Editorial

is true at your desk, apart from urgent circumstances, when you need resources to, say, interpret findings, create a management plan, or respond to a patient's question.

OBG@DOWDENHEALTH.COM

EDITOR'S NOTE: obgfindit is a no-fee, no-registration service of OBG MANAGEMENT available to all women's health-care practitioners. The obgfindit search tool can be found at its own url, www.obgfindit.com, or atop the home page of obgmanagement.com. Users can set the limits of their search three ways: the OBG MANAGEMENT archive; a pool of more than 100 other selected ObGyn and women's health Web sites; and the full PubMed literature database of the National Library of Medicine.

Comment & Controversy

"UPDATE ON PELVIC SURGERY,"
BY NAZEMA Y. SIDDIQUI, MD, AND CINDY L. AMUNDSEN, MD (OCTOBER)

More questions about the transobturator tape technique

Two serious concerns are implicit, but left unexplored in the Update on suburethral sling procedures:

- If the transobturator tape (TOT) sling is less effective than the retropubic tension-free vaginal tape (TVT) for intrinsic sphincter deficiency (ISD), and ISD increases with age, will we see increasing failure rates for TOT among women who have already undergone the procedure?
- If bladder perforation rates for TVT vary from zero in one study to 7% in another, is bladder perforation an intrinsic risk of the retropubic sling—or a preventable problem?

The study that compares the pubovaginal sling, TVT, and TOT for stress urinary incontinence with ISD is not the first to show that the transobturator approach is much less effective (35% cure at 2 years) than either TVT or the pubovaginal sling (87% each).[1] Another retrospective cohort study showed that failure was six times as common with TOT, compared with TVT, in patients who had borderline or low urethral closure pressure.[2] A study stratifying TOT outcomes by preoperative urethral function showed that TOT failed to cure incontinence in 67% of patients who had maximum urethral closure pressure <20 cm H_2O and Valsalva leak-point pressure <60 cm H_2O.[3] In contrast, several observational studies have showed cure rates from 73% to 86% for retropubic TVT in women who have ISD.[4–6]

Why the wide range of perforation rates?

As for bladder perforation, in the study comparing the pubovaginal sling, TVT, and TOT for stress urinary incontinence with ISD,[1] no perforation was reported in a total of 92 TVT procedures. In contrast, Barber and associates reported a 7% perforation rate with TVT, compared with 0% for TOT.[7] Other studies report TVT-related bladder-perforation rates ranging from 15% in a multicenter study[8] to 0.8% in a series by a single, experienced surgeon.[9] Why do bladder perforation rates differ so radically?

In my opinion, the study-to-study variability in the rate of perforation derives from three factors: **technique**, **training**, and **experience**. It is critical that surgeons learn to keep the TVT needle in immediate contact with the posterior surface of the pubic bone until the needle reaches the suprapubic skin incision at the superior edge of the bone, 2 cm lateral to the midline. If the bladder perforation rate for TVT can be minimized by correct technique, this would undermine one of the main arguments in favor of the transobturator approach.

George Flesh, MD
Boston, Mass

Dr. Flesh has no financial relationships relevant to his letter.

References

1. Jeon MJ, Jung HJ, Chung SM, Kim SK, Bai SW. Comparison of the treatment outcome of pubovaginal sling, tension-free vaginal tape, and transobturator tape for stress urinary incontinence with intrinsic sphincter deficiency. Am J Obstet Gynecol. 2008;199:76.e1–76.e4.
2. Miller JJ, Botros SM, Akl MN, et al. Is transobturator tape as effective as tension-free vaginal tape in patients with borderline maximum urethral closure pressure? Am J Obstet Gynecol. 2006;195:1799–1804.
3. Guerette NL, Biller DH, Bena JF, Davila GW. Development of a mathematical model to predict anti-incontinence surgery outcomes. Int Urogynecol J Pelvic Floor Dysfunct. 2005;16:S120.
4. Liapis A, Bakas P, Salamalekis E, Botsis D, Creatsas G. Tension-free vaginal tape (TVT) in women with low urethral closure pressure. Eur J Obstet Gynecol Reprod Biol. 2004;116:67–70.
5. Meschia M, Pifarotti P, Buonaguidi A, Gattei U, Spennachio M. Tension-free vaginal tape (TVT) for treatment of stress urinary incontinence in women with low-pressure urethra. Eur J Obstet Gynecol Reprod Biol. 2005;122:118–121.
6. Mutone N, Brizendine E, Hale D. Clinical outcome of tension-free vaginal tape procedure

for stress urinary incontinence without preoperative urethral hypermobility. J Pelvic Med Surg. 2003;9:75.
7. Bodelsson G, Henriksson L, Osser S, Stjernquist M. Short term complications of the tension free vaginal tape operation for stress urinary incontinence in women. BJOG. 2002;109:566–569.
8. Wang AC. The techniques of trocar insertion and intraoperative urethrocystoscopy in tension-free vaginal taping: an experience of 600 cases. Acta Obstet Gynecol Scand. 2004;83:293–298.
9. LaSala CA, Schimpf MO, Udoh E, O'Sullivan DM, Tulikangas P. Outcome of tension-free vaginal tape procedure when complicated by intraoperative cystotomy. Am J Obstet Gynecol. 2006;195:1857–1861.

›› Drs. Siddiqui and Amundsen respond:

How long will a sling hold?

We agree with Dr. Flesh. In a study by Barber and colleagues that compared TOT and TVT,[1] mean length of follow-up was 18 months; only time will tell if these results are maintained as the women age. TVT has now been studied for longer than a decade, but there is limited published data about its long-term efficacy—and that is true for any of the sling kits, including TOT.

Bladder perforation—short- or long-term concern?

When considering bladder perforation, Dr. Flesh brings up a good point about variability in technique and experience. Certainly, there is quite a range of cystotomy rates with TVT in published studies; that range may be the result of differences in experience and understanding of pelvic anatomy from one surgeon to another. The fact remains, however, that rates of cystotomy are generally higher with TVT than they are with TOT. This has been confirmed in multiple studies, including a systematic review of 11 randomized, controlled trials comparing transobturator approaches to retropubic slings.[2]

But are these differences clinically important? The answer is that, although the rate of cystotomy may vary, cystotomy that is recognized at the time a sling is placed has few long-term sequelae.

La Sala and co-workers studied this matter[3]: Patients who experienced cystotomy were more likely to go home with a catheter (short-term sequela) but were not otherwise at increased risk of urinary tract infection or voiding dysfunction (long-term sequela). Some experts argue that a transobturator approach may be favorable because it has, overall, a lower cystotomy rate. We counter with another question: Are minor differences in the rate of cystotomy even clinically significant?

References

1. Barber MD, Kleeman S, Karram MM, et al. Transobturator tape compared with tension-free vaginal tape for the treatment of stress urinary incontinence: a randomized controlled trial. Obstet Gynecol. 2008;111:611–621.
2. Latthe PM, Foon R, Toozs-Hobson P. Transobturator and retropubic tape procedures in stress urinary incontinence: a systematic review and meta-analysis of effectiveness and complications. BJOG. 2007;114:522–531.
3. LaSala CA, Schimpf MO, Udoh E, O'Sullivan DM, Tulikangas P. Outcome of tension-free vaginal tape procedure when complicated by intraoperative cystotomy. Am J Obstet Gynecol. 2006;195:1857–1861.

"THE LABORISTS ARE HERE, BUT CAN THEY THRIVE IN US HOSPITALS?"
BY JANELLE YATES (AUGUST)

It's safety first in our laborist program, lifestyle improvement second or third

I do not agree with the comments of Dr. Raksha Joshi, Medical Director of the Monmouth Family Health Center, who was quoted in Ms. Yates' article as saying that convenience to solo practitioners was a selling point for the laborist program at Monmouth Medical Center. The laborist group at Monmouth Medical Center—a separate entity from Monmouth Family Health Center, Dr. Joshi's employer—was implemented purely for patient safety. The number of patients in the hospital at any one time was excessive for the resident staff and doctor of the day, with a resident complement totaling eight and more than 4,200 births annually. The laborists are now considered the backup for private practice physicians, providing 24/7 coverage 365 days a year—for which they are compensated by the hospital. (There is cross coverage on an as-needed basis.)

We require the laborist staff (active private practitioners who elected to be part of the laborist group—approximately 30 ObGyns) to:

- be board-certified or board-eligible
- take a risk-management course
- be certified in basic life support, advanced clinical life support, neonatal advanced life support, and advanced life support in obstetrics.

Because the laborist group comprises contracted employees with private practices, hospital employees and faculty such as myself are not allowed to join. Members of the New Jersey Laborist Group, LLC, must adhere to the by-laws of the group or risk removal from it. (These by-laws are separate from those of the hospital.)

As a result of the move to laborists, we have seen:

- a 20% increase in patient volume
- a 50% reduction in cases presented to risk management
- an increase in vaginal birth after cesarean delivery (VBAC), with 78% of attempted VBACs delivered vaginally
- a decrease in NICU admission
- a reduction (to zero) in neonatal death
- a decrease in the C-section rate to 25% (the New Jersey C-section

Have a comment to share?
Send us an e-mail
obg@dowdenhealth.com

rate is the highest in the United States, at 37%)

- a 1.1% infection rate following C-section
- a rate of third- and fourth-degree laceration that is below the national average
- a decreasing length of stay.

The culture of the program is one of patient safety first and team effort. All patient management adheres to evidence-based protocols that are evaluated, updated, and approved by the staff and monitored by the performance improvement committee.

We are very pleased with the results. I wish to say that, although quality of life has improved for the physicians, the importance of this benefit pales in comparison with the improvement in the environment of safety in which we all now practice.

Robert A. Graebe, MD
Chairman and Residency Program Director
Department of Obstetrics and Gynecology
Monmouth Medical Center
Long Branch, NJ

Impetus for this laborist program was high percentage of births to mothers on Medicaid

I have been working as a laborist for the past 8 years at Southeastern Regional Medical Center in Lumberton, North Carolina. The program began almost 20 years ago, when hospital administrators grew concerned about limited access to obstetrical care for Medicaid recipients, who accounted for more than 50% of hospital deliveries. They hired an obstetrician to focus on delivering infants in-house, frequently for women who had had little or no prenatal care. Over the years, nurse-midwives were added to the mix, and the program began to establish relationships with pregnant women at health clinics in the area.

The program has won awards at the state and national levels for its effectiveness in reducing infant mortality and low birth weight. Today it employs two certified ObGyns (I am one of them) and three certified nurse-midwives. Almost 17,000 babies have been born since the program began.

Walter E. Neal Jr, MD
Lumberton, NC

Call for information

We are trying to start a laborist program at a hospital here in Charleston, using private practice-based physicians to stay in-house. I am seeking advice from individuals and institutions working with the laborist model to help get our program off the ground. Among the information I am seeking is the rate of pay per shift (both day and night) or for 24 hours. I also would like to know how hospitals and doctors divide the charges for the work done, or whether the hospital controls this aspect of the model completely.

Please email me at stan.ottinger@comcast.net if you have information to share. We can then set up a time to talk by phone, if you prefer.

Stan Ottinger, MD
Charleston, SC

For more on the laborist model of care, see these recent articles

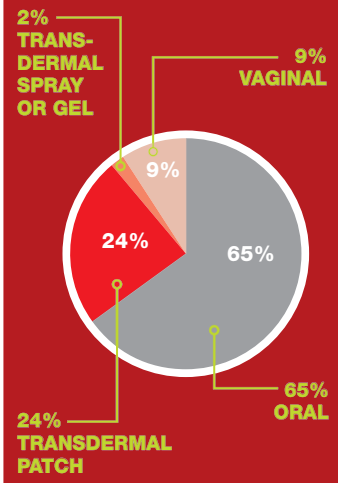
- *"The unbearable unhappiness of the ObGyn: A crisis looms," by Louis Weinstein, MD, in this issue on page 34*
- *"Laborists, nocturnalists, weekendists: Will the "ists" preserve the rewards of OB practice?" by Robert L. Barbieri, MD (September 2007). Available in our archive at www.obgmanagement.com.*

Instant Poll Results

AUGUST 2008

HOW DO YOU DELIVER ESTROGEN?

The route of administration of estrogen that I choose most often when I prescribe combination HT for a postmenopausal woman who has hot flashes and an intact uterus is:



Instant Poll → page 14