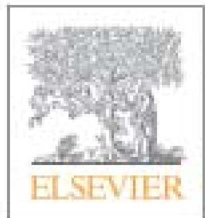

ADJUNCT BROMOCRIPTINE PROMISING FOR PPCM, PAGE 6

Ob.Gyn. News

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DWIGHT C. ANDREWS/UNIVERSITY OF TEXAS MEDICAL SCHOOL AT HOUSTON

"What we're seeing is people stopping their [obstetrics] practice very young," said ACOG committee chair Lisa M. Hollier.

OBs Still Face High Costs, Long Hours

BY MARY ELLEN SCHNEIDER
New York Bureau

With no federal action to address medical liability premiums, costs continue to rise for obstetricians, forcing many to leave the field or change how they practice, experts say.

"The problem hasn't gone away," said Dr. Lisa M. Hollier, chair of the committee on professional liability at the American College of Obstetricians and Gynecologists. ACOG officials continue to hear of problems across the country, Dr. Hollier said, with physicians leaving obstetrics, caring for fewer high-risk patients, or limiting their deliveries.

In a national survey of more than 10,000 ACOG fellows and junior fellows last year, nearly 70% reported that they had made one or more changes to their practice as a result of problems in being able to afford or obtain professional liability insurance.

For example, 29% increased the number of cesarean deliveries, 26% said they had stopped performing vaginal birth after cesarean, and 26% said they decreased the number of high-risk obstetrics patients under their care. In addition, 12% cut down on their total deliveries and 7% reported that they gave up obstetrics completely.

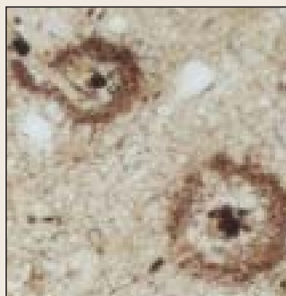
Another striking number revealed in the survey is the average age that physicians stop practicing obstetrics—age 48. "What we're seeing is people stopping their practice very young," Dr. Hollier said. "We're losing our most experienced physicians."

As for medical liability reform, efforts to pass noneconomic damage caps have failed to make it through the U.S. Senate and a number of state legislative bills calling for damage caps, health courts, or mediation have yet to gain traction, Dr. Hollier said.

In September, U.S. Rep. Michael C. Burgess (R-Tex.) introduced

See **High Costs** *page 7*

INSIDE



Statins vs. AD

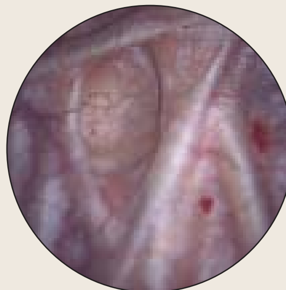
Statin drugs may slow the neurodegenerative processes in Alzheimer's disease.

PAGE 15

Antibiotics for MRSA

The choices are complex for this now common cause of serious soft-tissue infections.

PAGE 14

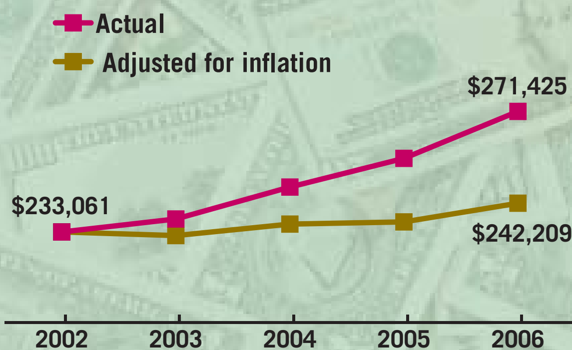


Master Class

Dr. Charles E. Miller and Dr. G. Willy Davila discuss the use of cystoscopy.

PAGE 22

VITAL SIGNS



ELSEVIER GLOBAL MEDICAL NEWS

Evista Approved for Reducing Invasive Breast Cancer Risk

Osteoporosis drug gains new indications.

BY ELIZABETH MECHCATIE
Senior Writer

The Food and Drug Administration has approved raloxifene hydrochloride (Evista) for two new indications: reducing the risk of invasive breast cancer in postmenopausal women with osteoporosis and in postmenopausal women at high risk for invasive breast cancer.

Raloxifene, a selective estrogen receptor modulator (SERM), is the second drug indicated to reduce the risk of breast cancer in women at high risk for the disease. Tamoxifen was the first.

Evista was first approved for preventing postmenopausal osteoporosis in 1997, then was approved for treating the condition in 1999, according to Eli Lilly, which markets the drug.

The FDA's Oncologic Drugs Advisory Committee had backed the approval of the new indications in its July meeting. The panel had reviewed four large studies submitted by Eli Lilly: the Study of Tamoxifen and Raloxifene (STAR) trial; Raloxifene Use for the Heart (RUTH) trial; Multiple Outcomes of Raloxifene Evaluation (MORE); and the Continuing Outcomes Relevant to Evista (CORE) trials.

A boxed warning about an increased risk of venous thromboembolism and fatal strokes as-

See **Evista** *page 4*

Teen Illicit Drug Use Down But Rx Drug Abuse Up

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — There's good news and bad news from the 2006 National Survey on Drug Use and Health: Overall drug use among adolescents has declined since 2002, but prescription drug misuse among young adults has skyrocketed.

In the federally funded annual survey of approximately 67,500 Americans, the proportion of adolescents aged 12-17 years who acknowledged drug use in the past month dropped from 11.6% in 2002 to 9.8% in 2006, similar to the 9.9% level in 2005. Current marijuana use in that age group declined even more significantly in those 4 years, from 8.2% to 6.7%.

"Illicit drug use among youth [aged] 12-17 is at a 5-year low. That's definitely cause for celebration. Tobacco use continues to decline and perceptions about risk for marijuana use continue to increase, and that's a great combination," said Terry L. Cline, Ph.D., administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), at a press briefing.

See **Drug Abuse** *page 7*

Insurance, Lifestyle Issues Key

High Costs *from page 1*

federal legislation (H.R. 3509) that reflects some of the reforms implemented in his home state in 2003: a $250,000 cap on noneconomic damages, criteria for who can serve as an expert witness in malpractice cases, and a statute of limitations on bringing suits.

This type of approach is unlikely to pass the U.S. Senate, Dr. Hollier acknowledged, but it does serve to reopen the discussion at the federal level.

Malpractice Rates Continue to Rise

On New York's Long Island, Dr. David Bergman is hoping for a state-level solution to rising malpractice rates.

A maternal-fetal medicine specialist practicing in the town of Great Neck, Dr. Bergman and his obstetrician colleagues will face a 14% increase in their professional liability premiums next year. The hike, which was approved in July, will raise annual premiums in parts of the state to as much as $196,000, according to ACOG's New York chapter.

In an effort to cope with premium increases, some physicians are leaving practice. Since 2003, 8.7% of ob.gyns. in the state have stopped practicing obstetrics and 12.6% have decreased the number of deliveries.

Dr. Bergman said he sees those trends reflected in his area as well. Compounding this issue is the fact that most physicians in the state are being paid roughly what they were in 1996, he said.

If state officials don't take action, Dr. Bergman predicted serious access problems will result in the next year or two.

In Pennsylvania, the combination of the steep professional liability premiums and low reimbursement rates has created yet another problem: A growing number of hospitals are closing their obstetrical units. Over the last 10 years, 33 such units have closed across the state, according to a report issued earlier this year by the Delaware Valley Healthcare Council.

The number of licensed obstetrical and obstetrical/gynecologic beds in southeast Pennsylvania has dropped by 28% during the same time period.

"It's really putting a big strain on the existing hospitals," said Dr. Ann Honebrink, chair of ACOG's Pennsylvania chapter.

Lifestyle Issues Play a Role

The long work hours and unpredictable schedules may be additional reasons why physicians at various stages of their careers are looking to change the way they practice.

One option that some physicians are considering is work as a laborist or OB hospitalist. "It's the hottest thing in the field right now," said Dr. Louis Weinstein, who is professor and chair of the department of ob.gyn. at Thomas Jefferson University, Philadelphia, and an advocate for laborist programs.

Under a model that Dr. Weinstein has been promoting, a laborist would manage labor and delivery in the hospital with a typical hospital program employing four laborists who each work about 42 hours a week. In an effort to maximize safety, Dr. Weinstein advises programs not to have physicians work more than an 18-hour shift or to maintain a private practice outside of their laborist work.

While laborists focus on labor and delivery, community ob.gyns. can focus on their office practice and avoid nights and weekends delivering babies, he said. "The days of one doctor from cradle to grave are gone."

A few years ago, the idea was initially popular with midcareer physicians who wanted a more predictable schedule and a break from the high cost of malpractice insurance, but today the field is attracting young doctors who put a high value on a balanced lifestyle, Dr. Weinstein said.

Another take on this concept is the OB hospitalist. Operating somewhat differently from a laborist, the OB hospitalist also is employed by the hospital and covers labor and delivery during set shifts. However, OB hospitalists generally manage emergency deliveries and cases in which the obstetrician requests their intervention.

Dr. John Y. Phelps, an obstetrician and an attorney, has been working as an OB hospitalist since 2000. Dr. Phelps spends his weekends delivering babies at the Parkridge East Hospital in Chattanooga, Tenn., and then commutes home to Texas, where during the week, he teaches residents at the University of Texas at Galveston and practices law.

During his shift at the hospital, which runs from 7 p.m. Friday to 7 a.m. Monday, Dr. Phelps is available for emergencies and provides triage. The situation is a win for all parties, he said. The hospital improves safety and decreases its liability by having an obstetrician immediately available, and physicians have a colleague on standby to evaluate patients or assist in a delivery.

Dr. Phelps said he suspects this model will be more popular with patients because they are managed by their own physician unless there is an emergency.

"The primary obstetrician still retains his or her autonomy," Dr. Phelps said. ■

In the coming months, Ob.Gyn. News will profile several physicians who have left obstetrics in favor of other opportunities in medicine. Stay tuned to read about how they are enjoying a good practice and a good life.

Painkillers Misused

Drug Abuse *from page 1*

But nonmedical use of prescription drugs among young adults aged 18-25 years increased from 5.4% in 2002 to 6.4% in 2006, largely because of a rise in the nonmedical use of pain relievers. "The survey also tells us there is much work left to be done. Many of these painkillers being abused are unused medications that should have been properly disposed [of]," Dr. Cline said.

SAMHSA has launched a national point-of-purchase public education campaign to release information about the proper disposal of unused medications, and the information soon will be available at more than 6,300 pharmacies across the country, he reported.

Underage drinking is another area of concern, as the level among 12- to 20-year-olds remains unchanged since 2002, at 28.3% in 2006. The Surgeon General's recently released Call to Action to Reduce and Prevent Underage Drinking is part of an interagency effort to target the problem, Dr. Cline noted.

John P. Walters, director of the White House Office of National Drug Control Policy (ONDCP), presented additional findings from the survey. Of note, he said, is that a huge difference in marijuana use was found between youth aged 12-17 years who reported that their parents strongly disapprove of marijuana use, at 4.6%, versus those who did not perceive strong parental disapproval, 26.5%, a fivefold difference.

Among young adults aged 18-24, the drop in marijuana use from 17.3% in 2002 to 16.3% in 2006 was "vastly overshadowed" by the increase in prescription drug use, 75% of which are pain relievers. That usage is now much greater than that of cocaine and heroin and is even reaching the initiation rate for marijuana. Most people who abuse prescription drugs get them from family and friends, Mr. Walters said.

"You have to help people understand that when they're done with prescription painkillers in particular, [they need to] throw them away. ... We have to start remembering that OxyContin and Vicodin in the medicine cabinet today, if not protected, are as dangerous as cocaine and heroin," said Mr. Walters, whose job title is known informally as "the nation's drug czar."

Miriam E. Tucker/Elsevier Global Medical News

National Drug Control Policy director John P. Walters, left, and SAMHSA head Terry L. Cline speak at briefing.

A somewhat surprising finding is the striking rise in drug use rates among Baby Boomers aged 50-54, which shot up by 76% over the 4-year survey period, from 3.4% to 6.0%. "What we have here is something we've never seen before: increasing rates of illicit drug use among older Americans. This was typically a problem of youth. But today, we have older Americans bringing those levels of substance abuse with them [as they age]. ... Once you become involved with these substances, it is very difficult to become clean and sober," Mr. Walters noted.

Dr. Cline said SAMHSA is collaborating with various entities to address the issues brought out by the survey. Among those efforts are a partnership with the ONDCP to provide resources to more than 700 communities to prevent drug abuse and provision of grants to 34 states, three territories, and five tribal organizations to promote science-based prevention strategies at the community level.

In addition, SAMHSA has just launched a new initiative called ACTION (Adopting Changes to Improve Outcomes Now), which aims to improve access to addiction treatment services and to keep clients engaged in treatment. "We need to make certain that addiction is treated with the same sense of urgency as other medical conditions," Dr. Cline said. ■

FDA Posts Warnings on Risks of Buccal Fentanyl

The manufacturer of the buccal formulation of fentanyl is notifying health care professionals about serious adverse events, including deaths, that have been reported in patients treated with the opioid analgesic drug, a result of improper patient selection and other factors.

A "Dear Healthcare Provider" and a "Dear Doctor" letter were issued by Cephalon Inc. and posted on the Food and Drug Administration's MedWatch Web site in September. Cephalon markets fentanyl buccal tablets under the trade name Fentora, an opioid agonist that is a schedule II controlled substance. Fentora is approved only for the management of breakthrough pain in patients with cancer who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain.

Use in opioid-nontolerant patients is among the causes of deaths in patients treated with Fentora. In addition to improper patient selection, deaths have resulted from improper dosing and/or improper product substitution, according to the letters, which emphasized that Fentora should be used only for the indications in the label and only in patients taking round-the-clock opioids. Fentora should not be prescribed for patients with acute pain, postoperative pain, headache/migraine, or sports injuries.

The letters also state that Fentora is not a generic version of Actiq, and should not be substituted for Actiq or other products containing fentanyl. Actiq is the trade name for oral transmucosal lozenges containing fentanyl.

Prescribers are urged to follow the dosing instructions carefully: Patients with unrelieved breakthrough pain should not take more than two Fentora tablets per episode, and patients should wait at least 4 hours before treating another breakthrough episode of pain with Fentora.

Health care providers with further questions can contact Cephalon at 1-800-896-5855.

—Elizabeth Mechcatie

The MedWatch summary, letters, and label with medication guide are available at www.fda.gov/medwatch/safety/2007/safety07.htm#Fentora.