VARIATIONS IN HYSTERECTOMY RATES IN ONTARIO

Although I am not an epidemiologist, I have some concerns about the article "Variations in hysterectomy rates in Ontario: Does the indication matter?" (Can Med Assoc J 1994; 151: 1713-1719), by Drs. Ruth E. Hall and Marsha M. Cohen.

The main indication for a hysterectomy found was "menstrual hemorrhage." I have yet to see this diagnosis on a discharge summary; for practising gynecologists, this term may be confusing. Most gynecologists find it somewhat misleading when patients use the term "hemorrhage" when, in fact, they have not had a hemorrhage but bleeding. Clearly, bleeding can be a problem, causing anemia and other adverse effects, but "hemorrhage" is usually restricted to its true definition.

Some of the terminology problems in the article could have been mitigated if it had been reviewed or cowritten with a practising gynecologist. This may have been the case, but no gynecologist is credited as an author or reviewer.

The hierarchic approach taken in this study may work well epidemiologically. However, it has inherent limitations when applying the article's conclusions to practice. Fibroids are often an incidental finding during a hysterectomy and are unrelated to the patient's problems. The presence of fibroids seems to weigh very heavily in this study, but, in fact, for the patient, this may have been an incidental finding. Most pathologists report fibroids of any size and include this finding in the pathologic report, which is often then coded. In this study, the code was significant in determining the hierarchic position of the indication.

In regard to prolapse, the authors state that "hysterectomy is indicated for symptomatic women with prolapse of the third degree or greater." This indication is too academic. The patient may have only first-degree or second-degree prolapse; however, functional symptoms such as stress incontinence, which may be associated with other pelvic problems, may indicate vaginal hysterectomy with repair. The study does not clearly address the complicated nature of pelvic repair beyond this pristine definition. It may have been better to exclude vaginal hysterectomy and limit the study to abdominal hysterectomy.

The authors comment that community hospitals may perform more hysterectomies to treat endometriosis than teaching hospitals because they lack the new technology needed for alternative treatments (i.e., hormonal therapy, endometrial ablation and pelviscopy). To the best of my knowledge, endometrial ablation is not helpful in nor is it related to the management of endometriosis. I am also uncertain about what "pelviscopy" is, since it is not defined in the article and rarely used in practice.

I was pleased to read that the patient's perspective was considered and included in this study. The article suggests that more information on treatment options would be useful for patients; this seems to suggest that such information would lead to a decrease in the rate of hysterectomy. However, most gynecologists spend a significant amount of their time, not only at community hospitals but also at tertiary care hospitals, talking patients out of a hysterectomy, not into one. The effect of a fully informed patient population in the province may be surprising and the opposite of what the authors expect.

Patients are, by and large, fairly well informed concerning hysterectomy. In most instances they have discussed it with their friends. This, of course, may lead to erroneous conclusions, either positive or negative, about the benefits and risks. Although patients claim to appreciate that a hysterectomy is major surgery, major complications are not to be treated lightly.

I think that this article provides some welcome information; however, the study would have benefited significantly from a shared interdisciplinary professional approach that included a gynecologist. Further studies of this nature are certainly welcomed by the practising gynecologists of Ontario.

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[One of the authors responds:]

Dr. Johnston raises various issues, none of which changes the overall message of our article. To assign indications, including menstrual hemorrhage and fibroids, we followed the codes from the clinical modification of the International Classification of Diseases, 9th revision,
DENIED TRAINING, PHYSICIAN HEARTENED BY SUPPORT

I wish to express my gratitude to the many physicians who re-

Denied training, physician heartened by support

sponded to my letter ("Licensed physician denied further training" Can Med Assoc J 1994; 151: 912 and "Physicians forced south, prevented from changing fields" [replies] Can Med Assoc J 1995; 152: 149, 152). It is heartwarming to know that at least some of my colleagues are disturbed by the changes to our profession and feel the social responsibility to protect its future. My case, in which the British Columbia government has refused to allow me to pursue a residency in ophthalmology at a top US centre, is a political injustice of the highest magnitude. Public sentiment is really the only recourse I have left. I would like to thank Drs. Philip P. Narini, Edwin M. Janke, Kevin P. Mudrik and, particularly, Dimitrios G. Oreopoulos, who was so troubled by my situation that he was willing to donate $500 toward a legal challenge.

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ADOPTED CHILDREN EXPOSED TO COCAINE IN UTERO: CONFOUNDING FACTORS

The article by Dr. Irena Nulman and associates ("Neurodevelopment of adopted children exposed in utero to cocaine," Can Med Assoc J 1994; 151: 1591–1597) describes an important result not previously reported in the literature. However, a confounding variable in the neurodevelopment of the adopted children examined in this study is the fact that adopted children, as a group, have a significantly higher prevalence of attention-deficit hyperactivity disorder (ADHD), which could account for some of the psychometric differences between the experimental (adopted) and the control (nonadopted) groups.

Furthermore, psychoactive substance use disorders are reported to be one of the most common comitant diagnoses among adults with ADHD. Thus, cocaine abuse by the biologic mothers increases the likelihood that they have ADHD. This underlines the need for additional control groups in studies such as the one by Nulman and associates. Additional groups of children raised by biologic, cocaine-using mothers and of children with ADHD raised by mothers with ADHD, whose outcomes could be compared with the experimental group, could help to disentangle this confounding variable.

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References

[Two of the authors respond:]

It is important to remember that domains other than cognition and language may be affected during intrauterine life, resulting in a range of serious problems. ADHD is one of these problems, but similarly con-