

HGOS Newsline

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To promote excellence in the practice of Gynecology and Obstetrics, enhance the opportunities for continuing education, encourage leadership and serve as the representative society for Obstetrics and Gynecology in the Houston area



FROM THE PRESIDENT



R. Todd Ivey, M.D.

Our next meeting will feature Liam J. Hurley, M.D. of North Andover, MA, to discuss a gynecologist's role in detection of bladder cancer in women. Our meeting is being sponsored by Alere Health.

**The meeting will be held on
Thursday, October 7th at 6:30 pm.
at Damian's Cucina Italiana
3011 Smith Street, Houston, Texas 77006**

The final meeting for the year will be a Residents' Research Night held in mid November. It will involve presentations by residents from each of our local programs. Thanks to Dr. Michael Frumovitz for organizing this meeting. This is great opportunity to see the future of our specialty. CME will be provided.

Announcements

Fall has arrived, however the weather does not seem to be cooperating. With warmer than average temperatures and several hurricanes in the Atlantic, it is hard to believe that Thanksgiving is a mere two months away. It seems that we are getting a break this week.

At our General Meeting in May, the Society passed an amendment to our by-laws. Article V, Section B, Number 1 now reads:

"A member expelled for failure to pay dues will be reinstated at his/her previous membership level immediately upon payment of dues and assessments for the current calendar year. The said member may be reinstated at the beginning of the next calendar year upon payment of dues for that year."

We recently lost a pillar in the Houston obstetrics and gynecology community. Dr. Warren Jacobs passed away September 9, 2010. Dr. Jacobs was an outstanding physician having worked in both academic and private practice settings. He served as professor in obstetrics and gynecology at Baylor College of Medicine before becoming a founding member of Obstetrical and Gynecological Associates here in Houston. He trained numerous residents and students, many of whom have remained in Houston. Our condolences go to his family and friends.

A few reminders:

The ACOG District XI meeting is scheduled for October 14 – 16, 2010 in Maui, Hawaii. This is a combined meeting with Districts VII, VIII, and IX. It promises to be a terrific meeting. Rooms are sold out so I hope you made reservations early.

Maintenance of certification – Answers for Part II (ABC) are due 9/30/2010. No late submissions will be accepted. For those of you who must begin the MOC process this year (this includes me), do not procrastinate on completion of your modules.

I look forward to seeing you at our next meeting.

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HOUSTON GYNECOLOGICAL & OBSTETRICAL SOCIETY (HGOS)

2010 HGOS Executive Board

President

R. Todd Ivey, M.D.
713-798-4691
rivey@bcm.tmc.edu

President-Elect

Jonna Miller, M.D.
713-795-1013
jmiller@hwca.net

Vice President

George Kuhn, M.D.
713-654-8128
drkuhn@kuhnmd.com

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Konrad Harms, M.D.
713-756-5959
kpharms@tmhs.org

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713-335-0335
swlaw@tmhs.org

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713-745-5498
peramire@mdanderson.org

Members at Large

Michael Frumovitz, M.D.
713-792-2455
mfrumovitz@mdanderson.org

Kathleen M. Schmeler, M.D.
713-745-3518
kschmele@mdanderson.com

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HGOS Office

Lisa Gasper
P.O. Box 272865
Houston, TX 77277-2865
Phone: 713-661-1839
Fax: 713-661-1303
Email: lgasper@hgos.org

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Executive Committee Updates

Additional topics from our recent meeting of the HGOS Executive Committee include:

-Our membership currently stands at 161. We have 135 active members and 26 life members.

-A new member was approved for the Society. Please welcome Audra Timmins, M.D.

Research Updates

In this section of the newsletter we offer highlights of recent publications relevant to our field. The goal of this segment is to keep the members of the society abreast of recent sentinel publications that may impact their clinical practice and patient care. Each article that is referenced may be found through a link in the Society website at www.hgos.org.

Uterine artery embolization vs hysterectomy in the treatment of symptomatic uterine fibroids: 5-year outcome from the randomized EMMY trial

Sanne M. van der Kooij, MD; Wouter J. K. Hehenkamp, MD, PhD; Nicole A. Volkers, MD, PhD; Erwin Birnie, PhD; Willem M. Ankum, MD, PhD; Jim A. Reekers, MD, PhD

Am J Obstet Gynecol 2010;203:105.e1-13.

OBJECTIVE: The purpose of this study was to compare clinical outcome and health related quality of life (HRQOL) 5 years after uterine artery embolization (UAE) or hysterectomy in the treatment of menorrhagia caused by uterine fibroids.

STUDY DESIGN: Patients with symptomatic uterine fibroids who were eligible for hysterectomy were assigned randomly 1:1 to hysterectomy or UAE. Endpoints after 5 years were reintervention rates, menorrhagia, and HRQOL measures that were assessed by validated questionnaires.

RESULTS: Patients were assigned randomly to UAE (n=88) or hysterectomy (n=89). Five years after treatment 23 of 81 UAE patients (28.4%) had undergone a hysterectomy because of insufficient improvement of complaints (24.7% after successful UAE). HRQOL measures improved significantly and remained stable until the 5-year follow-up evaluation, with no differences between the groups. UAE had a positive effect both on urinary and defecation function.

CONCLUSION: UAE is a well-established alternative to hysterectomy about which patients should be counseled. (Cont'd on page 3)

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Prevalence of Lymph Node Metastasis in Primary Mucinous Carcinoma of the Ovary

Kathleen M. Schmeler, MD, Xia Tao, MD, Michael Frumovitz, MD, MPH, Michael T. Deavers, MD, Charlotte C. Sun, DrPH, Anil K. Sood, MD, Jubilee Brown, MD, David M. Gershenson, MD, and Pedro T. Ramirez, MD

(Obstet Gynecol 2010; 116:269-73)

OBJECTIVE: To estimate the prevalence of lymph node involvement in women with primary mucinous ovarian carcinomas.

METHODS: A retrospective study was performed of patients with primary mucinous ovarian carcinomas evaluated at a single institution between 1985 and 2007. A gynecologic oncology pathologist evaluated all cases. Patients with tumors of low malignant potential and mucinous carcinomas metastatic to the ovary from other primary sites were excluded.

RESULTS: Patients with primary mucinous ovarian carcinomas were identified (n_107). All patients underwent primary surgery. At time of surgery, 93 patients (87%) had tumors that grossly appeared to be confined to the ovary, and 14 patients (13%) had evidence of extraovarian disease. Of the 93 patients with tumors that grossly appeared to be confined to the ovary at surgical exploration, 51 (55%) underwent lymphadenectomy (n_27 pelvic and paraaortic, n_19 pelvic only, n_5 paraaortic only).

Of these 51 patients, none had metastatic disease to the pelvic or paraaortic lymph nodes. In addition, there were no significant differences in progression-free survival and overall survival rates between the patients who underwent lymphadenectomy and those who did not.

CONCLUSION: There were no cases of isolated lymph node metastases among women with primary mucinous carcinoma grossly confined to the ovary, suggesting that routine lymphadenectomy may be omitted in these patients.

LEVEL OF EVIDENCE: III

Bipolar Radiofrequency Endometrial Ablation Compared With Hydrothermablation for Dysfunctional Uterine Bleeding
A Randomized Controlled Trial

Josien P.M. Penninx, MD, Ben Willem Mol, MD, Ruben Engels, MD, Minouche M.E. van Rumste, MD, Channa Kleijn, MD, Carolien A.M. Koks, MD, PhD, Roy F.P.M. Kruitwagen, MD, and Marlies Y. Bongers, MD, PhD

(Obstet Gynecol 2010;116:819-26)

OBJECTIVE: To compare the effectiveness of two second-generation ablation techniques, bipolar radiofrequency impedance-controlled endometrial ablation and hydrothermablation, in the treatment of menorrhagia.

METHODS: This study was a double-blind, randomized controlled trial, which took place in a large teaching hospital in The Netherlands with 500 beds. Women with menorrhagia were randomly allocated to bipolar radiofrequency ablation (bipolar group) and hydrothermablation (hydrotherm group). At follow-up, both women and observers remained unaware of the type of treatment that had been performed. The primary outcome was amenorrhea. Secondary outcome measures were patient satisfaction and reintervention.

RESULTS: We included 160 women in the study, of which 82 were allocated to the bipolar group and 78 to the hydrotherm group. No complications occurred in either of the treatment groups. After 12 months, 87% (65 of 75) of the patients in the bipolar group were completely satisfied with the result of the treatment compared with 68% (48 of 71) in the hydrotherm group (relative risk 1.3, 95% confidence interval [CI] 1.03–1.6). The amenorrhea rates were 47% (35 of 75) in the bipolar group and 24% (17 of 71) in the hydrotherm group (relative risk 2.0, 95% CI 1.2–3.1). The relative risks for a reintervention in the bipolar group compared with the hydrotherm group was 0.29 (95% CI 0.12–0.67), whereas for hysterectomy, this was 0.49 (95% CI 0.15–1.5).

CONCLUSION: In the treatment of menorrhagia, bipolar radiofrequency endometrial ablation system is superior to hydrothermablation.

LEVEL OF EVIDENCE: I (Cont'd on page 4)

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Prevention of Preeclampsia and Intrauterine Growth Restriction With Aspirin Started in Early Pregnancy
A Meta-Analysis

Emmanuel Bujold, MD, MSc, Stéphanie Roberge, MSc, Yves Lacasse, MD, MSc, Marc Bureau, MD, François Audibert, MD, MSc, Sylvie Marcoux, MD, PhD, Jean-Claude Forest, MD, PhD, and Yves Giguère, MD, PhD

(Obstet Gynecol 2010;116:402-14)

OBJECTIVE: To estimate the effect of low-dose aspirin started in early pregnancy on the incidence of preeclampsia and intrauterine growth restriction (IUGR).

DATA SOURCES: A systematic review and meta-analysis were performed through electronic database searches (PubMed, Cochrane, Embase).

METHODS OF STUDY SELECTION: Randomized controlled trials of pregnant women at risk of preeclampsia who were assigned to receive aspirin or placebo (or no treatment) were reviewed. Secondary outcomes included IUGR, severe preeclampsia and preterm birth. The effect of aspirin was analyzed as a function of gestational age at initiation of the intervention (16 weeks of gestation or less, 16 weeks of gestation or more).

TABULATION, INTEGRATION, AND RESULTS: Thirty four randomized controlled trials met the inclusion criteria, including 27 studies (11,348 women) with follow-up for the outcome of preeclampsia. Low-dose aspirin started at 16 weeks or earlier was associated with a significant reduction in preeclampsia (relative risk [RR] 0.47, 95% confidence interval [CI] 0.34-0.65, prevalence in 9.3% treated compared with 21.3% control) and IUGR (RR 0.44, 95% CI 0.30-0.65, 7% treated compared with 16.3% control), whereas aspirin started after 16 weeks was not (preeclampsia: RR 0.81, 95% CI 0.63-1.03, prevalence in 7.3% treated compared with 8.1% control; IUGR: RR 0.98, 95% CI 0.87-1.10, 10.3% treated compared with 10.5% control). Low-dose aspirin started at 16 weeks or earlier also was associated with a reduction in severe

preeclampsia (RR 0.09, 95% CI 0.02- 0.37, 0.7% treated compared with 15.0% control), gestational hypertension (RR 0.62, 95% CI 0.45- 0.84, 16.7% treated compared with 29.7% control), and preterm birth (RR 0.22, 95% CI 0.10-0.49, 3.5% treated compared with 16.9% control). Of note, all studies for which aspirin had been started at 16 weeks or earlier included women identified to be at moderate or high risk for preeclampsia.

CONCLUSION: Low-dose aspirin initiated in early pregnancy is an efficient method of reducing the incidence of preeclampsia and IUGR.

UPCOMING EVENTS:

HGOS General Meeting

October 7, 2010
Houston, TX - Damian's Cucina Italiana
Contact: Lisa Gasper 713-661-1839

ACOG District XI Meeting

(in conjunction with Districts VII, VIII, and IX)
October 14 - 16, 2010
Maui, Hawaii
Contact: Vicky Mitchell 202-863-2530

TMA Fall Conference

October 15-16
Austin, TX - Hyatt Regency
Contact: 1-800-880-1300

ACOG Coding Workshop

October 15 - 17, 2010
San Antonio, TX
Contact: Karen Barnes 202-863-2498

ACOG District Meeting (AFD)

October 17 - 20, 2010
San Antonio, TX
Contact: Valerie Borden 202-863-2571

Methodist Center for Restorative Pelvic Medicine CME Symposium - Stop the Leaks

October 30, 2010
Houston, TX
Hotel ZaZa
713-441-4971