10 practical, evidence-based suggestions to improve your gyn practice *now*

The start of a new decade—a good time to take specific steps to better outcomes in your practice

Mark D. Walters, MD

As a new year, and a new decade, open, attention to evidence-based guidelines and to outcomes for individual patients continues to drive medicine. As a busy practicing ObGyn, you're challenged to sort through the great, and growing, mass of medical information so you can focus on key issues that improve care.

Faced with such a task, it's not surprising that physicians are notoriously slow to make changes to their practice in response to new evidence.

Here is help. In this article, I present 10 succinct clinical topics and offer medical and surgical suggestions that are **easy to put into practice and backed by evidence.** If you haven't already done so, implementing some of these ideas can immediately improve the quality of your care. For each suggestion, I've included the pertinent reference.

Dr. Walters is Professor and Vice Chair of Gynecology, Center of Urogynecology and Pelvic Floor Disorders, OBGYN & Women's Health Institute, Cleveland Clinic, Cleveland, Ohio. He is Co-Editor-in-Chief of the on-line surgical education journal of the International Academy of Pelvic Surgery (IAPS) (www.academyofpelvicsurgery.com).

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1. Banish error

Embrace, and immediately implement, surgical time-out and safety checklists for all your surgeries and office procedures.

Altpeter T, Luckhardt K, Lewis JN, Harken AH, Polk HC Jr. Expanded surgical time out: a key to real-time data collection and quality improvement. J Am Coll Surg. 2007;204(4):527–532.

Surgical errors are rare, but we need to continually aim for "zero-error" conditions. These two quality assurance tools may help our efforts.

2. Route of hysterectomy

Make an effort to perform more vaginal hysterectomies and fewer open abdominal hysterectomies.

ACOG Committee Opinion No. 444: Choosing the route of hysterectomy for benign disease. Obstet Gynecol. 2009;114(5):1156–1158.

In cases when vaginal hysterectomy isn't feasible, consider laparoscopic (or, perhaps, robotic) hysterectomy more often. The role of robotic and single-port hysterectomies continues to evolve.

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Simple cystoscopy at hysterectomy
by Brent E. Seibel, MD

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*Free QR readers are available through the iPhone App Store, Android Market, or BlackBerry App World.

FAST TRACK

For evaluation of abnormal uterine bleeding, perform fewer blind endometrial biopsies and more imaging studies

3. Cystoscopy

Learn, get credentialed for, and perform more diagnostic cystoscopies after certain gynecologic procedures.

ACOG Committee Opinion No. 372, July 2007. The role of cystourethroscopy in the generalist obstetrician-gynecologist practice. Obstet Gynecol. 2007;110(1):221–224.

Cystoscopy is appropriate when a gyn procedure carries at least a 1% risk of lower urinary tract injury. At most centers, that probably includes laparoscopic and robotic hysterectomy and colpopexy.

4. Oophorectomy

Perform fewer prophylactic oophorectomies at hysterectomy in low-risk women whose ovaries are normal. When you do remove ovaries as a preventive measure, do so with careful thought and informed consent—especially when the patient is premenopausal.

Parker WH, Broder MS, Chang E, et al. Ovarian conservation at the time of hysterectomy and long-term health outcomes in the Nurses' Health Study. Obstet Gynecol. 2009;113(5):1027–1037.

In general, we probably perform too many "throw-in" oophorectomies at hysterectomy, with the aim of preventing cancer. But women who keep their ovaries may, in fact, live longer.

5. Preprocedure antibiotics

Give appropriate and properly timed (within 60 minutes of skin incision) antibiotic prophylaxis for hysterectomy, urogynecology procedures, hysterosalpingography or chromotubation, and surgical abortion.

ACOG Practice Bulletin No. 104: Antibiotic prophylaxis for gynecologic procedures. Obstet Gynecol. 2009;113(5):1180–1189.

A single-dose antibiotic is adequate before hysterectomy. Give a second dose when surgery will take more than 3 hours or, perhaps, blood loss is expected to be >1,500 mL. Subsequent doses are *not* indicated for prophylaxis alone. Antibiotic prophylaxis is unnecessary before diagnostic laparoscopy (level-A evidence), hysteroscopic surgery (level-B), or exploratory laparotomy (level-C).

6. Blind biopsy

For evaluation of abnormal uterine bleeding, perform fewer blind endometrial biopsies and more imaging studies, such as transvaginal ultrasonography or saline infusion sonography, or office hysteroscopy.

Goldstein SR. Modern evaluation of the endometrium. Obstet Gynecol. 2010;116(1):168–176.

Blind endometrial biopsy alone yields an unacceptably high rate of false-negative results when utilized to determine the cause of abnormal uterine bleeding.

7. Misoprostol

Pretreat with misoprostol before hysteroscopic procedures.

Choksuchat C. Clinical use of misoprostol in nonpregnant women: review article. J Minim Invasive Gynecol. 2010;17(4):449–455.

Misoprostol eases the force of cervical dilation, results in fewer cervical lacerations and less fluid absorption, and may lead to fewer uterine perforations. The dosage: 200–400 µg orally or intravaginally, at bedtime, for 1 or 2 days before the procedure.

8. Vaginal estrogen

Use intravaginal estrogen therapy as first-line treatment for postmenopausal women who experience vaginal irritation, dyspareunia, and frequent cystitis.

Krause M, Wheeler TL, Richter HE, Snyder TE. Systemic effects of vaginally administered estrogen therapy: a review. Female Pelvic Med Reconstr Surg. 2010;16(3):188–195.

Vaginal estrogen has many clear quality-of-life benefits and carries relatively low risk; risk is probably much lower than what is

reported with systemic hormone replacement therapy. Delivery can be by cream, suppository, or vaginal ring. The relatively high cost of vaginal estrogen therapy remains a problem for some women.

9. Vaginal apical support

Consider adding or augmenting some vaginal apical support to help your cystocele repairs.

Summers A, Winkel LA, Hussain HK, DeLancey JOL. The relationship between anterior and apical compartment support. Am J Obstet Gynecol. 2006;194(5):1438–1443.

In women who have anterior vaginal prolapse (cystocele), approximately half of the prolapse might be explained by a defect in apical attachment. In addition, consider performing prophylactic McCall's culdoplasty or uterosacral cuff suspension at the time of all hysterectomies, by all routes—even in the absence of prolapse.

10. Pap tests

Perform fewer, but better-timed, Pap tests.

Sawaya GF. Cervical-cancer screening—new guidelines and the balance between benefits and harms. N Engl J Med. 2009;361(26):2503–2305.

ACOG Practice Bulletin No. 109, December 2009. Cervical cytology screening. Obstet Gynecol. 2009;114(6):1409–1420.

New guidelines for cervical cancer screening that were issued by ACOG in November 2009 are meant to maximize benefit and minimize harm. The guidelines are summarized in the **TABLE.**

ACOG's 2009 guidelines for cervical cytology screening

Age (y)	Recommendation
Under 21	Avoid screening
21–29	Screen every 2 y
30–65 (or –70)	May screen every 3 y*
65–70	May discontinue screening†

*Applies only to women who have had three consecutive negative cytology tests; exceptions include women who have human immunodeficiency virus infection, compromised immunity, a history of grade-2 or -3 cervical intraepithelial neoplasia, or were exposed in utero to diethylstilbestrol.

†Applies only to women who have had three or more consecutive negative cytology tests and no abnormal tests in the preceding 10 years; exceptions include women who have multiple sexual partners.

Discontinue routine cytology in women who have had a total hysterectomy for benign indications and who do not have a history of high-grade cervical intraepithelial neoplasia (CIN).

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