LETTERS

Letters to journals read by primary care physicians might help them properly interpret WHI data.

Educating other docs about the WHI

Thank you for your May 2004 editorial on the Women's Health Initiative ("Overgeneralizing WHI: What are they thinking?"). I, too, am frustrated by the spin many of our primary care colleagues put on the use of any combination of estrogen/progestogen for any purpose. What are they thinking, anyway?

At a recent dinner sponsored by a drug company that produces no estrogen products, the speaker referred to "breast-cancer–causing estrogen," and all of us timid physicians just sat there and let him go on about statins and the like.

I wonder whether sending letters to journals read by internists, cardiologists, and other primary care physicians might help them properly interpret the data generated by the Women's Health Initiative. I cannot tell you how hard it is to counsel patients who have been wrongly discontinued from hormone replacement therapy by some poorly informed internist.

Roslyn Chosak, MD
New Haven, Conn

Dr. Barbieri responds:

I appreciate Dr. Chosak's comments and agree that Ob/Gyns need to help our internist colleagues place the findings of the Women's Health Initiative in appropriate clinical perspective.

Her suggestion to send letters to journals read by internists is an excellent idea!

1- or 2-layer closures for cesarean section?

I read with interest the July article on minimally invasive cesarean by Drs. Marco A. Pelosi II and Marco A. Pelosi III ("Minimally invasive cesarean: Improving an innovative technique"). Although I found many weaknesses within the article and several statements of fact that are, at best, borderline, 2 items in particular concern me.

First, recent studies have shown that patients who undergo single-layer closure of the uterus following a cesarean are twice as likely to dehisce and/or rupture during a subsequent pregnancy or vaginal birth after cesarean than those who have had double-layer closure.

Second, many general surgeons believe the parietal peritoneum should always be closed in any patient expected to need a second abdominal procedure. Otherwise, adhesions are much more extensive—especially when they involve the recti muscles.

Jonathan A. Fisch, MD
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Drs. Pelosi and Pelosi respond:

Since its inception, the cesarean operation has been standardized in precise steps, each with its own alleged purpose. But this time-honored approach is based more on anecdotal impressions than scientific evidence.

Regarding single- versus double-layer uterine closure, a review of the literature supports the former's effectiveness and safety. It is important to remember that the reduction in uterine size after delivery is not due to necrosis or degeneration of

uterine cellular components, but to reduction of fluid and protein content and simultaneous shrinking in uterine cell size. Ultrasound and computed tomography of the involuting puerperal uterus reveal that most of the decrease in uterine size occurs during the first 7 days (42% reduction).[1,2]

These findings indicate that the hysterotomy incision suture line (regardless of suture material or surgical closure technique) loosens in less than 7 days. They also indicate that the suture line's primary function is to provide early hemostasis and prevent uterine contents from escaping into the abdominal cavity. An excellent review was published in this journal by Bivins and Gallup.[3]

As for peritoneal nonclosure at cesarean, the evidence supporting it is overwhelming. While we do not routinely close the vesico-uterine fold and parietal peritoneum, we clearly stated in the article that we strongly recommend peritoneal closure in cases in which 1 or both rectus muscles have been transected. Otherwise, thick fibromuscular adhesions may develop between the lower anterior surface of the uterus and the undersurface of the rectus muscles.[4]

For more information, we recommend the Cochrane review of peritoneal nonclosure at cesarean section and the recent review by Tulandi et al.[5,6]

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Managed care price fixing: Call to action

I appreciated your August editorial on mounting student debt ("A difficult beginning: Starting out with disabling student debt"). Student debt is even more of a burden in the first 4 to 5 months after completing training, when students must wait for a Medicare number. During that time, their ability to make money is significantly impaired because, without this number, they are unlikely to be accepted into managed-care programs. Then, when they are accepted, their ability to set their own fees is substantially limited, since managed-care fees are about 25% of what they were in the late 1980s.

I fear that the assault on physician fees that has occurred over the past 10 to 15 years will decrease the number of people going into medicine. It has certainly harmed our specialty. The outrageously low reimbursements for obstetrics and, worse yet, gynecology, have made it impossible to earn a living. I speak from experience, as I had a large, busy practice in Florida but was unable to pay my bills.

If the medical field in general, and obstetrics and gynecology in particular, are to be resurrected, our national leaders must demand an end to the price-fixing of managed care, and physicians in the trenches must push for that demand.

Jesse A. Kane, MD
Jacksonville, Ark

National leaders must demand an end to managed-care price-fixing, and physicians must push for that demand.

Dr. Barbieri responds:

Many authorities believe "price fixing" by government agencies (RVU and RBRVS system) and health insurers is partially responsible for rapidly increasing costs and flat/decreasing revenues. This will likely create spot shortages of the most poorly reimbursed services. Two current examples: obstetrics and mammography. ■