

Vaginal Estrogen After Gyn. Surgery Advocated

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Contributing Writer

SANTA FE, N.M. — Vaginal estrogen should always be prescribed to menopausal women undergoing pelvic or urogynecologic surgery, Marvin H. Terry Grody, M.D., advised at a conference on gynecologic surgery sponsored by Omnia Education.

Estrogen therapy is essential to preserve the strength and elasticity of connective tissue and, ultimately, to extend the success of reconstructive surgery, according to Dr. Grody of Robert Wood Johnson Medical School in Camden, NJ.

“The pelvis is full of estrogen receptors going all the way from the urethra to the anus and extending unquestionably into the ligament supports of the pelvis that suspend the vault [and] suspend the uterus and the cervix, and the anterior and posterior upper reaches of the vagina,” he said. “Why are estrogen receptors there? They have a purpose, and to make our operations work, they ought to be fulfilled.”

Endometrial cancer is not usually a concern when preoperative estrogen is

prescribed, according to Dr. Grody, given that in these surgeries, the uterus has often been or will be removed. Possible cardiovascular and breast cancer effects are a worry to women as well as to physicians, however, and he warned that oral estrogen might elicit medical and/or legal concerns.

“The only way I see that we can handle this and play it safe for both the patient and ourselves is to use vaginal estrogen in one form or another in an

appropriate dosage,” Dr. Grody noted.

Vaginal cream, pulvules, and tablets are each an option, he said, citing a Duke University study that found half a gram of Premarin cream three times a week produced adequate effects in the pelvis without systemic distribution (Obstet. Gynecol. 1994;84:215-8).

Dr. Grody recommended starting vaginal estrogen at least 6 weeks before surgery and urging the patient to stay on vaginal estrogen for the rest of her life. ■

Ablation Device May Not Require Leuprolide Step

SANTA FE, N.M. — Although the manufacturer of the Hydro ThermAblator recommends the use of leuprolide acetate to thin the endometrium before performing ablation with the device, this step may be unnecessary, William E. Crowder Jr., M.D., said at the annual meeting of the American Association of Gynecologic Laparoscopists.

In a nonrandomized study, 89 women with menorrhagia were assigned to one of three groups before undergoing treatment with the Hydro ThermAblator (HTA): endometrial thinning with leuprolide (3.75 mg in a single dose), oral contraceptives, or cycle timing. In the cycle timing group, women underwent HTA treatment in the early proliferative phase of the menstrual cycle. On follow-up, there were no differences in menstrual bleeding or patient satisfaction, said Dr. Crowder, a consultant to Boston Scientific, which manufactures the HTA system.

Despite his findings, Dr. Crowder said he is not recommending abandoning endometrial thinning agents. He said he would have to see the results of a randomized trial, currently in process, before he could make that recommendation.

In the current study, women in the three treatment groups rated their post-treatment bleeding on a scale of 1-4 in which 1 is amenorrhea, 2 is hypomenorrhea, 3 is eumenorrhea, and 4 is menorrhagia. The three treatment groups averaged about 1.5 with no significant differences among them.

In terms of patient satisfaction, on a scale of 1-3 in which 1 is a good outcome, 2 is fair, and 3 is poor, the average for all three groups was slightly over 1.0. There were no significant differences between groups, said Dr. Crowder, an ob.gyn. in Conroe, Texas.

About half the women in each group underwent ultrasound examination to measure endometrial thickness. Women taking leuprolide had thickness of 7.9 mm, those on oral contraceptives had thickness of 9.1 mm, and those on cycle timing had thickness of 12.0 mm, confirming that leuprolide and oral contraceptives were effective in thinning the endometrium.

—Robert Finn

