"PATIENT WITH A BREAST MASS: WHY DID SHE PURSUE LITIGATION?"
JOSEPH S. SANFILIPPO, MD, MBA, AND STEVEN R. SMITH, JD (WHAT'S THE VERDICT?; DECEMBER 2016)

Clear communication is often key to avoiding litigation

Thank you for the article concerning the patient who commenced action for delay in diagnosis of her breast lesion. In my opinion the gynecologist lost control of the situation because of inadequate communication with the patient either on his or her part and/or on the part of the staff.

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"BENEFIT OF SELF-ADMINISTERED VAGINAL LIDOCAINE GEL IN IUD PLACEMENT"
ANDREW M. KAUNITZ, MD (COMMENTARY; DECEMBER 2016)

Use anesthesia for in-office GYN procedures

The recent article by Dr. Kaunitz on the use of self-administered lidocaine gel prior to intrauterine device (IUD) placement was excellent. Having been known as the "lidocaine queen" in the Department of ObGyn at the Mayo Clinic, I feel strongly that gynecologic office procedures should always involve some form of anesthesia, whether with topical lidocaine, intracervical lidocaine, or paracervical block. Such anesthesia often makes the procedure a "nonevent" for the patient. While Dr. Kaunitz describes the use of a fine-toothed tenaculum, I have found that after administration of lidocaine gel, an Allis clamp applied superficially to the cervix provides sufficient traction, is often not detected by the patient, and does not leave any holes. It is unusual for it to slip off.

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It is important to teach residents that it is not necessary for women to "tolerate" pain to have good health. I use the above techniques for endometrial biopsy and cervical biopsy as well—there is never a reason for a woman's biopsy to be done without anesthesia.

Ingrid Carlson, MD
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"DO YOU UTILIZE VASOPRESSIN IN YOUR DIFFICULT CESAREAN DELIVERY SURGERIES?"
ROBERT L. BARBIERI, MD (EDITORIAL; NOVEMBER 2016)

Avoid uterine vessels when injecting vasopressin

Thank you for your recent editorial discussing using vasopressin in difficult cesarean deliveries. I am very interested in using vasopressin for our placenta previa cases.

I reviewed the Kato et al article that Dr. Barbieri referenced, and the authors note a risk of injecting vasopressin into a vessel.[1] If you are injecting into the placental bed, how can you confirm you are not in a vessel? (When you withdraw, you will get some blood regardless.)

Sara Garmel, MD
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Reference

1. Kato S, Tanabe A, Kanki K, et al. Local injection of vasopressin reduces the blood loss during cesarean section in placenta previa. J Obstet Gynaecol Res. 2014;40(5):1249–1256.

›› Dr. Barbieri responds

I agree with Dr. Garmel that we should avoid the intravascular injection of vasopressin. As I noted in the editorial, "I prefer to inject vasopressin in the subserosa of the uterus rather than inject it in a highly vascular area such as the subendometrium or near the uterine artery and vein." Subserosal injection creates a depot bleb of vasopressin that is absorbed over a few minutes. You can visualize the reduced blood flow to the uterus following vasopressin injection because the uterus blanches and the diameter of the uterine vessels decreases significantly.

WE WANT TO HEAR FROM YOU!

Share your thoughts on an article you read in this issue or on any topic relevant to ObGyns and women's health practitioners.

We will consider publishing your letter in a future issue.

Contact us at **rbarbieri@frontlinemedcom.com**

Please include the city and state in which you practice.

›› Stay in touch! Your feedback is important to us!