

“LET’S INCREASE OUR USE OF IUDS AND IMPROVE CONTRACEPTIVE EFFECTIVENESS IN THIS COUNTRY” (AUGUST 2012)

AND

“LET’S INCREASE OUR USE OF IMPLANTS AND DMPA AND IMPROVE CONTRACEPTIVE EFFECTIVENESS IN THIS COUNTRY” (SEPTEMBER 2012)

ROBERT L. BARBIERI, MD (EDITORIALS)

LARC shouldn’t be bundled into the global obstetric fee

I appreciate Dr. Barbieri’s very timely editorials on long-acting reversible contraception (LARC). He mentioned a recent study by Tocce and colleagues, in which new mothers were offered a choice between insertion of an etonogestrel implant before hospital discharge or initiation of any contraceptive at the postpartum follow-up visit.¹ The women who chose the implant had a lower rate of pregnancy at 6 months than the women who deferred contraception to the postpartum visit (0% vs 9.9%).

Interestingly, I had recently been in contact with Dr. Tocce when I read Dr. Barbieri’s editorials. I was concerned about insurance companies’ bundling of the charge for LARC into the global obstetric fee. I have given a copy of the study by Tocce and colleagues to two large insurers in our community, arguing that it is cost-effective to unbundle this service. In addition, as Dr. Barbieri noted, the initiation of LARC immediately postpartum would help reduce the rate of unintended repeat pregnancy. I plan to send the insurers a copy of Dr. Barbieri’s editorials as well.

If insurers are willing to change their policy, perhaps Medicaid will follow their lead.

Kenneth R. Kahn, MD
Buffalo, New York

Reference

1. Tocce KM, Sheeder JL, Teal SB. Rapid repeat pregnancy in adolescents: do immediate postpartum contraceptive implants make a difference? *Am J Obstet Gynecol.* 2012;206(6):481.e1-e7.



SEPTEMBER 2012

Reimbursement for LARC is too low

I am an ObGyn in private practice, and I am absolutely in favor of LARC. I am probably one of the few ObGyns in my area who actually encourage patients to get an intrauterine device (IUD). I believe the reason that many docs do not recommend the IUD is the fact that reimbursement is less than the cost!

If private insurers and Medicaid would increase reimbursement, I am certain that more docs would encourage patients to use LARC. For some docs in private practice, however, it comes down to the bottom line. I’m sure we all appreciate the value of these contraceptives, but many of us just cannot absorb the cost.

Jennifer Nguyen, MD
Houston, Texas

>> Dr. Barbieri responds
In some locales, reimbursement for LARC is inadequate

I thank Dr. Kahn and Dr. Nguyen for their important commentary on barriers they face in using LARC. In my editorial, I neglected to mention that the reimbursement practices of

commercial insurers, Medicaid, and Medicare often create barriers to optimal patient care. In some locales, insurance practices, such as refusing to pay for the true cost of the contraceptive, discourage the use of LARC, especially in private office settings.¹ Advocacy and high-quality outcomes data² are sometimes effective in changing insurers’ reimbursement practices, and likely are our best hope for advancing the health of our patients.

References

1. Park HY, Rodriguez MI, Hulett D, Darney PD, Thiel de Bocanegra H. Long-acting reversible contraception method use among Title X providers and non-Title X providers in California [published online ahead of print May 25, 2012]. *Contraception.* doi:10.1016/j.contraception.2012.04.006.
2. Burlone S, Edelman AB, Caughey AB, Trussell J, Dantas S, Rodriguez MI. Extending contraceptive coverage under the Affordable Care Act saves public funds [published online ahead of print July 25, 2012]. *Contraception.* doi:10.1016/j.contraception.2012.06.009.

“HOW TO AVOID MAJOR VESSEL INJURY DURING GYNECOLOGIC LAPAROSCOPY”

MICHAEL BAGGISH, MD (AUGUST 2012)

Controlled trocar insertion can avert vascular injury

I commend Dr. Baggish on his thoughtful, well-organized, and complete review of trocar injuries. I also would like to point out that proper insertion of the trocar means that it barely enters the peritoneal cavity. For vascular injury to occur (with any means of trocar insertion), the trocar not only would have to enter the peritoneal cavity but would need to pass through it entirely and impale vessels against the posterior abdominal wall. That is not a controlled entry, but a completely uncontrolled entry, involving too much momentum and muscle strength and too little precision.

My experience with residents and others learning laparoscopy has revealed two common errors that may

lead to loss of control of the trocar:

- failure to incise the fascia sufficiently, which can cause the trocar to hang up on the fascia. When this occurs, the fascial defect should be enlarged, but some physicians apply more pressure to the trocar instead, increasing the risk of injury.
- a tendency to put the shoulder above the elbow when inserting the trocar, to gain more “oomph” at the cost of losing control.

As Harry Reich, MD, has often noted, if one jams a trocar into a hard surface, such as a table (or bone), one hears two taps in quick succession rather than a single tap. Presumably, this phenomenon arises when the energy behind the insertion leads to a rebound bounce. Clinically, that suggests that when trocar injury occurs, and a vessel perforation is found, the surgeon needs to look for that second-bounce perforation!

William J. Mann Jr., MD
Neptune Township, New Jersey

Robotic surgery led to injury

Dr. Baggish fails to describe the most important variable in preventing major vessel injury: Do not do the wrong procedure! The complications described in the opening case could have been avoided if the surgeon had performed a simple open laparoscopy or mini-laparotomy. How can anybody justify the risks and cost of a robotic approach in a woman with a body mass index of 25 kg/m²?

I am ashamed of colleagues who jump onto the new-technology bandwagon to improve their learning curve or for marketing reasons.

Pablo Pinzon, MD
Oklahoma City, Oklahoma

» Dr. Baggish responds
Sharp trocars enhance control
Dr. Mann makes a good point. Direction and angle are critical variables

in avoiding major vessel injury—but control of the trocar thrust is also an important part of the safety equation. Many of the aortic and iliac injuries I have studied are through-and-through injuries in which the trocar passed through the anterior abdominal wall, peritoneal cavity, and posterior wall, stopped only by the backbone.

Generally speaking, sharp disposable trocars require significantly less force to insert and provide better control for entry, provided the surgeon employs counter-traction and uses the thumb, index finger, and center finger to insert the trocar in the fashion of throwing a dart.¹ This approach is safer than the twisting and pushing forces required with optical trocars and dull reusable instruments.

Dr. Pinzon makes a good point. The case I presented did not require a robot—that was the surgeon’s choice. And the decision to insert a trocar several centimeters above the umbilicus in the midline was not one I would have made. The gynecologist also used an 11-inch trocar—a dangerous device, particularly when it is thrust at the wrong angle of entry. However, the great vessel injury in this case had nothing to do with the robot, as the injury occurred before a robot could be deployed.

Reference
1. Baggish MS, Gandhi S, Kasper G. Force required by laparoscopic trocar devices to penetrate the human female’s anterior wall. *J Gynecol Surg.* 2003;19(1):1–11.

“DOES MEDIOLATERAL EPISIOTOMY REDUCE THE RISK OF ANAL SPHINCTER INJURY IN OPERATIVE VAGINAL DELIVERY?”
ERROL R. NORWITZ, MD, PHD (EXAMINING THE EVIDENCE; AUGUST 2012)

Is proper episiotomy repair a waning art?
The study that Dr. Norwitz reviewed failed to consider blood loss,

postpartum healing, and subsequent dyspareunia when comparing midline and mediolateral episiotomies.¹ It also would be of interest to assess long-term outcomes after proper repair of third- and fourth-degree episiotomies.

I believe that declining experience in operative delivery is behind many lasting problems. Is it possible that knowledge of proper repair of third- and fourth-degree episiotomies is being lost, thereby changing these statistics?

L.J. Leeds, MD
Houston, Texas

Reference
1. de Vogel J, der Leeuw-van Beek A, Gietelink D, et al. The effect of mediolateral episiotomy during operative vaginal delivery on the risk of developing obstetrical anal sphincter injuries. *Am J Obstet Gynecol.* 2012;206(5):404.e1–e5.

“NEW DATA: HIV-INFECTED WOMEN DO NOT HAVE AN ELEVATED RISK OF CERVICAL CANCER”
JANELLE YATES (AUGUST 2012)

Study sheds new light on a long-held misconception

The data highlighted in this article come from an excellent study that has shed more light on the long-held misconception that HIV-infected women have a higher risk of cervical dysplasia and, perhaps, cervical cancer.¹ We need multicenter and multi-national studies of this kind to settle this issue once and for all. The outcome would be of great significance in terms of reducing health-care costs and unnecessary interventions that many HIV-infected women undergo as a result of frequent Pap testing.

Christopher Enakpene, MD
Brooklyn, New York

Reference
1. Keller MJ, Burk RD, Xie X, et al. Risk of cervical precancer and cancer among HIV-infected women with normal cervical cytology and no evidence of oncogenic HPV infection. *JAMA.* 2012;308(4):362–369.