The exchange of letters in the June issue was provocative ("Optical-access trocars: Good idea or higher risk?"). In my experience, direct trocar insertion is safer and saves time. Transumbilical insertion is best because the umbilicus is the thinnest part of the abdominal wall and the peritoneum is firmly attached to it, but trans-cul-de-sac insertion using a Veress needle is the better option if abdominal insertion is not possible in extremely obese patients.

In addition, in prolonged procedures, nitrous oxide makes a safer insufflation medium because it lacks the biochemical side effects of carbon dioxide. In fact, direct trocar insertion with nitrous oxide insufflation and a single-puncture laparoscope is an ideal setup in average, low-risk patients undergoing minor procedures under local and/or intravenous mild sedation and no uterine manipulation.

Hamid H. Sheikh, MD
Lexington, Ky

Dr. Michael Baggish responds:

Direct trocar insertion is an acceptable alternative to establishing pneumoperitoneum prior to trocar insertion. However, direct trocar insertion (no pneumoperitoneum) should be attempted with great caution when using a disposable device. Manufacturers recommend creating pneumoperitoneum to produce the most favorable environment for the shield to deploy. If an adverse outcome occurs because of a disposable trocar injury, the surgeon could be accused of failing to heed the manufacturer's written instructions for proper use of the trocar.

I find it hard to believe that a Veress needle (with a tip-to-hub measurement of 5 inches) cannot penetrate the most obese abdominal wall at the umbilicus. I prefer to create a pneumoperitoneum with a 3.5-inch Touhy epidural needle and have never failed to achieve pneumoperitoneum, even in a very obese person. In fact, I believe the unnecessarily long Veress needle presents some inherent penetration risks to underlying structures.

As for nitrous oxide, it does have advantages over carbon dioxide gas in that it is less irritating to the peritoneum. However, it also supports combustion (an electrosurgical device risk). Both gases tend to unfavorably cool the patient, especially when they are utilized over a protracted time.

Cut costs? Not when women expect perfection

In the May issue, Dr. Bruce Ettinger recommends that we avoid rushing to bone-preserving or enhancing drugs for low-risk women (Update on Menopause: "Curb your enthusiasm—no need to rush bone drugs if risk is low"). He notes that there is an extremely high cost per fracture avoided when treating women in their 50s to prevent osteoporosis. He goes on to recommend that we "give healthy women in their 50s permission not to take drugs if their risk

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"Attempt direct trocar insertion (no pneumoperitoneum) with great caution when using a disposable device"

of fracture within the next 5 to 10 years is low."

I believe the issue here is "beneficence" versus perfection. For example, in the field of obstetrics, we must achieve 100% success with every delivery or risk being sued. While Dr. Ettinger is giving permission to this particular subgroup of women to avoid medical therapy to reduce their fracture risk, I am interested in what their attorneys would have to say if a fracture occurred. Certainly, informed consent is critical here, as are risks and benefits. But we live in a society that expects 100% perfect outcomes all the time.

I think we should be encouraging all patients to be "cost-effective," but leave the final decision in their hands once we point out the pluses and minuses.

Laurence F. Mack, MD
North Massapequa, NY

Dr. Barbieri responds:

Dr. Mack highlights an important issue in the management of osteopenia and osteoporosis: the complexity of analyzing the overall clinical effectiveness of an intervention to prevent fractures. As a recent publication noted, the likely cost of alendronate treatment per quality-adjusted life-year in women with a T-score between –1.5 and –2.4 and no additional risk factors ranges from $70,000 to $332,000.[1] After weighing the risks and benefits, many women choose to start alendronate when their T-score ranges from –2 to –2.4 because their perception of the serious consequences of a fracture is far more important than the cost of the treatment.

The medical community will probably continue to adjust its recommendations for treating osteopenia and osteoporosis as more data are generated.

REFERENCE

1. Schousboe JT, Nyman JA, Kane RL, Ensrud KE. Cost-effectiveness of alendronate therapy for osteopenic postmenopausal women. Ann Intern Med. 2005;142:734–741.

For Pap testing, "every 3 years" means never

In his commentary on 2 studies of Pap testing practices, Dr. Neal M. Lonky chides the authors of those studies for failing to ask respondents why they cling to the outmoded ritual of the yearly Pap smear ("How many ObGyns follow the new rules on Pap testing?" [April]). Dr. Lonky suggests the question is essential to explain why most ObGyns have not yet adopted the every-2-to-3-years rule now being promulgated by the "experts." I'll give you my non-expert answer: People are not cattle.

Consider this patient: A.B., age 59 (the case is real, the initials are not), had had 1 husband, 1 gynecologist, and 18 consecutive negative Pap smears (the last 4 liquid-based) when she came to see me in 2001 for her annual exam. Her Pap that year: a high-grade squamous intraepithelial lesion. Her cone results: carcinoma in situ with gland involvement.

No doubt your experts would dismiss such cases as "anecdotal," which translates: "Evidence is what we say it is; believe what we tell you, not what you see." When pressed, the experts will admit to exceptions and failures, but these few unfortunate women must be sacrificed for the sake of avoiding all those costly colposcopies—ie, for the greater good of the herd.

When we say "once a year," we are hoping for every other. Start saying "every 3," and what you will get is never.

If a young man or woman starting medical school asked me today what specialty to enter, I would say gynecologic oncology. There will be a greater need for their services 5 to 10 years from now, thanks to today's experts.

Geoffrey C. Kincaid, MD
Knoxville, Tenn

"These few unfortunate women must be sacrificed for the sake of avoiding all those costly colposcopies"

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Dr. Lonky responds:
These studies explored the opinions of patients and physicians. Since we seldom ask the "why" question to determine what drives behavior, I chided the authors for omitting it. I am very pleased that Dr. Kincaid chose to answer the challenge!

Sometimes it is fear of losing the patient's trust, not scientific probabilities, that drives our practice. Dr. Kincaid certainly describes the challenges and potential conflicts behind managing and making decisions for large patient populations, as well as the decisions we make during 1-on-1 encounters. That is the relationship that makes the practice of medicine special. Thanks to Dr. Kincaid for his insights.

Tort reform sorely needed in Illinois

I value Dr. Barbieri's editorials on the issue of tort reform. Here in Illinois, the trial lawyers are decimating us physicians, and ObGyns are fleeing to nearby states where tort reform has been passed. Meanwhile, the trial lawyers hype the need for insurance reform, but never mention tort reform. Thanks for your dedication to this very serious issue.

Josh C. Tunca, MD
Palatine, Ill

"Trial lawyers hype the need for insurance reform, but never mention tort reform"

Dr. Barbieri responds:
I appreciate Dr. Tunca's supportive comments. We need to work together, as a discipline, to correct a tort system that is "out of control."

When a high C-section rate is an advantage

During the 1980s, I took pride in having the lowest C-section rate at my hospital: I delivered more than 220 babies a year with a primary rate of 12%. I delivered twins and breech presentations vaginally and was skilled with Laufe divergent forceps.

Some time during the 1990s, I reconsidered my approach. What if my birth outcomes were not so routinely good? Would I be able to defend the tactics I used to effect delivery? Could I defend myself with any breech birth?

Since my C-section outcomes were excellent, I decided to deliver all breech presentations and twins via cesarean. I have used this strategy for more than 10 years now and have no regrets about my higher C-section rate. Further, if I have any reservations about using forceps, I proceed with a C-section.

In 30 years of practice, I have been sued only once: for a delayed C-section in 2002. The hospital accepted responsibility and settled for $3 million, and I was dismissed from the case. That experience convinced me my strategy of performing C-sections is justified.

Ted E. Manos, MD
Eustis, Fla

We want to hear from you!

Have a comment on an article, editorial, illustration, or department? Drop us a line and let us know!

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