Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Vasectomy

To the Editor:

I wish to comment about the article entitled "Vasectomy" *(Brownlee HJ, Tibbels CK: Vasectomy. J Fam Pract 16:379, 1983)*, which appeared in your February 1983 issue.

In addition to its use in family planning, vasectomy is of established value in the prevention of recurrent epididymitis, since this infection ascends the vas from the prostatic urethra.

In the article the authors discuss preoperative counseling at length, and I completely endorse this. They mention using a booklet, which is a most important tool. I send one to the patient prior to the interview. It explains the procedure and its complications, and gives further information about what to expect. It has one highly important feature that I recommend to everyone who performs vasectomies: The last page of the booklet consists of a consent form, which is to be signed by the patient and his wife. The booklet then becomes part of the patient's records. The following points are stressed: (1) that the patient and wife *request* the vasectomy, (2) that the operation is intended to produce permanent sterility, (3) that they have read the booklet and fully understand the points therein and that all of their questions have been satisfactorily answered, and (4) that they agree to submit postoperative semen specimens for testing and will continue to use birth control methods until told that it is safe to discontinue. The legal profession continues to attempt to make physicians guarantee vasectomies, to pay for raising children born after failed vasectomies, and so on. This consent form affords protection against such suits.

The authors also discuss preoperative medication but fail to stress the necessity of then having the patient bring someone to drive him home after the procedure. A sedated patient could be a dangerous driver. I have never used preoperative medication, relying instead upon "verbal analgesia" and a gentle touch to relax the patient.

Brownlee and Tibbels misunderstand when they state that I advocate "excision of a small specimen for pathologic identification purposes."[1] I do not remove any of the vas, since it is of no value in guaranteeing success of the procedure. Rather, I stated that if the surgeon feels that he *must* do so, the segment should be the shortest possible. The vas deferens has a totally

Continued on page 686

Continued from page 683

characteristic feel. There is no other white, thick-walled scrotal structure whose lumen does not bleed. Proof of satisfactory surgery lies in the disappearance of sperm postoperatively and not in the trophy sent to the pathologist, or preserved in a bottle in the back room of the office. I have never had a failure using the technique the authors cite, but without excising any of the vas.

The simplest postoperative test is to set a goal of no sperm in the postoperative semen specimen. This permits examination of condom specimens and of specimens that must be transported long distances for analysis. Also, since the reservoirs of sperm may empty only to have a spontaneous anastomosis of the vas follow, I recommend that two negative samples be secured, with a one-month interval, before the patient is told that he is sterile.

It is unnecessary to excise a painful spermatic granuloma of the vas, and indeed this is a difficult task. If the granuloma is cystic it should be evacuated. The vas should then be transected and sealed proximal to the granuloma. Once the flow of sperm into the granuloma ceases, the granuloma will disappear.

The authors discuss postoperative epididymitis. I have never seen postvasectomy bacterial epididymitis. What is seen is an engorgement of the epididymis with spermatozoa, a temporary condition that subsides spontaneously, or a spermatic granuloma of the epididymis wherein the swelling is limited to one portion of the epididymis and subsides slowly. Antibacterials are without value in these conditions.

Having extensive experience in vasectomy reversal, I feel that its increased incidence (now 1 percent of my vasectomy patients) is due not to a failure of counseling, but rather to the public's awareness that reversals can be performed and that they often succeed. Most reversals are done during a subsequent marriage, years after the vasectomy, a matter that counseling might not have prevented.

Stanwood S. Schmidt, MD
Research Associate in Urology
University of California
Medical School
San Francisco, California

Reference

1. Schmidt SS: Technique of vasectomy. Br Med J 2:524, 1974

Screening for Gestational Diabetes

To the Editor:

I would like to take issue with a recommendation by Swinker in her recent paper in this journal, "Routine Screening for Gestational Diabetes in a Family Practice Center."[1] I take exception to the statement, "routine testing for carbohydrate intolerance in pregnancy is recommended for all patients because of the increased fetal morbidity and mortality in women with gestational diabetes. . . ." This is not consistent with current literature. Swinker cites the 1973 article by O'Sullivan et al[2] to support a 6.4 percent perinatal mortality in gestational diabetes compared with 1.5 percent in controls. However, this group also showed no increased fetal wastage in gestational diabetics less than 25 years of age. Swinker did not refer to the 1977 article by Gabbe et al,[3] which did not show increased fetal mortality with gestational diabetes. They did not support the finding of O'Sullivan et al that patients aged over 25 years are at greatest risk and therefore did not even support evaluating all patients over 25 years of age. Gabbe

Continued on page 688

Continued from page 686

et al did suggest that screening be done after the clinician seeks out certain historical and clinical clues including previous stillbirth, macrosomic infant, family history of diabetes, obesity, hypertension, and glycosuria.

The experience of Swinker does not prove the value of routine screening. It is unclear whether the three women found to have gestational diabetes were truly helped by the discovery. It is also unclear whether they would not also have been found by a routine prenatal urinalysis showing glycosuria. To spend resources to discover a condition that may not truly be associated with increased perinatal mortality and for which outcomes may not be improved as a result seems totally unjustified.

Until a study comparing outcomes in populations screened vs not screened has been undertaken, it is premature to recommend universal screening. The data are not convincing that one should change the approach of selective screening based on historical and clinical factors.

Sam C. Eggertsen, MD
Department of Family Medicine
University of Washington
Seattle, Washington

References

1. Swinker M: Routine screening for gestational diabetes mellitus in a family practice center. J Fam Pract 17:611, 1983
2. O'Sullivan JB, Charles D, Mahan CM, Dandrow R: Gestational diabetes and perinatal mortality rate. Am J Obstet Gynecol 116:901, 1973
3. Gabbe SG, Mestman JH, Freeman RK: Management and outcome of class A diabetes mellitus. Am J Obstet Gynecol 127:465, 1977

The preceding letter was referred to Dr. Swinker, who responds as follows:

In response to Dr. Eggertsen's letter, I would like to refer to Gabbe's 1978 article[1] in which he states, "Recent investigations would indicate that all patients should be screened no later than 28-30 weeks' gestation. In the past, screening was begun with a search for historical and/or clinical clues." To justify this position, Gabbe cites O'Sullivan's 1973 article[2] in which it was found that "over 50% of patients who subsequently developed diabetes in pregnancy failed to show the historical and clinical associations described above."

There is some disagreement in the literature about whether gestational-diabetic women have a higher rate of perinatal mortality. For example, Mestman,[3] Gabbe's colleague from Los Angeles, does not feel there is an increase in perinatal mortality in gestational diabetics who do not develop fasting hyperglycemia. Nevertheless, he advocates universal screening in all age groups. He notes that although the incidence of positive screening tests may be higher in patients with a positive history or increasing age, a significant number of patients will have abnormal tests without any historical medical clues, even in the younger age groups.

Thus, the rationale for making the diagnosis of gestational diabetes need not be based on increased mortality. The gestational diabetic is managed to avert hyperglycemia, and monitored for the development of fasting hyperglycemia (which would place the pregnancy in the risk category of an overt diabetic with potential for increased perinatal mortality). There is no question that infants of gestational diabetics experience increased perinatal morbidity, eg, hypoglycemia, hyperbilirubinemia. Awareness of possible neonatal problems may aid the physician so that hypoglycemia, for example, may be promptly recognized and treated.

Marian Swinker, MD
University Health Service
West Virginia University
Morgantown, West Virginia

References

1. Gabbe S: Application of scientific rationale to the management of the pregnant diabetic. Semin Perinatol 2:361, 1978
2. O'Sullivan J, Mahan C, Charles D, Dandrow R: Screening criteria for high risk gestational diabetic patients. Am J Obstet Gynecol 116:895, 1973
3. Mestman J: Outcome of diabetes screening in pregnancy and perinatal morbidity in infants of mothers with mild impairment in glucose tolerance. Diabetes Care 3:447, 1980

Insulin-Pump Therapy

To the Editor:

Recently, the use of insulin-pump therapy to improve diabetic control has become more popular, exemplified in recent reports from the Mason Clinic,[1] where experience with 100 patients on insulin pumps has been described. All of these patients were begun on insulin-pump therapy with a period of inpatient instruction.

Over the past year we have had the opportunity to begin 16 patients on insulin-pump therapy on an outpatient basis. All 16 patients had brittle diabetes and all had inadequate control with intensive diabetic treatment and home glucose monitoring.

All patients were first seen in a glucose-monitoring program two times a week in groups supervised by a nurse practitioner and an endocrinologist. The patients were initially instructed in nutrition and CHEMSTRIP use, and they kept daily graphs of their activity, insulin dosage, carbohydrate intake, insulin administration, and blood glucose by CHEMSTRIP seven times a day. All 16 patients had brittle diabetes (15 type I, 1 type II), unable to be controlled satisfactorily on this program and often involving

Continued on page 692

Continued from page 688

multiple doses of insulin; therefore, they were begun on insulin-pump therapy.

The patients were introduced to the use of an insulin pump during an office visit with a nurse practitioner in a 40-minute session. The mechanics of the pump were carefully explained, and the patient performed all procedures including mixing of insulins (for older model pumps) under the supervision of the nurse practitioner before going home. Insulin dosage was generally reduced by approximately 30 percent from the total dose taken by injection, and morning and overnight basal rates and premeal bolus amounts were determined. Possible problems with catheters, batteries, tape allergies, and so on, were discussed. Patients were given the telephone numbers of other patients on the pump, and 24-hour telephone access to a nurse practitioner or physician by beeper was available. These patients continued to be seen in biweekly home glucose-monitoring group sessions where serial clinical observations were made of the patient's course. In addition, an anonymous questionnaire was given to each patient to assess satisfaction with this outpatient program. Of interest is that some of these patients have been instructed on more than one type of pump by this method, and one patient has used successively the Millhill, Autosyringe, and CPI pumps, with each instruction occurring by the above method.

All patients rapidly achieved a high level of understanding and competence with the insulin pump. There were no untoward mishaps during the initial phase of insulin-pump therapy. After several patients were wearing a pump, they became a resource of information and support for additional patients being initiated in insulin-pump therapy during home glucose-monitoring group sessions. A number of patients (8 of 16) experienced initial apprehension upon taking the pump home, a problem that could have been eliminated by inpatient instruction. One patient specifically stated that 24 to 48 hours of inpatient instruction should be recommended.

Insulin pump therapy is being used with increasing frequency. One obstacle to such therapy is its expense. By initiating therapy on an outpatient basis with frequent peer-group follow-up visits, we have attempted to reduce the cost of initiating such therapy in 16 patients.

Of all our brittle diabetics, with excellent knowledge of home glucose monitoring, 50 percent felt satisfied with this approach. The other 50 percent experienced anxiety when confronted with the need to initiate pump therapy at home. There were no untoward initial problems experienced by these patients aside from their anxiety.

It is our conclusion that insulin-pump therapy can be safely begun on an outpatient basis, but that it is associated with some patient anxiety. A possible future approach to alleviate that anxiety while continuing to attempt outpatient initiation of therapy might be to see each patient on several successive days before or after the patient begins using the pump.

Stephen J. Gordon, MD
Christine Biby, RNP
R. James Dudl, MD
Southern California Permanente Medical Group
Kaiser Foundation Hospital
San Diego, California

Reference

1. Meckelburg RS, Benson JW Jr, Becker NM, et al: Clinical use of the insulin infusion pump in 100 patients with type I diabetes. N Engl J Med 307:513, 1982