OCs Called 'Fabulous' Adjunctive Tx for Acne

BY PATRICE WENDLING
Chicago Bureau

New Orleans — Oral contraceptives are a safe and effective treatment for acne but are best used as adjunct therapy, Julie C. Harper, M.D., reported at the annual meeting of the American Academy of Dermatology.

Topical retinoids such as adapalene, tazarotene, and tretinoin remain the first-line treatment for all grades of acne, followed by oral or topical antibiotics, and then hormonal therapy.

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"They [oral contraceptives] are fabulous to add to your acne treatment, but they aren't stand-alone medications or first-line treatments," Dr. Harper said.

Ortho Tri-Cyclen (norgestimate/ethinyl estradiol) and Estrostep (norethindrone acetate/ethinyl estradiol) have been approved by the Food and Drug Administration for the treatment of acne.

Newer contraceptives such as Yasmin, which contains the novel progestin drospirenone also are effective, said Dr. Harper of the department of dermatology at the University of Alabama, Birmingham.

A recent study showed that Yasmin was superior to Ortho Tri-Cyclen in reducing the total number of skin lesions in women with mild to moderate acne vulgaris after 6 months, and was rated superior by investigators for its therapeutic effect (Cutis. 2004;74:123-30).

Yasmin "tops" the other OCs in treating acne, but the difference is not dramatic, Dr. Harper said. It may take several months to see an improvement in acne on Yasmin, and she recommends a minimum of 3 months of treatment.

Yasmin combines ethinyl estradiol and 3 mg of drospirenone, a spironolactone analogue that has antimineralocorticoid and antiandrogenic activity. Androgens stimulate sebaceous epithelial cell (sebocyte) differentiation and sebum production. Excess sebum is a key factor in the development of acne.

All combined oral contraceptives have the potential to improve acne because they increase sex hormone–binding globulin, thereby decreasing serum androgen. This is true even when a woman's serum levels are in the normal range.

Most women with acne have normal circulating levels of androgen hormones, she said, adding that scientists now suspect an end-organ hyperresponsiveness to androgens in patients with acne.

OCs are used most safely to treat acne in younger women who don't smoke, do not have a history of migraines, and are normotensive. Dr. Harper will not prescribe OCs to women who smoke, are aged 35 years or older, or on rifampin.

Spironolactone 50-100 mg is recommended for women who aren't candidates for OCs and have failed conservative treatments.

The relative risk of breast cancer is 1.24 times higher in current OC users, she said.

The relative risk of stroke is 2.5 times higher in current contraceptive users, although there has been no evidence that Yasmin significantly increases thrombolytic events, compared with other OCs, Dr. Harper said. ■

Physicians Urged to Adopt Office Hysteroscopy

BY JANE SALODOF MacNEIL
Southwest Bureau

Santa Fe, N.M. — One hundred thirty-five years after Pantaleoni performed the first hysteroscopy, Stephen M. Cohen, M.D., urged physicians to move the diagnostic procedure from the operating room to the office.

New technology makes office hysteroscopy more effective, less expensive, safer, and easier to perform than invasive diagnostic alternatives, according to Dr. Cohen, chief of the division of gynecology and director of women's minimal access surgery at Albany (N.Y.) Medical College. Fertility investigations and some simple surgical procedures can be done in the office with hysteroscopy, he said at a conference on gynecologic surgery sponsored by Omnia Education.

"I think all of us in the next 5 years will be doing hysteroscopic sterilizations in the office," Dr. Cohen said, citing avoidance of intraabdominal complications and general anesthesia with hysteroscopy. "The laparoscopic sterilization will be a procedure of the past or used in very selected cases."

Office hysteroscopy is especially useful for direct diagnosis of the cause of abnormal uterine bleeding, according to Dr. Cohen, who has served on the speakers' bureau for Karl Storz, which manufactures hysteroscopes.

"So many patients have submucous fibroids," he said. "You can put the scope in and see those. … You can see endometrial polyps and take them out if you like."

Dr. Cohen described the basic equipment for office hysteroscopy as relatively simple—a scope, a light source, a camera, and a monitor. He said they could be purchased separately or in a compact combination unit for about $15,000. Auxiliary instruments would include scissors, biopsy forceps, and graspers.

If the physician is concerned about doing enough procedures to cover the expense, Dr. Cohen suggested renting a unit for one or two afternoons a month when office hysteroscopies are scheduled. "If you have it in your office, you are going to use it much more," he said.

Newer scopes allow the physician to see the entire uterus upon entering the cervix, according to Dr. Cohen. He cited the 3.5-mm Bettocchi scope as giving a "crystal clear view" and the Versascope for being disposable. Some physicians prefer flexible scopes, but they are somewhat more expensive and not absolutely necessary for office hysteroscopy, Dr. Cohen said.

Physicians also may want a printer so they can record exactly what they saw in the patient's chart. "It's also good if you get lots of patient referrals," Dr. Cohen said. "You send printouts back to the referring physician."

Dr. Cohen said he does office hysteroscopy entirely with local anesthesia, which is reimbursed by insurance companies and allows patients to watch in real time on the television screen.

The only painful part, Dr. Cohen said, comes at the end of the procedure when he uses a Pipelle to biopsy tissue. He saves this for last so as not to disturb the endometrium, which he also can measure during hysteroscopy. ■

Cervical Screening Guidelines Are Evolving for Adolescents

BY NANCY WALSH
New York Bureau

New York — With revisions to the consensus guidelines for the management of women with cervical cytological abnormalities expected in 2006, experts are taking a hard look at ways the guidelines might be tailored to be more age specific.

Much less is known about the natural history of cervical intraepithelial neoplasia (CIN) in young women, compared with older women. The 2001 guidelines do not provide specific recommendations for adolescents and young women, and the result today "is that we are probably doing a lot more harm than good," Thomas C. Wright, M.D., said at a gynecology conference sponsored by Mount Sinai School of Medicine.

Screening as it is practiced today is generating a large number of false positives, particularly among younger women. In adolescents aged 16-18 years, 1 in 10 will have a false positive result, and the cost implications of that are significant, he said.

Of course, false positives generate tremendous anxiety. "Today's 18-year-olds go on the Web, they know about HPV [human papillomavirus], they're afraid they are going to develop invasive cervical cancer. They are afraid they will be transmitting a disease to their boyfriends. There is a huge amount of concern associated with abnormal results in this population," he said.

Why all the false positives? High-risk strains of HPV are "essentially ubiquitous" among sexually active young women. "I have looked at young women serially over a period of 2-3 years, and found that two-thirds became HPV-DNA positive," said Dr. Wright, director of the division of gynecologic and obstetric pathology, Columbia University College of Physicians and Surgeons, New York City.

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DR. WRIGHT

In another study, more than 80% of college-aged women were HPV positive when tested monthly, but the vast majority are transient infections and clear spontaneously. In a study from Rutgers University, New Brunswick, N.J., where two-thirds of the participants were HPV positive, by 1 year, 70% of infections had cleared, and by 2 years, 92% had spontaneously cleared. Other studies have shown similar results.

Certain aspects of follow-up and management have been evolving differently for younger women. Among 18-year-olds with Pap smears classified as atypical squamous cells of undetermined significance (ASCUS), 71% will be positive for high-risk HPV and two-thirds will continue to be abnormal on a repeat Pap smear. "Anything you do in this population means that the bulk of them are going to end up getting sent for colposcopy," he said.

"We don't have a recommendation on how you should manage ASCUS, but I can tell you that in an 18-year-old it is probably not wise to be doing HPV-DNA testing. What we are doing at Columbia is following up with repeat cytology," he said.

For low-grade squamous intraepithelial lesions (LSIL), the options are to repeat the Pap smear, perform HPV testing, or to do a colposcopy. "HPV testing in a young woman with LSIL is a complete waste of time, as 87% are going to be HPV-DNA positive. If you repeat the Pap smear, 81% are going to remain abnormal unless you wait years for the infection to clear," he said. Most [physicians] believe adolescents with LSIL should undergo colposcopy, he said.

For high-grade squamous intraepithelial lesions (HSIL) in adolescents or young women colposcopy is recommended. "But if the lesions are not biopsy-confirmed cervical intraepithelial neoplasia (CIN) 2 or 3, rather than doing a loop electrosurgical excisional procedure, we can follow them by doing colposcopy and cytology at 4- to 6-month intervals provided the colposcopy is satisfactory, the endocervical curettage findings are essentially negative, and the patient accepts the risk of possible occult disease," Dr. Wright said. ■