

HRT treatment for osteoporosis challenged

In the January article, "SERMs: protection without worry?" Anthony Luciano, MD, states that the National Osteoporosis Foundation (NOF) "recommends hormone replacement therapy (HRT) as the first-line agent for the treatment and prevention of osteoporosis in the general population."

It is important to note that the FDA has approved HRT for the prevention and management of osteoporosis, but not for treatment. NOF's recommendations concur with these FDA indications.

*Ronald White, Assistant Executive Director
National Osteoporosis Foundation
Washington, DC*

DR. LUCIANO RESPONDS:

Indeed, the FDA has recently withdrawn its approval of HRT for the treatment of osteoporosis, but it continues to support HRT use for the prevention of osteoporosis. My recommendation is the same until further data suggest otherwise.

Few seek sex therapy with male partners

I concur with the points Barbara Levy, MD, raises in her article, "Break the silence: discussing female sexual dysfunction" [March], especially the need for physicians to raise the subject. In fact, I post an open letter in my office that informs patients of my willingness to provide sexual counseling, as it was a formal part of my OBG residency training. However, I insist that their male partners also participate. Perhaps because of this, very few have sought therapy.

It is important to note that of the patients who do seek counseling, perimenopausal women (ages 40 to 50+) most frequently report having decreased libido compared with other age groups.

*Gary Steinman, MD
Astoria, NY*

DR. LEVY RESPONDS:

I agree with Dr. Steinman that decreased libido is a common complaint among perimenopausal women. However, testosterone levels actually begin their decline much earlier. Another group who frequently report diminished libido are women

in their 30s, particularly those who are new mothers. Whether it is the abrupt change in lifestyle, the stress of motherhood, or declining testosterone levels that precipitate this often dramatic alteration in sexual function, remains to be elucidated. The key point is that without our direct solicitation, many women suffer these symptoms in silence.

Additional supracervical techniques offered

I read with interest Dr. Andrew Menzin's article, "Hysterectomy: total versus supracervical surgery" [March]. It has been my practice for some time to conserve the cervix whenever possible. However, my concern has not been for the preservation of sexual function. Rather, I believe the supracervical approach is safer for the patient and—from a legal perspective—the gynecologist. The majority of lawsuits related to hysterectomy arise from alleged damage to the bladder or ureters. These risks are minimized, if not eliminated, when the cervix is conserved. Additionally, the risk of hemorrhage is greatly reduced in a supracervical procedure.

My own technique is to clamp and divide the uterine arteries after creating a small bladder flap. I then take a single pedicle from the cardinal ligaments bilaterally. Using a transverse V-shaped incision, I separate the fundus from the cervix at the level of the internal os. Finally, I easily approximate the stump edges after coagulating the endocervical canal with electrocautery.

*Douglas Heritage, MD
Woodbridge, Va*

DR. MENZIN RESPONDS:

I appreciate Dr. Heritage's thoughts on the potential benefits of the supracervical hysterectomy. Several points regarding the procedure should be emphasized.

First, in his technique, the ureter is still at risk, as the uterine artery pedicle is one of the most common sites of ureteral injury during a hysterectomy.

Second, care should be taken to ensure removal of the upper cervix—as described both in the article and Dr. Heritage's letter—to avoid the presence of residual endometrial tissue at the cervical stump.

Lastly, preoperative counseling should include a thorough review of the risks and benefits along with a discussion of therapeutic alternatives.