"A NEW (TO THE US) FIRST-LINE AGENT FOR HEAVY MENSTRUAL BLEEDING"
ROBERT L. BARBIERI, MD
(EDITORIAL; OCTOBER 2010)

Cost is an issue in applicability of new agent

In regard to tranexamic acid [Lysteda] for menorrhagia, I find it hard to believe that anyone would, in good conscience, recommend this drug for long-term therapy unless all other options have been exhausted. The $2,000 yearly cost is prohibitive.

Ann Wasson, MD
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A question about the new drug

Is intrauterine tranexamic acid of any benefit?

George Kovacs, MD
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›› Dr. Barbieri responds:

Tranexamic acid is often a bridge to other approaches

I respect and share Dr. Wasson's concern that we should only use the most cost-effective treatments for our patients. In countries where tranexamic acid has been used for many years, it is typically prescribed as an initial treatment for menorrhagia and is often a bridge to a procedure-based approach such as placement of a levonorgestrel-releasing intrauterine system (LNG-IUS), endometrial ablation, hysteroscopic surgery for polyps or myomas, or hysterectomy.

Recently, I saw a patient with menorrhagia who would be a good candidate for a LNG-IUS. Her employer was a religious organization, and it was going to take 2 months to get insurance approval for the LNG-IUS. She did not want to use a hormone such as an estrogen-progestin or progestin pill. We used tranexamic acid for those 2 months until she received insurance approval for her LNG-IUS.

I appreciate Dr. Kovacs's creative idea. Major advances in medical treatments are often made by using an approved medication in a new manner. However, I know of no formulation of tranexamic acid that can be utilized as an intrauterine treatment.

OCTOBER 2010

"AT WHAT THICKNESS IS THE ENDOMETRIAL STRIPE CAUSE FOR CONCERN IN A WOMAN WHO HAS POSTMENOPAUSAL BLEEDING?"
LINDA R. DUSKA, MD
(EXAMINING THE EVIDENCE; OCTOBER 2010)

Endometrial assessment is not always clear-cut

I agree with Dr. Duska that lowering of the cutoff of endometrial thickness to 3 mm, with all values at that level or above meriting biopsy, would not be advisable at this time. I also fully support the ACOG Committee Opinion on ultrasonographic (US) assessment of the endometrium, which recommends that this cutoff be 4 mm.[1]

However, I would suggest the following refinements to terminology and practice:

- In its opinion, ACOG refers to "endometrial thickness." I refer to it as an "endometrial echo" on transvaginal US. The term "stripe" is not a medical term, and I would implore readers to abandon this slang terminology.
- Dr. Duska recommends that "only women who have postmenopausal bleeding and an endometrial stripe thicker than 4 mm need to undergo endometrial biopsy." The failure of endometrial biopsy to detect pathologies that are not global (i.e., >50% of surface area) is now well known and needs to be acknowledged and incorporated into the clinical recommendations.[2,3] For example, I would suggest that if a patient who has a thin echo (<4 mm) rebleeds, her risk of endometrial cancer is increased, indicating the need for further evaluation, such as hysteroscopy, sonohysterography, etc.[4]

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Endometrial thickness doesn't always reflect pathology or health

I enjoyed Dr. Duska's timely commentary on endometrial assessment.

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I recently had a patient who had an endometrial thickness of 3 mm. She underwent dilatation and curettage (D&C), and an endometrial carcinoma was detected. Another patient had endometrial thickness of 10 mm, but the endometrium was inactive and scant at the time of D&C. I suspect there is some variability between ultrasonographers in the measurement of endometrial thickness. To a radiologist, the endometrium appeared to be thin in the first case, but there was abundant tissue at D&C. In the second case, there was very little tissue, yet it was measured at 10 mm.

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›› **Dr. Duska responds:**

In the general population, we need to be aware of the potential for a high rate of false positives

I thank Dr. Goldstein and Dr. Avery for their thoughtful comments. And I agree that malignancy can exist even when the endometrial thickness is less than 4 mm. That is why, in practice, I recommend endometrial sampling—even in the presence of a so-called thin stripe—for a woman who has persistent endometrial bleeding, abnormal cervical cytology, or findings in her history or physical exam that render her at high risk of endometrial malignancy.

In the setting discussed in the meta-analysis by Timmermans and co-workers, however, pelvic US was used as a screening tool in the general (and mostly low-risk) population of women who had postmenopausal bleeding. In this population, we must be willing to accept a low rate of false-negative results to reduce an unacceptably high rate of false positives. Excessive endometrial sampling may increase our diagnostic accuracy, but it will also significantly increase patient discomfort and cost.

As clinicians, then, we must maintain suspicion in the settings listed above and as detailed under "What this evidence means for practice" in my original commentary. The method of sampling is left to the clinician. However, an office suction curette (Pipelle)—if technically feasible to use—is less expensive and potentially less complicated for the patient than a D&C. In many, but not all, cases, the Pipelle sample is adequate for diagnosis.

Although I agree with Dr. Goldstein about terminology, use of the word "stripe" is common in this setting and has become acceptable for communication between clinicians.

"LARGE PROLAPSED FIBROID LEFT UNTREATED, DESPITE SURGERY"
MEDICAL VERDICTS (OCTOBER 2010)

Only the jury got this one right!

I found the description of the case of a 48-year-old woman who had a large fibroid that had prolapsed into the vaginal vault especially troubling. The fibroid was not removed despite its presence being documented during a visit to the emergency room (ER) and despite an open myomectomy—to remove other fibroids—by the patient's ObGyn a few days later.

The only party that got its facts right was the jury, which awarded the plaintiff $248,160! This case clearly involved multiple errors:

- lapses during the preoperative history and physical examination, not to mention the consent discussion
- a failure of communication between the nurse practitioner (who, one hopes, had performed a pelvic examination) and the gynecologist during the postoperative visit
- a failure to heed several phone calls from the patient, all of which were related to the presence of an untreated lump of tissue that seemed to defy modern medicine's ability to deal with it effectively.

What has happened to the concept of the examination under anesthesia? This quick, easily accomplished precursor to essentially any gynecologic surgery could have alerted the surgeon to the fibroid's presence.

Most vaginally prolapsed fibroids get that way by being pedunculated. During an examination under anesthesia, it would have been easy to grasp the fibroid with a sponge stick, rotate the fibroid on its pedicle until it was excised, and proceed with the primary surgery.

During my residency in the early 1980s, we were taught, repeatedly, to "solve the problem" as the best way to avoid liability! During my career in ObGyn, I was called dozens of times to the ER for just such a scenario. My response: history-taking, a gentle exam, an explanation to the patient, a sponge stick on the fibroid, and about 10 to 20 twists to produce a vaginal myomectomy! The cost included the ER visit and a small bill for services rendered.

Those were the days of continuity, however. It was I who was called to the ER, who performed the procedure, who instructed the patient in follow-up care, and who saw her in the office a few days later.

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