Happy New Year to All!
I am looking forward to a great 2015 with the Obstetrical Society of Philadelphia. We will continue hosting energetic, thought-provoking monthly meetings that combine education, mentorship, and fellowship in Obstetrics and Gynecology for providers in the Philadelphia area. Join us on Thursday, January 8th, as Dr. Javier Magrina speaks about the safety of minimally invasive gynecology surgery and the morcellation controversy.

Jason Baxter, MD, MSCP

Upcoming Lecture:
The Safety of Minimally Invasive Gynecology Surgery and Morcellation

Javier Magrina, MD
Barbara Woodward Lipps Professor of Obstetrics and Gynecology
Co-Fellowship Program Director
Department of Gynecologic Surgery
Mayo Clinic – Phoenix, Arizona

A Joint Meeting with the Philadelphia Area Reproductive Endocrine Society

Javier Magrina, MD is a nationally and internationally recognized leader in laparoscopic and robotic surgery for benign and malignant female conditions including: ovarian cyst removal, excision of endometriosis, hysterectomy, myomectomy for uterine preservation, and endometrial and ovarian cancers. Dr. Magrina has lectured extensively and authored many scientific articles. He is Immediate Past President of the American Association of Gynecologic Laparoscopists, an organization that extends to over 110 countries.

Dr. Magrina completed his residency in Obstetrics and Gynecology at the Mayo Graduate School of Medicine, Mayo Clinic College of Medicine and his fellowship in Gynecologic Oncology at the University of Kansas Medical Center. Dr. Magrina received his medical degree from the University of Barcelona and also did fellowships in cytology at the Maternity Hospital of Diputacion Provincial of Barcelona, the Institut de Pathologie et de Cytologie Appliquee in Paris, and at Hammaersmith Hospital in London.
Larry R. Glazerman, MD, MBA, FACOG, FACS

Since the first report of a laparoscopic hysterectomy by Harry Reich¹, minimally invasive gynecologic surgery has exploded. Both the American College of Obstetrics and Gynecology (ACOG) and the American Association of Gynecologic Laparoscopists (AAGL) now recommend a minimally invasive approach for hysterectomy when possible. The advent of electromechanical power morcellation (EPM), first reported by Steiner², has made minimally invasive surgery possible for even the very large uterus.

The technique, however, has recently come under increased scrutiny, largely as the result of the case of Amy Reed, an anesthesiologist in Boston, whose unsuspected leiomyosarcoma (LMS) was discovered during a laparoscopic hysterectomy in 2013³. Dr. Reed and her husband, Dr. Hooman Norchashm, a cardiothoracic surgeon, have crusaded for a ban on morcellation of uterine tumors. As a result, in April 2014, the FDA issued an initial safety communication discouraging the use of power morcellation. The FDA issued an update in November, which required a black box warning on power morcellators. This FDA statement has not ended the controversy, and professional organizations, including ACOG and AAGL, still endorse the use of the morcellator in appropriate situations.

While EPM clearly offers the ability to perform minimally invasive hysterectomy in a multitude of situations, there are two major classes of concern with the procedure. Firstly, injuries to intra-abdominal organs such as bowel and major blood vessels (some which have led to deaths) have been reported⁴,⁵. The second concern involves the recent controversy regarding the risk of morcellating a previously undetected uterine malignancy, primarily LMS, since most other types of endometrial cancer can be detected preoperatively. One unfortunate fact is that despite advances in imaging, LMS is incredibly difficult, if not impossible, to diagnose preoperatively⁶. One small study from Japan⁷ demonstrated the possible usefulness of dynamic MRI in conjunction with the measurement of serum lactate dehydrogenase (LDH) isoenzymes in the diagnosis of LMS, but this study has yet to be reproduced in larger numbers.

The true rate of undetected sarcoma in hysterectomy specimens is unknown and difficult to ascertain. A large Nordic study showed the incidence of LMS in the population to be 0.4/100,000⁸. This finding has been confirmed in several other studies. The incidence of undetected sarcoma in hysterectomy specimens after morcellation is much harder to ascertain since most studies are small and retrospective. After morcellation, Seidman⁹ reported finding one LMS and one endometrial stromal sarcoma (ESS) in 1,091 patients at a tertiary hospital. Knight and Falcone¹⁰ reported an incidence of 1 in 572. Citing a population study in JAMA¹¹, Wright reported an incidence of 1 in 376 (the number quoted by the FDA). Finally, in a yet unpublished review, Pritts et al calculated a risk of 1 in 7450.

Beyond the difficulty in determining the true incidence of undetected sarcoma, the effect of morcellation on prognosis is also unclear. Park¹² published a study of 25 cases of LMS that were morcellated, showing a significant decrease in long-term survival as compared to 31 cases of LMS that were not morcellated. Seventeen of the 25 morcellated LMS cases were referred to their tertiary center, and only one of the 25 underwent EPM. The remainder of the cases was morcellated with a scalpel. Several other studies have also failed to separate power morcellation from morcellation by open hand or scalpel. Only one study to date¹³ has compared power morcellation of sarcoma to hand morcellation. With a median follow-up of 27 months, there was no difference in outcome between the groups.

Dr. Jubilee Brown, speaking on behalf of the AAGL at the FDA panel, presented a decision analysis calculating the effect of a total ban on power morcellation on mortality.

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She calculated that even using the highest calculated incidence of undetected LMS, conversion of all laparoscopic hysterectomies to open surgery would result in an additional 17 women dying from hysterectomy per year.

One possible solution that might decrease the risk of dissemination of tumor cells is contained power morcellation, which has been reported in several early studies. These techniques clearly deserve further research and development.

Moving forward, there is relative consensus on three issues:

1. Research needs to continue on better methods of preoperative diagnosis of malignancy in tumors presumed to be fibroids.

2. Development of better methods of tissue extraction is essential for the continued growth of minimally invasive hysterectomy.

3. Informed consent regarding all risks and benefits of minimally invasive surgery continues to be a crucial component of appropriate care for our patients.

Surgical photos courtesy of YouTube via Green Journal (https://www.youtube.com/watch?v=jw8KB-4P2F0)


LINKS TO MORCELLATION STATEMENTS

ACOG response to FDA initial Alert (April 17, 2014) http://www.acog.org/AboutACOG/Announcements/FDA-Issues-Safety-Communication-on-Laparoscopic-Uterine-Power-Morcellation
AAGL statement to the FDA on Morcellation (July 11, 2014): http://www.aagl.org/aaglnews/aagl-statement-to-the-fda-on-power-morcellation/
Summarizing into words November’s presentation is not necessarily a practical goal. Dr. Granai did not present multiple tables and graphs or long lists of facts. He did bestow depth and perspective. There was some introspection and some self-reflection. Dr. Granai imparted that the connections we make to people in our life are often random. We may not realize in the moment, that a person or persons make a difference in the paths we choose and that in turn, we may also have an impact on people’s choices along their life journey. Random events will change the course that we navigate. Our voyage will change from what we anticipate will be a straight line to one with twists and turns (maybe even some U-turns).

Dr. Granai touched on the different ways we can approach health care, as a science or as a business. In either case, he recommended that we not lose sight of the “human values.” Dr. Granai delineated “p-Values” (science-based part of medicine) and “h-Values” (human values) as both being important when creating a health care system or practice. Each profession or trade has its own p-Values or standards for practicing or doing a good job, no matter whether the job is carpentry, pediatrics or cooking professionally. P-Values may change for each profession, but it is likely the h-Values will be the same across the board.

We may not always agree with the choices our patients make for their health care, but who are we to judge their decisions? Although we may not understand how anyone feels about anything, we can try to anticipate what they may be feeling. What are the things that really matter in life? Time? Quality of that time? Dr. Granai told a number of anecdotes to stress the importance of some of the h-Values. Dr. Granai also pointed out that in order to see progress in cancer care, one must use the perspective gained by evaluating changes over extended periods of time. He reviewed some major changes that have occurred in the treatments and outcomes of breast and gynecologic cancers.

What did Dr. Granai tell us? Perhaps he told us things that we already know, but do not stop to think about very often. One must really witness Dr. Granai’s presentation in order to grasp the essence of his message. I encourage you to log onto the Obstetrical Society website in order to experience the video.

Fay D. Wright, MD
Obstetrical Society of Philadelphia
Newsletter Editor

(Continued on page 5)
The Obstetrical Society of Philadelphia sends a big THANK YOU to Ms. Whittaker and Ms. Perez-Lawson from Amgen (Prolia) for their sponsorship of and attendance at our November meeting.
The venue for the evening programs is:
The Top of the Bell Tower Building
1717 Arch Street – 50th Floor, Philadelphia, Pa.
Reception and Buffet from 5:30 – 7:00 p.m.
Lecture followed by Q/A 7:00 – 8:30 p.m.
Parking beneath the building

Please visit the website for registration information.

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**2015 Meeting Schedule**

**Thursday, January 8, 2015*** ***Joint Meeting with P.A.R.E.S***
**Javier Magrina, MD, Professor of Obstetrics & Gynecology, Mayo Clinic, Phoenix, Arizona**
“The Safety of Minimally Invasive Gynecology Surgery and Morcellation”

**Thursday, February 12, 2015**
**Mark DeFrancesco, MD, MBA, Assistant Clinical Professor, University of Connecticut School of Medicine, Westwood Women’s Health, President Elect in Nomination, ACOG**
 The Blockley Lecture – “The Future of OB/Gyn Practice”

**Thursday, March 12, 2015 ***Joint Meeting with the Philadelphia Perinatal Society***
**Mary D’Alton, MD, Chair, Department of Obstetrics & Gynecology, Maternal-Fetal Medicine, Willard C. Rappleye Professor of Obstetrics & Gynecology, Director of Services, Sloane Hospital for Women Columbia University Medical Center**
“The Safe Motherhood Initiative”

**Thursday, April 23, 2015**
**Michael Foley, MD, Chair and Program Director, Banner Good Samaritan Medical Center, Clinical Professor of Obstetrics & Gynecology, University of Arizona**
“Obstetric Hypertensive Emergencies”

**Friday, May 1, 2015**
RESIDENT EDUCATION DAY
– Hosted by Christiana Hospital

**Thursday, May 7, 2015**
**Jason K. Baxter, MD, MSCP, Director of Inpatient Obstetrics, Associate Professor of Obstetrics & Gynecology, Thomas Jefferson University Hospital**
President’s Night – “Making it Safe”

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**Announcements**

**All Pennsylvania Physicians Must Comply With Changes in Child Abuse Laws**

The most important thing to know about Pennsylvania’s new Child Protective Services Law (CPSL) is that physicians in every specialty are impacted by the changes in the law.

Physicians need to be prepared to comply with changes in their responsibilities that go into effect on Dec. 31, 2014. The law was amended to address concerns with the adequacy of protections for abused children in Pennsylvania.

Under the amended CPSL, all physicians seeking to renew their license on or after Jan. 1, 2015, will need to complete two hours of approved training on child abuse recognition and reporting, as a condition of licensure.

However, if you renew an unrestricted license before Dec. 31, 2014, you will have until 2016 (when these licenses are scheduled to be renewed again) to meet the new training requirement.


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**$200 Million Mcare Settlement**

**Will you get a refund?**

Where will YOUR portion go?

In mid-October, the Pennsylvania Medical Society (PAMED) and the Hospital and Health System Association of Pennsylvania (HAP) settled litigation with the Commonwealth regarding the Mcare Fund with the Commonwealth of Pennsylvania.

The agreement requires that $200 million be returned to physicians, hospitals, and other health care providers who paid money into the fund – $139 million in refunds for prior

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assessment overpayments and $61 million in a reduction to the 2015 Mcare assessment.

This settlement is a big win for physicians and came about thanks in large part to the Pennsylvania Medical Society. In a recent interview, David McKeighan, Executive Director of the Delaware County Medical Society stated, "This is a significant amount of money ($200 million) being returned directly to physicians. Without the strong advocacy of PAMED this would not have been possible. All too often our advocacy efforts are lost in the busy day-to-day practice of medicine. The medical society's efforts to pursue this settlement clearly demonstrates the need for a strong PAMED, we hope all Pennsylvania physicians will recognize our value and support our county and state medical societies with their membership".

FAQ’s

Who is eligible for the refunds?

Physicians will be eligible for a refund if they paid an Mcare assessment (or an assessment was paid for them) for the years 2009, 2010, 2011, 2012, or 2014 (excludes 2013). Some physicians have multiple primary policies and pay multiple assessments, so they would get a refund for each policy in each year that is involved. Refunds will be sent to the address on the physician’s medical license.

Why is 2013 excluded?

Refunds are for overpayments. Looking at assessment calculations over the years, it was determined that there were no overpayments in 2013, and thus there were no refunds for assessments paid in 2013.

We employ midwives. Will they be eligible?

Yes, any health care provider who paid an Mcare assessment for the covered years will be eligible.

When will I get my refund?

Refund payments may not be made until 2016, due to the extensive calculations required to determine the amount payable to each eligible health care provider and to the large number of providers involved. However, the 2015 assessment will be reduced by about $61 million (or one third).

Will I be required to remit my refund to an employer who wrote the check for my assessments?

The situation will vary depending on your circumstances. For example, even though your employer may have written the check, you may have ultimately paid the assessment via a reduction from your compensation pool. The settlement does not impact any contractual or other obligation that a health care provider may have to remit a refund.

How much will the refunds be?

Refunds will vary depending on the years in which an assessment was paid and the amount of the payment. A percentage reduction will be calculated for each year and you will receive a refund for each year in direct proportion to the assessment that you paid. For example, for 2011, the reduction is expected to be in the vicinity of 25 percent. So if you paid a $1,000 assessment, your refund for 2011 would be $250, but if you paid a $10,000 assessment, your refund for 2011 would be $2,500.

I’m going to be retired at end of this year. As a retiree, will I be part of this?

If you were practicing at any time between 2009-2014, you will be eligible for a refund for those years (excludes 2013). Since you will not be practicing and paying an assessment next year, you will not share in the 2015 prospective assessment relief.

- See more at: http://www.pamedsoc.org/MainMenuCategories/Laws-Politics/Analysis/Laws-Analysis/Mcare/Mcare-call.html#sthash.EjBchvhS.dpuf
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