9vHPV VACCINE: PREVENTION OF OROPHARYNGEAL CANCER
ROBERT L. BARBIERI, MD
(EDITORIAL; NOVEMBER 2020)

HPV vaccine for older ObGyns?

I am 67 years old and recently retired. I breathed in the smoke from laser conizations, LEEPs (loop electrosurgical excision procedures), and cautery of condyloma for 35 years. Am I a good candidate for the HPV vaccine?

Gus Barkett, DO
Muskegon, Michigan

Dr. Barbieri responds

I thank Dr. Barkett for his important question. As you know, the US Food and Drug Administration has approved 9vHPV vaccination for people 27 to 45 years of age. I do not believe there are sufficient data to provide an evidence-based answer for physicians with occupational exposure to HPV who are more than 45 years of age. My recommendation would be to have a consult with an otolaryngologist expert in HPV-induced oral-pharyngeal cancer.

EXAMINING THE EVIDENCE: HOW EFFECTIVE IS SCREENING MAMMOGRAPHY FOR PREVENTING BREAST CANCER MORTALITY?
ANDREW M. KAUNITZ, MD
(AUGUST 2020)

Discordant results on screening mammography

In regard to the discussion on screening mammography for preventing breast cancer mortality, I would like to call attention to a more recent study than the ones referenced in the article. The study by Duffy and colleagues was from Sweden and included almost 550,000 women.[1] Results of the study showed a statistically significant reduction of 41% in 10-year mortality and a 25% reduction in the incidence of advanced-stage disease at the time of diagnosis in women who underwent routine screening mammograms. In Sweden, routine screening is defined as a mammogram every 18 months for women aged 40 to 54 years and every 24 months after that, up to age 69.

I do not know if we will ever come to a consensus on the utility of mammograms or how often they should be done, but I wanted to illustrate this counterpoint.

Lisa Gennari, MD
Cincinnati, Ohio

NOVEMBER 2020

Reference
1. Duffy SW, Tabar L, Yen AM, et al. Mammography screening reduces rates of advanced and fatal breast cancers: results in 549,091 women. *Cancer.* 2020;126:2971-2979.

WE WANT TO HEAR FROM YOU!

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Please include the city and state in which you practice.

Dr. Kaunitz responds

I thank Dr. Gennari for her interest in the Examining the Evidence discussion that summarized the findings of an article from Australia published in late summer of last year.[1] That article indicated that as screening mammograms became common in the state of Victoria over several decades, the incidence of advanced breast cancer doubled, mirroring findings from the United States, Holland, and Norway. During the same time period, breast cancer mortality declined substantially. The authors concluded that all of the decline in breast cancer mortality that they observed since 1994 could be attributed not to screening mammography but rather to the introduction and uptake of adjuvant therapy (tamoxifen and chemotherapy).

In contrast, in the article Dr. Gennari cites, also published last summer, the authors found that the widespread uptake of screening mammograms among women residing in 9 counties in Sweden was associated with a decline in the incidence of advanced breast cancer. I am not able to explain these discrepant findings. However, as the authors pointed out, they employed a new strategy: measuring the incidence of breast cancer that proved fatal one decade after diagnosis.

Differing findings and interpretations of data that address benefits and risks of screening mammography lead to differing recommendations from professional societies and confusion among clinicians and our patients. Although it can be challenging in the constraints of time allotted for well-woman visits, I try to engage in shared decision making with my patients regarding when to start/stop mammography as well as frequency of screening.

Reference
1. Burton R, Stevenson C. Assessment of breast cancer mortality trends associated with mam-

mographic screening and adjuvant therapy from 1986 to 2013 in the state of Victoria, Australia. *JAMA Netw Open.* 2020:3:e208249.

NEW HORMONAL MEDICAL TREATMENT IS AN IMPORTANT ADVANCE FOR AUB CAUSED BY UTERINE FIBROIDS

ROBERT L. BARBIERI, MD
(EDITORIAL; AUGUST 2020)

New AUB medical treatment

I appreciate Dr. Barbieri's concise and pertinent review of myomatous disease etiology and treatments. I have a question regarding therapy with Oriahnn (elagolix, estradiol, and norethindrone acetate capsules). Most myomatous-related bleeding occurs in premenopausal women. The elagolix suppresses luteinizing hormone and follicle stimulating hormone, and the norethindrone is added to protect the endometrium from the estradiol. Do the elagolix and norethindrone also provide contraception?

Geoffrey J. Zann, MD, MBA
Boca Raton, Florida

Dr. Barbieri responds

Dr. Zann raises an important clinical question that arises often in practice. The US Food and Drug Administration (FDA) has not approved Oriahnn as a contraceptive. The FDA prescribing information recommends: Advise women to use non-hormonal contraception during treatment and for one week after discontinuing Oriahnn. Oriahnn may delay the ability to recognize the occurrence of a pregnancy because it alters menstrual bleeding. Perform pregnancy testing if pregnancy is suspected and discontinue Oriahnn if pregnancy is confirmed.

In Oriahnn, the elagolix dose is 300 mg twice daily. If a patient reliably takes 600 mg of elagolix daily, it is highly unlikely that she will ovulate. However, in practice, many patients miss doses of their medication, reducing the contraceptive effectiveness. For example, the combined estrogen-progestin contraceptive is highly effective at suppressing ovulation, but the Centers for Disease Control and Prevention (CDC) estimates that 9% of women taking an estrogen-progestin contraceptive will become pregnant each year.[1,2]

Oriahnn also contains norethindrone acetate at a dose of 0.5 mg daily. The FDA has approved norethindrone at a dose of 0.35 mg daily as a contraceptive. The CDC estimates that 9% of women prescribed a progestin-only pill will become pregnant each year with typical use.[1,2]

I counsel my patients that if they reliably take their prescribed Oriahnn medication as directed, they are unlikely to become pregnant, and a backup method of contraception will further help to reduce their risk of becoming pregnant.

References

1. Centers for Disease Control and Prevention. US selected practice recommendations for contraceptive use, 2013. *MMWR Morbid Mortal Weekly Rep.* 2013;62(RR-5):1-59.
2. Trussell J. Contraceptive failure in the United States. *Contraception.* 2011;83:397-404.