ARE WE READY FOR PRIMARY HPV TESTING FOR THE PREVENTION OF CERVICAL CANCER?
SARAH FELDMAN, MD, MPH; ROBERT L. BARBIERI, MD
(EDITORIAL; JULY 2018)

Multiple payment systems impede universal HPV screening access

Unless the issue of multiple systems of payment and access (that is, multiple insurance companies and providers) can be resolved in the United States, I do not believe there will be an advancement across the board for human papillomavirus (HPV) screening. In my opinion, we need to work toward access to health care for all and a single-payer system.

C.L. Conrad-Forrest, MD
Davis, California

Dr. Barbieri responds

I agree with Dr. Conrad-Forrest that improving cervical cancer screening would be advanced by interoperable electronic medical records and health systems that are designed to manage population health. I predict that a large integrated health system will be the first to adopt the use of high-risk HPV testing to screen for cervical cancer in the United States.

VIDEO: SIZE CAN MATTER: LAPAROSCOPIC HYSTERECTOMY FOR THE VERY LARGE UTERUS
DEIRDRE LUM, MD
(SOCIETY OF GYNECOLOGIC SURGEONS; JULY 2018)

Laparoscopic suturing is an option

Dr. Lum presented a nicely produced video demonstrating various strategies aimed at facilitating total laparoscopic hysterectomy (TLH) of the very large uterus (www.mdedge.com/obgyn/article/168309/surgery/size-can-matter-laparoscopic-hysterectomy-very-large-uterus).

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Her patient's evaluation included magnetic resonance imaging. In the video, she demonstrates a variety of interventions, including the use of a preoperative gonadotropin–releasing hormone (GNRH) agonist and immediate perioperative radial artery–uterine artery embolization. Intraoperative techniques include use of ureteral stents and securing the uterine arteries at their origins.

Clearly, TLH of a huge uterus is a technical challenge. However, I'd like to suggest that a relatively basic and important skill would greatly assist in such procedures and likely obviate the need for a GNRH agonist and/or uterine artery embolization. The vessel-sealing devices shown in the video are generally not capable of sealing such large vessels adequately, and this is what leads to the massive hemorrhaging that often occurs.

Laparoscopic suturing with extracorporeal knot tying can be used effectively to control the extremely large vessels associated with a huge uterus. The judicious placement of sutures can completely control such vessels and prevent bleeding from both proximal and distal ends when 2 sutures are placed and the vessels are transected between the stitches. Many laparoscopic surgeons have come to rely on bipolar energy or ultrasonic devices to coagulate vessels. But when dealing with huge vessels, a return to basics using laparoscopic suturing will greatly benefit the patient and the surgeon by reducing blood loss and operative time.

David L. Zisow, MD
Baltimore, Maryland

Dr. Lum responds

I thank Dr. Zisow for his thoughtful comments. I agree that laparoscopic suturing is an essential skill that can be utilized to suture ligate vessels. If we consider the basics of an open hysterectomy, the uterine artery is clamped first, then suture ligated. When approaching a very large vessel during TLH, I would be concerned that a simple suture around a large vessel might tear through and cause more bleeding. To mitigate this risk, the vessel can be clamped with a grasper first, similar to the approach in an open hysterectomy. However, once a vessel is compressed, a sealing device can usually work just as well as a suture. It becomes a matter of preference and cost.

During hysterectomy of a very large uterus, a big challenge is managing bleeding of the uterus itself during manipulation from above. Bleeding from the vascular sinuses of the myometrium can be brisk and obscure visualization, potentially leading to laparotomy conversion. A common misconception is that uterine artery embolization is equivalent to suturing the uterine arteries. In actuality, the goal of a uterine artery embolization is to embolize the distal branches of the uterine arteries, which can help with any potential bleeding from the uterus itself during hysterectomy.

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ARE WE USING THE RIGHT METRICS TO MEASURE CESAREAN RATES?

MYRON R. KANOFSKY, MD
(WEB EXCLUSIVE COMMENTARY; JUNE 19, 2018)

High cesarean delivery rate is related to many factors

I have been questioning the metrics, too. My cesarean delivery (CD) rate is high. Why? In my pre-retirement I do a lot of indigent work. Three public health clinics with nurse practitioners send me their patients to do their CDs. Morbid obesity is endemic among the Pacific Islanders.

Friedrich C. Bieling, MD
Tamuning, Guam

Use metrics for populations, not individuals

Dr. Kanofsky's commentary on CD metrics is 100% correct. As an ethical question for physicians and society alike, I would ask, is applying metrics to physicians even moral?

As an ObGyn for most of 4 decades, my approach to obstetrics has not changed. In some years, my CD rate was very low, and in others my rate was average. Women must be treated as individuals. Although the industrial revolution increased quality and decreased costs in manufacturing, I do not believe that we can or should apply those principles to our patients.

Government regulators, insurance companies, and many physician leaders have lost sight of the Oath of Maimonides, which states, "May the love of my art actuate me at all times; may neither avarice nor miserliness…engage my mind,"[1] as well as Hippocrates' ancient observation, "Whatsoever house I may enter, my visit shall be for the convenience and advantage of the patient."[2] In addition, in the modern version of the Hippocratic Oath that most schools use today, physicians swear to "apply, for the benefit of the sick, all measures [that] are required…"[3]—not to the benefit of the government, the federal budget, or an accountable care organization (ACO).

Clearly, the informed consent of a 42-year-old who had in vitro fertilization and has a floating presentation with a low Bishop score and an estimated fetal weight of 4,000 at 40 6/7 weeks must include not only the risks of primary CD but also the risks of a long labor that may result in a CD, the occasional risk of shoulder dystocia, or third- or fourth-degree extension. Not having had a case of shoulder dystocia or a third- or fourth-degree in more than a decade clearly justifies my rationale.

The morbidity of a multiple repeat CD or even a primary CD in an obese woman is significantly more risky than a non-labored elective CD in a woman of normal weight who plans to have only 1 or 2 children. We must individualize our care. Metrics are for populations, not individuals.

Health economists who aggressively advocate lower cesarean rates accept stillbirths and babies with hypoxic ischemic encephalopathy, cerebral palsy, or Erb's palsy as long as governmental expenditures are lowered. Do the parents of these children get a vote? The majority of practicing physicians like myself feel more aligned with the Hippocratic Oath and the Oath of Maimonides. We believe that we have a moral, ethical, and medical responsibility to the individual patient and not to an ACO or government bean counter.

I would suggest an overarching theme: choice—the freedom to make our own intelligent decisions based on reasonable data and interpretation of the medical literature.

One size does not fit all. So why do those pushing comparative metrics tell us there is only one way to practice obstetrics?

Howard C. Mandel, MD
Los Angeles, California

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HOW DOES ORAL CONTRACEPTIVE USE AFFECT ONE'S RISK OF OVARIAN, ENDOMETRIAL, BREAST, AND COLORECTAL CANCERS?

DANA M. SCOTT, MD;
MARK D. PEARLMAN, MD
(EXAMINING THE EVIDENCE; MAY 2018)

Agrees that OC use clearly reduces mortality

Recent evidence from long-term observations of hundreds of thousands of women, in 10 European countries, clearly demonstrated that the use of oral contraceptives (OCs) reduced mortality by roughly 10%.[1,2] Newer OCs increase women's overall survival.

In comparison, reducing obesity by 5 body mass index points would reduce mortality by only 5%, from 1.05 to 1.[3]

Dr. Stavros Saripanidis
Thessaloniki, Greece

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HOW TO DECIDE ON PURCHASING NEW MEDICAL EQUIPMENT
DAVID S. KIM, MD, PHD, MBA
(MAY 2018)

Astonished by physician hourly rate calculation

I always enjoy the articles and incredible insights presented in OBG MANAGEMENT. Some very sophisticated, well-founded ideas are presented in the article on deciding on purchasing medical equipment. Then, however, you get to the calculations: $50 for 30 minutes of physician time!

My plumber charges me $100 for the first half hour of a visit (okay, there are lots of cliched jokes about this), but on average a physician assistant costs almost that much. It is a sad day in the business of medicine when experts value the time of highly educated physicians at $100 per hour. Maybe someday we can expect to be reasonably compensated for our efforts and training. When I advise my colleagues, I calculate their time, depending on their practice model, between $300 and $400 per hour.

Hamid Banooni, MD
Farmington Hills, Michigan

Dr. Kim responds

I thank Dr. Banooni for his comment. I agree that physicians are highly skilled and educated and that their time deserves to be valued at more than $100 per hour. In the article and the example provided, the values (revenues, costs, and so on) were not meant to be exactly representative of the marketplace, but instead were used merely as an example for understanding the calculation tools for purchasing medical equipment. That being said, I arrived at the $100 per hour cost for physician time (included in the variable cost in the Figure, "Breakeven analysis for hysteroscope purchase for use in tubal sterilization") for 2 primary reasons. First, to simplify the calculation, and second, to use an equivalent universal hourly salary ($100 per hour) for a physician's comparative labor cost in the marketplace. Currently, the median hourly compensation for an ObGyn laborist is $110 per hour.[1] To simplify, I rounded down to $100. I wholeheartedly agree with Dr. Banooni, however, that a physician's time should be valued higher in society.

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