

**“2017 UPDATE ON ABNORMAL UTERINE BLEEDING”**

HOWARD T. SHARP, MD, AND  
MARISSA ADELMAN, MD (APRIL 2017)

**Hysteroscopy equipment too expensive for employed or small-group practitioners**

I could not agree more with Drs. Sharp and Adelman that diagnostic hysteroscopy should be performed in the office whenever possible. However, as a solo gynecologist in private practice, I could not afford or justify the cost of purchasing the equipment as well as its care and maintenance. Sometimes I was able to bring a third-party vendor to provide the equipment and a technician so that I could perform a diagnostic hysteroscopy in my office when I did an ablation with my own Thermochoice equipment and balloon system.

The hysteroscopy was bundled/required for the Current Procedural Terminology (CPT) code to work in the office. Most of these patients already had undergone an ultrasonography, endometrial biopsy, and some had an outpatient hysteroscopic dilation and curettage under general anesthesia, which did not resolve their bleeding. All of this adds to the cost and increased patient discomfort and inconvenience. Reimbursement for the office procedure was better than when performed at the hospital, and patients avoided \$500 to \$1,000 copays to the hospital and anesthesiologist.

When I closed my private practice and became employed by the hospital, I proposed that they purchase office hysteroscopy equipment for the other gynecologist and me to share. I continued to perform uterine ablations with my own equipment. Together we performed more than 100 outpatient diagnostic

hysteroscopies per year, some with global endometrial ablation. Since there were only 2 gyns, the 2 new hysteroscopy sets they purchased sat in the closet most of the time.

I suggested they “lease” the equipment back to us on a case-by-case basis for office use since they owned and managed our practices. The hospital administration basically saw office procedures as taking away revenue from the hospital and decreasing operating room volume. The patients I treated in the office setting did well, preferred to avoid general anesthesia, and enjoyed the cost savings.

Large ObGyn groups with multiple providers and high volumes can justify the expenses of the equipment, but for those in solo practice or employed by a hospital, it may not be feasible. I sincerely hope that articles focusing on in-office hysteroscopy will open up the discussion to enable and encourage more physicians and hospital administrators to see the advantages of office-based procedures.

**Steven R. Moffett, MD**  
Knoxville, Tennessee

**“TREATING POLYCYSTIC OVARY SYNDROME: START USING DUAL MEDICAL THERAPY”**

ROBERT L. BARBIERI, MD  
(EDITORIAL; APRIL 2017)

**Why extended release metformin?**

I read with interest Dr. Barbieri’s editorial on polycystic ovary syndrome. It left me wondering: Is there a metabolic or pharmacologic reason why you give metformin XR 1,500 mg with dinner instead of 750 mg orally twice per day?

**Marcelo Andreoli, MD**  
Vienna, Virginia

**>> Dr. Barbieri responds**

*I thank Dr. Andreoli for the important clinical question about one-time or multiple dosing of metformin. To improve patient adherence with metformin treatment, I think once-daily dosing at dinner with an extended-release formulation is more convenient than twice-daily dosing with immediate-release metformin. Following ingestion of immediate- or extended-release metformin, peak metformin blood concentrations are achieved after 2 and 7 hours, respectively.<sup>1</sup> There is some evidence that extended-release metformin has fewer gastrointestinal (GI) adverse effects than immediate-release metformin.<sup>2</sup> In one study, the reported rates of GI adverse effects were 29% versus 39% with extended-release and immediate-release formulations, respectively.<sup>2</sup>*

**References**

1. Ali S, Fonseca V. Overview of metformin: special focus on metformin extended release. *Expert Opin Pharmacother.* 2012;13(12):1797-1805.
2. Fujioka K, Pans M, Joyal S. Glycemic control in patients with type 2 diabetes mellitus switched from twice-daily immediate-release metformin to a once-daily extended-release formulation. *Clin Ther.* 2003;25(2):515-529.

**“WHY ARE THERE DELAYS IN THE DIAGNOSIS OF ENDOMETRIOSIS?”**

ROBERT L. BARBIERI, MD  
(EDITORIAL; MARCH 2017)

**Look for symptoms of IBS, PCOS, and PMS**

I practiced reproductive endocrinology for 40 years and saw too many patients whose endometriosis had been ignored or undertreated. I found that the initial suspicion for the disease could be discovered by looking for symptoms of 3 comorbidities: irritable bowel syndrome, polycystic ovary syndrome, and premenstrual syndrome.

**Wilbur (Dub) Howard, MD**  
Dallas, Texas

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**“ROBOT-ASSISTED LAPAROSCOPIC RESECTION OF A NONCOMMUNICATING CAVITARY RUDIMENTARY HORN”**

OBIANUJU SANDRA MADUEKE-LAVEAUX, MD, MPH; BETH W. RACKOW, MD; AND ARNOLD P. ADVINCULA, MD (VIDEO; JANUARY 2017)

**The fallopian tube should have been removed**

I watched the video by Dr. Advincula and colleagues and as always was impressed with the surgical skills demonstrated. While the robot-assisted approach is quite nice, this case could have been accomplished with only three 5-mm lower abdominal port sites and traditional straight-stick laparoscopic methods.

The cosmetic benefit to a 15-year-old patient of this alternative should have been considered.

More importantly, the fallopian tube separated from the rudimentary horn should have been removed. Leaving the right tube in situ exposes the patient to the possibility of a future ectopic pregnancy in that tube and provides no benefit to the patient.

**David L. Zisow, MD**  
Baltimore, Maryland

**» Dr. Advincula and team respond**

*We appreciate Dr. Zisow’s perspective. As is known, tool selection is based on surgeon preference. Inherent to this point, a discussion about route of*

*surgery, and any implications it would have, such as cosmesis, was had. Cosmesis was not an issue with this patient, and she was quite pleased with her cosmetic outcome.*

*We also discussed preoperatively, among our team and with the patient, the right fallopian tube. Although removal would have been optimal, there was concern intraoperatively of possible compromise to the ovary. Hence, a decision was made to forego removal particularly in light of the extremely rare risk of transperitoneal migration of spermatozoa weighed against the risk of compromising a perfectly healthy ovary in a 15-year-old woman.*