Reconcile Exam and Image

Pinpoint *from page 1*

percentage of the litigation involves a palpable breast mass discovered by the patient, who then comes to the clinician for an evaluation.

Litigated cases often lack any documentation of a breast examination.

Clinicians should carefully document everything: that they evaluated a patient for signs and symptoms of breast cancer, that they took a thorough clinical history, and that they referred the patient for genetic counseling if appropriate.

'The interplay between the clinical and mammographic findings often will convert subthreshold findings to threshold findings.'

Use a stamp or mnemonic in the chart to show that you examined the breasts and regional lymph nodes, Dr. Brenner suggested.

Try to reconcile clinical findings and imaging results.

"The interplay between the clinical and mammographic findings often will convert subthreshold findings to threshold findings. That needs to be appreciated," he said at the meeting, which was sponsored by Boston University.

Insist on getting a phone call from the radiologist if there is any suspicious finding on mammography or ultrasound, because written or electronic reports can get lost or misplaced, he added.

When you do get a mammography or ultrasound report, initial it to indicate that you looked at it, and to show a potential jury that it was your decision to do something further or not to do more, Kimberly D. Baker, J.D., said in a legal commentary session after Dr. Brenner's talk.

"Computerized records don't necessarily help. People can get the information more quickly, but it doesn't mean they pay attention to it," she noted.

Besides systematic documentation, a key component in reducing risk is good communication with the patient. Explain the difference between screening and a mammogram performed for specific clinical reasons, to emphasize the importance of following through, said Ms. Baker, a defense attorney in Seattle who also holds a BS degree in nursing.

Young women in particular may think of mammography as something for their mothers or aunts, not them.

"If they have risk factors, you need to talk them into getting a mammogram," she said. "A young breast cancer failure-to-diagnose case is very difficult to defend."

The effect of breast cancer treatments on fertility increasingly is becoming a legal issue.

Don't assume that a woman in her late 30s or 40s or even at age 50 is past thinking of a future pregnancy.

Find out what her plans are before treatment, and advise her accordingly, Ms. Baker said. ■

Local Complications Common With Postmastectomy Implants

BY MARY ANN MOON
Contributing Writer

Local complications are common after postmastectomy reconstructive breast implantation, with an adverse event rate of 31% in one large prospective study, reported Dr. Trine F. Henriksen of the Danish Registry for Plastic Surgery of the Breast, Copenhagen, and associates.

In what they described as "the first prospective epidemiological study to provide quantitative data on short-term local complications among women receiving implants for breast reconstruction," the investigators found that unplanned surgical or medical intervention is often required during the course of reconstruction. Some 20% of women needed surgical procedures to treat complications within the first 2 years of mastectomy, a rate that is nearly four times higher than that with cosmetic implantation.

"When evaluating benefits and risks associated with breast reconstruction, the surgeon and patient should consider that the reconstructive process often requires additional surgical intervention to treat local complications or to achieve the desired cosmetic result. Detailed information on the likelihood of local complications … should be an essential part of adequate informed consent" for mastectomy patients seeking breast implantation, Dr. Henriksen and associates said (Arch. Surg. 2005;140:1152-9).

They studied the issue using data from the Danish Registry for Plastic Surgery of the Breast, which provided the world's "first systematic collection of preoperative, perioperative, and postoperative data in relation to mammoplasty procedures."

The study included all 574 women who underwent 901 postmastectomy breast implantations in Denmark between June 1999 and July 2003.

There were 484 initial implant procedures and 417 reimplant procedures—implant exchanges or implant reinsertion after a prior removal. Just over half (51%) of these secondary procedures were unplanned; the remaining 49% were planned second-stage operations after tissue expansion. The mean patient age at initial implantation was 50 years, and the subjects were followed for a mean of 23 months after initial implantation and 24 months after subsequent implantation.

Unplanned repeat procedures were performed for a range of reasons, and patients often had more than one indication. Capsular contraction was the most common cause for repeat procedures (23%), followed by unacceptable asymmetry (20%), displacement of the implant (16%), and suspicion of implant rupture (5%).

After initial implantation, 31% of women experienced at least one adverse event, ranging from delayed wound healing to severe capsular contraction. Sixteen percent developed two adverse events, and 8% developed at least three. Wound infection was the most common immediate adverse event, affecting 7% of women. Skin perforation, seroma, periprosthetic infection, and hematoma each affected 3% of the women.

After a repeat implantation procedure, 36% of the women developed one adverse event, 19% developed two, and 8% developed three or more adverse events. Asymmetry and displacement of the implant were the most frequently reported problems, affecting 19% of women. Hematoma, capsular contraction, prolonged pain, wrinkles, and scar indentation each affected 3% of the women.

A total of 21% of the women required surgical intervention after initial implantation and another 3% required other treatments.

Approximately half of the complications occurred within the first 3 months after implantation, 67% within the first 6 months, and 91% within the first year. ■

HSV-2 Infection May Raise Risk for Pelvic Inflammatory Disease

BY MIRIAM E. TUCKER
Senior Writer

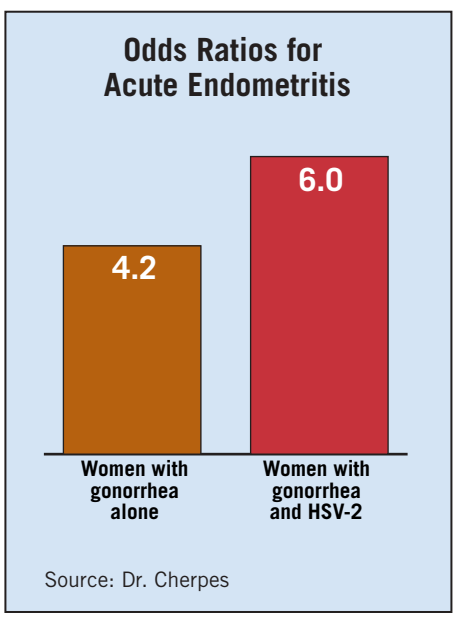
WASHINGTON — Herpes simplex virus type 2 infection in women may be associated with an increased risk of pelvic inflammatory disease, Dr. Thomas L. Cherpes reported in a poster at the annual Interscience Conference on Antimicrobial Agents and Chemotherapy.

The role of chronic genital viral infections in the pathogenesis of pelvic inflammatory disease (PID) may be more significant than currently recognized, although no etiologic link has as yet been defined, noted Dr. Cherpes and his associates at the University of Pittsburgh.

A total of 725 nonpregnant women aged 15-30 years who were either diagnosed with a lower bacterial genital tract infection (purulent cervical discharge, untreated *Neisseria gonorrhoeae* or *Chlamydia trachomatis* infection, symptomatic bacterial vaginosis) or were at risk for such an infection (sexual contact with a male diagnosed with gonorrheal, chlamydial, or nongonococcal urethritis) were recruited from sexually transmitted disease clinics and gynecology clinics. Of those, 43% (309) were seropositive for herpes simplex virus type 2 (HSV-2).

Of the 86 women with acute endometritis, 55% (47) were HSV-2 seropositive, as were 51% (70) of the 136 women found to have plasma cell endometritis. Acute endometritis was independently associated with black race (odds ratio 1.7) as well as infections with *C. trachomatis* (3.3), *N. gonorrhoeae* (2.8), *Trichomonas vaginalis* (2.4), and HSV-2 (2.2). Black race also was associated with plasma cell endometritis (odds ratio 1.9), but HSV-2 was the only reproductive tract infection significantly associated with that condition (odds ratio 1.5), they reported.

Coinfection with HSV-2 and a genital tract bacterial pathogen significantly increased the likelihood of PID, compared with having one or the other alone. For example, the odds ratio for acute endometritis was 5.0 for women with chlamydia and 2.6 for those with HSV-2, compared with women who did not have those conditions. However, the odds ratio jumped to 7.3 for women coinfected with both. Similarly, women with gonorrhea alone had a 4.2-fold increased risk for acute endometritis, which rose to 6.0 if they were also infected with HSV-2.



Among 471 of the women who underwent hysterosalpingography, 8.1% (38) had both HSV-2 infection and evidence of fallopian tube obstruction: Those 38 women accounted for 19% of the 199 women who were HSV-2 positive and 54% of the 71 with fallopian tube blockage.

Of course, these data do not exclude the possibility that the higher prevalence of HSV-2 among women with PID may simply reflect a marker for sexual activity and/or the coacquisition of a PID-associated bacterial pathogen.

However, "as PID remains the most frequent gynecologic cause for emergency room visits as well as the most frequent infectious cause of infertility, confirmation and further exploration of these findings could have important clinical implications," Dr. Cherpes and his associates wrote.

The conference was sponsored by the American Society for Microbiology. ■