Survey: Doctors Overestimate HT's Risks, Benefits

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

White Sulphur Springs, W.Va. — Most physicians who prescribe hormone therapy still overestimate both its long-term risks and benefits, R. Stan Williams, M.D., said at the annual meeting of the South Atlantic Association of Obstetricians and Gynecologists.

Compared with internists and family doctors, ob.gyns. were the most likely to display an accurate understanding of these issues. But a large portion still gave incorrect answers to Dr. Williams' statewide physician survey on hormone therapy (HT).

"These people thought they understood the results of the Women's Health Initiative [WHI] and said they were counseling their patients about it, but only 28% of their answers were correct," said Dr. Williams, professor of ob.gyn of the University of Florida, Gainesville, and chief of the university's division of reproductive endocrinology and infertility.

"Most respondents (67%) dramatically overestimated the risks and benefits," and 5% of the answers "were actually in the wrong direction; they thought it was a risk when it was actually a benefit," he said.

In March 2004, Dr. Williams mailed his survey to all primary care physicians in Florida. The survey asked a specific question about the percentage of annual attributable change of risk of heart disease, stroke, venous thrombosis, breast cancer, colon cancer, hip fracture and death, as reported in the WHI.

He sent out more than 6,000 surveys; 600 were returned (203 from ob.gyns., 145 from internists, 219 from family physicians, and 33 from other physicians).

'These people thought they understood the results of the Women's Health Initiative ... but only 28% of their answers were correct.'

About 35% of ob.gyns., 30% of family physicians, and 17% of internists correctly answered that HT increased the risk of heart disease by less than 1% per year of use. Many thought there was no change in risk (35% of internists, 33% of ob.gyns, and 27% of family physicians). About 20% of internists and 15% of family physicians said the risk was increased 10%-30% per year of use.

About 50% of ob.gyns., 35% of internists, and 30% of family physicians correctly answered that HT increased the risk of stroke by less than 1% per year of use. About 20% of family physicians, 17% of internists, and 15% of ob.gyns. said the increased risk was 10%-30% per year of use.

About 50% of ob.gyns., 30% of internists, and 27% of family physicians correctly answered that HT increases the risk of venous thrombosis by less than 1% per year of use. About 30% of ob.gyns., 25% of internists, and 30% of family physicians said the risk was increased by 10%-30% per year of use.

About half of ob.gyns, half of family physicians, and 40% of internists correctly answered that HT increases the risk of breast cancer by less than 1% per year of use. About 17% of internists, 15% of family physicians, and 8% of ob.gyns said the increased risk was 10%-30% per year of use.

The benefits of HT also were misunderstood. Only about 35% of ob.gyns, 20% of internists, and 17% of family physicians correctly answered that the decrease in risk of breast cancer was about 1% per year of use.

Most internists (70%) and family physicians (55%) and 30% of ob.gyns. said HT did not change the risk of colon cancer. Only 20% of ob.gyns., 18% of family physicians, and 20% of internists correctly answered that the decreased risk was 1% per year of use.

About 17% of ob.gyns., 15% of internists, and 10% of family physicians correctly answered that HT decreases the risk of osteoporotic hip fracture by 1% per year of use.

About 60% of family physicians, 55% of ob.gyns., and 50% of family physicians thought the risk reduction was 10%-30% per year of use.

Most respondents understood that there is no change in overall mortality rates associated with HT use. About 85% of ob.gyns. and 65% of internists and family physicians answered correctly. But a few respondents said the overall mortality risk increased 3%-10% per year of use.

Dr. Williams also asked respondents' views of HT on a scale of 1-5, with 5 being positive. The average rating was 3.89 among ob.gyns., 3.0 among family physicians, and 2.7 among internists.

In 2004, Dr. Williams presented the results of a similar survey he conducted among 1,000 women aged 45-65. This study showed that up to 36% believed that their attributable risk for heart disease and stroke was 10%-30% per year of HT use.

More than half believed the risk for breast cancer was 10%-30% per year of HT, and 60% believed HT could reduce their risk of osteoporotic hip fracture by up to 30% per year. ■

Combined Approach Helps Ease Pelvic Floor Dysfunction

BY HEIDI SPLETE
Senior Writer

Washington — Brooke Gurland, M.D., realized that, despite her training as a colorectal surgeon, she didn't have a complete perspective on pelvic floor dysfunction.

Fellows in colorectal surgery "weren't even trained to know the anatomy of the other organs, much less how to work with other pelvic specialists in the hospital system," said Dr. Gurland, a colorectal surgeon at Maimonides Hospital in New York.

A multidisciplinary approach to women's pelvic floor disorders is important, because multiple pelvic floor defects often exist in the absence of patient complaints, she said at the annual meeting of the Gerontological Society of America.

Older women tend to underreport pelvic floor problems, especially those associated with fecal incontinence or defecation problems, because they don't feel comfortable raising the subject with their doctors, or because they find ways to compensate, such as using an enema or finger to complete their defecation.

Research in pelvic floor symptomatology is limited, and many physicians don't know that different treatment options exist for pelvic floor dysfunction, said Dr. Gurland, who is spearheading a pelvic floor task force at Maimonides. The main objectives are to establish a center to evaluate the pelvic floor compartments as a functional unit, to educate health professionals and the community about pelvic floor disorders, to create a database, and to coordinate studies of multicompartment pelvic floor disorders to improve knowledge in this area.

To help finance these efforts, Dr. Gurland received a career development grant totaling $200,000 over 2 years from the American Geriatrics Society to establish the Maimonides Center for Pelvic Floor Dysfunction and Reconstructive Surgery.

A multidisciplinary approach is important, because multiple pelvic floor defects often exist in the absence of patient complaints.

The first step was to identify a pelvic floor task force that includes physicians, nurse practitioners, continence specialists, physician assistants, and pain specialists from fields such as urology, gynecology, colorectal surgery, and geriatrics.

Education plans have included a nurses' public health symposium and a fellowship program in which an ob.gyn. would work with Dr. Gurland and a colleague in urogynecology. The staff conducted community outreach by placing ads in local newspapers to encourage women with pelvic floor complaints to visit the center.

"We are getting patients who would not have approached their primary doctors, but are seeking us out specifically," Dr. Gurland noted.

The designated support staff has made all the difference in establishing the center and creating a multidisciplinary treatment protocol, she said. "I have two physician assistants and two medical assistants who coordinate care between subspecialists. They coordinate surgeries and are trained to do pelvic floor rehabilitation and biofeedback, and provide emotional support to the patients."

In addition, Dr. Gurland combines office hours with a urogynecologist, which minimizes patient visits and eases the travel burden for elderly patients.

"Once we make a decision on how to care for a patient, I can sit down with the urogynecologist and create a plan," Dr. Gurland commented. "We can also see the postops together and see how people are responding to treatment."

Dr. Gurland and her colleagues list the symptoms of fecal dysfunction on their database for tracking patients and conducting research. They use the Wexner fecal incontinence score, which ranges from 0 to 20 (no incontinence to complete fecal incontinence) and included incontinence to flatus, liquid, and solid stool. The frequency of accidents and its effect on lifestyle also are included. In addition, the Rome criteria are used to define obstructive defecation, such as a feeling of anal blockage 25% of the time and the need for an enema or other help to fully evacuate.

Dr. Gurland reported results from the first 70 patients treated at the center. The women enrolled in the database had symptoms of urinary dysfunction and prolapse and either fecal incontinence or difficult evacuation.

The average age was 66 years, with an average parity of 3. Seventeen had undergone hysterectomies.

Although urinary incontinence was the most common symptom, 38 patients had fecal incontinence, 28 had obstructive defecation, and 22 reported rectal pressure.

Of those with fecal incontinence, 89% had urinary incontinence, 61% had pelvic pressure or a bulge, and 3% had pelvic pain.

An overwhelming majority, 82%, of those with obstructed defecation had rectal pressure, 43% had pelvic pressure or bulge, and 25% had pelvic pain. And of those with rectal pressure, 73% had urinary incontinence, 68% had pelvic pressure, and 18% had pelvic pain.

Rectocele was the most common physical finding in the entire group (60% of patients), followed by cystocele, enterocele, rectal prolapse, and anal sphincter defects diagnosed by endorectal ultrasound.

As for the outcomes, 35% had surgery, 25% are undergoing biofeedback treatment, and approximately 28% are considering surgical or nonsurgical treatment. An additional 10% decided they were satisfied with their quality of life and declined treatment. ■

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