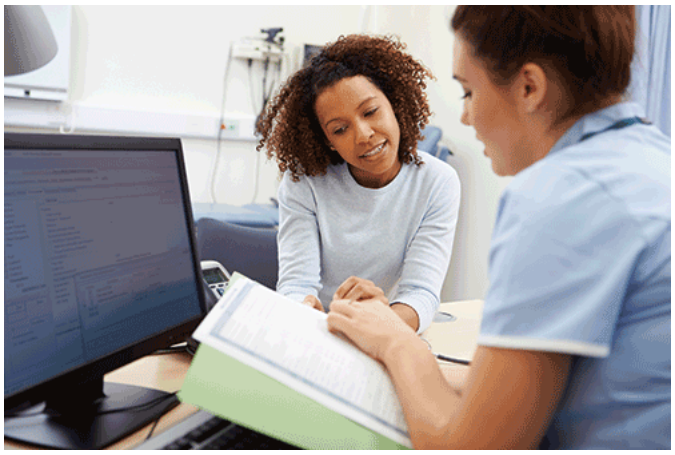
Feature: A case for collaboration

Working with OB-GYNs to improve patient care for women

BY SUSAN ROSE WINTER 2018



Interventional radiology plays an important role in women's health. However, as the society reported in 2017, awareness of that role by patients and referring physicians still lags far behind.

Consider the prevalence of the two most common women's health conditions that IRs provide relief for.

Uterine fibroids: Between 80 and 90 percent of African American women and 70 percent of white women will develop fibroids by age 50. More than 90 percent of women with fibroids seek medical or surgical treatment for the condition within one year of the diagnosis.[1] Yet, despite these numbers and the efficacy of IR treatments, many gynecologists don't collaborate with IR early in the patient journey.

Postpartum hemorrhage: Accreta (when all or part of the placenta does not separate from the uterine wall) shows up in about one in 500 births. One in 14 American women with accreta die, usually from hemorrhaging.[2] Although the evidence still needs to be developed and published, IR certainly has a role in treating this patient population, as well. However, there

remains tremendous variability from site to site in whether a hospital will reach out to IR for these patients. Hospitals that routinely consult IR are typically more likely to establish protocols for involving them in patients with potential for postpartum hemorrhaging, so establishing a collaborative OB-IR relationship is an important first step.

If interventional radiology procedures have the potential to help so many women, why aren't gynecological colleagues collaborating with IRs more often?

Talk to five OB-GYNs and you'll get five answers to this question—from personal preference to work setting. However, these same doctors agree there are three broad areas that can help IRs strengthen partnerships with their colleagues in women's health.

1. Foster relationships

"Learning and collaboration: these are two traits that will get the OB-GYN's attention," said Jacquelyn Howitt, MD, OB-GYN physician at Rochester General Hospital. She says fostering relationships with other practice areas to figure out how they can together provide the best treatment option for the individual patient is key, and it requires "a clinical approach, a desire to collaborate and a thirst for learning."

Dr. Howitt's relationship with Raj Pyne, MD, an interventional radiologist at Rochester General Hospital, demonstrates how actively fostering that connection pays off for the patient. Drs. Pyne and Howitt met at a hospital social event, during which they discussed what IR could do for a woman with accreta. A few months later, Dr. Howitt had a case where the young woman was bleeding badly and the usual interventions weren't working. She remembered speaking with Dr. Pyne and called him.

"The rapid response from Dr. Pyne and his team were instrumental in saving the patient's life. That event was pivotal in our relationship, not only because of the skills, but also because of the kindness inherent in his approach to the patient and her husband and his willingness to work with the OB-GYN providers to best care for this patient."

"I remember she hugged me after the procedure, literally just embraced me," said Dr. Pyne. "That had never happened to me before. But she thought her patient was going to die. She's a wonderful doctor who is very close to the patients."
The two doctors now collaborate often, especially with high-risk patients. Dr. Pyne believes this collaboration is possible because, as a clinician, he talks to his patients. "I'll tell them I hope I never see them again, but here's what will happen if I do. I educate them on what might happen and why. I think that collaboration is very important," he said.

Both doctors stress that this relationship works because it is based on trust and collaboration.

While Tammy Lockett-Benjamin, MD, FACOG (an OB-GYN physician in Northern Virginia), and Eric Rappaport, MD (a retired OB-GYN physician in Raleigh, North Carolina), worked with IRs, neither had relationships that close with them—due primarily to their hospital-based setting. "We knew what they could do, and if there was an emergency we called them," said Dr. Lockett-Benjamin. She said it was the same for UFE referrals.

Dr. Rappaport says much of his comfort in calling on the IRs is that they're "real doctors"—that is, he appreciates IRs' clinical nature and desire to talk to patients and work with other practitioners. Again, relationships were important.

Laura Korman, MD, gynecologist at Synergy Women's Health in Portland, Oregon, says that another key is getting involved in the local OB-GYN organization, giving presentations and reaching out to their members. She says she wants to know that the IR is as passionate about women's health as she is.

2. Foster mutual respect

The steps for building relationships naturally follow into mutual respect. "Mutual respect starts with valuing our gynecology colleagues," says Mary Marcelle Costantino, MD, an interventional radiologist in Portland who has a strong working relationship with Dr. Korman. "Gynecologists are our collaborators in women's health and our backup in

complicated cases. I want my patients to be fully informed, and I often refer patients who come to me for UFE to a gynecologist to understand their surgical options. I'm a big believer in that. If we're going to talk about knowing all your options, that really means knowing your options, both minimally invasive and surgical."

"It was really nice to connect with someone who is so passionate about outcomes, passionate about individuals and also interested in the academic aspect of the treatments," said Dr. Korman. "Mary is so personable and passionate about the patients and doing the right thing for the patient. It's a spirit and energy shared by lot of OB-GYNs."

3. Educate, educate, educate

When Dr. Costantino started her practice, she encountered a lot resistance to referring for UFE, in part because the gynecologists were uninformed. While certainly some gynecologists viewed alternatives to hysterectomy as competition, most didn't really know much about it. However, many of these gynecologists were open to UAE and happy to have an IR to refer interested patients. So Dr. Costantino set about educating her colleagues, visiting their practices and attending the local OB-GYN meetings.

"The biggest hurdle was not that I needed to convince gynecologists to send me patients, it was needing to educate the community about proper patient selection and the evolution of the procedure. Not all gynecologists train in a university setting with access to IR, and the lack of exposure carries into their practice following residency. I definitely encountered gynecologists who have had bad experiences with UAE and subsequently decided UAE doesn't work, or they were unimpressed with the clinical care," said Dr. Costantino.

Dr. Lockett-Benjamin agrees that doing the footwork and educating gynecologists is important. "In my experience from both hospital and private practice settings, not all OB-GYNs know exactly the full scope of IR practice," she said. Going on grand rounds, calling in at private practices, attending meetings—all of these efforts elevate awareness.

And according to Dr. Rappaport, his priority is a better understanding of the criteria IRs used so that he only referred women who were clearly candidates for the procedure.

Dr. Constantino adds that IRs "absolutely need to publish outcomes in the gynecology literature. We need to educate our colleagues through data and evidence-based medicine."

Remaining barriers

Despite these tactics for building working relationships, IRs may still face barriers.

"Gynecologists—not OB-GYNs but GYNs in particular—like to take a surgical approach," said Dr. Howitt. She says that while GYNs find minimally invasive options like UFE interesting, many still have reservations about taking that approach—as do their patients. "If you come from a surgical mentality like I do, you know that you've dealt with the problem that way before. If someone has fibroids and you take out their uterus, the problem is gone forever. It's hard to recommend a procedure that may not fix the problem for good."

Some of that bias may be based on geographic location. Dr. Lockett-Benjamin noticed a stark difference between her patients in New York and in Northern Virginia. Patients in Brooklyn wanted to keep their uterus no matter what—even if they looked like they were eight months pregnant with fibroids. Patients in Virginia were quicker to accept a hysterectomy; in fact, she was surprised at how often hysterectomies were performed for fibroids. She says, however, that she is open to trying UFE first if it makes sense because, if it doesn't work, the open surgical option remains.

To address such lingering concerns and reservations, it all comes down to getting to know the people you would work with—the GYNs (and their patients) as individuals. Find out what they need and want from you, and always be open to talking and collaborating.

References

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