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Ultrasonographic Screening for Ovarian Abnormalities Does Not Decrease Mortality From Ovarian Cancer

ABSTRACT & COMMENTARY

In 1981, a study of 5479 women was performed in the United Kingdom with the purpose of determining whether ultrasonography of the ovaries might be useful in the early detection of ovarian cancer. At that time, the scans were performed with the transabdominal approach. The study participants were self-referred and were required to be in good health. Each woman had three screens, at one-year intervals. A detailed history including family history was obtained from all participants. Women who had "persistent" abnormal findings were recommended to have surgical intervention. The mean age of the cohort was 52.

Approximately one in every 17 women had at least one "persistent" abnormality. Of the 326 women who had such abnormalities, only 10% declined further investigation. Of those who agreed with intervention, approximately one-third had laparoscopy and two-thirds had laparotomy. Ninety percent of the women who had laparotomy had a bilateral salpingo-oophorectomy.

Nine cancers were identified, including four borderline and four metastatic ovarian cancers. Of the remaining 284 women, 88 had a benign epithelial tumor and 16 had a benign germ-cell tumor. The large majority of women had simple cysts, follicular cysts, or corpus lutea.

Years later (the article does not state when follow-up began), this cohort was traced. Ninety-five percent of the original participants were identified. The number of expected and observed deaths from all causes, and from cancer causes was calculated. Based on the expected number of deaths from ovarian cancer, the study had an 80% power to detect a decreased risk of ovarian cancer of 0.6 or an increase of 1.67.

Volume 17 • Number 2 • June 2000 • Pages 9-16

INSIDE

Overall, the death rate of the women in this study was reduced from expected population rates. Crayford and colleagues point out that this is not a surprising finding since the participants in the project were all 'healthy volunteers.' Overall, there was no decrease in deaths from ovarian cancer (Crayford JB, et al. *Lancet* 2000;355:1060-1063).

COMMENT BY KENNETH L. NOLLER, MD

The early detection of ovarian cancer remains one of the major goals in the field of gynecology. Although only a few women in every 100,000 will develop the disease in any given year, the lifetime risk of developing the disease is approximately one in 70. In addition, because the disease is almost always detected at a late, nonsalvageable stage, most women with this diagnosis die from the disease. During the past two decades, there have been numerous attempts to develop a method that is both sensitive and specific that can be used for the early detection of ovarian cancer. Unfortunately, to date, none of the methods fulfill the criteria required for routine use as a screening test.

I particularly like this article because it involves the prospective follow-up of a screening trial for ovarian cancer. Although the 1981 screening was rather crude by modern ultrasonographic standards, enough information was collected on the cohort to make follow-up interesting. The results were not surprising. Despite performing some 300 surgical procedures for "persistent abnormalities" of the ovaries, the authors failed to reduce the risk of death from ovarian cancer. ❖

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Cesarean Deliveries for Lack of Progress in Labor

ABSTRACT & COMMENTARY

Synopsis: *Lack of progress in labor is an important reason for cesarean deliveries and many of these procedures are done during the latent phase of labor or in the second stage of labor before it is prolonged.*

Source: Gifford DS, et al. *Obstet Gynecol* 2000;95: 589-595.

To estimate the prevalence of lack of progress in labor as an indication for unplanned cesarean delivery and to compare the course of labor in women with this diagnosis and established criteria for lack of progress in labor, Gifford and associates performed a retrospective review of medical records as well as postpartum telephone interviews to collect data from 733 women who delivered full-term singleton infants weighing between 2500-4500 g in vertex presentation. Births were sampled from 18 hospitals in Los Angeles county, with more than 1500 deliveries annually and 12 hospitals in Iowa, with more than 500 births each year. Only nulliparous and primiparous patients were studied. Gifford et al asked the following questions regarding progress in labor: 1) Was the patient in the active phase of labor at the time of the cesarean? 2) If the patient reached the active phase of labor, did she have a protraction disorder? and 3) If the patient reached complete dilatation, was there evidence of a prolonged second stage? Cesarean delivery was attributed to lack of progress in labor if the physician's notes included terms usually associated with lack of progress such as dysfunctional labor, cephalopelvic disproportion, failure to progress, protracted labor, arrest of dilatation, or arrest of descent. While lack of progress in labor was a reason for the cesarean delivery, it was not necessarily

the only reason. Gifford et al compared the characteristics of the patient's labor to the criteria established by the American College of Obstetricians and Gynecologists (ACOG) for the diagnosis of lack of progress.

Lack of progress was a reason for 68% of unplanned cesarean deliveries. At least 16% of the women studied, or 24% of those who had a cesarean delivery for lack of progress, were in the latent phase of labor as defined by ACOG criteria. Furthermore, the second stage was not prolonged in 36% of the women who reached complete dilatation.

Gifford et al conclude that lack of progress in labor is an important reason for cesarean deliveries and that many of these procedures are done during the latent phase of labor, or in the second stage of labor before it is prolonged according to criteria established by ACOG.

COMMENT BY STEVEN G. GABBE, MD

Lack of progress in labor or dystocia is responsible for 30% of all cesarean deliveries performed in the United States each year and ranks second only to repeat cesarean delivery as an indication for this procedure. In 1989, the diagnosis of lack of progress of labor as an indication for cesarean delivery reached nearly 12%, — three times higher than in 1970. To determine how often cesarean deliveries are performed for lack of progress in labor, Gifford et al colleagues studied delivery records from large urban and smaller rural hospitals. The study sample included only women who were nulliparous or primiparous. To determine if the patients had abnormal labor patterns as defined by ACOG, Gifford et al compared the documentation of the progress of labor with the criteria established for active labor, protraction disorders, and prolonged second stage. They found that a large proportion of cesarean deliveries for lack of progress were actually performed in the latent phase of labor, 16% at 0-2 cm cervical dilatation and 24% at 0-3 cm. Gifford et al were able to calculate the slope of the active phase in 80% of the study subjects, and 98% did meet the criteria for a protraction disorder.

It is important to note that in this study, lack of progress in labor was only one of the indications for the cesarean delivery. In 51% of these cases, an indication other than lack of progress was recorded and most often it was non-reassuring fetal status. Nevertheless, it is concerning that so many patients underwent a cesarean delivery for lack of progress while still in the latent phase of labor. Determining what factors influenced the obstetrician to make this decision could go a long way in helping us develop strategies to lower the cesarean delivery rate. ❖

Working Conditions and Adverse Pregnancy Outcome: A Meta-Analysis

ABSTRACT & COMMENTARY

Synopsis: *Physically demanding work increases a woman's likelihood of an adverse pregnancy outcome.*

Source: Mozurkewich EL, et al. *Obstet Gynecol* 2000; 95:623-635.

During the past several years, a number of articles have appeared in the English literature that have explored the role of working conditions on the outcome of pregnancy. Mozurkewich and associates of this article reviewed the published English literature through 1999 and performed a careful meta-analysis.

Mozurkewich et al examined only the following work related exposures: physically demanding work, prolonged standing, long work hours, shift work, and work fatigue score. The outcomes they investigated included: preterm birth, hypertension, preeclampsia, and small for gestational age (SGA) birth.

Mozurkewich et al performed appropriate inclusions and exclusions of published articles. They attempted to use raw data rather than statistically adjusted data.

The results of the meta-analysis were clear: physically demanding work was associated both with preterm birth and hypertension/preeclampsia. Preterm birth was also associated with prolonged standing and shift (night) work. There was no association with long work hours and premature birth. The identified increased risks were moderate. For example, physically demanding work was associated with a 22% increased risk of preterm birth, a 37% increased risk of SGA, and a 60% increased risk for hypertension or preeclampsia. Mozurkewich et al conclude that it is possible that the preterm births might be decreased by changing women's work habits, but that prospective trials would be needed to determine whether a true benefit could be achieved.

COMMENT BY KENNETH L. NOLLER, MD

Very often when I review an article that I think is excellent, I suggest to all readers that they obtain the article and review it. In this case, I specifically suggest that you do not try to read this article unless you are a study design nerd, like me. The article is included at the very back of the April issue of *Obstetrics & Gynecology* and is written in a way that makes it almost impossible

to understand unless you love study methodology. Unfortunately, such writing style is absolutely essential for a good meta-analysis. Far too many articles have been published that claim to use the meta-analysis technique but fall far short.

Overall, this article is important. Based on what is now overwhelming evidence, it appears that hard physical work and long periods of standing adversely affect pregnancy outcome. Women who take part in such activities during pregnancy are about 20-30% more likely to have a preterm birth, an SGA infant, or (probably) a hypertensive disorder. Since work is one of the very few modifiable adverse conditions during pregnancy which is associated with poor outcomes, it could be argued that all of us (health care providers, work place managers, pregnant women, and government) should be more aggressive in our attempts to have pregnant women reassigned to less strenuous work. Obviously, this issue is large, expensive, and controversial. However, at the very least, we should be telling our pregnant patients who participate in strenuous work activities that they have an increased risk of an adverse pregnancy outcome. ❖

What Does a Low Bone Density Measurement Mean?

ABSTRACT & COMMENTARY

Synopsis: *Bone loss measured after one year of treatment is not a certain indication that the patient is not responding to therapy.*

Source: Cummings SR, et al. *JAMA* 2000;283: 1318-1321.

Cummings and colleagues from the Fracture Intervention Trial Research Group analyzed hip and spinal bone mineral density data from the randomized clinical trials assessing the effects of alendronate and raloxifene in postmenopausal women with osteoporosis. They found that women who lost bone mineral density after one year of treatment were likely to gain bone during the second year. For example, 83% of the women taking alendronate whose hip bone density decreased by more than 4% in the first year had increases in the second year of treatment. Those who gained an extreme amount of bone in the first year tended to lose in the second year. Similar results were observed with raloxifene treatment. The more extreme the measurement after one year of treatment, the more likely the next year's measurement indicated a reversal. The same results were observed in the women receiving placebo treatment. Cummings et al argue that these results illustrate the principle of regression to the mean. Regression to the mean is a phenomenon due to extreme results of measurement being in part due to random error, and therefore, repeat results are usually closer to the mean for a population. Cumming et al recommend that bone treatments should not be discontinued when measurements in the first year indicate loss of bone density.

COMMENT BY LEON SPEROFF, MD

Not all women will maintain or gain bone density on postmenopausal hormone therapy; in one study, 12% of treated women lost bone despite apparently good compliance.[1] In the PEPI 3-year clinical trial, where compliance rates were probably maximal, 4% of treated women lost bone in the spine and 6% in the hip.[2] In women who started hormone therapy at menopause, I recommend a bone density measurement in the mid 60s to detect nonresponse. In women who have started treatment later in life, or who have started treatment because a bone density measurement has already indicated the presence of osteoporosis, the above report indicates a repeat measurement one year later is not the best method of management.

First, I believe it is important to check for compliance and with estrogen therapy adequate dosing. Compliance with alendronate is a problem because of the requirement for an empty stomach and upright posture for at least 30 minutes. I check compliance with estrogen by measuring blood estradiol levels. Monitoring the estradiol blood level in postmenopausal women receiving hormone therapy is not as straightforward as it would seem. There are two primary difficulties. First, the clinical assays available differ considerably in their technique and quality (laboratory and antibody variations). Second, the various commercial products represent a diverse collection of estrogenic compounds, ranging from estradiol to unique equine estrogens. What each clinician must do is learn what blood level of estradiol as performed by the local laboratory is associated with the standard doses of hormone therapy (0.625 conjugated estrogens, 1 mg estradiol, 50 mg transdermal estradiol). In our laboratory, this range is 40-100 pg/mL estradiol. Remember that because FSH is regulated by a factor other than estrogen (i.e., inhibin), FSH levels cannot be used to monitor estrogen dosage.

If compliance with medication is not a problem, make sure there isn't another cause of bone loss, especially due to medications or eating disorders.

- **Drugs:** Heparin, anticonvulsants, high intake of

alcohol.

- **Chronic Disease:** Renal and hepatic.
- **Endocrine Diseases:** Excess glucocorticoids, hyperthyroidism, hyperparathyroidism.
- **Nutritional:** Calcium, phosphorous, vitamin D deficiencies.

If a reason for the apparent lack of response is not detected, I recommend measuring one of the urinary biochemical markers of bone turnover. If the marker level is not in the premenopausal range, then this patient is truly a nonresponder. If the marker level is in the premenopausal range, then the bone density measurement probably reflects the problem reviewed by Cummings et al, regression to the mean. Treatment should not be changed and a repeat bone density measurement a year or two later will probably indicate response. Therefore, I would change treatment only if the marker level is not in the premenopausal range.

The reason why some women fail to respond is unknown. It is further unknown whether these patients will respond to added treatment, such as calcitonin or a bisphosphonate, but it is worth special evaluation, treatment, and surveillance. Until we learn more about this group of women, they should be treated with combination therapy (e.g., estrogen and alendronate), and we should closely monitor their response. But keep in mind that fractures reflect a more complex story than just bone mineral density. It is likely that apparent nonresponders as determined by bone mineral density still have some treatment-induced protection against fractures. ❖

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Valvular Heart Disease and Exposure to Dexfenfluramine or Phenteramine/fenfluramine

ABSTRACT & COMMENTARY

Synopsis: *There were no statistical differences in prevalence of serious cardiac events in treated and untreated patients.*

Source: Gardin JG, et al. *JAMA* 2000;283:485-491.

Gardin et al report a reader-blinded controlled study of 1473 obese patients evaluated by history, physical examination, and echocardiogram for the presence of valvular heart disease associated with the use of anorexigenic medication. The study population consisted of obese subjects, 74% women, mean age 47, and mean BMI 35.0 kg/m2 with 479 treated with dexfenfluramine, 455 treated with phenteramine/fenfluramine, and 539 untreated by anorexigenic medication. Patients treated with anorexigenic medication were excluded if exposure had ended more than 14 months prior to the study or if they had taken over-the-counter anorexigens or serotonergic migraine headache medications in the five years prior to the study. This study was designed to look at a general population of patients who had taken anorexigenic medication; therefore, patients with a prior cardiac history were not excluded. Echocardiograms were performed by sonographers and interpreted at a central cardiology laboratory by cardiologists specializing in echocardiography using standard methods for grading of valvular regurgitation. Both sonographers and cardiologists were blinded to all patient historical information.

Results of the study included the prevalence of valvular disorders, duration of treatment, and median maximum daily doses. The duration of treatment for dexfenfluramine-treated patients was 6.0 months and 11.9 months for phenteramine/fenfluramine. The median maximum daily doses were within recommended dosage guidelines, but some patients had been treated with doses two or three times the usual recommended daily dose. The prevalence of aortic regurgitation (AR) was 8.9% in the dexfenfluramine group (RR, 2.18; 95% confidence interval [CI], 1.32-3.59), 13.7% in the phenteramine/fenfluramine treated group (RR, 3.34; 95% CI, 2.09-5.35), and 4.1% in the untreated group ($P < 0.001$). When all grades of mitral regurgitation (MR) were included, there was a statistically significant increase in the anorexigen-treated group compared to the untreated group ($P = 0.2$). There were no statistical differences in AR prevalence in untreated patients and those patients who had been treated with anorexigens for less than three months, although this group of patients was very small, limiting the power to detect a difference to less than 50%. There were no statistical differences in prevalence of serious cardiac events in treated and untreated patients.

COMMENT BY ELLEN L. SAKORNBUT, MD

When the FDA initially reported valvular abnormalities in fenfluramine-treated patients, the prevalence of valvular disorders was alarming—up to 32%

of treated patients. The valve disorders described consisted of diffuse thickening consistent with carcinoid and ergotamine-induced valve disease. The proposed mechanism of damage common to these conditions is an elevation in serotonin levels. Dexfenfluramine, phenteramine/fenfluramine, sibutramine, ergotamine, sumatriptan, and numerous other medications all affect serotonin receptors, transport proteins, or serotonin release by platelets.

The study by Gardin et al provides no information on long term consequences of these medications. However, a long-term follow-up study in the United Kingdom covering eight years included information on more than 8000 fenfluramine-treated patients. Of these patients, a small number demonstrated symptomatic idiopathic valvular disease (approximately 1 in 1000), and 9 of 11 of these patients had been treated for longer than three months. These findings suggest that valvular changes do not frequently progress to clinically symptomatic disease. Additionally, a newer medication, sibutramine, was not associated with an increase in valvular abnormalities in a 12-month study . It is not known at this time whether the risk of primary pulmonary hypertension is increased with this medication.

The clinician is left with the following concerns: which patients should be screened for valvular heart disease following anorexigen exposure? Can other anorexigenic medications be safely prescribed and with what precautions? The following guidelines are suggested:

1. Patients with less than three months exposure to phenteramine/fenfluramine or dexfenfluramine and without cardiac history or physical findings are at low risk and need not be evaluated by echocardiogram. Patients with murmurs, cardiac symptoms, or longer exposures should be screened for valvular defects.
2. Sibutramine should not be prescribed for patients with hypertension or borderline blood pressure elevation, undiagnosed heart murmurs or a history of valvular heart disease, patients treated with ergots or "triptan" medications for migraine, or in combination with SSRI's. Other contraindicated medications include ketoconazole, erythromycin, pseudoephedrine, phenylpropanolamine, and MAO inhibitors. Patients should be compliant and should be followed closely on this medication, looking for elevated blood pressures, cardiac symptoms, and findings related to the cardiopulmonary system. Its safety has not been demonstrated for periods of use greater than one year. The manufacturer recommends that its use be reconsidered if the patient does not lose at least 1 lb/wk in the first four weeks of therapy.
3. Some questions about the safety of anorexigenic medication remain unanswered (such as the link to primary pulmonary hypertension). A number of medications have been removed from the market, but phenteramine remains available. There seems to be no rationale for prescription of this class of drug for obesity unless risk for valvular heart disease has been proven to be low. Given that many obese patients are not candidates for sibutramine, many physicians will prefer to avoid the use of anorexigenic medication per se. "First, do no harm."

Author's note: *Terminology varies with these medications. An alternative term used in some publications is "appetite suppressant."* ❖

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Inhaled Corticosteroid Use and Bone-Mineral Density in Patients With Asthma

ABSTRACT & COMMENTARY

Synopsis: *This study demonstrated an inverse relationship between inhaled corticosteroid dose and bone-mineral density in adults ages 20-40 years.*

Source: Wong CA, et al. *Lancet* 2000;355:1399-1403.

Inhaled steroids are a key therapy for patients with asthma and related conditions such as allergic rhinitis and chronic allergic sinusitis. One in three British asthmatic patients takes an inhaled corticosteroid regularly and frequently for a prolonged duration. While it is commonly believed that inhaled steroids are devoid of the systemic effects and risks seen with oral use, this notion has been called into question. Inhaled steroids have been associated with bruising, cataracts, and glaucoma. Doses in the range of 1000-1500 mg daily can suppress adrenal function. This study was undertaken to determine if inhaled glucocorticoids also retard bone accretion. To avoid confounding variables such as menopause and other effects of age, Wong and associates studied 196 adults (119

women) between the ages of 20-40 years who regularly used inhaled steroids for the management of asthma, but who had minimal exposure to other routes of delivery. Bone mineral density (BMD) of the lumbar spine and left hip (femoral neck, Ward's triangle, and trochanter) was determined by dual energy X-ray absorptiometry using Lunar equipment. The median duration of inhaled steroid use was six years with a median cumulative dose of 876 mg. There was a clear negative correlation between dose and BMD at all sites. The effect was comparable for cortical and trabecular bone. In univariate analysis, BMD was also related to weight, body mass index, never smoking, calcium intake, cumulative estrogen exposure, and physical activity. None of the subjects had severe asthma that limited activity and the mean forced expiratory volume was 93% of expected. Thus, inactivity and disease severity are unlikely to account for the findings. The inverse association was comparable in men and women. The effect size was not dramatic. One would have to use a dose of 2000 mg daily for seven years to reduce bone mass by one standard deviation and thereby theoretically double the risk of fracture. However, chronic use is common because asthma rarely remits with time. Further, some studies have suggested that fracture occurs at a higher BMD in individuals exposed to exogenous glucocorticoids. Thus, Wong et al suggest that the results of this study have important public health implications.

COMMENT BY SARAH L. BERGA, MD

Several smaller studies have suggested that inhaled glucocorticoids impair bone accretion, but this is the first to demonstrate the impact so clearly. Thus, the point can no longer be reasonably argued. There has always been this fantasy that drugs delivered by nonoral routes stay where they are put. In fact, drugs delivered to the lung are very well absorbed, as are drugs delivered vaginally and transdermally. Oral delivery may be one of the least effective routes of administration because the liver metabolizes a certain fraction of that drug prior to delivery into the circulation. The same obviously doesn't hold for nonoral routes of delivery.

The take-home message is clear. Add chronic use of inhaled glucocorticoids to the list of reasons to screen for osteoporosis. Patients who must use inhaled glucocorticoids should use the least dose possible. If BMD is low, it may be worthwhile to take a bisphosphonate. Although glucocorticoids primary impair bone formation and bisphosphonates primarily lessen bone resorption, bisphosphonates nonetheless do help to maintain BMD in this context. ❖

Special Feature

Lifestyle, Stress, and the Gynecologic Oncologist

By David M. Gershenson, MD

It seems as if everyone i know in the field of gynecologic oncology is expressing the opinion that they are working harder and enjoying life less than they did in the past. I have listened to this theme equally from both academic and community practice gynecologic oncologists. Of course, all of us complain to some degree or another about our problems and the frustrations we experience. Isn't that what accounts, at least partially, for so many in the upper echelons of our society pursuing counseling or psychotherapy? And is it simply routine complaining or is there really something going on that separates us from our parents' generation?

A recent report on job satisfaction among gynecologic oncologists practicing in the United States sheds some light on this topic.[1] The authors surveyed all U.S. gynecologic oncologists who were members of the Society of Gynecologic Oncologists in an effort to compile information on demographics, training, motivating factors, overall professional satisfaction, and the effect of managed care. Of 767 members polled, there were 344 (47%) respondents. Of the respondents, the majority was male (80%), white (86%), married (85%), and board certified (82%). Fifty-seven percent identified themselves as academic, as defined by practicing in either a university setting or in a community hospital training program. Respondents were classified based on the time frame in which they completed their training. The percentage of women steadily increased from 0% prior to 1965 to 30% after 1995. An increasing percentage of gynecologic oncologists have left their initial job within five years—from approximately 30% of those who completed training before 1965 to more than 50% of those who finished between 1986 and 1995. The authors note that the most common explanation for leaving a job was "difficulty with colleagues and/or the department chairperson." The mean number of partners and the mean number of hospitals attended in their current job is also greater for the younger gynecologic oncologists (3.8 vs 2.0, and 3.7 vs 2.5, respectively). All groups before 1995 showed a statistically significant increase in the reported number of hours per week spent personally dealing with insurance company paperwork or phone calls. Forty-eight percent of the respondents

reported having been sued, with an average of one lawsuit per individual. Female gynecologic oncologists reported having been sued half as often as male gynecologic oncologists—25% vs. 54%—but this appeared to be related to the higher number of years in practice for the latter. Of academic gynecologic oncologists, the proportion of their salary that depended on clinical productivity increased from 39% in their first job to 66% in their current job.

The authors asked respondents to rank 10 motivational factors in order of importance at the time they were looking for their first jobs and their current jobs and in how they contributed to professional satisfaction once they were in these jobs. In all generations of gynecologic oncologists, four of the following five characteristics were rated as the most important factors in both looking for a job and in contributing to job satisfaction: 1) practice characteristics; 2) potential for professional growth; 3) location; 4) colleagues and/or department chair; and 5) salary. There were no significant differences between male and female respondents. However, gynecologic oncologists in private practice ranked location as their most important factor while academic gynecologic oncologists ranked practice characteristics as the most important factor.

In terms of overall job satisfaction, there were no differences between men and women or between academic and private gynecologic oncologists (all in the range of 4-5 on a scale of 1 to 10). In addition, the average respondent stated that managed care had significantly decreased their job satisfaction and their quality of care.

In a recent article entitled, "The Balanced Life: A Discussion of Stress in Gynecologic Oncology," Leo Lagasse, MD, a much-respected senior member of our discipline, noted that "our subspecialty is one of the four or five highest stress areas in medicine."[2] He discussed the practice stresses that we face—death and dying, surgical complication, and specialty overlap—as well as administrative pressures—peer review, malpractice, managed care, and the myriad hospital committees—to name a few. He also underscored the personal stresses in our lives, including family commitments and relationships. For both men and women, balancing our professional lives and our family obligations is a major challenge. As one of my friends recently told me, "There is no longer any down time in my life. Life is always a rush to get to the next commitment or deadline." And I agree; life does seem more frenetic than before. Faxes, e-mail, and cell phones have undoubtedly contributed to this dramatic change in lifestyle. Lagasse encourages us to find a balance in our lives by setting priorities and by de-emphasizing professional gratification (money, power, honors, etc.) and focusing on our personal lives. He also offers other potential options, including support groups, flexible work schedules, shared positions, and fitness programs.

Finding balance in our life and minimizing stress are important and desirable goals for each one of us. And of course, the problems discussed herein are not restricted to the practice of gynecologic oncology, but rather have much broader implications. I do firmly believe that the introduction of the younger generation, particularly women, into our subspecialty has caused all of us to reexamine our priorities. Each one of us will deal with these challenges in different ways, but the overriding message is quite clear—life is considerably more complex than it was for our parents' generation, and we need to find our own balance. ❖

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CME Questions

23. Based on the article by Crayford et al, which of the following statements concerning screening for ovarian cancer is true?

a. Transabdominal ultrasonography can detect ovarian cancer but does not reduce mortality from the disease.
b. Removal of ovaries that show persistent abnormalities reduces the risk of ovarian cancer.
c. Surgical intervention is indicated in women with persistently abnormal ultrasonographic findings of the ovaries.
d. Transabdominal ultrasonography cannot reduce ovarian cancer deaths but does reduce overall cancer deaths.

24. According to the article by Mozurkewich et al, which of the following activities was *not* associated with an increase in adverse pregnancy outcome?

a. Physically demanding work
b. Prolonged standing
c. Shift (night) work
d. Long work hours

In Future Issues:

Diet Quality and Mortality in Women