

# LETTERS

## Absence of global ablation device questioned

In "Endometrial ablation: a look at the newest global procedures" [February], Keith Isaacson, MD, does a good job of summarizing the 3 most recently approved devices for global endometrial ablation. However, I find it puzzling that he failed to mention the device that launched the breakthrough in second-generation global ablation techniques: Gynecare's Thermachoice Uterine Balloon Therapy System. Since 1997, approximately 175,000 cases have been performed with this system, producing excellent results, a low incidence of complications, and no reported cases of endometrial cancer.

Dr. Isaacson states that the long-term consequences of endometrial ablation remain unknown because follow-up data beyond 24 months are minimal. That is not true. In fact, at the recent annual meeting of the American Association of Gynecologic Laparoscopists (AAGL), Frank Loffer, MD, and David Grainger, MD, presented 5-year follow-up data of patients participating in the Thermachoice trial. The data verified the efficacy and safety originally reported. The authors concluded that uterine balloon therapy is effective for treating menorrhagia, and "clinical outcomes are similar to rollerball ablation at 5 years post-procedure." Clearly, the omission of uterine balloon therapy resulted in an unbalanced article.

*Martin Weisberg, MD  
Department of Medical Affairs  
Ethicon, Inc  
Somerville, NJ*

### DR. ISAACSON RESPONDS:

I would like to thank Dr. Weisberg for his comments. Indeed, the article was intended to highlight only the newest global endometrial ablation devices, i.e., those that were approved by the Food and Drug Administration (FDA) in 2001. Thus, the article focused on cryoablation, circulating heated saline, and bipolar desiccation. The exclusion of other global ablation devices, including uterine bal-



loon therapy, does not imply that they are less significant or effective.

With regard to Dr. Weisberg's second point, the only long-term follow-up data for second-generation global endometrial ablation techniques is the previously noted unpublished abstract presented at the AAGL meeting. If Dr. Weisberg would like to send me that abstract, I would be happy to comment on it.

## Additional conization techniques offered

OBG MANAGEMENT continues to offer concise, timely, and clinically relevant articles; January 2002 is no exception.

I would like to add my pearls to Dr. Marc Togli's article, "Cone biopsy: perfecting the procedure," on cold-knife conization.

- Use 4 units of vasopressin and 40 cc of 1% lidocaine (10 cc in each quadrant of the cervical stroma). Vasopressin is less arrhythmogenic than epinephrine.
- Use the Newman endocervical tenaculum to better define the internal os. Place lateral hemostatic sutures at 3 o'clock and 9 o'clock. Avoid sutures postconization, as they will distort the cervix and make follow-up colposcopy more challenging.
- After completing the procedure, open the specimen at 12 o'clock and affix to a paraffin block or tongue blade. This enables a pathologist to "step-section" the specimen, affording more accurate assessment.

*Paul Caporossi, MD  
Hickory, NC*

### DR. TOGLIA RESPONDS:

I would like to thank Dr. Caporossi for his additional pearls.

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