

**“YOUR TEENAGE PATIENT AND CONTRACEPTION: THINK ‘LONG-ACTING’ FIRST”**

DAVID R. KATTAN, MD, MPH, AND RONALD T. BURKMAN, MD (SEPTEMBER 2015)

**What does Liletta cost to non-340B providers?**

Drs. Kattan and Burkman state in their article: “For providers who practice in settings eligible for 340B pricing, Liletta costs \$50, a fraction of the cost of alternative intrauterine devices (IUDs). The cost is slightly higher for non-340B providers but is still significantly lower than the cost of other IUDs.”

Could you provide a cost range and the source for the non-340B cost?

**Sharon J. Hawthorne, MBA**  
St. Louis, Missouri

» Drs. Kattan and Burkman respond: Thank you for your question and for allowing us to clarify. The manufacturer of Liletta, Actavis, offers a Patient Savings Program for private insurance patients to limit their out-of-pocket cost to \$75. This program will end on December 31, 2015. Information is available at <http://www.lilettacard.com>.

For non-340B providers, the cost per IUD is higher, although this should be reimbursed by the patient’s insurance program. After volume discounts, the price per device is as low as \$537. Without volume discounts, the price per device is \$600. For more information, visit: <https://www.lilettahcp.com/content/pdf/LILETTA-Quick-Reference-Guide.pdf>.

Medicines360, the nonprofit partner of Actavis, states the following on its Web site (<http://medicines360.org/our-mission>): “Through our pharmaceutical partnerships, commercial product sales help support an affordable price



SEPTEMBER 2015

to public sector clinics. This allows low income women or those without insurance the opportunity to access more healthcare choices.”

**“DOES PREOPERATIVE URODYNAMICS IMPROVE OUTCOMES FOR WOMEN UNDERGOING SURGERY FOR STRESS URINARY INCONTINENCE?”**

CHARLES W. NAGER, MD (EXAMINING THE EVIDENCE; AUGUST 2015)

**Priorities for determining the etiology of incontinence**

While I believe Dr. Nager’s approach accurately interprets current clinical evidence, it also reflects an inadequate paradigm. Whether or not incontinence surgery should be preceded by formal invasive urodynamic evaluation is not the question. As director of urodynamics at UConn, I understand that even the most advanced clinical urodynamics evaluation is limited in what it can measure. Nowhere in that data set is “determine the etiology of incontinence.” Therefore, the more appropriate question is: When should one consider

urodynamic evaluation before making a diagnosis requiring therapy? The answer: By prioritizing aspects of lower urinary tract function.

As recommended by the International Continence Society, the diagnosing physician actually must conduct the urodynamic testing. This physician’s first priority is to determine if the bladder can maintain low storage pressures. History and physical examination must include an acknowledgment of potential causes, including chronic urethral obstruction or failure of autonomic/sympathetic regulation. Yes, in an otherwise healthy 45-year-old vaginally parous woman with stress urinary incontinence (SUI) symptoms, it is unlikely that storage pressures aren’t normally regulated. It takes little office visit time to reach that conclusion.

The diagnosing physician’s second priority is to determine the actual functional size of the urinary reservoir. Only the bladder can expel urine actively. Is there a bladder diverticulum or reflux into the upper tracts augmenting the reservoir? Bladder/urethral function is about volume management, yet the sphincteric mechanism is not tolerant of very high volumes, even in “normal” patients. Knowing reservoir volumes when leakage occurs and the relationship of these volumes to perceptions of “empty” and “full” is critical to determining how to respond to sphincteric insufficiency that produces SUI symptoms. I agree that an otherwise healthy 45-year-old vaginally parous woman with SUI symptoms will have a problem here. However, if the diagnosing physician has any reason to doubt that the urinary reservoir has the same functionality as the bladder and that operational volumes are “normal,” then

CONTINUED ON PAGE 16

CONTINUED FROM PAGE 14

videourodynamic investigation is the most direct approach.

The third priority during evaluation is to determine how the reservoir empties. What is the source of the expulsive pressure of voiding? What is the interaction of the expulsive pressure and the urethral opening? How effectively does the bladder empty? In an otherwise healthy 45-year-old vaginally parous woman with SUI symptoms, it is unlikely that there is a problem, but if the physician doesn't consider how this patient's bladder empties, determining how the sphincter is stressed during storage and how the patient might respond to intervention is impossible. If normal efficient voiding by detrusor pressurization cannot be assured by office evaluation, then urodynamic examination, including a pressure/flow study, is necessary.

The last priority is to determine how the urine storage/emptying system is controlled. This is most important to the patient but least important for diagnosis. Often this can be deduced from a simple office evaluation that includes urinalysis, a voiding diary, standing stress test, possibly simple "office cystometry" (with a large Toomey syringe, a straight catheter, and saline solution), and the patient's history. No aspect of this last priority requires invasive computerized urodynamics—unless the physician just cannot figure it out even after considering results of the first 3 steps.

Once these evaluative priorities have been completed, a diagnosis can be considered and treatment options determined. But only then.

**Phillip P. Smith, MD**  
Farmington, Connecticut

» Dr. Nager responds:

*Dr. Smith provides a very nice review of what the bladder and urethra need to do. As he points out, the most appropriate question is: When should one consider urodynamic evaluation before making a diagnosis requiring therapy? Well, when a reliable diagnosis cannot be made by history, physical examination, and simple office tests.*

*The literature suggests that a neurologically normal woman without prolapse and without previous incontinence surgeries can receive a reliable diagnosis without urodynamic testing. If she demonstrates SUI on office stress testing, she is not storing urine normally and urodynamics will confirm urodynamic stress incontinence 97% of the time.<sup>1</sup> If she voluntarily voids with a normal postvoid residual, her emptying function has been assessed and is normal.*

*I think Dr. Smith and I both agree that, "In an otherwise healthy 45-year-old vaginally parous woman with SUI symptoms, it is unlikely that there is a problem." We also both agree that whenever the diagnosis is unclear, or the situation is complicated, urodynamic testing is a helpful tool to assess the bladder's storage and emptying function. I perform urodynamics regularly in my practice; it just is not necessary before surgery in a woman without prolapse and without previous incontinence surgeries who demonstrates her SUI and has a normal urinalysis and normal postvoid residual. We seem to agree on that point also.*

**Reference**

1. Nager C, Brubaker L, Litman H, et al; Urinary Incontinence Treatment Network. A randomized trial of urodynamic testing before stress-incontinence surgery. *N Engl J Med.* 2012;366(21):1987-1997.

**"UPDATE ON MENOPAUSE"**

ANDREW M. KAUNITZ, MD (JUNE 2015)

**Should Provera still be used?**

Dr. Kaunitz provided an excellent review of the Women's Health Initiative (WHI) study and a recent testosterone trial in women in his update on hormone therapy in menopause.

After the WHI revealed differences between the estrogen-alone and estrogen-progestin study arms, implicating medroxyprogesterone acetate for increased risk of breast cancer, why is Provera still being advocated by the American College of Obstetricians and Gynecologists as a progestin safe for use in menopause?

**Kathleen Norman, MD**  
Phoenix, Arizona

» Dr. Barbieri responds:

*Many insurance formularies favor the use of Provera because it is inexpensive. I try to avoid using it in my practice. Many experts do not yet diligently avoid the use of Provera; some are worried about the cost impact for patients.*

*For additional information on reducing the use of Provera, see my July 2014 editorial, "Hormone therapy for menopausal vasomotor symptoms," at [obgmanagement.com](http://obgmanagement.com).*

» Dr. Kaunitz responds:

*My preference is to use micronized oral progesterone (formulated in peanut oil) for endometrial protection in menopausal women using estrogen. I use progesterone 100 mg nightly in women taking standard-dose estrogen (estradiol patch 0.05 mg, oral estradiol 1 mg, or conjugated equine estrogen 0.625 mg). However, some patients request generic medroxyprogesterone acetate because it is so inexpensive (often \$4 each month).*