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Evidence-based commentaries on women's reproductive health

ABSTRACT & COMMENTARY

Measuring the Quality of Care Provided to Women with Pelvic Organ Prolapse

By Chiara Ghetti, MD

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Dr. Ghetti reports no financial relationships relevant to this field of study.

SYNOPSIS: Quality can be measured for women with pelvic organ prolapse, and in many areas the care of women with pelvic organ prolapse can be improved.

SOURCE: Alas AN, et al. Measuring the quality of care provided to women with pelvic organ prolapse. *Am J Obstet Gynecol* 2015;212:471.e1-9.

The objective of this study was to assess the feasibility of recently developed quality indicators in the care of women with pelvic organ prolapse and identify areas with possible deficits in care. Previously, an expert panel developed quality indicators that addressed screening, diagnosis, and management of prolapse. Study subjects were identified in a hospital-based multispecialty group based on ICD-9 code for prolapse (codes 618.0-618.9), and eligible subjects needed to have a complaint of prolapse and qualify for at least one quality indicator. Trained nurses with experience in chart abstraction and quality assessment performed a retrospective chart abstraction. Care was assessed at the patient level, and abstractors considered all parts of the patient's records when assessing whether a patient was eligible for and received the indicated care over a 6-month period of time. Ten percent of records were reabstracted to evaluate the interrater agreement, which was 97%.

In the 238 patients identified, 98% of those with a new complaint of prolapse had a pelvic exam. The extent of prolapse was not documented in 25%. Only 43% of records had documentation that pessary management was discussed with a patient. Among those managed with pessaries, the majority (98%) had vaginal exams at least every 6 months. Of those undergoing surgery, only 49% had complete prolapse staging preoperatively. Only 20% of women having apical surgery had documented counseling

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Farewell and Welcome

Congratulations to Professor Michael Thomas on his election in June to a 3- to 6-year term as a member of the Reproductive Endocrinology/Infertility Division of the American Board of Obstetrics & Gynecology. Unfortunately, this new obligation will require Mike to step down from his role as an associate editor of *OB/GYN Clinical Alert*. Please join me in wishing him well with this new activity. His great commentaries over the last two years will be missed.

Although we will miss Mike, I am extremely pleased to announce that Dr. Robert Rebar has agreed to join the editorial board as a regular contributor with this issue. Bob served as the Executive Director of the American Society for Reproductive Medicine (ASRM) from 2003 through 2013, and is currently Professor of Obstetrics and Gynecology at the new Western Michigan University Homer Stryker M.D. School of Medicine. Prior to accepting the position with ASRM, he was Professor and Head of the Division of Reproductive Endocrinology and Infertility in the Department of Obstetrics and Gynecology at the Northwestern University School of Medicine, and Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Cincinnati College of Medicine. His numerous successful REI trainees include our own Dr. Thomas! We are fortunate to attract someone of Dr. Rebar's caliber to provide commentary on the critical areas of reproductive endocrinology, menopause, and infertility. I look forward to the important clinical insights that his unique perspective will bring to the current literature. Please join me in welcoming Dr. Rebar to *OB/GYN Clinical Alert*.

about different surgical options. Only 48% of women undergoing hysterectomy for prolapse had a concomitant vault suspension. Only 14% of patients had documented counseling regarding risks of mesh, and only one-third of women implanted with mesh for prolapse had documented follow-up at 1 year. In the majority of women (86%) undergoing anterior wall or apical repair, cystoscopy was performed.

■ COMMENTARY

Today's healthcare environment is increasingly focused on patient-centered clinical outcomes and quality assessment and improvement. In recent years, the American Urogynecologic Society determined that quality-of-care research is needed in the area of pelvic floor disorders.[1] This is one of the first studies evaluating the feasibility of assessing quality indicators in the care of women with prolapse. It also identified that care was insufficient and that only two-thirds of patients receive the minimum of care, including recommended evaluation, treatment, and follow-up, based on the quality indicators for which they qualified. A multispecialty group that included primary care providers, female pelvic medicine and reconstructive surgery specialists, general gynecologists, and urologists cared for the patients in the study.

Five of the 14 reported quality indicators were most striking in lack of compliance. These include: 1) documenting the extent of prolapse in all comportments (anterior, posterior, and apical); 2) ensuring all women with prolapse are offered conservative management as a first-line treatment; 3) counseling women who undergo surgery for an apical defect about alternative surgical approaches, unique success and failure rates, and complication profiles; 4) counseling women undergoing transvaginal mesh placement about the risk of mesh complications; and 5) performing concomitant apical support procedures at time of hysterectomies for prolapse. The findings of this study can serve as a basis for quality improvement interventions in our own practices.

While not a randomized trial, the findings of this study have immediate clinical impact to gynecologists and subspecialists alike. This study demonstrates that quality indicators can be successfully used to assess the care delivered to patients with prolapse. Most likely, hospitals, payers, and patients will use quality indicators in the near future to measure the quality of care provided by physicians. For providers who currently care for women with prolapse, quality indicators will likely be adopted that are very similar to those used in this study. It would behoove us to become familiar with these indicators and begin to incorporate them in our daily practice. ■

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ABSTRACT & COMMENTARY

Another Study Shows Increased VTE Risk with Newer Progestins — Time for Concern?

By Jeffrey T. Jensen, MD, MPH

Leon Speroff Professor and Vice Chair for Research, Department of Obstetrics and Gynecology, Oregon Health & Science University, Portland

Dr. Jensen reports he is a consultant for and receives grant/research support from HRA Pharma, Bayer Healthcare, Merck, Agile Pharm, Population Council, AbbVie, Evofem, and ContraMed; and is a consultant for Teva Pharmaceuticals and MicroChips.

SYNOPSIS: A new population-based, case-control study using two large primary care databases found an elevated risk of venous thromboembolism in users of combined pills containing desogestrel and drospirenone compared to levonorgestrel. However, several findings, including an inverse dose response for estrogen, suggest that preferential prescribing continues to blur this association.

SOURCE: Vinogradova Y, et al. Use of combined oral contraceptives and risk of venous thromboembolism: Nested case-control studies using the QResearch and CPRD databases. *BMJ* 2015;350:h2135 (available online in advance of print).

The authors used two large United Kingdom general practice databases, the Clinical Practice Research Datalink (CPRD; 618 practices) and the QResearch primary care database (722 practices), to provide data for a case-control study. The stated objective was to quantify the associations between use of combined oral contraceptives (COC) and risk of venous thrombosis (VTE), adjusting for comorbidities and other available confounding factors. In particular, they sought to analyze and quantify risks associated with various types of progestogens and different doses of estrogen. Cases were women aged 15-49 years with a first diagnosis of venous thromboembolism in 2001-2013. Each case was matched with up to five controls by age, practice, and calendar year. Odds ratios were calculated for incident VTE and use of COCs in the previous year, and adjusted for smoking status, alcohol consumption, ethnic group, body mass index, comorbidities, and other contraceptive drugs. Results were calculated separately for the two datasets and then combined. A total of 10,562 cases of VTE were identified (5062 from CPRD and 5500 from QResearch). Compared to non-use of hormonal contraception, current exposure to any COC was associated with an increased risk of venous thromboembolism (adjusted odds ratio [aOR], 2.97; 95% confidence interval [CI], 2.78-3.17). Setting levonorgestrel (LNG) products as the reference, an increased odds of VTE was seen in women using desogestrel (aOR, 1.80; CI, 1.52-2.13), gestodene (aOR, 1.52; CI, 1.24-1.87), drospirenone (aOR, 1.75; CI, 1.43-2.12), and cyproterone (aOR, 1.80; CI, 1.49-2.18). The odds were not increased for norgestimate or norethisterone (norethindrone). The authors estimated that compared to non-users, the number of extra cases of venous thromboembolism expected per year for 10,000 COC-treated women would be lowest for levonorgestrel (6 cases; CI, 5-7) and norgestimate (6; CI, 5-8), and highest for desogestrel (14; CI, 11-17) and cyproterone (14; CI, 11-17).

■ COMMENTARY

I first learned about this publication from Leon Speroff, MD. He, in turn, had been notified by another Dr. Speroff, his daughter Elena, an adult nurse practitioner in Boise who recently completed her doctorate in nursing practice. Elena had forwarded a commentary from Physician's First Watch, an electronic newsletter. The headline for a review of this manuscript was "Link between newer oral contraceptives and excess VTE risk strengthened." Really?

Strengths of the manuscript include the large number of cases of VTE (10,562) and extensive use of matching of cases to control. Since the databases provided all of the associated diagnoses recorded by general practitioners for each case and control, a wide variety of comorbid conditions were available for adjustment. Of particular importance was the availability of information on body mass index (BMI) in most, but not all, of the cases (12-20% not available) and controls (16-22%). The final analyses were adjusted for BMI, smoking status, alcohol consumption, ethnic group, chronic and acute conditions, and use of other hormonal contraceptives. However, key confounders that may influence prescription (polycystic ovarian syndrome, acne, and hirsutism) were not available or considered in the adjustment. To be fair, in response to an online comment, the authors recalculated the ORs with "additional adjustment for possible symptoms of polycystic ovary syndrome," and noted that this did not change the magnitude or significance of their findings (see http://www.bmj.com/content/350/bmj.h2135/rapid-responses).

However, it is unlikely this adjustment completely corrected for the core problem with database and case-control studies — preferential prescription of low androgen progestogens to women at higher risk of VTE.[1,2] Another interesting finding suggesting prescription bias and healthy user effect

Table 1: Inverse Dose-response Relationships with Dose of Estrogen with Desogestrel and Cyproterone

Study	Reference	Case Patients	OR	95% CI	Case Patients	OR	95% CI
		Desogestrel + 20 mcg EE			Desogestrel + 30 mcg EE		
WHO	Nonusers	8	38.2	4.5-325	27	7.6	3.9-14.7
Transnational	LNG	13	2.8	1.3-6.5	32	1.5	0.9-2.5
BCDSP (Jick)	LNG	4	2.7	NA	26	1.9	NA
MediPlus UK	LNG	13	2.9	0.9-10.0	19	0.6	0.3-1.5
		Cyproterone + 35 mcg EE			Cyproterone + 50 mcg EE		
WHO	LNG	9	5.1	1.3-20.3	9	1.3	0.5-3.8

Adapted from: Farmer RD, Lawrenson RA. Oral contraceptives and venous thromboembolic disease: The findings from database studies in the United Kingdom and Germany. *Am J Obstet Gynecol* 1998; 179 (3 Pt 2):S78-S86.

is the analysis in the current paper for duration of use; a significantly increased risk for new users and restarters was seen only for LNG products. One possible explanation (not reported by the authors) is that large numbers of women have been moved from newer progestogens to LNG in recent years, increasing the high-risk pool among LNG users. It may take another decade to sort this out in epidemiologic studies.

Preferential prescribing of newer low-dose/low-androgen products is also the likely explanation for the findings seen with respect to estrogen dose. Farmer initially pointed out the "inverse-dose response" for ethinyl estradiol (EE) and VTE risk during the first pill scare in the 1990s (*see Table 1*).[3] A biologically non-plausible increase in VTE risk was seen with more recently introduced 20 mcg EE desogestrel and cyproterone pills compared to higher-dose pills with the same dose of the progestogen. Similar results are observed (but not discussed) in the current paper. I calculated the crude OR for VTE (compared to LNG) for 20 mcg EE norethisterone at 1.25 (CI, 0.95-1.64), while for 30/40 mcg the OR is 1.02 (CI, 0.82-1.27). For 20 mcg gestodene, the OR is 2.24 (CI, 1.46-3.44) while for 30 mcg the OR is reduced at 1.46 (CI, 1.18-1.80). Only with the desogestrel preparations was the risk higher with 30/40 mcg EE (OR 1.87; CI, 1.54-2.25) than for 20 mcg (OR, 1.71; CI, 1.34-2.17). Data for 20 mcg and 30 mcg drospirenone was not provided. The only explanations for this "inverse dose response" are preferential prescription of lower estrogen pills to women at greater risk of VTE and the healthy user effect (new starts and switchers have a higher risk of VTE than continuing users).[4] This provides strong evidence that the observed differential effect of progestogen type seen in the Vinogradova paper also reflects preferential prescribing of newer low-androgen pills to high-risk women.

To conclude, this new publication does not "strengthen the association" of low-androgen progestogens and VTE risk. Although the paper is consistent with the findings of the quasi-prospective Danish database studies performed by Lidegaard,[5] the methodology is inferior to the true prospective post-marketing studies conducted by Dinger and the ZEG Institute.[6-8] The passion of this issue is evident in every publication. The current manuscript places numbers of actual women at risk in the abstract, suggesting an additional eight cases of VTE per 10,000 women using desogestrel compared to LNG COCs. However, I do not find these data convincing and neither should you.

My recommendations remain unchanged: Approach the subject of pill prescription in terms of efficacy and safety. For many women, a long-acting reversible contraceptive method may be better. For women who prefer to use an OC, most will do very well on low-cost generic pills, and generally these should be recommended first. Moving to first-line prescription of LNG products is reasonable as they are inexpensive and effective. However, some women may have baseline concerns about androgen-related side effects, such as acne, and this should be taken into account during counseling. Although there are insufficient data to compare various preparations head-to-head, low androgen pills may be preferable under these circumstances. Other medical problems (cyclic mood disorders, heavy bleeding) also should be considered. All combined products carry an increase in VTE risk that is 2-3 times higher than baseline, but about half as high as the risk seen in pregnancy. Although I personally disagree with the conclusion that drospirenone and desogestrel (including the etonogestrel ring) products are associated with an increase in risk, the FDA mandated package insert of drospirenone pills discusses this, so it needs to be mentioned. During the clinical encounter, you and your patient need to decide on her priorities and goals for prescription of a combined hormonal method. You should carefully document both the pertinent positive and negative findings on your history and exam, as well as the clinical decision-making used to choose a product. As mentioned previously, I think this practice provides protection to you and choice to your patient. ■

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ABSTRACT & COMMENTARY

Vulvar Lichen Sclerosus: How Long Should Women Be Treated?

By Rebecca H. Allen, MD, MPH

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Dr. Allen reports she is a Nexplanon trainer for Merck, a Liletta trainer for Actavis, and on the advisory board for Bayer, Actavis, and Vermillion.

SYNOPSIS: In this prospective cohort study, women with vulvar lichen sclerosus who were compliant with preventive topical corticosteroids were significantly less likely to develop vulvar intraepithelial neoplasia and squamous cell carcinoma than women who were partially compliant with therapy.

SOURCE: Lee A, et al. Long-term management of adult vulvar lichen sclerosus: A prospective cohort study of 507 women. *JAMA Dermatol* Published online June 12, 2015.

This is an Australian prospective cohort study of 507 adult women with biopsy-proven vulvar lichen sclerosus from January 2008 to September 2014 in a single practice. The cohort was divided into two groups based on self-report of compliance: compliant (followed treatment instructions most or all of the time) and partially compliant (followed treatment instructions some or a little of the time or not at all). All women had to have at least 2 years of follow-up, and follow-up occurred every 3 to 6 months for the first 2 years, then annually thereafter. Data recorded included age, ethnicity, menopausal status, symptoms, clinical features, severity of disease, and adverse effects. Initial treatment regimens were determined based on severity of hyperkeratosis:

- Very mild: 1% hydrocortisone ointment
- Mild: 0.1% methylprednisolone aceponate ointment
- Moderate: 0.05% betamethasone dipropionate ointment
- Severe: 0.05% betamethasone dipropionate ointment
- Very severe: 0.05% clobetasol propionate ointment

Once the vulvar skin had returned to normal color and texture and symptoms were alleviated, long-term preventive management was initiated with a gradual reduction in topical corticosteroid potency. However, women were instructed to use the ointment at least three times a week for maintenance, whether or not they were having symptoms.

The mean age of the cohort was 55.4 years (range 18-86 years) with a mean duration of symptoms of 5 years (range 0.1-40 years). The vast majority of the sample was white (94%) and almost 70% were postmenopausal. The mean duration of follow-up was 4.7 years (range 2-6.8 years). Nearly all women were symptomatic (97%) and three-quarters of those who were sexually active had dyspareunia. Most patients had mild-to-moderate disease; however, 30% had severe disease. Approximately two-thirds of the cohort (70%) reported that they were compliant with treatment and 30% were partially compliant. In total, 86% of compliant patients achieved complete resolution of symptoms and skin changes for the long-term compared to 73% of the partially compliant patients. There were no cases of squamous cell carcinoma (SCC) or vulvar intraepithelial neoplasia (VIN) in the compliant group and seven cases in the partially compliant group (3 SCC and 4 VIN, $P < 0.001$). There was no difference between the two groups in corticosteroid dermatitis (2.2% vs 4%, $P = 0.37$) or atrophy (1.1% vs 2%, $P = 0.43$).

■ COMMENTARY

Vulvar lichen sclerosus is a skin condition that causes itching, irritation, and dyspareunia.[1] Characteristically it involves loss of normal vulvar architecture, which can include fusion of the clitoral hood, labia minora fused to the labia majora leading to complete resorption of minora, and posterior midline fusion, which narrows the vaginal opening. Accepted initial treatment for vulvar lichen sclerosus includes topical superpotent steroid ointment, such as 0.05% clobetasol propionate.[1] If left untreated, it is estimated that 5% of vulvar lichen sclerosus cases will progress to squamous cell carcinoma.[2] The ideal long-term management of vulvar lichen sclerosus is unclear. Some experts advocate lifelong preventive therapy while other experts believe that only severe cases need to be regularly

followed. Some practitioners advocate treating only when symptoms are bothersome. In addition, there is concern over the possible risk of adverse effects of chronic topical corticosteroids such as corticosteroid dermatitis and skin atrophy.[3] This prospective cohort study set out to determine the answer to that question.

This is one of the largest studies of vulvar lichen sclerosus in the literature, with an average follow-up of 4.7 years. Since the ideal study design, a randomized controlled trial, was not able to be performed, the authors divided their cohort into those who were compliant with therapy and those who were partially compliant. The partially compliant group contained women who applied treatment only when symptomatic, forgot to use their treatment, used the treatment less often than recommended, or refused any topical corticosteroid more potent than 1% hydrocortisone for fear of side effects. The authors were able to show significantly higher levels of symptom resolution, reduced progression of adhesions or scarring, and improvement in dyspareunia for the compliant group compared to the partially compliant group. Importantly, no cases of VIN or squamous cell carcinoma developed in the compliant group, and side effects of long-term corticosteroid treatment were uncommon. The weakness of this study is the reliance on self-report of the woman as to whether or not she had been compliant. Without prospective data collection, such as diaries, this kind of reporting can be subject to many biases. Nevertheless, this study adds important information to the treatment of vulvar lichen sclerosus. Women who are compliant with therapy can achieve both remission of symptoms and prevent progression of scarring and the development of SCC and VIN. This should motivate women to adhere to preventive therapy. Although no randomized controlled trials provide evidence of the most effective steroid regimen, a reasonable approach is to begin with once-daily application of ultrapotent topical steroids for 4 weeks, tapering to alternate days for 4 weeks, followed by 4 weeks of twice-weekly application.[1] This protocol will need to be individualized to the patient, as some women will need longer initial treatment periods to control symptoms before reaching maintenance. Once patients reach the maintenance phase of treatment (2-3 times weekly), they should be reminded to return to be seen at least annually and as needed if persistent lesions appear for biopsy evaluation to rule out VIN and SCC.[3] This study adds valuable information to providers about patient counseling regarding the prognosis of vulvar lichen sclerosus. ■

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SPECIAL FEATURE

Mammography and the Overdiagnosis of Breast Cancer: What to Do?

By Jeffrey T. Jensen, MD, MPH

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Dr. Jensen reports he is a consultant for and receives grant/research support from HRA Pharma, Bayer Healthcare, Merck, Agile Pharm, Population Council, AbbVie, Evofem, and ContraMed; and is a consultant for Teva Pharmaceuticals and MicroChips.

SYNOPSIS: A new study reports that in the United States, the incidence of breast cancer is higher in counties with high rates of mammography screening, but screening is not associated with a decrease in breast cancer deaths. The decision of whether and how often to perform mammography requires a discussion of the potential consequences of both true positive and false positive screening tests.

SOURCE: Harding C, et al. Breast cancer screening, incidence, and mortality across U.S. counties. *JAMA Intern Med* 2015; Jul 6. doi: 10.1001/jamainternmed.2015.3043. [Epub ahead of print].

A new study by Harding et al in *JAMA Internal Medicine* took advantage of the natural variation in screening mammography rates across the United States to investigate the associations of screening with breast cancer incidence, tumor size, and mortality using an ecological study design.[1] The study population was 16 million women 40 years of age or older who resided in 547 counties reporting to the Surveillance, Epidemiology, and End Results cancer registries during the year 2000. During that year 53,207 women within this population were diagnosed with breast cancer, and 10-year follow-up was available for 95%. The study exposure was the percentage of women who had a mammogram in the past 2 years in each county as published by the National Cancer Institute's Small Area Estimates for Screening Behaviors program. The main outcome measure was the breast cancer incidence in 2000 and incidence-based breast cancer mortality during the 10-year follow-up. The incidence and mortality calculated for each county were

adjusted for age to the U.S. population. The size of the tumor was also correlated to mammogram exposure in the population.

Although a positive correlation was found across these U.S. counties, between the extent of mammogram screening and breast cancer incidence (weighted r = 0.54; $P < 0.001$), there was no correlation between screening and breast cancer mortality over the 10 years of follow-up (weighted r = 0.00; $P = 0.98$). Looking across all counties, an absolute increase of 10 percentage points in the extent of screening was accompanied by 16% more breast cancer diagnoses (relative risk [RR], 1.16; 95% confidence interval [CI], 1.13-1.19) but no significant reduction in breast cancer deaths (RR, 1.01; CI, 0.96-1.06). An increase of 10 percentage points in screening rates was also associated with a significant increase in the incidence of both small (< 2 cm; RR, 1.25; CI, 1.18-1.32) and large (RR, 1.07; CI, 1.02-1.12) breast cancers, but the effect for large tumors was not clinically important. Put another way, screening increased the detection of small tumors but not large tumors. The authors concluded that these findings — an increase in the diagnosis of additional small cancers with no concomitant decline in the detection of larger cancers or breast cancer mortality — support the conclusion that screening mammography leads to widespread overdiagnosis.

I have previously discussed the results from several studies[2,3] that support the conclusions of Harding et al that mammography results in widespread overdiagnosis of breast cancer. Overdiagnosis is a true positive result of screening that fails to result in a net benefit to the patient. In the case of breast cancer overdiagnosis, the possibility of harm is real when one considers mastectomy, chemotherapy, and out-of-pocket treatment costs. This is in addition to the false-positive screens that result in additional unnecessary worry and follow-up interventions.[4] However, a companion commentary by Joann Elmore published in the same issue of *JAMA Internal Medicine* eloquently states the clinical conundrum: "Women will increasingly approach their physicians with questions and concerns about overdiagnosis, and we have no clear answers to provide. We do not know the actual percentage of overdiagnosed cases among women screened, and we are not able to identify which women with newly diagnosed DCIS or invasive cancer are over-diagnosed. Many screening guidelines now mandate shared and informed decision making in the patient-physician relationship, but this is not an easy task."[5]

Since it is not possible for us to determine which early breast cancers will behave in an indolent fashion and which will be aggressive, the decision to screen must be personal. This requires a different type of counseling than most women receive. Consider whether your own discussions reflect this controversy. The commentary by Elmore cited three studies that should influence the discussions you have with patients tomorrow. First, while most women (96.3%) report that their healthcare providers discussed the benefits of screening mammography, few (19.5%) mention that their provider discussed potential harms such as overdiagnosis.[6]

In the second study, the investigators conducted focus groups of Australian women to explore how awareness of overdiagnosis might influence attitudes and intentions about screening mammography.[7] While subjects overwhelmingly reacted to information about overdiagnosis with surprise, the effects on attitudes to screening varied. About half remained committed to screening despite the problems associated with overdiagnosis, while others would give further thought to the screening decision or to a treatment decision if a screen was positive. Regardless of the decision, most participants felt that receiving information regarding overdiagnosis was important in order to make an informed choice. Of interest, some subjects expressed suspicion that overdiagnosis research was actually a government plot to cut funding for mammography screening! The authors of this qualitative study then went on to complete a randomized clinical trial that evaluated the effects of a decision aid providing information about the concept and frequency of overdiagnosis.[8] They found that compared to controls who did not use the decision aid, users of the aid reported a significant increase in overall knowledge (29% vs 17%; $P < 0.0001$), with fewer users expressing positive attitudes toward screening (69% vs 83%; $P < 0.0001$) and intention to be screened (74% vs 87%; $P < 0.0001$).

Taken together, these studies suggest that giving women more information will help them come to the best decision. Many will chose to continue annual screening. Some will choose a less frequent interval or will avoid mammography screening altogether. You don't need a decision aid; you just need to take a little extra time in counseling for this important decision. Although this takes a formally routine conversation to a different level of uncertainty, your patients will appreciate the honest and extra attention.

As was true in the qualitative study, I find most patients in my practice regard the limitations of mammography surprising and somewhat disappointing. Although both true positives (overdiagnosis) and false positives from mammography can result in real harm, a better alternative does not exist. The U.S. Preventive Services Task Force (USPSTF) recommends against routine screening mammography in women age 40-49 years, concluding that the risk of harm attributable to screening exceeds the potential benefit for low-risk women.[4] Mammography for women age 50-74 years is recommended, but only every 2 years, and the USPSTF concluded that the evidence of additional benefits and harms of screening mammography in women 75 years or older was inconclusive. Based on all this information, some of my patients have decided to reduce the interval of screening mammograms and a few have discontinued screening. More than half accept these limitations and continue with annual screening. Providing information and choice allows a woman to make the best decision for herself. ■

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CME QUESTIONS

1. This study of women with pelvic organ prolapse found providers most compliant with which of the following quality indicators?
a. Documenting extent of prolapse in all comportments
b. Ensuring all women with prolapse are offered conservative management as a first-line treatment
c. Performing vaginal exam every 6 months in women managed with a pessary
d. Counseling women undergoing transvaginal mesh placement about the risk of mesh complications
e. Performing concomitant apical support procedures at time of hysterectomies for prolapse

2. The primary conclusion of the new U.K. study of hormonal contraception and VTE risk can be summarized as which of the following?
a. The limitations of the case-control design suggest that prescription bias may explain the finding of increased odds ratio of VTE risk seen with desogestrel, drospirenone, and cyproterone combined pills compared to levonorgestrel.
b. All women of northern European background should have a screening test for the Factor V Leiden mutation before any hormonal contraception prescription.
c. Obese women should always use a norethindrone containing 30 mcg EE pill.
d. Women with acne have a reduced risk of VTE when using desogestrel combined pills compared to levonorgestrel combined pills.

3. In the study by Lee et al, women with vulvar lichen sclerosus who were compliant with preventive corticosteroid therapy were less likely to develop VIN or SCC.
a. True
b. False

4. Using data from the Surveillance, Epidemiology, and End Results cancer registries and county statistics for mammogram screening as published by the National Cancer Institute's Small Area Estimates for Screening Behaviors program, Harding et al found that:
a. as the extent of mammography screening increased, the incidence of breast cancer increased.
b. as the extent of mammography screening increased, the detection of large breast cancers decreased.
c. as the extent of mammography screening increased, 10-year breast cancer mortality decreased.
d. All of the above

CME OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- Explain the latest data regarding diagnosis and treatment of various diseases affecting women;
- Discuss new data concerning prenatal care, neonatal health, and complications arising in pregnancy and the perinatal period; and
- Discuss the advantages, disadvantages, and cost-effectiveness of new testing procedures in women's health.

[IN FUTURE ISSUES]

Morcellation: Has it Improved Outcomes or Put Women at Risk?