Advances in breast cancer screening, diagnosis, and treatment

As clinicians try to detect breast cancer earlier and assess tumors better, the use of magnetic resonance imaging has become more common. But experts caution that MRI should not be used as a routine screening tool in average-risk women.

“Breast MRI is not a substitute for a mammogram,” according to Past ACOG President Vicki L. Seltzer, MD, chair emeritus of ob-gyn at North Shore University Hospital and Long Island Jewish Medical Center, New Hyde Park, NY. “Breast MRI should not presently be used for routine screening of the average-risk woman. It has false positives, and sometimes it will miss a lesion that a mammogram will detect.”

Instead, breast MRI can be used in some circumstances as a supplement to mammography in screening and as another diagnostic tool. Dr. Seltzer outlined three primary circumstances in which breast MRI may be helpful as a screening tool:

1. As part of a regular screening regimen, in addition to mammography, for women at a substantially increased risk for breast cancer
2. When cancer is found in one breast, to evaluate the contralateral breast for simultaneous cancer
3. In women with breast implants in whom mammography is difficult or to determine the integrity of implants

Dr. Seltzer also discussed three primary instances in which MRI may be helpful as a diagnostic tool:

1. To further characterize a lesion, when other evaluations are inconclusive. However, Dr. Seltzer cautioned, a breast MRI is not a substitute for a biopsy. Suspicious lesions require biopsy
2. To use in an MRI-guided biopsy
3. In patients who have been diagnosed with breast cancer, to help physicians evaluate the extent of the disease and whether it exists elsewhere in the breast

The role of breast MRI is constantly evolving.

“MRIs are more sensitive and less specific. Finding the right role of MRI is a work in progress,” said Fellow Barbara S. Levy, MD, medical director of the Women’s Health and Breast Center, Franciscan Health System, Federal Way, WA.

In a study published in August in the Journal of the American College of Surgeons, breast MRI did not improve margin status or breast-conserving therapy attempts and was associated with a delay in treatment and an increase in mastectomies. (See “info” on page 11 for study reference.)

According to the article, MRI advocates presume that greater sensitivity will improve...
EXECUTIVE DESK

Fighting for health care reform

As I write this Executive Desk in early September, health care reform is front and center in the news. The first bill to come forward was HR 3200, the result of three committees of the US House of Representatives coming together to formulate a plan. This bill was more than 1,000 pages long and included a tremendous number of proposals. Many were similar to key ACOG proposals, but many were not. This was not a final bill, and even the drafters acknowledged it would change significantly once debate occurred on the House floor. Unfortunately, the subsequent reaction from the media and the public assumed this was a final bill, even though the Senate had not even stated what it wished to do.

In order to remain a part of the discussion and to hopefully include all of ACOG’s priority issues, ACOG endorsed HR 3200 with reservations. We have received numerous letters and emails condemning and supporting the ACOG position. Most seem to be unaware of how the legislative process works. The bill includes very positive aspects for our members, including:

- The prohibition of exclusions for preexisting conditions
- No coverage denials for pregnancy and no higher premiums for women
- Universal care for obstetric patients
- Changes in today’s unfair reimbursement formula

Even a small step toward medical liability reform was ultimately included. We are pushing for medical liability reform as a high priority in meetings with the House and Senate. However, to be able to participate in attempts to include liability reform, we needed to endorse HR 3200. In the District of Columbia there is an old saying about the issues you wish to be a part of in Congress: “If you are not at the table, you are on the menu.” The menu in this case may have caused extensive harm to the practicing ob-gyn. Fortunately, ACOG President Gerald F. Joseph, Jr, MD, and our Government Affairs staff, led by Lucia DiVenere, have been very effective in preventing many incursions into your practice under the guise of health care reform.

Congress returned to session in September, and a bill is expected to be completed before Congress recesses in December. ACOG and its staff and officers will monitor closely every issue and work hard to protect our specialty from attack. We do not anticipate winning every issue, and we have no idea what the Senate will propose, but by now you will have seen the Senate version of reform. The House and Senate will need to resolve any differences, and that is where ACOG influence will be most important.

Ralph W. Hale, MD, FACOG
Executive Vice President
THE SEARCH COMMITTEE OF ACOG INVITES APPLICATIONS FOR THE POSITION OF

Executive Vice President
American Congress of Obstetricians and Gynecologists
American College of Obstetricians and Gynecologists

The selected individual will be capable of continuing the outstanding leadership and direction of the College and the Congress and their policies at both the public level and staff level. A national reputation and an academic background are highly desirable. Qualified candidates must be board-certified obstetrician-gynecologists, who have served in one or more roles with the Congress or the College and are able to devote at least 10 years to this position. They must have proven substantive management and business skills, including fiscal management, in-depth experience in practice, and the ability to represent the College and the Congress articulately in a wide variety of circumstances. They must be a clear, concise communicator with a demonstrated personality for collaboration. Considerable national and international travel is required.

The chosen candidate must be able to assume full duties in July 2011, but with a phase-in period of three months preceding that date. The position is located in Washington, DC, and reports to the Executive Boards of the Congress and the College. Questions should be addressed to Elsa Brown at the College office. Interested persons must send their letters of interest and curriculum vitae no later than October 15, 2009, to:
Search Committee
c/o Elsa P. Brown, Vice President of Administration
American College of Obstetricians and Gynecologists
409 12th Street SW Washington, DC 20024-2188

Fellow voting begins online in December

The 2010 fellow district and section officer elections will be held online, with voting beginning December 15.

Fellows will be able to access online ballots by using their last name and their ACOG ID number, which can be found on all ACOG mailings or obtained by contacting the ACOG Membership Department. Paper ballots will be offered only by request.

More information will be in the November/December issue of ACOG Today, as well as in the online monthly resource notices, on the ACOG website, and by email.

Voting begins December 15:
https://eballot3.votenet.com/acogfellow

info

» For your ACOG ID, contact the Membership Department: membership@acog.org; 800-673-8444
» For election updates, on the ACOG website, acog.org, under “Membership,” click on “District and Section Activities”
» For questions about elections, contact Megan Willis Mazur: 800-673-8444, ext 2531; mwillis@acog.org

acog.org/acm

58th Annual Clinical Meeting
May 15–19, 2010
San Francisco

For your calendars
Early-bird registration opening soon
ACM film festival abstracts are due by November 6
ACOG partners for television cancer event

After you’ve stuffed yourself full of turkey and sweet potatoes and collapsed onto the sofa on Thanksgiving Day, be sure to tune in to the television special Kaleidoscope. ACOG joins the nation’s leading cancer advocacy groups in this cancer awareness event that will combine sport, entertainment, and health awareness. The event will bring together Olympic figure skaters, including Scott Hamilton and Dorothy Hamill, with Grammy Award-winning musicians, including Olivia Newton-John and composer David Foster.

Last year’s event, Frosted Pink with a Twist, has been expanded to focus not just on breast cancer but other cancers also affecting women. Lung cancer is the No. 1 cancer killer of women, followed by breast cancer and colon cancer.

The television special will air on Thanksgiving, Nov 26, on FOX, from 4 to 5:30 pm Eastern time.

info
> womenandcancer.com

Expanding MORE OB patient safety program in the US

ACOG signed an agreement with the Society of Obstetricians and Gynaecologists of Canada and Salus Global Corporation in June to support the expansion of the MORE OB patient safety program in the US. MORE OB (Managing Obstetrical Risk Efficiency) is a comprehensive patient safety, efficiency improvement, and professional development program for caregivers and administrators in hospital obstetric units.

From left to right, ACOG President Gerald F. Joseph, Jr, MD; J.K. Mline, MD, president and CEO of Salus Global Corporation; and Scott A. Farrell, MD, then-president of SOGC.
Communication breakdown is a leading cause of medical errors. Here are some key concepts to be aware of and a few tips to improve communication in your practice.

Avoid the doorknob complaint
Physicians tend to interrupt patients within 20–30 seconds of patients explaining the reason for their visit or their medical history. Such interruptions can cause patients to feel intimidated, forget an important detail, or neglect to announce a major complaint until the doctor’s hand is on the door to leave the room.

“I actually believe that many docs are not aware they are interrupting,” said Patrice M. Weiss, MD, chair of ACOG’s Committee on Patient Safety and Quality Improvement. “The communication challenge is that patients speak the language of wanting to tell the story of their illness, while docs are speaking a language of ‘find it and fix it’ and constantly formulating differential diagnosis, even subconsciously.”

Daniel J. Wilkowski, MD, the District I representative on the patient safety committee, offers some advice: “Start every encounter without anything in your hands. Start with a handshake, and make eye contact when greeting her. Ask an open-ended question like, ‘How are you?’ or ‘Why did you come in to see me?’ and sit in front of her. This helps clear any barriers and takes away any agenda you may have.”

Beware of the authority gradient
“Authority gradient” refers to the balance of decision-making power or the steepness of command hierarchy in a given situation, according to the Agency for Healthcare Research and Quality Patient Safety Network. A domineering or intimidating physician can cause nurses, staff, physicians with less experience, and even patients to be wary of expressing concerns or to question the physician, which can lead to medical errors.

“As the leaders, physicians must ‘flatten’ the authority gradient by their words and actions,” said Paul A. Gluck, MD, former chair of the ACOG Committee on Patient Safety and Quality Improvement. “Nurses and staff must be valued as members of the team and not just be there to do the doctor’s bidding. If a nurse or resident makes the physician aware of a potential problem, compliment them for a good pick-up. If their concern is incorrect, thank them for trying to help the patient and then explain to them, respectfully, why it is not an issue. Encourage them to continue to be vigilant in case there are other problems in the future.”

Strive to improve the handoff process
Properly executed handoffs are interactive and include the opportunity for questions and answers. Addressing aspects such as physical environment, confidentiality, language, organizational culture, communication method, and documentation is key to improving the process, according to ACOG’s patient safety Committee Opinion Communication Strategies for Patient Handoffs (#367, June 2007, reaffirmed 2009).

“Handoffs are the Bermuda Triangle of health care,” said Paul A. Gluck, MD, former chair of the ACOG Committee on Patient Safety and Quality Improvement. “Critical information may be lost or misinterpreted. Handoffs often occur in an environment that is noisy. The physicians are often interrupted. There is time pressure by the physician who is going off call to be relieved of responsibility, and there is time pressure by the physician coming on call to ‘get to work.’ Handoffs should ideally be face-to-face in a quiet area less likely to be interrupted. There should be a clear transfer of responsibility and authority. Each physician should know exactly what he or she is expected to do going forward and what items are pending for the care of the patients.”
Earlier this year, the Institute of Medicine proposed further reductions to residency duty-hour limits implemented in 2003 by the Accreditation Council for Graduate Medical Education. Recommended changes include a mandatory five-hour nap during extended shifts, a 16-hour limit for shifts without naps, and adherence to the 80-hour work week.

While the IOM and others believe these changes would lead to better-rested residents, and, thus, better learners and physicians, the issue is much more complex. The changes would affect patients, residents, hospital staff, and the entire health care system in several significant ways—financially, educationally, even ethically. An ACGME task force is currently studying the IOM proposal.

“In 2003, when the restrictions were implemented, the stated goals were to improve in three areas: patient safety, resident education, and resident well-being,” said May Hsieh Blanchard, MD, general ob-gyn division chief, residency program director, and assistant professor of ob-gyn at the University of Maryland School of Medicine in Baltimore. “Since then, have these things improved? There has been much debate, and although we have some studies that show improvements, we have limited measurable outcomes.” Dr. Blanchard is also a Fellow-at-Large on the ACOG Executive Board and a past chair of the Junior Fellow College Advisory Council.

Handoffs can affect patient safety
There have been many studies conducted outside the field of medicine that demonstrate that sleep deprivation results in sub-par performance and leads to accidents. However, studies focusing on patient safety and its relation to resident work hours are few and inconclusive.

Some are concerned that because reduced work hours result in more handoffs, important patient data are missed or misinterpreted. Others argue that while some information may be lost during handoffs, it is better to have a well-rested resident take over. Still others say that staying with the patient throughout a critical period overrides all other considerations because that physician has the best overall knowledge of the patient’s condition.

Some practicing physicians worry that residents working within a reduced-hour schedule will not be properly trained for the rigors of a career in medicine—including not having enough surgical experience.

The shift mentality does pose a problem because although we want to limit the number of hours that residents work, both in terms of physician health and well-being and to optimize patient care, it is not an accurate assessment of what we do as women’s health physicians,” said JFCAC Chair Taraneh Shirazian, MD. “We provide continuity care and not shift care. In fact, leaving in the middle of a case or crisis is not acceptable as a practicing ob-gyn in providing appropriate patient care.”

Resident education would become more focused
ACOG Past President Douglas W. Laube, MD, MEd, former professor and chair of the ob-gyn department at the University of Wisconsin-Madison, has been studying resident education for the past 30 years. He admits the issues related to the new IOM proposal are complex, yet predicts these changes will force residency education to become more focused and that this will lead to other changes in medicine, such as niche practices.

“Today, there is so much more information that it simply is not possible to learn everything there is to know about an entire specialty,” he said. “With reduced hours, it will force residents into more focused learning, such as choosing a more limited aspect of obstetrics and/or gynecology.”

Gretchen Glaser, MD, a resident at Abington Memorial Hospital outside Philadelphia and the resident representative to the Ob-Gyn Residency Review Committee of the ACGME, believes the 80-hour work week is working well for residents.

“With this restriction, residents are able to avoid dangerous exhaustion, while still gaining a comprehensive education,” Dr. Glaser said.

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The 80-hour work week can help residents develop into more well-rounded people who can bring valuable, holistic perspectives to their practices, she added.

The next step
Deciding whether or not to accept the IOM proposal is only the first step. Step two is determining how it will be funded. Will hospitals redistribute graduate medical education funding? Will the health care industry pay? Or does there need to be a nonprofit/private source in conjunction with the government? Presently, no one has a definitive answer. The ACGME task force will present its response to the IOM proposal in 2010.
Submit ‘Projects in a Box’ entries by November 30

Submit summaries of your successful projects for ACOG’s new “Project in a Box” contest. The contest, created by the Junior Fellow College Advisory Council, will highlight notable projects, posting project descriptions on the JFCAC website so that others can duplicate the projects in their own communities.

All Junior Fellows are eligible to submit descriptions of successful educational or community service projects. Entries must be submitted online (see “info” below) and are due by November 30.

The winner will receive a $2,500 prize for travel and meeting expenses to present his or her project at the 2010 Annual Clinical Meeting in San Francisco, May 15–19. ♀

info

➡ For more information or to submit a project, go to acog.org and click on “Junior Fellows” in the “Quick Links” box on the left.

SUBMISSION REQUIREMENTS

- A description, including the project name, objectives, and target audience
- Dates the project was done
- Venue
- Supplies needed
- Prep time
- Outline and budget
- Promotional efforts
- Photos

The JFCAC ‘Year of Service’

By Taranah Shirazian, MD, JFCAC chair

THE YEAR IS IN FULL SWING, and the Junior Fellow College Advisory Council is focusing on service benefitting our communities and women nationally and internationally, and, of course by extension, ourselves and our colleagues.

To facilitate Junior Fellow participation in service activities, we are creating a number of opportunities for involvement. Many Junior Fellows have great project ideas that educate and motivate medical students and colleagues to be involved in women’s health in our communities, such as organizing local food and clothing drives, serving in a homeless shelter, or providing much-needed materials to a foreign country. We want to share these great projects with our Junior Fellows together to network and give back to the community.

To this end, we have created our first “Project in a Box” contest. The contest will choose the best community service, educational, or policy project that has been implemented. Projects will be judged on the basis of the impact on the community, relevance to women’s health, originality, and reproducibility. The winner will receive a $2,500 prize to present the project at the Annual Clinical Meeting in San Francisco, May 15–19, 2010.

The goal of this contest is to collect information about Junior Fellow service projects and list them on the Junior Fellow section of the ACOG website. This will allow Junior Fellows to review the projects and implement them.

This contest serves as a great way to involve medical students and to gather Junior Fellows together to network and give back to the community.

The deadline is November 30. I hope to see many submissions! ♀

info

➡ To submit a project, visit acog.org and click on “Junior Fellows” in the “Quick Links” box on the left.

Submit your intriguing cases for 2010
Stump the Professors

SUBMITTING CASES

- You must be a Junior Fellow in Training to submit a case
- Cases should require deliberation and consider potential change in practice
- Cases must be submitted online
- Submissions should include a one-page summary of 700 words or less, including a final diagnosis
- The deadline for submissions is November 30

S UBMIT YOUR UNIQUE, CHALLENGING, and unforgettable ob-gyn cases by the November 30 deadline for The Gerald and Barbara Holzman Stump the Professors program at the 2010 Annual Clinical Meeting, May 15–19, in San Francisco.

Four Junior Fellows will be selected to present their cases at the ACM. The event will be held from 9:30 to 11 am on Tuesday, May 18. Each presenter will receive free Junior Fellow ACM registration, coach airfare, and travel and hotel expenses for three days. ♀

info

➡ At acog.org, click on “Junior Fellows” in the “Quick Links” box on the left side
➡ Erica Bukevicz: 800-673-8444, ext 2428; ebukevicz@acog.org
Washington state ob-gyns discussed health care reform with Sen. Maria Cantwell (D-WA), fourth from left, during ACOG’s 2009 Congressional Leadership Conference.

EARN CME CREDITS

Attend ACOG’s 2010 Congressional Leadership Conference


Following two days of advocacy training at the CME-accredited conference, ACOG Fellows and Junior Fellows will urge congressional action on key issues. Participants will learn to communicate with legislators at federal and state levels, gain valuable knowledge from Washington insiders about legislation that affects the specialty and patients, and meet with members of Congress on women’s health issues.

Fellows and Junior Fellows are sponsored by their district or section chairs to attend the conference. Sponsorship typically covers travel, registration, lodging, and incidental expenses. Participants who self-sponsor can attend by paying a $300 registration fee, plus travel and lodging expenses.

INFO

Contact your district or section chair by November 20 if you’re interested in attending. For more information, contact Stacie Mischikowski in ACOG’s Government Affairs Department: 800-673-8444, ext 2505; smischikowski@acog.org

The fight for health care reform

SEVERAL OF ACOG’S WOMEN’S HEALTH CARE PRIORITIES HAVE been included in the draft US House and Senate health care reform bills. In September, three House committees—Ways and Means, Energy and Commerce, and Education and Labor—were aiming to consolidate their versions of HR 3200, America’s Affordable Health Choices Act, into one bill. In the US Senate, the Health, Education, Labor and Pensions Committee approved its Affordable Health Choices Act in July, and the chair of the Senate Finance Committee, Sen. Max Baucus (D-MT), unveiled his bill in mid-September. (See Executive Desk on page 2 for ACOG’s involvement.)

Protesters call attention to the need for health care reform. For information and updates on ACOG efforts to push key women’s health priorities, visit acog.org, and click on “Government Relations and Outreach” under the “Advocacy” tab.

Lawmakers talk with ACOG about health care reform

IN A PIVOTAL YEAR FOR HEALTH care reform, ACOG’s “Health Care for Women, Health Care for All” message was prominent at the 2009 National Conference of State Legislatures Annual Legislative Summit in Philadelphia, July 20–25.

ACOG once again partnered with other health organizations to sponsor a “Physicians Advocating for Patients” booth. ACOG’s booth featured an image of two women and declared “Like Mother, Like Daughter. Uninsured.”

ACOG Fellow Peter A. Schwartz, MD, on the left, with a state legislator. Dr. Schwartz helped staff ACOG’s conference booth.
How to begin using email with your patients

**Q** I have avoided using email with patients out of privacy, security, and liability concerns, but I'm reconsidering because of the potential cost savings and increased efficiency to my practice. What are some of the key issues to consider?

**A** If you want to enhance communication with your patients by using email, it is advisable to develop policies and procedures specifically for email. Issues to consider include:

- What types of communication with patients do you want to take place through email? Appointment scheduling and other administrative tasks? Prescription refill requests? Medical advice? Test results?
- What types of communication should not be handled by email? Are there topics you do not want to discuss with patients through email? For example, you might decide that prenatal genetic testing results will not be conveyed through email.
- How will you protect the privacy and security of patient email communications? For example, email is not HIPAA compliant unless both the office and the patient's systems are secure.
- How often will you be able to check email? What will your turnaround time be for responding?
- Will nonphysician staff review and triage email messages?
- How will you ensure that email communications with a patient are incorporated into her medical record?
- How will you handle messages that require prompt action or immediate referral to a physician?
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- Will nonphysician staff review and triage email messages?

**Using a secure system**

A secure email system will allow you to send and receive messages with special provisions for authentication, encryption, and protection by a firewall. With such a system, the patient must enter a user identification and password, both for sending and receiving messages. She would be notified in her regular email when you have posted a message to her on the secure system. Secure email programs that comply with HIPAA privacy rules are available from several vendors and can also be worked into your practice website.

Once you have determined your email policies and procedures, you should put them in writing and make sure office staff have been informed of and trained on your email policies and that they adhere to them. Add the email policies and procedures to your office’s “Notice of Privacy Practices.” A few ways to help ensure that incorporating email into your patient communications does not expose you to greater liability risk are:

- Develop procedures to ensure that email messages do not fall through the cracks.
- Be sure patients understand your email policies and procedures. If a patient wants to communicate by email, have her read and sign a copy of your practice’s email policy. Keep a copy in her medical record.
- Stress to patients that they should not use email for urgent problems or emergencies. If staff will be handling patient emails, develop guidelines for handling messages that require prompt action or immediate referral to a physician.
- Limit email communications to patients with whom you have already established a physician-patient relationship.

To reduce the chances of miscommunication, take these precautions when sending email:

- Use as much care in composing an email to a patient or colleague as you would in writing or dictating a letter.
- Pay close attention to the tone of your email. Do not be sarcastic or attempt humor.
- Remember that nonverbal communication (eg, facial expressions, body language) will be absent from email.
- Always proofread email before you send it. Misspellings and grammatical errors give the impression that you are a sloppy physician, and errors could provide incorrect information.

**info**

- American Medical Association’s Guidelines for Physician-Patient Electronic Communications: At ama-assn.org, search “electronic communications”
- American Medical Informatics Association’s Guidelines for the Clinical Use of Electronic Mail with Patients: amia.org/mbrcenter/wg/kim/docs/email_guidelines.html

The information in this article should not be construed as legal advice. As always, physicians should consult their personal attorney about legal requirements in their jurisdiction and for legal advice on a particular matter.
Advances in breast cancer screening, diagnosis, and treatment

the selection of patients for breast-conserving therapy and increase the likelihood of obtaining negative margins during the first lumpectomy attempt. However, the study showed that patients undergoing MRI did not have fewer positive margins at lumpectomy or conversions from breast-conserving therapy to mastectomy.

Among 377 patients seen at a breast cancer clinic, 130 had pretreatment MRI. MRI was associated with a 22-4-day delay in pretreatment evaluation. Patients that had MRI were younger, and MRI use increased each year during the study, conducted from 2004 to 2006. The authors noted that there was a 1.8-fold increase in the odds ratio of undergoing mastectomy after MRI.

“We have noted an increasing trend toward the use of mastectomy, with more prophylactic and contralateral mastectomies being performed. Researchers think it could be secondary to increased use of MR because so many things can be seen on the MRI,” said Fellow Mary L. Gemignani, MD, MPH, associate attending surgeon, breast service, in the department of surgery at Memorial Sloan-Kettering Cancer Center in New York City.

Seeing more unknown findings on MRI may lead to more biopsies, Dr. Levy said, which can make patients anxious enough to choose to have a mastectomy.

“Patients see all these funny areas all over the breast—which may be nothing—and they get really scared,” she said.

Digital mammography
With mammography remaining the best screening tool currently available for breast cancer, more and more screening centers are switching to digital mammography. It appears traditional mammography may go the way of the old film camera.

“Digital mammography is becoming standard. There are so many advantages,” Dr. Levy said. “Images can be manipulated and blown up, you can focus in on a particular area, you can easily send images electronically, you can make copies, and they’re easy to store.

“But as we pick up more and more with digital mammography, we don’t know how meaningful all of these [pick-ups] may or may not be,” she continued. “We need more research to determine how we should respond to tiny areas of microcalcifications that would not have been visible on analog mammograms. Our algorithms for biopsy are based upon a different technology. It may be that we should watch carefully and wait rather than biopsy every area of abnormality.”

A digital mammography is particularly helpful with high-risk premenopausal patients and patients with high breast tissue density.

“Dense breasts are an independent risk factor for breast cancer,” said Fellow Carolyn D. Runowicz, MD, director of the Carole and Ray Neag Comprehensive Cancer Center at the University of Connecticut Health Center and past president of the American Cancer Society. “Dense breasts are common in premenopausal women and in postmenopausal women are not uncommon.”

Radiation advances
The Radiation Therapy Oncology Group is overseeing a randomized trial comparing standard radiation to three types of partial breast radiation: high dose-rate multicatheter brachytherapy, high dose-rate single catheter balloon brachytherapy (MammoSite), and three-dimensional conformal external beam radiation therapy.

“When people have a recurrence of breast cancer, a lot of times the recurrence occurs in the same quadrant where the breast cancer was. So people are asking whether we need to treat the entire breast or just the quadrant,” Dr. Gemignani said. “It will be interesting to see the trial results, but the long-term outcomes are also important because breast cancer can reappear many years later.”

With MammoSite, instead of undergoing a 5- to 7-week course of radiation, patients are given radiation directly at the tumor site over a 5-day period. Radiation is focused into a small catheter balloon inserted in the base of the tumor bed.

“It looks very promising,” Dr. Levy said. “It’s able to deliver the radiation faster, and the heart and lungs and other parts of the chest receive less radiation exposure.”

The treatment appears to have few side effects and a good cosmetic result, but it’s so new that no 10-year outcomes are available yet.
Researchers are also studying a more extensive, shorter course of standard radiation therapy called accelerated hypofractionated whole breast irradiation. In study results released at the American Society for Therapeutic Radiology and Oncology Annual Meeting in 2008, less radiation overall was given during a three-week course than during a five-week course, but the amount of radiation at each treatment was increased in the shorter three-week course. The women were followed for 12 years, and, after 10 years, cancer returned in 6.2% of those treated with the accelerated therapy, compared with 6.7% treated with standard therapy. Both groups had good or excellent cosmetic outcomes. (See “info” below for study reference.)

**Targeted chemotherapy**

Trials are under way that could lead to a new way of targeting cancerous tumors.

“We’re trying to tailor the actual treatment to the make-up of the cancer,” Dr. Gemignani said.

In some of the latest findings, cancer tumors have shrunk by inhibiting poly ADP-ribose polymerases, or PARPs, which is a family of enzymes that helps with DNA repair. When PARPs are inhibited in cancers that already have defects in their DNA repair, such as BRCA1 and BRCA2, the cancer cells die.

Results of a phase 1 trial in Europe were published in the *New England Journal of Medicine* in July.

In the trial, 60 patients were given the oral PARP inhibitor olaparib; 22 of the patients were carriers of BRCA1 or BRCA2 and another had a strong family history of BRCA-associated cancer but chose not to undergo BRCA testing. Adverse effects were primarily only grade 1 or 2, with 32% experiencing nausea; 30%, fatigue; 20%, vomiting; 13%, taste alteration; and 12%, anorexia. Three patients had anemia, and two patients had grade 4 thrombocytopenia.

“The results are exciting; it’s a new therapy, and it has shown a very impressive response rate for patients with BRCA mutations,” Dr. Runowicz said.

Another exciting new area is the development of prognostic assays, such as Oncotype Dx, a molecular test that provides a “cancer recurrence” score, allowing the oncologist to classify a patient’s risk to determine which patients should be offered chemotherapy.

“It’s not a perfect science yet,” Dr. Levy said.

“IT can’t tell you in any one individual the outcome. It’s just statistics.”

With continuing advances in screening and diagnosis that are zeroing in on a patient’s unique cancer, breast cancer treatment is becoming increasingly complex.

“Breast cancer is not just viewed as one disease anymore,” Dr. Runowicz said. “That’s important because when we find breast cancer in a patient we need to make sure they go to breast care centers that have a team approach with surgery, radiation, and chemotherapy/hormone therapy to determine what’s the best treatment for that patient.”

**info**

- ACOG Committee Opinion Role of the Obstetrician-Gynecologist in the Screening and Diagnosis of Breast Masses (#334, May 2006, reaffirmed 2008)
- ACOG Practice Bulletin Hereditary Breast and Ovarian Cancer Syndrome (#103, April 2009)
Screening can uncover hidden alcohol abusers

She may have appeared to be any mom, driving home in her red minivan full of children. But after going nearly two miles down the wrong way on a New York state parkway, the woman’s minivan slammed into a SUV and burst into flames, killing herself, her daughter, her three nieces, and three men in the SUV. Only her son survived.

Later, police reported that the woman had consumed twice the legal limit of alcohol and had marijuana in her system. Her family has protested furiously that she was not an alcoholic or drug user.

This horrific case in July sparked a nationwide debate: Were family members in denial or unaware of her heavy drinking and drug use? Could she hide it from them that well? Hiding alcohol use is a big component of alcoholism. Family members may be unaware, and doctors aren’t able to detect alcohol abuse through a routine physical exam.

“Unless someone is acutely intoxicated, a patient will not show significant signs of alcohol addiction at her doctor’s visit. Waiting for signs is going to lead you to stereotypes,” said Fellow Mishka Terplan, MD, assistant professor of ob-gyn at the University of Maryland. “Addiction is something that affects all segments of our population, every ethnicity, every socioeconomic level, and it can be a destructive illness to anybody. It’s unlikely that women will bring up their addictions with their doctors on their own. That’s what makes screening so important.”

ACOG supports universal substance abuse screening in ob-gyn practices, which can be as simple as adding a few questions to a standard patient intake form. Among 18- to 25-year-old women, 34% binge drink and 10% are heavy drinkers, according to the ACOG Committee Opinion At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice. Among women age 26 and older, 12.8% binge drink and 2.4% are heavy drinkers. And yet universal screening is not always happening, Dr. Terplan said.

“What sometimes happens is that universal screening is intended, but risk-based screening is undertaken instead: poor women of color who weren’t compliant with prenatal care are going to get a tox screen,” Dr. Terplan said. “White women actually consume more drugs overall, and they also consume more alcohol. The only way you’re ever going to figure out who’s using is by screening.”

Fellow Tricia E. Wright, MD, admits that when she was in private practice, she didn’t screen everyone because of time constraints. “I found out later that [in a couple of instances] if I’d just have asked the question, she would have said yes, she was using drugs or drinking too much alcohol,” said Dr. Wright, assistant ob-gyn professor at the University of Hawaii and director of a clinic that provides prenatal and postpartum care for women with substance abuse.

There are several validated alcohol and substance abuse screening tools that can be used in a busy clinical office setting. Helpful tools can be found on the National Institute on Drug Abuse website at drugabuse.gov/nidamed.

Physician practices can be ready for patients who screen positive by developing a referral list ahead of time.

Dr. Wright also suggests brief intervention and motivational interviewing as effective tools.

info

- Treatment locator: findtreatment.samhsa.gov
- A free online drug abuse screening tool is now available at drugabuse.gov/nidamed.

ADDICTION SOCIETY CREATES WOMEN’S HEALTH GROUP

Ob-gyns have helped create a new work group of the American Society of Addiction Medicine that focuses on the unique issues of women and addiction. The group comprises 10 physicians, including four ob-gyns, and is chaired by Fellow Mishka Terplan, MD, assistant professor of ob-gyn at the University of Maryland.

“Addiction is something important for ob-gyns to understand—as it is important for addiction physicians to understand women’s health,” Dr. Terplan said. “Approximately 10% of all women age 14 to 44 need treatment. However, only about 15% of those who need treatment actually get it. Therefore, most women with dependence or abuse will not be under the care of an addiction specialist but will likely be seen instead by a general ob-gyn.”

The work group plans to submit testimony on behalf of ASAM to the federal Office on Women’s Health regarding the direction of the federally funded research agenda over the next decade and to review all ASAM publications that relate to women.
ONE-PILL VERSION OF PLAN B APPROVED

THE US FOOD AND DRUG ADMINISTRATION HAS approved a new one-pill formulation of the emergency contraceptive Plan B. The new formulation of EC, called Plan B One-Step, will simplify this important pregnancy prevention treatment. The FDA also approved Next Choice, a generic version of the original two-pill Plan B formulation. Currently, the generic EC is obtainable by prescription only to those ages 17 and younger.

In July 1999 the FDA approved Plan B by prescription only. In 2003, Plan B’s manufacturer filed an application with the FDA to make the contraceptive available over the counter without a prescription. After an unusually delayed decision, the FDA granted behind-the-counter nonprescription status for EC, but only to those age 18 and older. Earlier this year, after a federal district court in New York ordered the FDA to make EC available without a prescription to women younger than age 18, the FDA lowered the age limit to 17 for nonprescription EC.

Although ACOG is encouraged by recent FDA actions, the College reiterates its long-held position that there is no valid scientific or medical reason to impose an age restriction on the availability of EC because it is safe and effective for adolescents and women of all ages. ACOG continues to urge the FDA to withdraw the age restriction altogether and eliminate the behind-the-counter status for EC.

ACOG Fellow joins national panel on preventive services

A S AN OB-GYN AND PERINATAL epidemiologist, Fellow Wanda K. Nicholson, MD, MPH, MBA, knows the importance of evidence-based practice and the value in recommendations for patient care based on research. So, when she was asked by ACOG to serve as a nominee for the US Preventive Services Task Force, she immediately accepted and soon became one of two ob-gyns on the panel of 16 physicians.

For more than 20 years, USPSTF has been recognized as the leading independent panel of experts in prevention and primary care. Its goal is to make evidence-based recommendations for preventive services. It evaluates the benefits of individual services based on age, gender, and risk factors for disease and advises which preventive services should be incorporated into primary medical care for patients.

“It is important for physicians to make recommendations by pulling evidence together,” Dr. Nicholson said. “This panel of highly trained physicians can be trusted to make recommendations not only based on evidence but based on its members’ backgrounds and expertise as well.”

Dr. Nicholson is an associate professor in the departments of ob-gyn and population, family, and reproductive health at Johns Hopkins School of Medicine and Bloomberg School of Public Health in Baltimore. She is also a member of the ACOG Committee on Health Care for Underserved Women and the Centers for Disease Control and Prevention’s public health working group on preconception care and health care. Her research focuses on the epidemiology of chronic conditions in women, including gestational and type 2 diabetes and obesity and the effect of depressive symptoms on health-related quality of life.

Dr. Nicholson replaced Fellow George F. Sawaya, MD, on USPSTF and serves alongside Fellow Kimberly D. Gregory, MD, MPH. Dr. Gregory’s term is scheduled to expire this year, and recruitment is under way for another ob-gyn for the task force.

“Having ob-gyns on the task force maintains good communication,” Dr. Nicholson said. “ACOG can communicate to the task force what some of the main dilemmas and unanswered questions are for ob-gyns. In turn, the task force can communicate evidence-based recommendations to the College that can then be related to ACOG Fellows.”

ACOG is one of the task force’s “primary care partners,” professional organizations that review draft documents and help disseminate USPSTF recommendations. However, the College relies on its own expertise and evidence reviews when it develops recommendations, a process that sometimes leads to ACOG recommendations that differ from those developed by the USPSTF. Still, the task force fills an important purpose.

“The recommendations of the task force can assist physicians as we attempt to stay on the pulse of research.”

—Dr. Wanda K. Nicholson

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“The recommendations of the task force can assist physicians as we attempt to stay on the pulse of research. It’s important to know there is an interdisciplinary group of health care professionals taking questions physicians and patients may have, looking at the research, and offering evidence-based recommendations,” Dr. Nicholson said.

info

 rumors.gov/clinic/prevenix.htm
ACOG does not expand screening for Ashkenazi Jews

ACOG continues to recommend carrier screening be offered to individuals of Eastern European Jewish ancestry for Tay-Sachs disease, Canavan disease, cystic fibrosis, and familial dysautonomia, according to the revised Committee Opinion Preconceptional and Prenatal Carrier Screening for Genetic Diseases in Individuals of Eastern European Jewish Decent, which was published in the October issue of Obstetrics & Gynecology.

ACOG’s guidelines differ from those of the American College of Medical Genetics, which expanded its carrier screening recommendations for Ashkenazi Jews to include five more conditions: Fanconi anemia (Group C), Niemann-Pick (Type A), Bloom syndrome, mucolipidosis IV, and Gaucher disease.

According to the Committee Opinion, the additional screening recommendations appear to be based on the relatively high detection rate for disease-causing mutations in this ethnic group.

While the recommended panel of diseases in the ACOG guidelines uses carrier rates of greater than 1 in 40, the additional diseases listed by ACMG have carrier frequencies from 1 in 89 for Fanconi anemia (Group C) to 1 in 127 for mucolipidosis IV. The carrier frequency for Gaucher disease type 1 is approximately 1 in 18, but the disease can be very mild and treatment is available.

“ACOG is staying with the recommendation to offer preconception or prenatal screening for the four conditions in the Ashkenazi Jewish population, but we recognize that patients may come to their doctors with information from their community about this expanded list. This updated Committee Opinion can help physicians talk over screening options with their patients,” said Thomas J. Musci, MD, chair of ACOG’s Committee on Genetics. “The committee continues to recommend that carrier screening should be offered before conception or during early pregnancy.”

Occasional air travel safe during uncomplicated pregnancies

In the absence of obstetric or medical complications, pregnant women can observe the same precautions for air travel as the general population and fly safely, according to a new ACOG Committee Opinion. Air Travel During Pregnancy, which was first published in 2001, has been updated and published in the October issue of Obstetrics & Gynecology.

“Since the last version of this Committee Opinion, a number of well-designed observational studies have been published confirming that air travel is generally safe during an uncomplicated pregnancy,” said William H. Barth, Jr, MD, chair of the Committee on Obstetric Practice. “These new studies have made our previous recommendations stronger and more detailed.”

Radiation exposure
The updated Committee Opinion offers new information that addresses concerns about exposure to cosmic radiation during air travel. Even the longest available intercontinental flights will expose passengers to no more than 15% of the limit of cosmic radiation exposure recommended by the National Council on Radiation Protection and Measurements and the International Commission on Radiological Protection. However, it is possible that flight crew individuals or frequent flyers may exceed the recommended limit of exposure.

The Committee Opinion includes a website link to a Federal Aviation Administration tool that can help patients estimate their exposure to cosmic radiation from specific flights. The FAA tool is available at jag. cami.jcabi.gov/carpiprofile.asp.

“Questions from patients about air travel during pregnancy are some of the most common during obstetric visits,” Dr. Barth said. “Based on the material in the new Committee Opinion, when a patient with an uncomplicated pregnancy asks about occasional flying, clinicians should feel comfortable saying, ‘It’s safe.’”

The committee still recommends that pregnant women who have medical or obstetric conditions that may be exacerbated by flight or that could require emergency care not fly at any time during their pregnancy. Clinicians should also suggest that patients check with their airline for specific requirements regarding pregnant women. Most commercial airlines allow pregnant women to fly up to 36 weeks of gestation.
OCTOBER

1–3
ACOG District V Annual Meeting
Indianapolis
202-888-2574

2–4
ACOG District VIII and IX Annual Meeting
Napa, CA
916-920-8100

4–9
International Federation of Gynecology and Obstetrics (FIGO) World Congress of Gynecology and Obstetrics
Cape Town, South Africa
figo2009.org.za
figo@figo.org

6–11
American Association of Medical Colleges Annual Meeting
Boston
aamc.org

7–10
American Medical Association Interim Meeting
Houston
ama.interimmeeting.org

ACOG W EBCAST
Team Training and Simulation in Ob-Gyn Risk Management
1-2:30 pm ET
800-673-8444, ext 2498

2010
JANUARY

16–17
12th Annual ACOG Treasurers Conference
Phoenix
scathcart@acog.org
800-281-1551

22–24
Maine Section Winter Meeting
Sugarloaf, ME
crotec@mmc.org
jnaliboff@fchn.org

28–30
Montana Section Annual Meeting
Big Sky, MT
406-752-5260

Gynecologic Oncology Group Semiannual Meeting
San Diego
gog.org

FEBRUARY

1–6
Society for Maternal Fetal Medicine 30th Annual Meeting—The Pregnancy Meeting
Chicago
smfm.org

10–13
36th Annual Meeting of the North American Society for Psychosocial Obstetrics and Gynecology
Richmond, VA
nasposg.org
202-888-2570

18–21
International Society for the Study of Women’s Sexual Health
St. Petersburg, FL
isswsf.org

ACOG Courses
1. For Postgraduate Courses, call 800-673-8444, ext 2540/2541, weekdays 9 am-4:45 pm ET or visit www.acog.org and click on “Postgraduate Courses and CPT Coding Workshops” under “Meetings.”

2. For Coding Workshops, visit www.acog.org and click on “Postgraduate Courses and CPT Coding Workshops” under “Meetings.” Telephone registration is not accepted for Coding Workshops.

Registration must be received one week before the course. On-site registration subject to availability.

OCTOBER

16–18
ACOG District IV Annual Meeting
Asheville, NC
202-888-2488

16–18
ACOG District I and III Annual Meeting
Orlando, FL
202-888-2574

17–21
American Society for Reproductive Medicine 65th Annual Meeting
Atlanta
asrm.org

23–25
ACOG District II Annual Meeting
New York City
516-436-3461

25–28
ACOG District VI Annual Meeting, in conjunction with the Central Association of Obstetricians and Gynecologists Annual Meeting
Maul, HI

30–Nov 1
American Association for Gynecologic Laparoscopists 38th Annual Meeting
Orlando, FL
aagl.org/annual-meeting

30–Nov 1
American Association of Gynecologic Oncologists Annual State of the Art Conference
Rosemont, IL
cmss.org

DECEMBER

4
ACOG W EBCAST
Preview of New Codes for 2010
1-2:30 pm ET
800-673-8444, ext 2498

12–14
Practical Obstetrics and Gynecology
Las Vegas

November

13–15
Coding Workshop
Atlanta

DECEMBER

3–5
Update on Cervical Diseases
New York City

4–6
Coding Workshop
Tampa, FL

10–12
Incorporating Gynecologic Ultrasound Into Your Office Practice
Chicago

October 2009 | acog TODAY 15
SGO conference in November in Washington, DC

Attend the Society of Gynecologic Oncologists Annual State of the Art Conference “Personalized Gynecologic Cancer Care: Moving from the Disease to the Patient” in early November and take part in the Gynecologic Cancer Foundation Inaugural Race to End Women’s Cancer. The conference will be held on Friday, November 6, at the Mandarin Oriental Hotel in Washington, DC. For more information visit sgo.org.

On November 7, the Gynecologic Cancer Foundation will offer three free concurrent survivors courses for cervical cancer, endometrial cancer, and ovarian cancer survivors and their friends and families. Registration is available at wcn.org/courses.

On November 8, the inaugural Gynecologic Cancer Foundation Race to End Women’s Cancer will begin at 7 am. This is a half-marathon/5K/1-mile walk, with the start/finish line on Pennsylvania Avenue near the White House. The race is open to the public, and a number of survivors and their families and friends are expected to participate. SGO members are invited to participate in surgeon teams for the half marathon or in half-marathon relay teams. More information and registration is at gcfrace.com.

ACOG treasurers invited to conference

Current and incoming district treasurers and new section treasurers are invited to the 12th Annual Treasurers Conference, Jan 16–17, 2010, in Phoenix. Other officers and administrators responsible for the financial management of their district or section are also invited. There is no registration fee to attend the conference. The deadline to register is December 20.

The conference is a two-day educational meeting designed to train officers and administrators in the financial management of their district or section and update them on new ACOG policies and changes in tax laws. There will also be a discussion about the financial implications of the startup of the 501(c)(6) Congress in 2010.

Presenters will include ACOG finance staff, national and district officers, and outside investment managers.

Info

For info or to register, contact Steve Cathcart, CPA, at 800-281-155; scathcart@acog.org