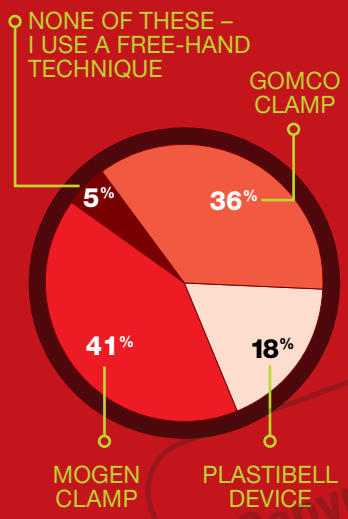
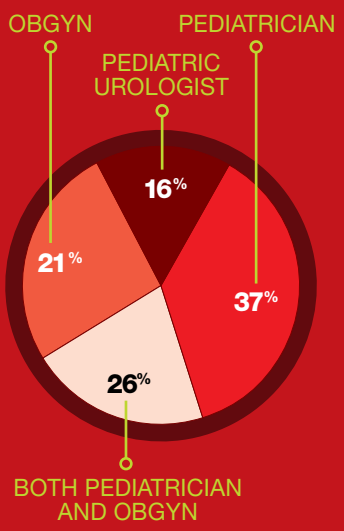
Instant Poll Results

From May 2009

What instrument do you use most often to circumcise a newborn?



Which specialist should be assigned responsibility for performing neonatal circumcision?



"UPDATE ON INFECTIOUS DISEASE"
PATRICK DUFF, MD (JUNE 2009)

What drug is best for penicillin-allergic women who undergo C-section?

Dr. Duff's recommendations for therapy are most helpful. He includes a recommendation for antibiotic prophylaxis in penicillin-allergic patients undergoing perineal repair, but not for women undergoing cesarean delivery. What is Dr. Duff's recommendation in that case?

Jane Helwig, MD
Lancaster, SC

JUNE 2009

» Dr. Duff responds:

A combination of drugs is recommended

Dr. Helwig poses a very thoughtful question. If a patient has an immediate, life-threatening allergy to beta-lactam antibiotics, she should not receive a cephalosporin antibiotic for prophylaxis. Rather, I would give a single dose of clindamycin (900 mg intravenously [IV]) plus gentamicin (1.5 mg/kg of actual weight, IV) plus azithromycin (500 mg IV). The first two drugs can be administered rapidly. However, azithromycin should be administered slowly over the course of 1 hour. We begin the infusions before surgery.

"UPDATE ON MENOPAUSE"
ANDREW M. KAUNITZ, MD (MAY 2009)

Oophorectomy in young women may not be so harmful

One headline in the Update on Menopause was misleading. It said: "Bilateral oophorectomy raises young women's risk of cardiovascular death." In the article itself, in much finer print, it was explained that the mortality rate does not rise if the woman is given hormone replacement therapy immediately after oophorectomy and continues to take it until she is at least 45 years old.

The article does not mention the rather severe surgical difficulties that are often encountered when a physician attempts to remove the ovaries after hysterectomy. I'm sure every gynecologic surgeon has had numerous cases in which the ovaries were plastered to the posterior peritoneum, immediately adjacent to the ureters. These cases are technically difficult and dramatically increase the risk of ureteral injury—and subsequent lawsuit. Also relevant is the fact that there is an incidence of ovarian cyst formation of about 20% in the years following hysterectomy, necessitating oophorectomy. It is important that the patient be informed of this possibility during counseling.

The happiest posthysterectomy patients I have cared for are those who undergo concurrent bilateral salpingo-oophorectomy and spend years comfortably taking estrogen.

David Priver, MD
San Diego, Calif

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›› Dr. Kaunitz responds:

The ovaries can be preserved at many hysterectomies

Dr. Priver appropriately points out that, in some cases, oophorectomy at the time of hysterectomy may be safer for the patient than ovarian conservation. Concomitant oophorectomy at the time of hysterectomy for benign disease may be indicated for a number of reasons, including endometriosis, BRCA mutation, or, as Dr. Priver indicates, surgical or anatomic reasons. However, in many cases, none of these indications are present. As obstetrician-gynecologists, we cannot always predict whether a young surgically castrated woman will be compliant with estrogen therapy over years or even decades. Given this uncertainty and growing evidence of the risks associated with concomitant oophorectomy in young women, gynecologic surgeons should hesitate to remove the ovaries at the time of hysterectomy unless a specific indication is present.

"WHAT YOU NEED TO KNOW ABOUT IMMUNIZING YOUR ADULT PATIENTS"
JANELLE YATES
(WEB EXCLUSIVE, MAY 2009)

Many insurers fail to reimburse for immunization

I enjoyed the article on the obstetrician-gynecologist's role in adult immunization. One element that is frequently not considered is the cost of immunization in many settings in which it is provided. Immunizations that are provided during pregnancy, while the woman is in the hospital, or during postpartum visits to the physician's office are unlikely to be reimbursed by Medicaid or insurers, as global fees are paid.

In 2008, our hospital's OB-Peds inpatient unit provided more than $150,000 of unreimbursed immunizations (against the flu; measles, mumps, and rubella; Tdap for new mothers; and hepatitis B, mostly for newborns). At another hospital of which I am aware, physicians order the first human papillomavirus vaccine for postpartum patients who desire immunization.

There is no doubt in my mind that immunization represents the best investment in health care. Do you think the new health-care reform efforts might include reimbursement for immunizations regardless of where they are provided?

Not likely.

Charles W. Schauberger, MD, MS
Cedar Rapids, Iowa

"BEST PRACTICES FOR CALL—TO MAKE FOR A SUSTAINABLE CAREER"
CHARLES W. SCHAUBERGER, MD, MS, AND ROBERT K. GRIBBLE, MD (APRIL)

In a small town, call is a different ballgame

I enjoyed the article on best practices for call! But how about those of us who are not in bigger groups? Life is definitely different for us.

I am in solo practice in a small town, practice in a community hospital, and delivered 210 babies last year. For the past few years, I have shared call with the only other OB in my community. The two of us have chosen to be "on call" every day, unless one of us wants to go fishing or out of town, when we ask the other for coverage. It helps that I live 4 minutes from the hospital.

We recently had a third OB join our community, so we are experimenting with a weekend call schedule. It has been 2 months since we began this new arrangement, but it still seems strange to have two whole days off! We take care of our own patients during the week.

When I have been up most of the night, I usually reschedule the next morning's appointments if it's a clinic day. That helps a lot. And our patients do seem to understand.

Life in a small practice in a small town is a different world!

Margaret Gustafson, MD
Ludington, Mich

›› Dr. Schauberger responds:

The best call schedule for a small town is one that works

I very much appreciate Dr. Gustafson's comments. Indeed, life in a small town is considerably different than life in other population centers. Arrangements between partners who share call develop according to the needs of the participants and the resources available to them. I would not be critical of anyone's call schedule as long as the quality and safety of the care provided is the primary consideration. Also, the call arrangements must be sustainable for the long term. It sounds like Dr. Gustafson's call is working well.

We want to hear from you!

Please take a moment to share your opinion! Have a comment? Drop us a line and let us know what you think. You can send a letter 1 of 3 ways.

1 **E-mail** obg@dowdenhealth.com
2 **Fax** 201-391-2778
3 **Mail** OBG Management, 110 Summit Ave., Montvale, NJ 07645

Letters should be addressed to the Editor, OBG MANAGEMENT, and be 200 words or less. They may be edited prior to publication.