"I'VE BEEN RETHINKING MY ZEAL FOR BREAST CANCER SCREENING"
ANDREW M. KAUNITZ, MD
(EDITORIAL, DECEMBER 2009)

Breast self-exam is a valuable tool

Dr. Kaunitz has it wrong. Not only do I encourage breast self-examination (BSE), I instruct patients carefully so that they gain the skill and confidence they need. We may lack level-1 evidence that BSE reduces the mortality rate, but common sense and more than 50 years of clinical practice have convinced me that it would be wrong to discourage such a simple, painless, cost-free procedure.

Herb Kotz, MD
Bethesda, Md

Reason for status quo in breast-cancer screening? Fear of litigation

In his editorial, Dr. Kaunitz answers his own rhetorical question—"Will I continue to recommend screening mammograms?"—with a fairly equivocal "Yes, unless—until—guidelines change." I submit that this is exactly how most practicing clinicians regard this issue.

When we send a patient for a mammogram, we know we are not reducing the incidence of invasive cancer. Moreover, for every cancer death prevented, the cost of screening to society is $2.5 million for mammograms alone. Why do we keep sending patients for annual mammograms? Why do we so cavalierly spend this money? Why haven't guidelines already changed? Why have groups representing practicing physicians been so resistant to new guidelines from the US Preventive Services Task Force? And why does Dr. Kaunitz still recommend screening mammograms?

The answer is simple: No one wants to get sued for missing the diagnosis of breast cancer.

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Although doing what the medical evidence tells us we should do—reduce the use of screening mammograms—would save the United States easily over $500 billion in 10 years, our president and Congress would rather cut Medicare by that amount over 10 years than include any measure that vaguely resembles tort reform in any version of the health reform bill.

Neither adherence to guidelines nor the current version of healthcare reform offers any refuge from litigation. So, rather than "rethink our zeal" for breast cancer screening, let us restate our position in unequivocal terms: Doctors have every right to protect themselves from lawsuits that lack merit. If keeping lawyers happy is more important to our political leadership than implementing tort reform, it will not be at the expense of the medical profession alone. We will continue to recommend the status quo in breast-cancer screening so as not to have to defend ourselves from unnecessary litigation. That is the way it is and will continue to be unless and until things change.

Howard N. Smith, MD, MHA
Washington, DC

›› Dr. Kaunitz responds:

BSE doesn't prevent death, but screening mammography does

I appreciate these two thoughtful letters. I recognize that many ObGyns continue to instruct their patients in BSE and encourage them to perform the exam. However, as I indicated in my article, my own experience has been that patients feel guilty because they do not perform BSE or anxious because they do *perform it but do not know what they are palpating each month. In the absence of data suggesting that BSE saves lives (see references 3 and 4 in my editorial), I cannot advocate this strategy. However, I encourage my patients to immediately let me know about any breast lumps they become aware of or any other breast concerns they may have.*

Dr. Smith raises a number of interesting points. Please recognize, however, that I wrote my article before *the US Preventive Services Task Force updated its guidelines in late 2009. I agree with Dr. Smith that ObGyns wish to avoid being sued for failure to diagnosis breast cancer. However, the reason we encourage our patients to undergo screening is because mammography can save lives.*

Among the facts highlighted in a later article on mammography screening are the different practices recommended by different organizations.[1] Controversy is likely to persist over who should be screened and how often screening should occur. However, there should be no confusion regarding the ability of early detection to prevent mortality from breast cancer.[2] That is why we encourage our patients to undergo screening mammograms.

References

1. Yates J. Confused about mammography guidelines: 7 questions answered. OBG Management. 2010;22(1):28–34.
2. Partridge AH, Winer EP. On mammography—more agreement than disagreement. N Engl J Med. 2009;361(26):2499–2501.

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Comment & Controversy

"UPDATE ON URINARY INCONTINENCE"
JHANSI REDDY, MD, AND MARIE FIDELA R. PARAISO, MD (DECEMBER 2009)

Surgeons' ineptitude should have been the focus

I am an avid reader of OBG MANAGEMENT, but this is my first letter to the editor. I am writing today because I am surprised and puzzled by the inclusion and discussion of a study of 67 cases—involving placement of a midurethral sling—in which surgeons sustained six bladder perforations and had a failure rate of 21% after 6 months.[1]

These results do not reflect the quality and benefit of the procedure, but the ineptitude of the ones performing it.

Guy E. Blaudeau, MD
Birmingham, Ala

Reference

1. Schierlitz L, Dwyer PL, Rosamilia A, et al. Effectiveness of tension-free vaginal tape compared with transobturator tape in women with stress urinary incontinence and intrinsic sphincter deficiency: a randomized controlled trial. Obstet Gynecol. 2008;112(6):1253–1261.

›› Drs. Reddy and Paraiso respond: *TVT complication rates vary widely*

We appreciate Dr. Blaudeau's interest in our Update on Urinary Incontinence. We chose to include the article by Schierlitz and colleagues to highlight the growing trend of identifying urodynamic parameters that may raise the risk of failure with certain midurethral slings. Because it was a recent, randomized, controlled comparison of transvaginal tape (TVT) and transobturator tape in the treatment of intrinsic sphincter deficiency, we thought it might be of interest.

In the literature, the incidence of bladder perforation during TVT is highly variable. At our own institution (the Cleveland Clinic), we reported an incidence of 7% in 2008, but others have observed much higher rates.[1] For example, Andonian and colleagues reported a rate of 23% in 2005.[2]

In a comprehensive review of midurethral sling complications, Stanford and Paraiso reported a 5% bladder perforation rate with TVT.[3] Many surgeons have postulated that the risk of bladder perforation is commensurate with experience and pointed to the learning curve involved. This is an important variable for academic centers invested in the training residents and fellows.

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The definition of success after a midurethral sling procedure also remains a topic of considerable debate. Many surgeons base success on the patient's lack of symptoms; others utilize objective measures such as a negative cough stress test, a 1-hour pad test, or urodynamic parameters. In the study mentioned by Dr. Blaudeau, only 84% of subjects underwent urodynamic testing 6 months postoperatively, potentially biasing the results.

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(3):611–621.
2. Andonian S, Chen T, St. Denis B, Corcos J. Randomized clinical trial comparing suprapubic arch sling (SPARC) and tension-free vaginal tape (TVT) : one-year results. Eur Urol. 2005;47(4):537–541.
3. Stanford EJ, Parasio MF. A comprehensive review of suburethral sling procedure complications. J Minim Invasive Gynecol. 2008;15(2):132–145.

"WHAT YOU SHOULD KNOW ABOUT HETEROTOPIC PREGNANCY"
DANIEL M. AVERY, MD,
MARION D. REED, MD, AND
WILLIAM L. LENAHAN, MD (OCTOBER 2009)

Heterotopic pregnancy is still underdiagnosed

Back in the days before assisted reproduction, I encountered three cases of heterotopic pregnancy in a short time, prompting the article cited below.[1] As the authors mentioned, this phenomenon is still underdiagnosed—less so today than in 1961, when we did without the benefit of both ultrasonography and the ability to rapidly and accurately measure human chorionic gonadotropin (hCG) levels.

Arthur A. Fleisher II, MD
Northridge, Calif

Reference

1. Fleisher AA, Seaman I. Heterotopic pregnancy: the effect of shock on the first-trimester fetus. Obstet Gynecol. 1961;18:763–766.

›› Dr. Avery responds:

Diagnosis of heterotopic pregnancy without the benefit of technology is a real achievement

I appreciate Dr. Fleisher's letter and mention of his paper. I had the pleasure of reading this paper from 1961 describing his series of heterotopic pregnancies. As he mentioned, these cases were diagnosed at the time of surgery and subsequent delivery in most cases without the availability of ultrasonography and quantitative hCG levels. This would be a fascinating paper for any practitioner of obstetrics and gynecology to read. We often take for granted the technological advances available to us today to make difficult diagnoses. I thank Dr. Fleisher for making this paper available to us. I will add his experience to our list of cases.