Reconcile Exam and Image

percentage of the litigation in- volves a palpable breast mass dis- covered by the patient, who then comes to the clinician for an eval- uation. Litigated cases often lack any docu- mentation of a breast mass.
Clinicians should carefully docu- ment everything that they evaluated a patient for signs and symptoms of breast cancer, that they took a thor-ough clinical history, and that they re- ferred the patient for genetic counsel- ing if appropriate. Use a stamp or mnemonic in the chart to show that you examined the breasts and regional lymph nodes. Dr. Brenner suggested.
Try to reconcile clinical findings and imaging results.
“The interplay between the clin- ical and mammographic findings often will convert subthreshold findings to threshold findings. That needs to be appreciated,” he said at the meeting, which was sponsored by Emory University.
In sist on getting a phone call from the radiologist if there is any suspicious finding on mammogra- phy or ultrasound, because written or electronic reports can get lost or misplaced, he added.
When you do get a mammog- raphy or ultrasound report, initial it to indicate that you looked at it, and to show a potential jury that it was your decision to do something further or not to do more. Kimberly D. Baker, J.D., said in a legal commentary session after Dr. Brenner’s talk.
“Computerized records don’t necessarily help. Peo- ple can get the infor- mation more quickly, but it doesn’t mean they pay attention to it,” she noted.
Besides systematic documentation, a key component in re- ducing risk is good communication with the patient. Explain the difference be- tween screening and a mammogram per- formed for specific clinical reasons, to emphasize the importance of following through, said Ms. Baker, a defense attorney in Seattle who also holds a BS de- gree in nursing.
Young women in particular may think of mammography as some- thing for their mothers or aunts, not them.
“If they have risk factors, you need to talk to them about getting a mammogram,” she said. “A young breast cancer failure-to-di- agnosis case is very difficult to defend.”
The effect of breast cancer treat- ments on fertility increasingly is be- coming a legal issue. Don’t assume that a woman in her late 30s or 40s or even at age 50 is past thinking of a future pregnancy.
Find out what her plans are be- fore treatment, and advise her ac- cordingly. Ms. Baker said.

Local Complications Common With Postmastectomy Implants

BY MARY ANN MOON
Contributing Writer

There were 484 initial implant procedures and 417 reimplant procedures—implant ex- changes or implant reinsertion after a prior re- moval. Just over half (51%) of these secondary procedures were unplanned; the remaining 49% were planned second-stage operations or tus- sue expansion. The mean patient age at initial implantation was 50 years, and the subjects were followed for a mean of 23 months after ini- tial implantation and 24 months after subse- quent implantation.
Unplanned repeat procedures were performed for a range of reasons, and patients often had more than one indication. Capsular contrac- tion was the most common cause for repeat pro- cedures (23%), followed by unacceptable asym- metricity (20%), displacement of the implant (16%), and suspicion of implant rupture (9%).
After initial implantation, 31% of women ex- perienced at least one adverse event, ranging from delayed wound healing to severe capsular con- traction. Sixteen percent developed two adverse events, and 6% developed at least three. Wound infection was the most common immediate ad- verse event, affecting 7% of women. Skin perfor- ration, seroma, periprosthetic infection, and hematoma each affected 3% of the women.
After a repeat implantation procedure, 36% of the women developed one adverse event, 19% developed two, and 8% developed three or more adverse events. Asymmetry and displac- ement of the implant were the most frequently reported problems, affecting 19% of women. Hematoma, capsular contraction, prolonged pain, wrinkles, and scar indentation each af- fected 3% of the women.
A total of 21% of the women required surgi- cal intervention after initial implantation and an- other 3% required other treatments.
Approximately half of the complications oc- curred within the first 3 months after implanta- tion, 67% within the first 6 months, and 91% within the first year.

HSV-2 Infection May Raise Risk for Pelvic Inflammatory Disease

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — Herpes simplex virus type 2 infec- tion in women may be associated with an increased risk of pelvic inflammatory disease, Dr. Thomas L. Cherpes reported in a poster at the annual Interscience Conference on Antimicrobial Agents and Chemotherapy.

The role of chronic genital viral infections in the pathogenesis of pelvic inflammatory disease (PID) may be more significant than currently recognized, although no etiologic link has as yet been defined, noted Dr. Cher- pes and his associates at the University of Pittsburgh.

A total of 725 nonpregnant women aged 15-50 years who were either diagnosed with a lower bacterial geni- tal tract infection (purulent cervical discharge, untreated Neisseria gonorrhoeae or Chlamydia trachomatis infection, symptomatic bacterial vaginosis) or were at risk for such an infection (male contact with a male diagnosed with gonorrhea, chlamydial, or nongonococcal urethritis) were recruited from sexually transmitted disease clinics and gynecology clinics. Of those, 43% (309) were seropositive for HSV-2. Of the 86 women with acute endometritis, 55% (47) were HSV-2 seropositive, as were 51% (70) of the 136 women found to have plasma cell endometritis. Acute en- dometritis was independently as- sociated with black race (odds ra- tio 1.7) as well as infections with C. trachomatis (3.3), N. gonorrhoeae (2.8), Trichomonas vaginalis (2.4), and HSV-2 (2.2). Black race also was associated with plasma cell endometritis (odds ratio 1.9), but HSV-2 was the only reproductive tract infection significantly associ- ated with that condition (odds ra- tio 1.5), they reported.

Coinfection with HSV-2 and a genital tract bacterial pathogen sig- nificantly increased the likelihood of PID, compared with having one or the other alone. For example, the odds ratio for acute endo- metritis was 5.0 for women with chlamydia and 2.6 for those with HSV-2, compared with women who did not have those conditions. However, the odds ra- tio justifies the inclusion of both. Sim- ilarly, women with gonorrhea alone had a 4.2-fold in- creased risk for acute endometritis, which rose to 6.0 if they were also infected with HSV-2.

Odds Ratios for Acute Endometritis

Women with gonorrhea alone

Women with gonorrhea and HSV-2

Source: Dr. Cherpes

There were 471 of the women who underwent hysterosalpingography, 8.1% (38) had both HSV-2 infec- tion and evidence of fallopian tube obstruction. Those 38 women ac- counted for 19% of the 192 women who were HSV-2 positive and 54% of the 71 with fallopian tube blockage.

Of course, these data do not ex- clude the possibility that the high- er prevalence of HSV-2 among women with PID may simply reflect a marker for sexual activity and/or the coacquisition of a PID- associated bacterial pathogen.

However, “as PID remains the most frequent gynecologic cause for emergency room visits as well as the most frequent infectious cause of infertility, confirmation and further exploration of these findings could have impor- tant clinical implications,” Dr. Cherpes and his as- sociates wrote.

The conference was sponsored by the American Soci- ety for Microbiology.