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according to a company investor presentation, and hysterectomy is one of four “target” gynecologic procedures, along with sacral colpopexy, myomectomy, and endometrial resection.

With an estimated 600,000 hysterectomies being performed each year in the United States, Intuitive sees potential for growth. As of this fall, the 2011 surgical volume with the da Vinci had increased 30% over 2010 volume across all types of procedures, said Intuitive Surgical’s Mr. Simmonds.

Having a surgical robot has become a status symbol of sorts for hospitals in many urban areas – as of September, Intuitive had installed 1,478 da Vinci surgical systems in the United States – and ob.gyns. may feel compelled to keep up with market demands.

“General ob.gyns. don’t want to be the only physicians in the community not offering it,” said Dr. Delmore, who teaches robotic surgery as a proctor for Intuitive Surgical.

Many ob.gyns., moreover, find robotic-assisted laparoscopy much easier than conventional laparoscopy to learn and adopt. Suturing is easier, and

‘If it turns out that over time fewer women end up having vaginal hysterectomies, and have robotic hysterectomies instead, there will be greater expense to individuals and society.’

Dr. Magrina and other proponents of robotics maintain that the advantages of instrument articulation and steady three-dimensional vision have proven even higher than expected – for hysterectomies as well as more complex gynecologic procedures.

While the learning curve for robotics is said to be relatively short, Dr. Pasic and his coauthors caution that robotic assistance should not be used by physicians who are unwilling to invest time and effort into laparoscopic training. Exuberance for the da Vinci could have an “unintended negative effect on resident and fellow training as it relates to overall laparoscopic competencies,” they said.

Institutions, in the meantime, are individually attempting to determine how best to train residents in robotic-assisted surgery. The University of Kansas is implementing a training model for ob.gyn. residents that includes an online tutorial, training with inanimate objects, animal lab training, and bedside assistance in real robotic-assisted hysterectomies.

Dr. Delmore and his colleagues have a study underway to look at how graduate ob.gyns. utilize this training. “What if residents go somewhere afterward where there isn’t a robot, for instance? Will [they have learned enough] to safely operate?” he said.

Dr. Magrina said he had no relevant financial disclosures. Dr. Delmore teaches robotic surgery as a proctor for Intuitive Surgical. Dr. Pasic is a speaker for Ethicon Endo-Surgery. ■

Postpartum Perineal Clinic: When Pelvic Floor Complaints Just Can’t Wait

BY AMY ROTHMAN
SCHONFELD

FROM THE ANNUAL MEETING OF THE
AMERICAN UROGYNECOLOGIC SOCIETY

PROVIDENCE, R.I. – A postpartum perineal clinic staffed by urogynecologists has been established at the University of Michigan to expedite the assessment and treatment of pelvic floor disorders resulting from maternal birth injuries, according to Dr. Cynthia Brincat, who described the clinic in an oral poster presentation at the meeting.

“About 10% of women develop complications associated with childbirth. We are a one-stop location for these women to be seen during a very busy and very stressful time in their lives,” Dr. Brincat said in an interview. “We provide focused, problem-based, short-term therapy. Patients then can go back to their regular providers, often with a care plan that can be carried out in that setting.” Dr. Brincat worked at the clinic as a fellow in female pelvic medicine and reconstructive surgery at the University of Michigan Medical Center, and is now with the University of Wisconsin–Madison.

At the Michigan Healthy Healing After Delivery Program, patients are seen within 2 weeks of requesting an appointment. It offers its services to women with such symptoms as fecal or urinary incontinence, painful or nonhealing episiotomy, anal fissures, third- or fourth-degree lacerations, rectovaginal fistulas, postpartum urinary retention, pelvic organ prolapse, and painful intercourse.

The clinic provides a range of services. “Some of the treatments we provide center around asking the right questions and uncovering what is going on. We do a lot of patient education. Once a patient understands what has happened to her, she can take better care of herself,” said Dr. Brincat. “For example, if she has a third- or fourth-degree laceration, she

can understand how important it is to keep her stool consistency soft.” Patients can consult with a PhD nurse continence expert and physical therapists who can develop a pelvic floor muscle-strengthening program or provide advice concerning diet and lifestyle changes to promote healthy living and prevent future incontinence problems. Counseling in the clinic deals with the patient’s emotional well-being and fears about future pregnancies.

More focused interventions include cauterization of granulation tissue, application of nitroglycerin paste for anal fissures, trigger-point injections for pain relief, or estrogen application for atrophic vaginal tissue. Biofeedback is commonly used for helping patients visualize the most effective ways to perform pelvic floor muscle contraction exercises. Other services provided include endoanal ultrasound for the assessment of sphincter anatomy and multichannel urodynamics to assess bladder function. MRI studies, performed under approved research protocols, are useful for detailing birth trauma such as injury to the levator ani and can help physicians establish a plan for avoiding injuries with subsequent births. Some patients require surgical management for incontinence, anal sphincter repair, or debridement.

Now in its fourth year, the practice has been steadily growing. Total new patient visits increased 35% from year 1 to year 2 (from 40 to 62) and 7.5% between year 2 and year 3 (62 to 66). “This year we are on track to see 80 new patients,” said Dr. Brincat. The most common presenting problems were follow-up of third-degree lacerations, urinary incontinence, and perineal pain.

Analysis of referral distribution indicated that less than one-third of referrals were from the University of Michigan’s in-house generalist practice. Thirty-one percent came from the resident practice,

and 41% were referred from family medicine practice, certified nurse-midwife practice, outside physician referrals, and self-referrals.

“We knew we had to build a broad referral base to be successful,” said Dr. Brincat. To accomplish this, the nurse coordinator and staff members undertook direct patient marketing via Web search engines, YouTube videos, podcasts, and distribution of printed patient education materials. Peer-to-peer programs targeted nurses and other obstetric providers. All referrals are cleared through one point of entry, a knowledgeable nurse who can triage patients and serve as an ongoing contact.

Although there was some initial reluctance among generalists to refer patients, that no longer holds true. “Patients often don’t see us more than once – our average number of visits is about 1.6,” said Dr. Brincat. Once a primary provider sees that the patient returns to his or her practice, the provider is less reluctant to refer the next patient. In fact, she said, the bond with the primary provider is often strengthened once the patient realizes that the provider values the patient’s outcome enough to send the patient for specialized treatment when necessary.

“In the United Kingdom and most European countries, anyone who has undergone a traumatic birth injury is seen in a follow-up clinic right away. In the United States, that’s not the standard of care. What we’re trying to do is change that,” said Dr. Brincat. “In general, the assessment and treatment of women with birth injuries is not given enough attention. If this was about professional football players or baseball players, and we said 1 in 10 of them would experience a traumatic injury and not be seen for weeks afterwards, I think the issue would get a lot more attention.”

Dr. Brincat said she had no relevant financial disclosures. ■

Hip Fracture Risk Rose at Start of Loop Diuretics

BY BRUCE JANCIN

FROM THE ANNUAL MEETING OF THE
AMERICAN SOCIETY FOR BONE AND
MINERAL RESEARCH

SAN DIEGO – The risk of hip fracture nearly doubles during the week following a new prescription for a loop diuretic.

In contrast, there is no spike in the risk of hip fracture in the 7 days following a new prescription for other classes of diuretics or for ACE inhibitors, according to an analysis of the massive The Health Improvement Network (THIN) database involving more than 400 U.K. primary care practices.

The most likely explanation for the short-term jump in risk of hip fracture may be related to the prominent urinary symptoms that often accompany a

new prescription for loop diuretics. The resultant rush to the bathroom could lead to an increased rate of falls during that initial adjustment period, Dr. Sarah D. Berry speculated at the meeting.

She reported on 28,703 subjects who experienced an incident hip fracture and more than 2 million others who did not during 15.1 million person-years of follow-up recorded in the THIN primary care database. In a nested, case-crossover study, she and her coworkers compared the occurrence of new diuretic prescriptions in the 7 days prior to the hip fracture to the occurrence of new diuretic prescriptions during the control period 31-37 days before the fracture.

The adjusted odds ratio of an incident hip fracture was significantly increased by 80% during the 7 days following a

new prescription for a loop diuretic. That being said, it needs to be emphasized that the absolute risk during this week-long window of increased vulnerability remained low: 2.9 hip fractures per 100,000 new loop diuretic prescriptions, according to Dr. Berry of the Hebrew SeniorLife Institute for Aging Research and Beth Israel Deaconess Medical Center, Boston.

Counseling vulnerable older adults and their caregivers about the need for increased awareness and careful ambulation to the bathroom during the 7 days after going on a loop diuretic might help reduce hip fractures, she added.

Dr. Berry declared having no financial conflicts regarding the study, which was supported by the National Institutes of Health and Hebrew SeniorLife. ■