

“The result will be that our hysterectomies disappear into their intervention rooms”

Do we really want interventional radiology in every local hospital?

In Dr. Robert L. Barbieri's December editorial, "Massive obstetric hemorrhage: High- and low-tech tools," he posed the following question: "Should all obstetric services have access to the high-technology interventional radiology procedures?" My answer: definitely not; it is too expensive.

Why are health-care costs spiraling? Because of the frequent introduction of new, high-tech (and therefore expensive) techniques. Is there any proof that the balloon, compression sutures, and artery ligation are inferior to embolization? Until there is, I avoid recommending radiological techniques.

Here's another important question: Do we really want experienced radiologists ready to embolize in every community hospital? The result will be that our hysterectomies disappear into their intervention rooms, and I am strictly against that.

On a lighter note, thank you for taking such great care of OBG MANAGEMENT! You succeed in selecting truly relevant topics, which are then presented just right! I also appreciate the "Fast Track"; it is so nice to go straight to the important places.

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Dr. Barbieri responds:

We thank Dr. Muenzer for his kind words concerning the "Fast Track" feature in OBG MANAGEMENT. The editorial staff recognizes that our readers have exceptional

pressures on their time and need to have clinically important information presented as concisely as possible. The "Fast Track" was specifically designed with this in mind.

Regarding the December editorial, I agree that 2 factors that should dampen our enthusiasm for introducing interventional radiology services in every hospital that provides obstetrical services are the multimillion-dollar cost associated with interventional radiology and the potential impact of its widespread use on the high-acuity case volume of obstetricians.



4 tips to avert ureteral injury

Kudos for the excellent roundtable, "Avoiding lower urinary tract injury," moderated by Dr. Mickey Karam (September). As Dr. Geoffrey Cundiff pointed out in that article, visualizing the ureter and confirming its integrity at the end of the procedure prevent injury and allow early recognition if it occurs. I'd like to add 4 suggestions:

1. Elevate the infundibulopelvic ligament, turning potential space between the vessels and ureter into actual space, and place clamps with the ureter in view.
2. Remember that the ureter runs along the posterior leaf of the pelvic peritoneum.
3. Sharply dissect the bladder downward before placing the clamp on the uterine artery to obtain lateral displacement of the ureter.
4. Document in the operative report your visualization and efforts to identify the ureter.

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