"The new HPV vaccine: What the ObGyn needs to know," an expert panel moderated by Thomas C. Wright, MD (January)

More questions about the HPV vaccine
The roundtable discussion of the new vaccine was outstanding. Here are 3 more questions about how to integrate the vaccine into clinical practice:
1. Is it ethical to deny the vaccine to a woman over age 26 when it could potentially prevent cervical cancer?
2. What about men and their role in “carrying” the virus?
3. Can the vaccine be used as a treatment, as opposed to prophylaxis, for women with abnormal Pap smears?

Daniel M. Avery, MD
Associate Professor and Chairman
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University of Alabama School of Medicine
Tuscaloosa, Ala

"Why is it assumed that we will buy this expensive vaccine, administer it to our patients, and then hope to be reimbursed by someone?"

Cost of HPV vaccine is patient’s responsibility
In the roundtable discussion of the new HPV vaccine, the question was raised—"who pays?" Why is it assumed that we will buy this expensive vaccine, administer it to our patients, and then hope to be reimbursed by someone—either the insurance company or the patient? We advise our patients to be vaccinated against HPV, but address the problem of reimbursement in a practical fashion. We don’t buy anything.

With other injectables and related medical items such as the levonorgestrel-releasing intrauterine system (Mirena), the amount reimbursed by some insurers is less than the true cost of the items. Because we lost money every time we administered these medications, including the HPV vaccine (Gardasil), we decided to change course. Now we write a prescription for the medication and instruct the patient to have it filled at her pharmacy. In the case of IUDs, the items are mailed directly to our office by the company. Medroxyprogesterone acetate and the HPV vaccine are dispensed to the patient, who brings the medications to our office for injection.

By refusing to buy and stock these agents, we put the financial responsibility back where it belongs: on the patient and her insurance company. If every gynecologist did as we do, these medications would be covered like any other drug we prescribe. Then we could get back to the business of delivering good medicine without taking financial risks that belong elsewhere.

Marion Pandiscio, MD
Bradenton, Fla

Dr. Wright responds:
For now, focus should be on young women
I appreciate Dr. Avery’s questions about clinical applications of the new HPV vaccine, and offer the following responses:
1. When considering whether to vaccinate women over age 26, one point in particular is key: The vaccine is not
approved for use in this age group, and we lack safety and efficacy data for this application. I believe the vaccine will be proven safe in women over age 26, but its efficacy will probably be lower than in younger women for a couple of reasons. First, as we age, we tend to become less responsive to vaccines. Second, older women are more likely to have been exposed to the vaccine HPV types than young women are.

2. In most instances, men are vectors for the transmission of HPV to women. However, infections typically are spread in a different pattern when they are transmitted sexually, as opposed to other forms of transmission. Core groups are composed of individuals who are especially active, with many sexual partners, and these groups contribute disproportionately to the spread of infection. Although HPV is not restricted to these core groups, a male vaccination program is unlikely to have a significant impact on infections in women until it achieves high coverage rates in men.

3. To date no data indicate that the vaccine can be used as a treatment for women with abnormal Pap tests.

As Dr. Pandiscio points out, reimbursement for expensive vaccines and other medical items is a significant issue for most practitioners—not just ObGyns. Unfortunately, when patients obtain vaccines at a pharmacy, they often pay more for them. There are reports of pharmacies charging up to $185 per dose for Gardasil, which is more than 50% higher than the wholesale cost.

“There are reports of pharmacies charging up to $185 per dose for Gardasil, which is more than 50% higher than the wholesale cost”

“Postpartum hemorrhage: Solutions to 2 intractable cases,” by Michael L. Stitely, MD, and Robert B. Gherman, MD (April 2007)

No mention of hypogastic artery ligation?

Although I enjoyed the article on postpartum hemorrhage, I was disappointed that the authors left out hypogastic artery ligation when they discussed management options for intractable hemorrhage. Bilateral ligation is effective and can spare patients from hysterectomy.

Eric Rothschild, MD
Fort Lauderdale, Fla

Dr. Stitely and Dr. Gherman respond:

Technique is useful in select circumstances

Although we did not mention it in our article, we do agree that hypogastic artery ligation is useful in select circumstances. However, under emergent conditions in the face of ongoing massive hemorrhage, the technique can be risky. The decision to use it should be based on the physician’s level of surgical skill and, to a more limited degree, clinical experience. Many chief residents graduating today have rarely, if ever, performed this procedure. Even some seasoned obstetricians have never had the opportunity to practice it. Moreover, small community-based hospitals may not have the surgical assistants or instruments necessary for this technique, whereas the other conservative measures described in our paper, such as the B-Lynch suture, are easily executed by inexperienced providers, involve limited maternal morbidity, and take only a few moments to perform.

Although hypogastic artery ligation can reduce pulse pressure by 50%, maternal risks include vascular injury to the hypogastic artery or iliac vein, ureteral damage, sloughing of the gluteal muscles, and femoral artery insufficiency. There is also a concern that hypogastic artery ligation will fail and could potentially delay hysterectomy, leading to more blood loss. In Clark’s series, 57% of patients (11/19) required hysterectomy after hypogastic artery ligation. These patients had more blood loss and significant intraoperative morbidity, compared with patients who underwent hysterectomy without it.¹

Reference

Obesity complicates the operative-delivery decision

Dr. Belfort outlined a strategy for determining the likelihood of success of operative vaginal delivery: “the rule of fifths.” I agree that this rule can be very helpful at the time of abdominal palpation, but it can be difficult to apply when the patient is obese. This is discouraging because the incidence of obesity is especially high in the United States, and obese women have an increased incidence of macrosomia and difficult operative delivery.

Another way to determine the likelihood of success is to ask the patient to bear down as you perform a vaginal examination. If the fetal head exhibits mobility and some descent, success is more likely. A “tight fit” would be an indication for a trial of forceps in the operating room.

In some cases, an ultrasound scan may help determine the position of the fetal head.

The most important determination is whether forceps delivery can be performed in the labor and delivery suite or is better limited to a trial of forceps in the operating room. The proper application of the forceps is vital to avoid maternal and fetal injury.

Dr. Belfort responds:

Informative abdominal exam is possible even in the obese

I agree that determining the number of fifths of the fetal head above the maternal symphysis pubis may be more difficult in an obese patient. However, even in an extremely obese woman, it is still possible to elevate the pannus and feel the symphysis in most cases (even if an assistant has to help). If there is any doubt that the head is palpated, further efforts may be appropriate to ensure that the fetal head is engaged, including, as Dr. Michael suggested, use of ultrasound.

While I agree in theory that descent of the fetal head with maternal pushing efforts is important, I would not


