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Evidence-based commentaries on women's reproductive health

ABSTRACT & COMMENTARY

After the WHI: How Is Your Sex Life?

By Jeffrey T. Jensen, MD, MPH

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Dr. Jensen reports he is a consultant for and receives grant/research support from Bayer, Merck, ContraMed, and FHI360; receives grant/research support from Abbvie, HRA Pharma, Medicines 360, and CONRAD; and is a consultant for the Population Council.

SYNOPSIS: Women who discontinued systemic postmenopausal hormonal therapy following participation in the Women's Health Initiative studies experienced an increase in vaginal and sexual symptoms.

SOURCE: Gass M, Larson J, Cochrane B, et al. Sexual activity and vaginal symptoms in the postintervention phase of the Women's Health Initiative Hormone Therapy Trials. *Menopause* 2018;25:252-264.

Although it is well-established that hormonal therapy (HT) improves symptoms of genital atrophy, the effect of postmenopausal HT on sexual function remains controversial. Gass and colleagues analyzed data from the postintervention phase of the Women's Health Initiative (WHI) study to determine the effect of HT discontinuation on sexual function.

The WHI studies randomized 27,347 postmenopausal women aged 50 to 79 years to receive either combined hormonal therapy (daily oral conjugated equine estrogens [CEE] 0.625 mg plus oral 2.5 mg medroxyprogesterone acetate) or, if hysterectomized, estrogen-only (CEE 0.625 mg) or placebo. Although the study excluded women symptomatic with vasomotor symptoms, genital symptoms were not specified as exclusion criteria. All participants completed extensive questionnaires at baseline that included sexual history. Both studies were discontinued prematurely, and women received notification of their randomization group, breaking the blind. After this notification, subjects were invited to participate in a postintervention follow-up survey. Investigators added questions to these postintervention surveys regarding sexual function, which included seven key clinical characteristics of sexual activity: frequency of intercourse, discomfort with intercourse, desire, arousal, ability to climax, vaginal tightness, and satisfaction with sexual activity. The response options differed slightly between the estrogen-progestin therapy (EPT; compared current symptoms with symptoms while on treatment)

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and estrogen therapy (ET; asked about current symptom frequency only) studies.

A total of 13,902 women (9,450 in the EPT trial; 4,452 in the ET trial) responded to postintervention questionnaires, representing response rates of 93% and 90%, respectively. The majority (92%) of responses to these surveys were received between eight and 13 months after each trial stopped. There was no difference in the response rate or baseline characteristics between subjects randomized to active treatment or placebo. Overall, women with medical conditions (e.g., cancer, myocardial infarction, congestive heart failure, diabetes mellitus, hyperlipidemia, hypertension, arthritis, and depression) reported significantly lower levels of sexual activity than healthy women. Although the survey asked questions about sexual activity with and without a partner, about half of the women reported no sexual activity since discontinuing HT, and the main explanation for this was lack of a partner. Sexual activity also declined with age, from 46% among women younger than 60 years of age to only 9% among women older than 80 years of age.

The change in function following discontinuation of HT represents the primary results of interest. Here, we see a mixed effect. The prevalence of sexual activity postintervention was not significantly different between former EPT (36%) and placebo (34%, $P = 0.37$). However, women in the EPT study who had received active treatment during the intervention period were significantly more likely (20%) to report a decreased frequency of intercourse postintervention than the group formerly randomized to placebo (9%), and also more likely to report a decrease in desire (17% vs. 6%), arousal (17% vs. 7%), ability to climax (19% vs. 7%), and satisfaction with sexual activity (17% vs. 8%); an increase in tightness of vagina (12% vs. 3%); and discomfort with intercourse (15% vs. 3%).

Sexual activity reported by former ET users following discontinuation was 5.6% higher than placebo users (27.6% vs. 22.0%; $P < 0.001$). Only two of the sexual function items yielded statistically significant differences by intervention arm in the ET trial: Women formerly assigned to placebo reported both desire and arousal to be "rarely" or "not at all" present more frequently than those who had discontinued active treatment.

These results suggest that changes in sexual function occur over time in postmenopausal women, with HT associated with modest protection that declines following discontinuation.

■ COMMENTARY

The WHI continues to provide opportunity for investigators seeking to understand the benefits and risks of HT. Although the large sample size and randomized design are enormous strengths, representativeness remains a major criticism of the study, as the population enrolled was asymptomatic and approximately 10 years postmenopausal — a decade older than the age at which women commonly start HT. The older age and exclusion of women with vasomotor symptoms affects generalizability to healthy younger menopausal women. The exclusion of women with vasomotor symptoms also likely excluded many women with comorbid symptoms of vulvovaginal atrophy. This conclusion is reinforced by supplemental material presented by Gass et al; only 13% of sexually active women in the original WHI population reported vaginal dryness at enrollment.

So, can we learn anything from studying the sexual health of this population following discontinuation of HT? After notification of randomization that "broke the blind," was this effectively turning the WHI into a cohort study? A fundamental weakness is that the researchers asked subjects to recall sexual outcomes while on treatment (or placebo) and compare these to postintervention status. We do know that HT improved vaginal dryness after one year of treatment, decreasing to 8% among women assigned to HT while staying essentially the same among women randomized to placebo (12%). We also see a postintervention climb back to baseline (14%) among those formerly assigned to HT but a decrease to 8% among those who received placebo. Although this supports a rapid reversal of the treatment effect of HT, we can't ignore the fact that unblinding occurred. The decrease among placebo users suggests that women find other means of accommodating dryness over time, perhaps through the use of lubricants. The authors of a recently published study in *JAMA Internal Medicine* suggested that lubricants work just as well as vaginal estrogen, but the length of treatment and dose of estrogen may not have made this a fair comparison.[1] An alternative hypothesis is that some women simply avoid sex, for a myriad of reasons. While the proportion of women reporting sex with a partner postintervention did not differ between women randomized to active treatment and placebo in the EPT study, when the question was asked differently in the

ET study (e.g., over the past three months), significantly fewer former placebo users (37% vs. 44%) reported having had sex. Also, as noted above, women in the EPT group reported a significant decrease in the frequency of sex with a partner postintervention. The study did not provide any comparison of absolute frequency between the groups. Other studies have shown that intercourse frequency may be driven by male partners and is not associated with satisfying sex for women.

Although flawed, this postintervention follow-up study provides limited insight into the effects of discontinuation of HT on sexual symptoms. In the early 2000s, I saw a busy referral practice of women with vulvodynia and sexual pain disorders. Following the publicity of the initial findings of the WHI, I noticed a steep increase in new complaints of dyspareunia and a return of symptoms in many women with prior successful treatments for vulvar dermatoses. Many cases were associated with discontinuation of HT. Although a number of local hormonal and nonhormonal options will improve vulvovaginal symptoms, for many women the convenience of systemic HT will make sense, particularly when bone protection is considered. As clinicians, we need to bring sexual health into the conversation around menopausal HT. ■

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ABSTRACT & COMMENTARY

Can We Use Manual Vacuum Aspiration for Molar Pregnancies?

By Rebecca H. Allen, MD, MPH

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Dr. Allen reports she is a Nexplanon trainer for Merck.

SYNOPSIS: In this retrospective cohort study, manual vacuum aspiration in a hospital setting was equivalent to electric suction for uterine evacuation of molar pregnancy in terms of the risks of incomplete abortion and development of postmolar gestational trophoblastic disease.

SOURCE: Padron L, Rezende Filho J, Amim Junior J, et al. Manual compared with electric vacuum aspiration for treatment of molar pregnancy. *Obstet Gynecol* 2018;131:652-659.

Padron et al conducted this retrospective cohort study from January 2007 to December 2016 in Brazil to evaluate manual compared to electric vacuum aspiration for the treatment of molar pregnancy. Molar pregnancy (partial or complete) was confirmed on histology postoperatively. Standard preoperative evaluation at the study sites included complete metabolic profile, complete blood count, chest X-ray, and serum quantitative hCG, as well as pelvic ultrasound. All procedures were performed in an operating room setting and two units of packed red blood cells were reserved preoperatively for all subjects. Choice of vacuum source depended on the study site, as electric suction machines were not always available. All subjects received sharp curettage and total intravenous anesthesia. Oxytocin was not given routinely intraoperatively, but 10 units were administered intravenously in the recovery room over six hours as part of hospital protocol. All patients were observed for at least 24 hours and followed with serial hCG levels. Remission was defined as three consecutive weekly hCG values less than assay, followed by monthly hCG for six months in case of spontaneous remission and 12 months after completion of chemotherapy in cases of gestational trophoblastic neoplasia (GTN). Primary study outcomes were incomplete abortion (defined by clinical, hormonal, and ultrasound evaluation), uterine perforation, development of Asherman's syndrome (amenorrhea plus intrauterine synechia on hysteroscopy), and development of postmolar GTN.

A total of 1,727 women were included in the study with 1,206 undergoing electric vacuum aspiration (EVA) and 521 manual vacuum aspiration (MVA). There were no differences between the two groups in terms of age, parity, and gestational age at diagnosis. Approximately 80% in each group had complete molar pregnancies while 20% had partial molar pregnancies. Half of each group had ultrasound guidance during the procedure, which was determined by physician discretion or uterine size greater than dates (51.5% EVA vs. 49.8% MVA, $P = 0.174$), and almost 60% received oxytocin intraoperatively (58% EVA vs. 55.7% MVA, $P = 0.187$). Approximately 13% of subjects had an incomplete abortion in each group ($P = 0.949$). Operative times were shorter for the EVA group (25.3 vs. 34.2 minutes; $P < 0.001$), but there was a slightly higher rate of uterine perforation (0.7% vs. 0.0%; $P = 0.051$). There was no statistically significant difference between the two groups in the development of postmolar

GTN (14.2% EVA vs. 17.3% MVA; $P = 0.074$) or blood transfusion (6.3% EVA vs. 8.6% MVA; $P = 0.714$). There was a higher risk of Asherman's syndrome in the EVA group compared to the MVA group (5.2% vs. 1.3%; $P < 0.001$).

■ COMMENTARY

The treatment of molar pregnancy is uterine evacuation with a suction dilation and curettage (D&C).[1] In the United States, electric suction has been used because that is standard practice in American hospitals. Furthermore, for molar pregnancies that are diagnosed preoperatively, most OB/GYNs perform the procedure in a hospital operating room because of the risk of bleeding so they have access to a blood bank, intensive care unit, and anesthesia services. The manual vacuum aspirator was invented in the 1970s and currently is used worldwide to perform uterine evacuation whether for incomplete, spontaneous, or induced abortion.[2] Often, it is used in the United States for uterine evacuation in office settings in which an electric suction machine is not available. Padron et al undertook this study to determine the safety of MVA in the treatment of molar pregnancy. They reported that one of the study sites (Antonio Pedro University Hospital of Fluminense Federal University) did not have an electric suction machine, allowing them to perform a natural experiment.

The findings of this study are reassuring in that there were no differences between MVA and EVA in terms of incomplete abortion, blood transfusion, and development of postmolar GTN. I do find an incomplete abortion rate of 13% quite high, but the authors did not describe specifically how this was diagnosed. It may be that this complication occurs more frequently after molar pregnancy evacuation compared to normal pregnancy evacuation where incomplete abortion rates are low. It is not surprising that operative times are faster for electric suction, as it provides a constant suction source compared to the MVA syringe, which must be emptied after it is full and recharged. Although initially I thought this article was going to describe the use of MVA in the office for molar pregnancy, both groups had procedures done in a hospital operating room under anesthesia with 24 hours of observation postoperatively and an oxytocin drip. Therefore, this study cannot be used to comment on the safety of uterine evacuation of known molar pregnancies in a non-hospital setting. This study has several strengths, including large numbers of subjects, histologic confirmation of molar pregnancy, and choice of suction source based on equipment available rather than physician discretion, avoiding bias.

The surprising finding was the decreased risk of Asherman's syndrome (intrauterine synechia) with MVA compared to electric suction. It is interesting to me because both groups routinely received sharp curettage, which has been associated more with the development of Asherman's than suction source.[3] The authors speculated that this may have occurred because the MVA applies less vacuum pressure to the uterus compared with electric suction and, therefore, disrupts the endometrium less. This is an interesting theory and deserves further study. Unfortunately, as a retrospective study, we cannot know whether women in the EVA group also developed Asherman's at a similar rate but did not present for care. In sum, although I don't see this study necessarily changing practice in the United States, it is reassuring that both suction techniques are similar in case MVA is all that is available. ■

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ABSTRACT & COMMENTARY

Interpregnancy Interval and Chances for Recurrent Miscarriage

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

SYNOPSIS: Authors of a recent study surprisingly have shown that the best chances of avoiding another early pregnancy loss is to become pregnant within six months of a miscarriage.

SOURCE: Sundermann AC, Hartmann KE, Jones SH, et al. Interpregnancy interval after pregnancy loss and risk of repeat miscarriage. *Obstet Gynecol* 2018;130:1312-1318.

A discussion of the interpregnancy interval (IPI) has been a consistent component of preconception counseling. However, most studies dealing with this subject have been cross-sectional studies focusing on three outcomes: preterm birth (PTB), low birth weight (LBW), and small for gestational age (SGA). However, in these studies, three

independent variables (previous normal outcomes, late fetal losses, or miscarriages) all have been lumped together. Authors of a recent study homed in on only one category: risk of recurrent pregnancy loss at less than 20 weeks in those who have had miscarriages in their prior pregnancies.

The study was restricted to 514 newly pregnant patients recruited from eight metropolitan areas in North Carolina and Tennessee whose last pregnancies ended in early pregnancy losses. At their initial interview at less than 12 weeks of gestation, the interval between the date of their miscarriage and their last menstrual period in the current pregnancy was tabulated. Also, the patients were asked how long during their IPIs had they tried to conceive. Patients undergoing treatment for infertility were excluded from the study.

Analysis involved IPIs < 3 months, 3 to 6 months, 6 to 18 months, and > 18 months. The overall miscarriage rate was 15.7%, but when patients were older than 34 years of age it was 20%. More than half (58.9%) had IPIs < 6 months and in only 15%, the IPI exceeded 18 months. Interestingly, the lowest repeat loss rate was when IPI < 3 months (7.3% vs. 22.1% in the 6 to 18 months group; adjusted hazard ratio, 0.33; 95% confidence interval [CI], 0.16-0.71). There were no significant differences between any other groupings, although there was a non-statistically significant trend downward in patients with IPIs > 18 months, resulting in an adjusted hazard risk of 0.53 (95% CI, 0.25-1.12). There was no association between the time the patient waited before attempting to conceive and repeat pregnancy loss < 20 weeks. Those with shorter IPIs had a greater tendency to be white, college-educated patients, and those with longer IPI were more likely to be obese and of lower socioeconomic status.

■ COMMENTARY

Last year, I wrote a Special Feature devoted to optimizing pregnancy outcomes through preconceptual counseling.[1] My recommendations of postponing pregnancy for greater than 18 months was based on the cross-sectional data from the literature on all comers or in those having had fetal demise in their previous pregnancies. Sundermann et al's paper certainly challenges that common admonition, specifically in those whose last pregnancy ended in a miscarriage.

Another study in the same issue of *Obstetrics and Gynecology* correlating IPI with PTB, LBW, and SGA was enlightening.[2] Class et al showed in a large Swedish population that a short IPI (< 6 months) and long IPI (> 60 months) were associated with a significant increase in all three of the above adverse outcome variables. However, the authors cleverly looked for possible confounding familial factors by using sibling and cousin comparisons. After accounting for familial predispositions, the only significant outcome variable that remained with short IPI (< 6 months) was PTB. However, after 60 months all three variables were increased significantly.

Although the concept of giving the reproductive tract a chance to recover after a late fetal loss or normal pregnancy may seem to be a reasonable suggestion, the data from the miscarriage study point in the opposite direction — that there might be some benefit to attempting conception within six months while the reproductive system is still "primed" for pregnancy. In contrast, the results from both studies in the December 2017 issue of *Obstetrics and Gynecology* strongly suggest that waiting until more than 60 months has elapsed certainly is not the best strategy. ■

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SPECIAL FEATURE

Update on Early Pregnancy Loss Management

By Rebecca H. Allen, MD, MPH

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Dr. Allen reports she is a Nexplanon trainer for Merck.

Early pregnancy failure typically is defined as an intrauterine pregnancy in the first trimester that is not viable, either because the gestational sac is empty or because the embryo or fetus has no cardiac activity.[1] Most commonly, diagnosis is made by ultrasound and the patient may or may not be symptomatic. The Society of Radiologists in Ultrasound issued guidelines in 2013 that proposed conservative radiologic criteria for the diagnosis of early pregnancy failure.[2] (*See Table 1.*) These guidelines are important especially for women whose pregnancies are desired and for women who want to wait for absolute certainty that there has been a failed pregnancy prior to intervention. Otherwise, these guidelines can be interpreted according to individual patient circumstances, which

Table 1: Transvaginal Ultrasound Findings Diagnostic of and Suspicious for Pregnancy Failure

Findings diagnostic of pregnancy failure	Findings suspicious for, but not diagnostic of, pregnancy failure
• Crown rump length (CRL) of ≥ 7 mm and no heartbeat • Mean sac diameter (MSD) of ≥ 25 mm and no embryo • Absence of embryo with heartbeat ≥ 2 weeks after a scan that showed a gestational sac without a yolk sac • Absence of embryo with heartbeat ≥ 11 days after a scan that showed a gestational sac with a yolk sac	• CRL of < 7 mm and no heartbeat • MSD of 16 to 24 mm and no embryo • Absence of embryo with heartbeat 7 to 13 days after a scan that showed a gestational sac without a yolk sac • Absence of embryo with heartbeat 7 to 10 days after a scan that showed a gestational sac with a yolk sac • Absence of embryo ≥ 6 weeks after the last menstrual period • Empty amnion • Enlarged yolk sac (> 7 mm) • Small gestational sac in relation to the size of the embryo (< 5 mm difference between MSD and CRL)

Adapted from: Doubilet PM, Benson CB, Bourne T, et al. Diagnostic criteria for nonviable pregnancy early in the first trimester. *N Engl J Med* 2013;369:1443-1451.

may include wanting a pregnancy termination to avoid unwanted spontaneous passage of pregnancy tissue or the need for an unscheduled visit or procedure.

For women who are stable without hemorrhage or infection, there are three main options for the management of early pregnancy failure: expectant management, medical management with misoprostol, and surgical management. Women's preferences should guide treatment decisions, given that all three options are medically safe. Factors that patients may consider include shortest time to completion, probability of success, desire to avoid surgery or anesthesia, least amount of pain and bleeding, or number of clinic visits required. Overall, the success rates of each method depend on the time allowed for completion. For expectant management, the success rates also may depend on the type of early pregnancy failure. In one study, by two weeks, 84% of women with an incomplete abortion, 59% of women with an embryonic/fetal demise, and 52% of women with an anembryonic pregnancy had a complete abortion.[3] With misoprostol management, authors of a large U.S. randomized, controlled trial reported success rates of 71% by day 3 with 800 mcg of vaginal misoprostol.[4] The success rate was increased to 84% when women took a second dose of 800 mcg of vaginal misoprostol, if needed. The ~85% success rate of misoprostol alone (with a second dose) has led investigators to look for agents that may increase completion rates. Given its efficacy in inducing abortion with misoprostol, mifepristone has been researched as a supplementary drug. Preliminary trials have been performed but, to date, evidence is inconclusive.[5] We are still waiting for the publication of a large, randomized, controlled trial to settle the issue. Finally, surgical management with manual vacuum aspiration in the office or suction dilation and curettage (D&C) in the operating room is an option, with a success rate of 97%.[4]

If misoprostol management fails, the question for women is whether to pursue expectant management or surgical management. This is highly preference driven, as evidenced by a recent randomized, controlled trial that approached 340 women in this situation and only 59 were willing to be randomized.[6] In this Dutch trial, adult women with incomplete abortion after misoprostol treatment were enrolled. The authors excluded women who still had a retained gestational sac for unclear reasons. Perhaps the Dutch practice in that setting is always surgical evacuation, but this was not explained. Incomplete abortion was defined sonographically as visual evidence of retained products of conception or an endometrial stripe thickness of 11 mm or more. It is unclear why this endometrial stripe measurement was chosen. Exclusion criteria included severe vaginal bleeding or abdominal pain requiring immediate surgical intervention, fever, or any contraindications to suction curettage. Women allocated to curettage underwent the procedure within three days. In this study, curettage could include vacuum aspiration or sharp curettage. All women were contacted in two weeks and an ultrasound was performed at six weeks. Success was defined as an empty uterus with endometrial stripe < 10 mm at six weeks or an uneventful clinical course during three months of follow-up if no ultrasound was performed. Secondary outcomes included excessive blood loss (> 500 mL), blood transfusion, antibiotic treatment, and any subsequent surgical intervention. Mean gestational age at misoprostol use was 10 weeks in both arms.

A total of 29/30 (97%) women who underwent surgery compared to 22/29 (76%) women allocated to expectant management had complete abortions (relative risk [RR], 1.3; 95% confidence interval [CI], 1.03-1.6). Equal numbers of women in the two groups experienced a complication (RR, 0.97, 95% CI, 0.21-4.4): three of 30 women in the surgical group (with one post-spinal headache, one Asherman's syndrome, and one antibiotic treatment) vs. three of 29 in the expectant management group (with two emergency curettages because of excessive blood loss and one antibiotic treatment). Ultimately, four more women in the expectant management group underwent either repeat curettage for persistent vaginal bleeding or hysteroscopy for retained products of conception on ultrasound.

The same authors also offered enrollment in a cohort study to the women who declined randomization.[7] A total of 197 women agreed to participate; 132 elected expectant management while 65 chose surgical evacuation. In this cohort, 62/65 (95%) in the curettage arm and 112/132 (85%) in the expectant management arm had complete abortions (RR, 1.12; 95% CI, 1.03-1.23). Complication rates were not significantly different, with 6.2% in the curettage group and 2.3% in the expectant management group (RR, 2.70; 95% CI, 0.6-11.7).[7] Overall, the take-home message from both of these studies is that more than three-quarters of women in the expectant management group did not require intervention when they had an "incomplete" abortion after misoprostol treatment for early pregnancy failure. This study aligns with previous studies showing endometrial stripe thickness does not predict the need for intervention and that a thickened endometrial lining after miscarriage can be a normal finding.[1] Therefore, clinical signs and symptoms should guide management in this setting, and it is reasonable for women to opt for expectant management as long as they are aware of the small risk of needing surgical evacuation for bleeding.

Patients may be concerned with the effects on future fertility of the three different management options. There has been a historical concern regarding surgical treatment potentially leading to procedural complications and subsequent Asherman's syndrome (intrauterine adhesions). In one specialized clinic in Vancouver, British Columbia, 884 women were evaluated for early pregnancy failure between July 2011 and December 2012.[8] Of these women, 210 chose misoprostol, 191 chose manual vacuum aspiration in the office under local anesthesia, 406 chose suction D&C under IV moderate sedation in an ambulatory surgical center, and 77 underwent suction D&C under general anesthesia in the hospital operating room. Afterward, six women contacted the clinic complaining of amenorrhea more than eight weeks postoperatively. All six women had undergone sharp curettage at the time of their suction D&C under IV or general anesthesia, which was practiced routinely at the clinic. Three of these women also had repeat procedures for retained products of conception that also included sharp curettage. All six were revealed to have intrauterine adhesions on hysteroscopy consistent with Asherman's syndrome. There were no cases reported after manual vacuum aspiration that did not include sharp curettage. The authors decided to stop using sharp curettage routinely with suction D&C procedures. This corresponds to standard practice in the United States.[1]

Although there are limitations to the data, including no active follow-up on all the patients, the results are intriguing. The true incidence of intrauterine adhesions after suction D&C is unknown, as women can be asymptomatic, but one can imagine that sharp curettage may be more likely to injure the basal layer of the endometrium compared to suction alone and it is not really necessary to ensure complete evacuation. One systematic review reported a pooled prevalence of intrauterine adhesions on hysteroscopy of 19% (95% CI, 12.8-27.5%) after suction D&C for early pregnancy failure.[9] The majority of the intrauterine adhesions were classified as mild (58%), followed by moderate (28.2%) and severe (13.7%). The authors did not report whether sharp curettage was used, and the clinical relevance of these intrauterine adhesions is unknown. The authors of this systematic review found no studies reporting on the link between intrauterine adhesions and long-term reproductive outcome after miscarriage.

Meanwhile, several studies have shown similar pregnancy outcomes subsequent to expectant, medical, or surgical management of early pregnancy failure.[1] For example, pregnancy outcomes were ascertained in the same population of Dutch women who participated in the randomized trial and cohort study evaluating curettage vs. expectant management for women who had incomplete abortion after misoprostol treatment of early pregnancy failure.[10] Of the 211 women in both studies with follow-up data, 198 had tried to conceive after early pregnancy failure. Of these, 73 had received curettage and 125 were managed expectantly. In the curettage group, 69 women conceived (92%) compared to 120 (96%) of the expectant management group ($P = 0.34$). The mean time to pregnancy was 32 weeks for women in the curettage group and 29 weeks for women in the expectant management group (nonsignificant).

In sum, we can reassure women that there is very low risk that any treatment will affect future fertility, so this should not be a deciding factor in the decision-making process. Rather, women should choose the option that feels most comfortable to them and fits into their lifestyles. ■

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CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to AHCMedia.com and click on My Account. First-time users must register on the site using the eight-digit subscriber number printed on your mailing label, invoice, or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CME/CE QUESTIONS

1. **In the WHI postintervention survey of sexual health, compared to participants formerly randomized to placebo, those who had received active therapy reported which of the following?**
   a. An increase in the frequency of vaginal dryness symptoms
   b. An improvement in libido and orgasm
   c. Greater overall sexual satisfaction
   d. An increase in sexual frequency with a partner.

2. **In the study by Padron et al, which of the following was associated with manual vacuum aspiration?**
   a. Shorter operative time
   b. Increased risk of blood transfusion
   c. Decreased risk of incomplete abortion
   d. Decreased risk of Asherman's syndrome

3. **According to the study by Sundermann et al, family predisposition to fetal loss may play a role in the recurrence of this outcome.**
   a. True
   b. False

CME/CE 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]

Fertility Preservation in Women with Borderline Ovarian Tumors

Is Vaginal Estrogen Still the Gold Standard for Treating Genitourinary Syndrome of Menopause?