"UPDATE ON MINIMALLY INVASIVE SURGERY"
AMY GARCIA, MD (APRIL 2012)

Minimally invasive surgery is not always the best option

The AAGL and OBG MANAGEMENT are acting irresponsibly by implying that physicians who perform abdominal hysterectomy are not taking good care of their patients. Many of our patients simply are not candidates for a minimally invasive approach. Dr. Garcia ignores the broad range of patient clinical presentations and the wide variation in surgical training available throughout the United States.

In addition, when AAGL proposes that surgeons act in concert with insurance companies to encourage the minimally invasive approach, the organization goes way past the line of responsibility to our profession. To suggest that physicians attack each other in the form of economic credentialing goes beyond the pale.

David Rogers, MD
Dallas, Texas

›› Dr. Garcia responds

The AAGL seeks to improve the quality of women's surgical care

I agree that the AAGL makes a bold statement. I think it is important to clarify that statement here because it is intended to improve the quality of surgical care for women.

The AAGL position statement acknowledges that abdominal hysterectomy may be the best option in some cases:

- *when the patient has a medical condition, such as cardiopulmonary disease, that elevates the risk of general anesthesia or renders the increased intraperitoneal pressure associated with laparoscopy unadvisable*

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- *when morcellation is likely or known to be required and uterine malignancy is known or suspected*
- *when hysterectomy is indicated but there is no access to the surgeons or facilities required for vaginal hysterectomy (VH) or laparoscopic hysterectomy (LH), and referral is not feasible*
- *when anatomy is so distorted by uterine disease or adhesions that a vaginal or laparoscopic approach is not deemed safe or reasonable by individuals with recognized expertise in either VH or LH techniques.*

I do understand that, in some places, no experienced minimally invasive surgeon may be available. However, when there is someone with the requisite surgical training, skills, and experience to perform vaginal or laparoscopic hysterectomy, then the patient should be referred to that surgeon, or the help of that surgeon should be enlisted to avoid an abdominal procedure.

We have too much clinical evidence of the benefits of these minimally invasive surgical procedures over abdominal hysterectomy to stand in the way of providing women with access to better care just because we lack the ability to perform them ourselves. The AAGL calls us to a higher level of responsibility and patient care. I applaud its courage.

"ACT FAST WHEN CONFRONTED BY A COAGULOPATHY POSTPARTUM"
ROBERT L. BARBIERI, MD
(EDITORIAL; MARCH 2012)

For a postpartum coagulopathy, start with cryoprecipitate

My first chairman (and mentor) taught me to administer cryoprecipitate before any other clotting factors. Cryoprecipitate is the richest source of fibrinogen and carries the least volume load for the patient. Hypofibrinogenemia is at the root of most coagulopathies associated with obstetric complications. Cryoprecipitate quickly solves the problem without adding to the fluid overload.

Genevieve B. Sicuranza, MD
Mineola, New York

Three additional steps can help identify and resolve coagulopathy postpartum

I appreciated Dr. Barbieri's recommendations for identifying and managing a coagulopathy postpartum. I'd like to offer three additional suggestions:

- inspection of the placenta and manual examination of the uterus to rule out retained products of conception
- establishment of a protocol for preparing blood products as soon as possible, as Dr. Barbieri suggested, including drills every 3 months
- immediate consultation with a hematologist—in person or by phone.

This protocol should be in every labor and delivery unit. It's the kind

of proactive, life-saving protocol the Joint Commission ought to be emphasizing instead of its usual nitpicking.

Richard Stokes, MD
Reston, Virginia

Is thromboelastography useful?

Dr. Barbieri's editorial on postpartum coagulopathies was timely and useful. I will be checking with the lab in my small district hospital about the availability of RiaSTAP (lyophilized fibrinogen concentrate [human]; CSL Behring).

A recent article in another journal on the same topic mentioned thromboelastography (TEG). What is Dr. Barbieri's opinion of TEG?

K. Pang, MD
Tulare, California

›› Dr. Barbieri responds

An experienced and alert clinician may be the best remedy

I thank Dr. Sicuranza for her succinct point: ***If your patient has a postpartum coagulopathy, the best treatment is fibrinogen.*** *I agree with her advice. One challenge is that many blood banks need to thaw cryoprecipitate before making it available to the patient, and thawing routinely takes 30 minutes. In contrast, most blood banks have prethawed, fresh, frozen plasma on hand that can be sent to the patient-care area within 5 minutes.*

A new option is RiaSTAP, a lyophilized formulation of fibrinogen. The usual dose of RiaSTAP for postpartum hemorrhage is 2 vials. Compared with fresh frozen plasma or cryoprecipitate, RiaSTAP is very expensive.

Dr. Stokes' clinical advice to ensure that the placenta is completely removed, to perform hemorrhage drills, and to consult a hematologist are excellent. I will emphasize those points when I write about postpartum hemorrhage in the future.

Dr. Pang raises the question of the value of TEG in the management of postpartum hemorrhage. TEG measures the viscosity of blood, a proxy for its ability to initiate and maintain a clot. A recent review of postpartum hemorrhage recommended TEG.[1] *However, in practice, I wonder who is going to run the test. In the hospital, a certified technician or physician would be needed to do so. Until the test is easier to perform, I doubt that it will be used widely in obstetric practice.*

To assess the coagulation profile, I recommend the use of the whole-blood clotting test ("red-top tube test"), described in my editorial, and the measurement of prothrombin time, partial thromboplastin time, platelets, and fibrinogen. An experienced and alert clinician is the best measure of incoagulable blood.

Reference

1. Pacheco LD, Saade GR, Gei AF, Hankins GD. Cutting-edge advances in the medical management of obstetrical hemorrhage. Am J Obstet Gynecol. 2011;205(6):526–532.

"HAVE YOU TRIED A PROGESTIN FOR YOUR PATIENT'S PELVIC PAIN?"
ROBERT L. BARBIERI, MD
(EDITORIAL; FEBRUARY 2012)

For pelvic pain, try the LNG-IUS

It is reassuring to discover that I counsel patients who use medical therapy for chronic pelvic pain and endometriosis in a manner similar to that of Dr. Barbieri. Progestin-only therapy, particularly norethindrone acetate (NEA), is too often overlooked. In many cases, various birth control pills have been tried without much success yet plenty of adverse effects.

When presented with the options of NEA, oral medroxyprogesterone acetate (MPA), and depot medroxyprogesterone acetate (DMPA), many women express an interest in NEA because of the clinically proven benefit. In addition, many women who already have abandoned several therapies because of unpleasant side effects desire the potential for more rapid reversibility with NEA, compared with DMPA. Nevertheless, over the past few years, I have encountered many women (far beyond the incidences reported in the observational study Dr. Barbieri mentioned[1]) who dislike the androgenic effects of long-term use of NEA. Therefore, I increasingly rely on the levonorgestrel-releasing intrauterine system (LNG-IUS; Mirena, Bayer), regardless of parity, to provide a potent progestin with fewer undesirable systemic effects.

That said, I am curious to see where aromatase inhibitors and other new medical therapies ultimately fit into the picture.

Marc Kleinberg, MD
Chicago, Illinois

Reference

1. Kaser DJ, Missmer SA, Berry KF, Laufer MR. Use of norethindrone acetate alone for postoperative suppression of endometriosis symptoms. J Pediatr Adolesc Gynecol. 2012;25(2):105–108.

Other remedies for pelvic pain

I enjoyed the editorial on the use of progestins in the management of endometriosis-related pain. Does Dr. Barbieri also warn patients about the risk of pregnancy?

I have started giving my patients pycnogenol 30 mg twice per day because some studies show that it is effective in decreasing inflammation. I also prescribe mefenamic acid (Ponstel, Shionogi Inc) for dysmenorrhea-related pain with endometriosis.

I find that some patients just want to undergo repeat laparoscopic resection every few years to manage

their endometriosis until they reach their 40s, when they opt for more definitive treatment.

Nicole Varasteh, MD
Concord, New Hampshire

Adding an aromatase inhibitor to an OC

When oral contraceptives (OCs) or gonadotropin-releasing hormone (GnRH) agonists fail to relieve pain, I prescribe a continuous OC with an aromatase inhibitor—typically letrozole (Femara, Novartis) at a dosage of 2.5 mg/day. This regimen has worked extremely well over the past 4 or 5 years for these patients.

Donald C. Young, DO
Clive, Iowa

›› Dr. Barbieri responds

LNG-IUS is a useful tool

I thank Dr. Kleinberg for sharing his expert clinical experience with our readers. I agree that the LNG-IUS is an excellent way to deliver a progestin to the endometrium and pelvic tissues. Data continue to accumulate showing that the LNG-IUS is effective in the treatment of pelvic pain caused by endometriosis.[1]

As Dr. Varasteh recommends, anti-inflammatory agents often are effective in the treatment of pelvic pain. Unlike ibuprofen (a propionic acid anti-inflammatory), mefenamic acid is a fenamate anti-inflammatory agent and may be effective when propionic anti-inflammatory agents are not. However, mefenamic acid is expensive in the United States—between $4 and $18 per 250-mg pill (pricing from www.drugstore.com).

I agree with Dr. Young that, for patients who have endometriosis and pelvic pain and who do not experience sufficient relief with an OC or GnRH agonist, a combination of an OC and an aromatase inhibitor, or NEA plus an aromatase inhibitor, may be effective.[2,3]

References

1. Tanmahasamut P, Rattanachaiyanont M, Angsuwathana S, Techatraisak K, Indhavivadhana S, Leerasiri P. Postoperative levonorgestrel-releasing intrauterine system for pelvic endometriosis-related pain. Obstet Gynecol. 2012;119(3):519–526.
2. Ferrero S, Venturini P, Gillott DJ, Remorgida V. Letrozole and norethisterone acetate versus letrozole and triptorelin in the treatment of endometriosis related pain symptoms: a randomized controlled trial. Reprod Biol Endocrinol. 2011;9:88.
3. Ferrero S, Gillott DJ, Venturini PL, Remorgida V. Use of aromatase inhibitors to treat endometriosis-related pain symptoms: a systematic review. Reprod Biol Endocrinol. 2011;9:89.

"IS THE HCG DISCRIMINATORY ZONE A RELIABLE INDICATOR OF INTRAUTERINE OR ECTOPIC PREGNANCY?"
ANDREW M. KAUNITZ, MD (EXAMINING THE EVIDENCE; FEBRUARY 2012)

Many providers misinterpret the hCG level

I have been teaching and lecturing on ectopic pregnancy for many years, and I share some of the concerns that Dr. Kaunitz and others have raised in regard to the human chorionic gonadotropin (hCG) discriminatory zone.

The concept is misleading or misunderstood by some community providers, who commonly administer methotrexate when the hCG level is 2,000 mIU/mL or higher and no intrauterine pregnancy is visible on ultrasonography (US). This practice could interrupt a normal intrauterine pregnancy and should be discouraged.

In his response to other letters on the subject (see the April 2012 installment of "Comment & Controversy" at obgmanagement.com), Dr. Kaunitz mentioned Europe, where this practice is uncommon. I might add that most European countries have an early pregnancy unit that assesses the patient and follows her until the issue of a pregnancy "of unknown location" is resolved. We need to develop a similar approach in the United States and stop relying so heavily on the discriminatory zone.

Sebhat Afework, MD
Los Angeles, California

No more "medicine by the numbers"

As a mother as well as a clinician, I would agree that we should do away with "medicine by the numbers."

I was informed that my third pregnancy was an incomplete abortion, based on the hCG level and a preliminary US showing a shadow "where the sac was attached—but now it's gone" (or so I was told). I had been taking an oral contraceptive, so I had no idea of the correct date of my last menstrual period. After the US, my OB scheduled a dilatation and curettage for the next morning. However, because I was scheduled to work in a busy labor and delivery unit for the next 3 days, and because I was stable, with no pain and minimal bleeding (spotting), I asked to postpone the procedure until the following week. The next week, I requested another US, which revealed a gestational sac and fetal pole—a healthy pregnancy.

I understand the worry about women who could have an ectopic pregnancy or incomplete abortion and become unstable and trigger a lawsuit, but with good counseling, we could prevent the unwitting termination of a potentially normal pregnancy.

Traci Corder, MSN, RN, WHNP-BC
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