LETTERS

Additional treatment for uterine fibroids offered

I read with interest "Abnormal uterine bleeding: a quick guide to evaluation and treatment" [April] by Linda Bradley, MD. However, I noted that she failed to mention the use of myolysis as a technique for treating uterine fibroids in patients who no longer desire fertility.

I have been using this procedure for 11 years and am convinced that myolysis should be practiced with increasing frequency in cases of moderate-sized fibroids, with or without the use of endometrial ablation or hysteroscopic resection. It is a disservice to patients not to include this procedure when discussing treatment options for fibroids.

Herbert Goldfarb, MD
Montclair, NJ

DR. BRADLEY RESPONDS:

I'd like to thank Dr. Goldfarb for his comments on the management of abnormal uterine bleeding and fibroids. My article only included techniques that are widely used and validated by several centers. A review of the literature regarding myolysis shows reports of case series and/or personal experiences, not comparative trials, published from only 1 center.

Ethics challenged, universal health care proposed

While the medical community is still struggling to recover from the knockout blows delivered this past decade by the insurance/banking cabal and its HMOs, it is disappointing to have Frank Chervenak, MD, and Laurence McCullough, PhD, serve up their solutions in such an admonitory way as in "Rising to the challenge: ethics in the era of managed care" [May]. Such a chimeric attitude is just about the last thing we physicians need. As they noted, our profession is one based on trust, so being fiduciary is our first priority. Perhaps, now that sides have been drawn, the lineup of physician and patient versus hospital and HMO is finally right.

It was not clear whether the authors agreed with managed care organizations that there is an oversupply of physicians in the United States. The contrary is true. In fact, the U.S. has a population-to-doctor ratio of 350:1; double the optimum 180:1, which is achieved only in Cuba and Israel. Also, we lag behind national health-care plan countries such as Canada and England, both with ratios of 260:1. The bottom line: Doctors are needed in the U.S.

Drs. Chervenak and McCullough never approached the root of the problem: The U.S. is the only developed nation without a universal health-care plan. Arguably, that is our greatest shame. The answers are not found in pondering our ethics. Instead, we need to declare health care a right, not a privilege.

Lastly, the authors concluded with "anger does not lead to appropriate... solutions." But they should have urged doctors, in their fiduciary role, to stay angry—and to get even angrier. Only then will there be a chance to put medicine back into the hands of physicians. Until then, our ethical manipulations will only fall into the hands of those who have taken over, leaving the public to obtain health care from MBAs rather than MDs.

Don Sloan, MD
New York, NY

DRS. CHERVENAK AND MCCULLOUGH RESPOND:

We thank Dr. Sloan for his interesting and provocative comments. He appears to be of the view that managed care organizations—and perhaps, hospitals—are the enemies of the physicians and patients. Indeed, if this were the case, physicians should become very angry and dig in for the long twilight struggle of good versus evil, confident that if they were to regain power, everything would be fine.

However, in our judgment, this advice would misdirect the reader's moral energies down the fruitless path of anger. To control

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If you have it, you want to share it...

but if you share it, you don't have it.

What is it?

costs, managed care organizations do not respond to us, but to those who pay for health care, e.g., employers and government agencies such as Medicare. Getting angry at economic rationale may feel good—for a few minutes, at best—but only will serve to provide an ineffective response to the implacable realities.

In addition, Dr. Sloan states that we negligently excluded our thoughts on what the best patient-physician ratio is and whether the U.S. should create a universal right to health care. However, these are large public policy questions to which there are no reliable answers.

The purpose of our article was to equip physicians with professional virtues, enabling them to respond to the business tools of the managed practice of medicine. Physicians should never expect to regain sole control of medical care. Rather, they can and must be able to conduct themselves in an ethically responsible fashion in order to freely and systematically assume fiduciary responsibility for patients and hold managed care organizations and hospitals to their cofiduciary responsibilities. Throughout the history of medicine, ethics has shown itself to be a far more effective tool for responsible leadership and change than anger.

Vacuum followed by forceps questioned

I greatly appreciated "Vacuum extraction: optimizing outcomes, reducing legal risk" [April] by Karen Koscica, DO, and Martin Gimovsky, MD. While they described a "contraindication" to vacuum delivery as "prior failed forceps," they later stated, "If vacuum delivery is abandoned, do not switch to forceps unless the physician has extensive experience utilizing both instruments."

As far as I know, the current published literature on sequential operative vaginal delivery does not differentiate between forceps followed by vacuum or vacuum followed by forceps. If such literature exists supporting the contention that vacuum followed by forceps carries equal risk to vacuum alone, I would be most interested in the citation. Again, thank you for an excellent article on vacuum delivery.

Russel Jelsema, MD
Grand Rapids, Mich

DRS. KOSCICA AND GIMOVSKY RESPOND:

We thank Dr. Jelsema for his interest in our article. We do agree with his statement that

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the current literature on sequential operative vaginal delivery does not differentiate between vacuum followed by forceps or forceps followed by vacuum. However, in a trial of instrumental delivery with either vacuum or forceps, the most important rule to follow is immediate descent of the fetal head with the initial traction effort. If this is not achieved, consider the cause of failure to be either true disproportion, improper instrument placement, or traction technique.

The reality of complications at complex vaginal hysterectomy

It is imperative that I clarify the section on complications in my Surgical Techniques article "Complex hysterectomy: opting for the vaginal approach" [April]. Due to a misinterpretation, it was incorrectly stated that "bladder perforation and ureteral damage (entrapment or severance) are common complications of complex vaginal hysterectomy."

Although bladder perforations and ureteral damage are major concerns with complex vaginal hysterectomy, such mishaps are, in fact, uncommon because of the precise surgical techniques involved. In fact, the risk for these complications is greater with the abdominal approach because it is more difficult to access the lower urinary tract. It is fear of these potential complications that is common, not their actual occurrence.

In truth, the most common complication of complex vaginal hysterectomy is excessive bleeding. This can be avoided by adequately ligating the uterine vessels and injecting vasoconstrictive agents. Proper hemostasis generally eliminates hemorrhage as a complication. Again, the fear of excessive bleeding plus trepidation regarding mechanical accessibility drive the untrained surgeon to unnecessarily pursue the more arduous and less efficient hysterectomy route—via the abdomen.

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THE EDITORS RESPOND:

We would like to thank Dr. Grody for elucidating the complications of complex vaginal hysterectomy. Our intent was to alert readers that ureteral and bladder injury were possible complications, not that they occur commonly.