

“OOPHORECTOMY OR SALPINGECTOMY—WHICH MAKES MORE SENSE?”

WILLIAM H. PARKER, MD (MARCH 2014)

Estrogen does not cause breast cancer

Excellent article by Dr. Parker, with one exception—he continues to promulgate the erroneous misconception that estrogen is what causes breast cancer. He repeats the inaccurate early conclusion of the Women’s Health Initiative (WHI) in 2002 that reported an increased risk of breast cancer. Yet review of that early data suggested that progestin was responsible for the increase, because patients taking estrogen alone had a lower breast cancer risk. Indeed, final and comprehensive review of the WHI studies in 2011 indicates that the estrogen-only arm of the study demonstrated lower breast cancer risks than the placebo group; that distinction continued in the post-intervention period as well.

We need to stop perpetuating the misconception that estrogen causes breast cancer, as the idea continues to be a major deterrent for patients to take estrogen during menopause, to the detriment of their health.

Rafael Haciski, MD
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» Dr. Parker responds:

Dr. Haciski is absolutely right about the fact that the estrogen-only arm of the WHI found a lower risk of breast cancer. The point I was trying to make, perhaps unsuccessfully, was that, in response to the 2002 WHI publication findings of an increased risk of breast cancer after estrogen and progesterone administration, the rate of oophorectomy declined. One interpretation of this trend toward ovarian conservation is that it reflected

women deciding to keep their own ovarian hormones, rather than take exogenous hormones associated with health-related risks. While the 2004 WHI estrogen-only publication found a trend toward lower breast cancer risk, this association was not fully confirmed until 2012.¹ Even now, many women find the WHI estrogen-progestin and the estrogen-only publications confusing. It was not my intention to add to that confusion.

Reference

1. Anderson GL, Chlebowski RT, Aragaki AK, et al. Conjugated equine oestrogen and breast cancer incidence and mortality in postmenopausal women with hysterectomy: extended follow-up of the Women’s Health Initiative randomised placebo-controlled trial. *Lancet Oncol.* 2012;13(5):476–486.

“UPDATE ON MINIMALLY INVASIVE GYNECOLOGY”

AMY GARCIA, MD (APRIL 2014)

Terminology is important: A cesarean scar pregnancy is not an ectopic pregnancy

I read with great interest the excellent “Update on minimally invasive gynecology,” by Amy Garcia, MD, co-member of OBG MANAGEMENT’S Board of Editors. In it she gives an excellent definition and discussion of an increase in the epidemic of cesarean scar defects (CSD). Her update focuses on intermenstrual bleeding when the menstrual blood presumably collects in the defect and comes out externally, and unpredictably, as old dark blood. I strongly agree with how she managed her clinical case, as I too have had success in such cases using the lowest dosed birth control pills.

My concern, however, is for a potentially fatal outcome because of our use of the term “cesarean scar ectopic pregnancy,” which she mentions as being an additional clinical

outcome as described in the review article by Tower and colleagues.¹ The strictest definition of ectopic pregnancy is “a pregnancy that occurs outside the uterus.” Many clinicians, however, refer to any pregnancy outside the normal endometrial cavity as being “ectopic.” Regardless of the definition used, I am aware of cases when this nomenclature has been responsible (at least in part) for maternal mortality.

Here is a scenario: A clinician gets an imaging report that there is a cesarean scar ectopic pregnancy. The patient is then treated with a methotrexate protocol² for the ectopic pregnancy, even though the sac size is small and there is no embryo or cardiac activity.

This patient did not actually have a cesarean scar ectopic pregnancy. Ninety-eight percent of ectopic pregnancies are tubal and these are the ones in which methotrexate has been studied adequately and used. Cesarean scar pregnancies (and, in my opinion, cervical pregnancies as well as cornual pregnancies) are very different from “garden variety” tubal ectopic pregnancies, and should not automatically be plugged into existing methotrexate protocols. In my experience, the existing methotrexate protocols do not work for cesarean scar pregnancies, and place these women at risk for potential harm, such as severe hemorrhage.

We should be meticulous in referring to these as cesarean scar pregnancies—not cesarean scar ectopic pregnancies—to help keep well-meaning clinicians from being misled.

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References

1. Tower AM, Frishman GN. Cesarean scar defects: an underrecognized cause of abnormal uterine bleeding and other gynecologic complications. *J Minim Invasive Gynecol.* 2013;20(5):562-572.
2. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin No. 94: Medical management of ectopic pregnancy. *Obstet Gynecol.* 2008;111(6):1479-1485.

» Dr. Garcia responds:

While I can appreciate the comments from my co-editor, Dr. Goldstein, I believe he is defocusing the real issue regarding pregnancies occurring in scar defects caused by previous cesarean section. Rather than creating an issue with the semantics of “ectopic,” I would have preferred to read that Dr. Goldstein was emphasizing the potentially significant, if not fatal, complications and management of cesarean scar pregnancies as he did with co-authors Dr. Timor-Trisch and Dr. Monteagudo in a recent OBG MANAGEMENT article.¹

To clarify the terminology, I used “cesarean scar ectopic pregnancy”

as it was quoted from the work of Tower and colleagues.² This terminology adequately describes the location of the pregnancy, as many cesarean scar defects are not just located in the isthmus of the uterus but in the cervix itself.³ And by all accounts a pregnancy at this location would be considered to be a cervical pregnancy, which ACOG defines as ectopic. The following definition of ectopic pregnancy is taken from Dr. Goldstein’s reference to ACOG Practice Bulletin #94: “Nearly all ectopic pregnancies (97%) are implanted within the fallopian tube, although implantation can occur within the abdomen, cervix, ovary, or uterine cornua.”⁴ Indeed if ACOG uses “ectopic” to describe a pregnancy within the cervix, then “cesarean scar ectopic pregnancy” should be adequate to describe the location of a potentially dangerous pregnancy.

Dr. Goldstein is concerned that our colleagues may become confused

by the terminology “cesarean scar ectopic pregnancy” because the word “ectopic” might denote a less clinically significant scenario. Yet I say that anyone confused by the location of the pregnancy has not understood the part of the descriptive term that is “cesarean scar” regardless of the use of “ectopic.” Any clinician treating a patient with a cesarean scar pregnancy would benefit from Dr. Goldstein and his colleagues’ article for diagnosis and management of this critical and potentially life-threatening scenario.

References

1. Timor-Trisch IE, Monteagudo A, Goldstein SR. How to identify and manage cesarean scar pregnancy. *OBG Manag.* 2014;26(6):19-27.
2. Tower AM, Frishman GN. Cesarean scar defects: an underrecognized cause of abnormal uterine bleeding and other gynecologic complications. *J Minim Invasive Gynecol.* 2013;20(5):562-572.
3. Garcia A. Update on minimally invasive gynecology. *OBG Manag.* 2014;26(4):18-32.
4. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin No. 94: Medical management of ectopic pregnancy. *Obstet Gynecol.* 2008;111(6):1479-1485.