"REMOVE THE OVARIES AT HYSTERECTOMY? HERE'S THE LOW-DOWN ON RISKS AND BENEFITS"
WILLIAM H. PARKER, MD
(FEBRUARY 2010)`

Ovarian conservation argument still prompts questions

Little has changed in Dr. Parker's view of ovarian conservation since publication of an earlier article in 2005,[1] and little has changed in my thoughts on the matter since I wrote a letter in response to that earlier article.[2]

In this latest article on the subject, Dr. Parker does say that "estrogen and other drugs mitigate the risks associated with oophorectomy," but he goes on to qualify that statement by adding that "many women avoid or discontinue these medications."

I was pleased that Dr. Parker acknowledged the availability of estrogen supplementation, bisphosphonates, and lipid-lowering drugs, but I was disappointed that the discontinuation rates for these medications were used as an argument for ovarian conservation.

Balancing the relatively small risk of ovarian cancer against the larger risk of coronary artery disease (CAD) and osteoporosis is not really a fair comparison because atherosclerosis and osteoporosis **1)** have a major genetic component, **2)** begin long before the decision regarding ovarian conservation is made, and **3)** are subject to multiple interpretations.

I propose that patients undergoing pelvic surgery for benign disease be counseled fully about the hazards of repeat surgery, ovarian and fallopian tube carcinoma, and the need for continuation of statin and bisphosphonate drugs to maximize protection.

Does Dr. Parker really believe that ovarian conservation 2 years after menopause confers any real benefit on bones or the cholesterol level when the ovaries are inactive?

FEBRUARY 2010

Until we have a better method of predicting the likelihood of ovarian and tubal carcinoma—and detecting and treating these cancers—we should exercise every opportunity to appropriately lower that risk.

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2. Wallach RC. Ovarian conservation at the time of hysterectomy for benign disease [letter]. Obstet Gynecol. 2005;106(5, Part 1):1106–1107.

›› Dr. Parker responds: *One-issue counseling no longer suffices*

Because he is an oncologist, I understand Dr. Wallach's concerns about ovarian conservation, but I am sorry to disagree with a few of the points he makes. First, contrary to Dr. Wallach's assertion, a number of groups (as explained in the article) have shown that the ovaries are not at all inactive after menopause.

Ovarian cancer is a terrible disease. However, as I noted in my article, it affects less than 1% of women, excluding known BRCA carriers or others with a strong family history of ovarian or breast cancer. Many women undergo prophylactic oophorectomy at the time of hysterectomy long before osteoporosis or CAD have appreciably developed (66% of those having hysterectomy between the ages of 45 and 49 years, for example), and our data show a significantly increased risk of CAD, the major cause of death for women, after their ovaries are removed. This seems to suggest that reducing the rate of oophorectomy would be a good place to start for primary prevention of CAD.[1,2]

As I also noted in the article, the continuation rates of estrogen (especially following the Women's Health Initiative studies), bisphosphonates, and statins are extremely low. In one of the studies I cited, women were counseled extensively about the importance of taking the medication, to no avail. Similar studies in other specialties show comparable results.

We both agree that current information should be used to better counsel women about both risks and benefits of ovarian conservation; a one-issue conversation about ovarian cancer prevention no longer suffices. I also look forward to the time when gynecologists can both achieve early diagnosis and offer effective treatment for women with ovarian cancer.

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"WHAT YOU CAN DO TO OPTIMIZE BLOOD CONSERVATION IN OBGYN PRACTICE"
ERIC J. BIEBER, MD; LINDA SCOTT, RN; CORINNA MULLER, DO; NANCY NUSS, RN; EDIE L. DERIAN, MD
(FEBRUARY 2010)

Information on blood conservation was sorely needed

Thank you, thank you, thank you. I am going to use this article today in our ObGyn meeting. I am a manager of blood conservation, and this information is very helpful in this format and definitely needed. Kudos to you for covering it and putting yourself out there to back it. It's been too long in coming.

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"ACCESS TO SCREENING MAMMOGRAPHY: PRICELESS"
ROBERT L. BARBIERI, MD
(EDITORIAL; JANUARY 2010)

When patients compete, everybody wins

Certainly, there is little to disagree with in Dr. Barbieri's assessment of the US Preventive Services Task Force recommendation against mammographic screening for breast cancer in women 40 to 50 years old. Certainly, we will all continue to follow the guidelines put forth by the American Cancer Society when counseling our patients about their risk of breast cancer.

What irks me is the fact that none of my patients understand what screening mammography costs. Nor do we ObGyns fully comprehend what hospitals and outpatient imaging centers charge for a screening mammogram.

Physicians have not had a place at the table during the debate on health-care reform, and I am not sure that we deserve one until our leadership has a better grasp of fundamental microeconomic principles.

Mammograms are screening tools. Health insurance should be designed for catastrophe (like house and car insurance).

I can't for the life of me figure out why there isn't more of a push for high-deductible health savings accounts, with deductibles of $10,000, $15,000 or even $20,000 annually, from the medical community. We all want tort reform, of course—but this strategy would have far greater economic impact. It would force patients to become consumers instead of blindly forking over copays in the office and at the hospital.

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acquire a sexually transmitted disease, she should be instructed to report this change to her clinician immediately. The use of a barrier method as a partial protection against acquiring sexually transmitted diseases should be strongly recommended. Removal of Mirena should be considered.

Mirena should be removed for the following medical reasons:

- New onset menorrhagia and/or metrorrhagia producing anemia
- Sexually transmitted disease
- Pelvic infection; endometritis
- Symptomatic genital actinomycosis
- Intractable pelvic pain
- Severe dyspareunia
- Pregnancy
- Endometrial or cervical malignancy
- Uterine or cervical perforation.

Removal of the system should also be considered if any of the following conditions arise for the first time:

- Migraine, focal migraine with asymmetrical visual loss or other symptoms indicating transient cerebral ischemia
- Exceptionally severe headache
- Jaundice
- Marked increase of blood pressure
- Severe arterial disease such as stroke or myocardial infarction.

Removal may be associated with some pain and/or bleeding or neurovascular episodes.

5.14 Glucose Tolerance

Levonorgestrel may affect glucose tolerance, and the blood glucose concentration should be monitored in diabetic users of Mirena.

6 ADVERSE REACTIONS

The following most serious adverse reactions associated with the use of Mirena are discussed in greater detail in the *Warnings and Precautions section (5)*:

- Ectopic Pregnancy *[see Warnings and Precautions (5.1)]*
- Intrauterine Pregnancy *[see Warnings and Precautions (5.2)]*
- Group A streptococcal sepsis (GAS) *[see Warnings and Precautions (5.3)]*
- Pelvic Inflammatory Disease *[see Warnings and Precautions (5.4)]*
- Embedment *[see Warnings and Precautions (5.6)]*
- Perforation *[see Warnings and Precautions (5.7)]*
- Breast Cancer *[see Warnings and Precautions (5.10)]*

6.1 Clinical Trial Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The data provided reflect the experience with the use of Mirena in the adequate and well-controlled studies for contraception (n=2,339) and heavy menstrual bleeding (n=80). For the contraception indication, Mirena was compared to a copper IUD (n=1,855), to another formulation of levonorgestrel intrauterine system (n=390) and to a combined oral contraceptive (n=94) in women 18 to 35 years old. The data cover more than 92,000 woman-months of exposure. For the treatment of heavy menstrual bleeding indication (n=80), the subjects included women aged 26 to 50 with confirmed heavy bleeding and exposed for a median of 183 treatment days of Mirena (range 7 to 295 days). The frequencies of reported adverse drug reactions represent crude incidences.

The adverse reactions seen across the 2 indications overlapped, and are reported using the frequencies from the contraception studies.

The most common adverse reactions (≥5% users) are uterine/vaginal bleeding alterations (51.9%), amenorrhea (23.9%), intermenstrual bleeding and spotting (23.4%), abdominal/pelvic pain (12.8%), ovarian cysts (12%), headache/migraine (7.7%), acne (7.2%), depressed/altered mood (6.4%), menorrhagia (6.3%), breast tenderness/pain (4.9%), vaginal discharge (4.9%) and IUD expulsion (4.9%). Other relevant adverse reactions occurring in <5% of subjects include nausea, nervousness, vulvovaginitis, dysmenorrhea, back pain, weight increase, decreased libido, cervicitis/ Papanicolaou smear normal/class II, hypertension, dyspareunia, anemia, alopecia, skin disorders including eczema, pruritus, rash and urticaria, abdominal distention, hirsutism and edema.

6.2 Postmarketing Experience

The following adverse reactions have been identified during post approval use of Mirena: device breakage and angioedema. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

One TV commercial has the catchphrase, "When banks compete, you win." The same can be said for competition in health care. If patients are paying substantially lower premiums and paying cash for tests (because of the high deductible), they will shop around for the best price, and that will bring prices down.

We are physicians now, but we will all eventually be patients—and patients need to have more control over their health care, not less.

John F. Pappas, MD
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» Dr. Barbieri responds:

Consumer-driven care is a good idea, but it is unlikely to materialize

I would like to thank Dr. Pappas for taking time from his busy schedule to offer a logical and elegant approach to the twin health-care challenges of access and cost. I agree with Dr. Pappas that putting consumers in charge of health care and allowing market forces to constrain the cost of noncatastrophic health-care services and improve quality are a valid approach to managing a system that is excessively expensive.

Many experts agree with Dr. Pappas, including Professor Regina E. Herzlinger, PhD, of Harvard Business School. Dr. Herzlinger has written extensively on the subject in award-winning publications, Consumer-Driven Health Care*, and "Let's put consumers in charge of health care."*[1,2] *In contrast, in recent speeches, President Obama promised that his health-care reform legislation would make all preventive services "cost-free," removing the consumer from the cost equation. When the time comes to decide how to evolve the health-care system, President Obama's views will be more influential than Professor Herzlinger's.*

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"OPTIONS IN ENDOMETRIAL ABLATION"
JOSEPH S. SANFILIPPO, MD, MBA, EDITOR (SUPPLEMENT; DECEMBER 2009)

Postablation contraception is vital

I'm a maternal-fetal medicine specialist, so I don't usually read articles on gynecologic surgery. I did happen to skim the supplement to OBG Management on endometrial ablation, however, and was dismayed by the lack of information on the need for contraception after ablation.

Earlier this week, I delivered by cesarean a patient with a history of endometrial ablation who experienced preterm, premature rupture of membranes. Earlier this month, I consulted in the care of another patient who had postablation pregnancy. I have seen three other postablation pregnancies over the past few years, each of them very complicated.

The two most recent patients did not need contraception at the time of ablation because their current partner had undergone vasectomy. Both patients forgot their gynecologist's admonition to use contraception if they changed partners.

I would encourage my gynecology colleagues to remind their ablation patients to consider permanent sterilization and to inform the women of the dangers of pregnancy if contraception fails.

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