"INS AND OUTS OF STRAIGHT-STICK LAPAROSCOPIC MYOMECTOMY"
JAMES ROBINSON, MD, MS, AND GABY MOAWAD, MD (SEPTEMBER 2012)

Is adhesion formation reduced after laparoscopic myomectomy?

I would like to thank Dr. Robinson and Dr. Moawad for their excellent presentation. In one of the videos that accompanied this article, the authors closed the uterus laparoscopically, but the incision was large. I wonder whether they have performed any second-look laparoscopies to determine whether adhesion formation is reduced in these women.

Michael D. Birnbaum, MD
Elkins Park, Pennsylvania

›› Dr. Robinson responds

Sound microsurgical principles are recommended

We advocate making incisions that approximate the diameter of the fibroid to facilitate its removal. We have had the opportunity to perform second-look laparoscopies in some patients who needed another surgery—either because of a complication of the first surgery or for an unrelated issue. In general, we have been pleased by the low level of postoperative adhesion formation.

Many of our myomectomy patients have had prior myomectomies (laparoscopic or abdominal). We counsel such patients that the prior myomectomy puts them at significant risk for complications associated with adhesions; we also advise them that future surgery may be complicated by adhesions that occur as a result of the surgery we are performing. In our experience, laparoscopy appears to cause fewer adhesions but is not entirely protective. We have seen patients who have undergone prior laparoscopic myomectomies who have extensive and dense adhesions at their repeat surgery, and patients who have had extensive prior open myomectomies who do not have significant adhesions at their repeat surgery.

The time-honored microsurgical principles of hemostasis, gentle tissue handling, and tissue approximation without strangulation, along with the use of a good adhesion barrier, are more important than the route of surgery—in my unscientific and biased opinion. When laparoscopy leads to less tissue injury than laparotomy, we can extrapolate that postoperative adhesion formation should also be less. A good review article on the subject from the perspective of the American Society for Reproductive Medicine Practice Committee appears in the supplement to the November 2006 issue of the journal Fertility and Sterility (*pages 1–5*).

SEPTEMBER 2012

"MALPOSITIONED IUDS: WHEN YOU SHOULD INTERVENE (AND WHEN YOU SHOULD NOT)"
KARI P. BRAATEN, MD, MPH, AND ALISA B. GOLDBERG, MD, MPH (AUGUST 2012)

How to manage a partially expelled IUD

Dr. Braaten and Dr. Goldberg made no mention of the partially expelled intrauterine device (IUD)—unless that is the phenomenon they described as the "downward displaced" IUD.

When I have a patient who has a partially expelled IUD, I remove the device and initiate another form of birth control, such as another IUD, depot medroxyprogesterone acetate, or an oral contraceptive. I never advance a partially expelled IUD back into the uterine cavity.

Jonathan Watt, MD
Vancouver, Washington

Article on malpositioned IUDs is greatly appreciated

I really enjoyed the article on malpositioned IUDs, especially the visual elements and their respective explanations. The article provided me with an excellent understanding of the problem and showed me how to manage it in a scientific manner. I'll share it with my colleagues and keep it on hand as a guide. Thank you!

Mariella Camargo, CNM
Port Chester, New York

"STOP PERFORMING MEDIAN EPISIOTOMY!"
ROBERT L. BARBIERI, MD (EDITORIAL; APRIL 2012)

Delivery of the shoulders often gets overlooked in discussions of episiotomy

I have practiced obstetrics and gynecology since my internship in 1974! In my opinion, much is said about delivering the baby's head, whereas delivery of the shoulders often gets overlooked in discussions. We must remember that the biacromial diameter is the largest diameter that must be delivered.

After observing—and being involved in—thousands of deliveries, I have concluded that there is gross disregard for the shoulders once the head is delivered. In my deliveries, I

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protect the perineum—with or without episiotomy—until both shoulders have been delivered. I perform external rotation and delivery of both shoulders with one hand while the other hand holds the perineum together.

None of the articles I have read on episiotomy have mentioned management of the shoulders.

Miguel A. Cintron, MD
Harlingen, Texas

Median episiotomy is easier on the patient

I take issue with Dr. Barbieri's recommendation to stop performing median episiotomy. Although I avoid liberal use of episiotomy, I sometimes perform it in challenging vaginal deliveries. When I do, I opt for a midline episiotomy rather than a mediolateral one.

My observations—"science" notwithstanding—are that patients who undergo mediolateral episiotomy are always significantly more uncomfortable than those who receive a midline episiotomy, and they experience discomfort for a significantly longer time. Moreover, the mediolateral approach does not always eliminate extension into the rectum. In 33 years of practice, I have not encountered rectovaginal fistula or anal incontinence among my patients who have a midline episiotomy. Nevertheless, I ask about anal continence at every postpartum visit—and try to ensure that every patient is seen postpartum by calling all women who fail to make an appointment. I also inquire about anal continence at every yearly exam.

Gerald L. Vitamvas, MD
Milwaukee, Wisconsin

›› Dr. Barbieri responds

Pay attention to the shoulders

I agree with Dr. Cintron that the fetal shoulders should be delivered with attention and care. In my experience, all obstetricians take great care in delivering the head across the perineum to avoid lacerations. Not all obstetricians focus as much attention on gentle delivery of the shoulders; this lack of attention can increase the risk of perineal laceration.

I deeply respect the clinical experience and insights of Dr. Vitamvas, and I agree that a median episiotomy is better tolerated by the patient. I wonder if he would consider performing a mediolateral episiotomy occasionally during operative vaginal delivery? A recent article concluded that, in this setting, a mediolateral episiotomy is associated with a sixfold reduction in the odds of developing an obstetric anal sphincter injury, compared with a median episiotomy.[1]

Reference

1. de Vogel J, van der Leeuw-van Beek A, Gietelink D, et al. The effect of a mediolateral episiotomy during operative vaginal delivery on the risk of developing obstetrical anal sphincter injuries. Am J Obstet Gynecol. 2012;206(5):404.e1–e5.

A coding question on the Bakri balloon

Q. What CPT code should be reported when the Bakri balloon is used to stanch postpartum bleeding?

A. Placement of the Bakri balloon to control postpartum bleeding does not have a specific Current Procedural Terminology (CPT) code. However, the additional work involved should be captured so that you can be reimbursed by the payer. I recommend two options:

- **If the patient has not been sent to recovery** when the bleeding is noted, simply add a modifier **-22** (increased procedural services) to the delivery code.
- **If the bleeding is noted after the patient has been moved to recovery**, use the unlisted code **59899** with the modifier **-78** to reflect a return to the operating room or a procedure suite.

If you use the modifier -22, be sure to document the reason for the additional work and the length of time it took to stop the bleeding. Please refer to the CPT guidelines (in the CPT book) for use of this modifier.

If you use the unlisted code 59899, you need to link the work to an existing CPT code so that the payer can determine whether your charge is reasonable. For instance, a similar scenario might involve code **43460** (*Esophagogastric tamponade, with balloon [Sengstaken type]*) to control variceal bleeding. This code has 6.65 relative value units (RVUs). However, if the bleeding is controlled quickly, it might be better to use code **46604** (*Anoscopy; with dilation* [eg, balloon, guide wire, bougie]), which has 1.94 RVUs, or code **51703** (*Insertion of temporary indwelling catheter; complicated* [eg, altered anatomy, fractured catheter/balloon]), which has 2.41 RVUs.

This is one of those times when you must not only document the work you perform but feel comfortable setting the charge for that work. In other words, be prepared to defend your choice when you select a code to support your charge.

—Melanie Witt, RN, CPC, COBGC, MA

Editor's note: Ms. Witt is an independent coding and documentation consultant and former program manager, department of coding and nomenclature, American College of Obstetricians and Gynecologists.