**Episode 20: Monthly Checkup – July 2017**

Dr. Joe Chappelle: Hello everyone, and welcome back. I’m Joe Chappelle and you’re listening to Episode 20 of the OB/GYN Podcast. Today, I am lucky enough to have Dr. Sara Kim with me for a brand-new episode format. This is called the Monthly Checkup, where myself and a guest or two will talk about some recent topics in Ob/Gyn or medicine at large. I hope you enjoy the discussion on recent events and so with that, why don’t we get started. Dr. Kim, are you ready?

Dr. Sara Kim: I’m ready.

Dr. Joe Chappelle: Alright, so let’s do it. The first topic today is actually a CDC article or bulletin that was published last month, and I’ll summarize it first. Essentially, it describes the case of a woman who delivered at 37 weeks, who was found to be GBS negative. The baby unfortunately developed GBS sepsis right after birth, was admitted to the NICU and was treated for 11 days with ampicillin. That particular strain of GBS, and this is important, was penicillin sensitive but clindamycin intermediate. After the 11 days, the baby was discharged home, and then 5 days later was readmitted with late onset GBS sepsis. This is, like I said it was important, this particular strain the baby had now was penicillin sensitive and also clindamycin sensitive, and so we assume that it’s a different GBS strain than the first one it had.

Now, where the case gets interesting and where the CDC comes in, is that this mother had started eating encapsulated placenta 3 days postpartum. When the admitting doctor found out about this, she asked her to stop eating the placental capsules and she had the placental capsules tested. They found that both the capsule and the infant both tested positive for the same strain of GBS and so, presumably, the infant had late onset GBS sepsis due to maternal colonization from eating encapsulated placenta. I thought this was a very interesting topic about something that has become I think more prevalent, or at least there are more people talking about it in the last few years, but there’s very little science behind it or data behind it, and it brought up, at least… it may be rare, but definitely a complication of that.

Dr. Sara Kim: Yeah, I agree. Just reading the article, it made me realize, especially being on the floor, I feel like I’m seeing more and more patients requesting to take the placenta home for encapsulation, and I think most of them used different companies, and to be honest I didn’t really know what their process is, and after reading this article I looked at what different companies do to go through the process of encapsulation and there’s really no standard protocol. And that’s what’s concerning, and I wonder if people, when they request to take the placenta home, how much research actually goes into what company A’s doing versus what’s company B, and the fact that none of this is regulated is also concerning, because that could definitely lead to more of these uninformed decisions that potentially will lead to an event like this.

Dr. Joe Chappelle: That’s exactly what was my thought on it as well. I think is going to end up being a podcast episode of its own, about placental encapsulation, because it’s interesting. But when I looked at it, I started thinking, what are the beneficial effects? And then, what are the risks? Like we do with any treatment or anything else. For this, I did exactly what you did and looked at what are people doing, and there are some companies but it’s also just a lot of people online who do it themselves. And so, what I found, the process, for those at home who don’t know this like I didn’t, what most women do or most companies do is they start by steaming the placenta for 15 to 30 minutes to cook it. And then after it’s been cooked, it usually loses about half its volume, they then cut it up into strips and then bake it in order to dehydrate it. And that I found very variable numbers. People did it for 6 hours, 14 hours, 24 hours… And the temperatures were all over the place.

Dr. Sara Kim: Right. Yeah. I found the same thing, where they say the protocol was to steam it and they think that’s the way to kill the bacteria and it causes the baking process, the dissection, but there’s nothing that shows one method that’s better than the other and the article says, heating at 130oF for 121 minutes was required to reduce Salmonella bacteria counts by 7 log10 and I wonder if the protocols that these companies have made have looked into what is required to kill X amount of colony counts of bacteria, because they are all over the place.

Dr. Joe Chappelle: Yeah. Agreed. And I would love to see some research where… hey, maybe we could do this, where we take some placentas and you culture them before you do anything and then you steam them at a certain temperature for a certain number of minutes and then you look at the colony counts again to see how long you have to do it before you get rid of most of the bacteria.

Dr. Sara Kim: I agree, that would be an excellent way, I think, to see what would be maybe the standard protocol, and I wonder if these companies even did something like that to test what would be the way to best kill the bacteria. At least from the little… the companies, I didn’t really see too many references or trials or studies that looked at that.

Dr. Joe Chappelle: Yeah. I mean, at least at our hospital, where we both work, I know that there aren’t really companies that are doing this, there are people, and you call this woman who comes and picks up your placenta and then a couple of days later brings you the capsules to eat.

Dr. Sara Kim: Sometimes we even joke around, like, “how do you know it’s even your own placenta?” Because there’s no way to know that.

Dr. Joe Chappelle: That’s entirely true, and we could bring that all the way back to, how do you know what you buy at the health store is what it says it is, because it’s not regulated. And then, if you look on these websites, these women say… I’m saying women because it’s mostly the women who post these blog pages, but they say, “don’t cook it too long because then you’re reducing the nutritional benefit of eating the placenta.” Like cooking vegetables, don’t cook your vegetables because you’re getting rid of the nutrients. But right there, we’re running up against the bacteria versus nutrients. And again, we don’t know how true that actually is, because no one’s actually looked at it.

Dr. Sara Kim: Right. And even looking at the prose, I agree. Usually, the biggest argument for placenta encapsulation and to ingest it is for nutrition, but how much nutritional content has really… did we test the capsules to see how much nutritional content it actually has? I’m not sure they really looked at that.

Dr. Joe Chappelle: Yeah. I could only find two studies, and they were from the same group. One of them… this is by Young et al. in Nutritional Research published August 2016, and they took encapsulated placenta and they tested them to see how many elements were actually in there. They found that, if you took… I forget exactly how many capsules per day, but whatever the capsules… I guess three times a day, you got 24% of your daily iron intake for a breastfeeding woman, 7.1% of your selenium, I don't know how important that is, 1.5% of your zinc and 1.4% of your copper. They also found that there were trace amount of arsenic, cadmium, lead, mercury and uranium, and they were really trace, and well below what the FDA considers to be safe, so it’s okay. But that got me thinking. Alright, well, you’re getting at least iron and selenium, so that’s something. So, how important is that? Well, the same group then went back and looked at women, they did a randomized controlled trial, doubled blinded, with encapsulated placenta versus placebo, and they found that although yes, the encapsulated placenta had more iron, the women had no difference in any of their hemoglobin, hematocrit indices or their iron levels after a month of eating their placenta.

Dr. Sara Kim: Wow. That’s actually pretty impressive, that’s a good study to look at and I wonder if women know about that when they’re going and singing up for this placenta encapsulation, because if one of the biggest reasons, and we talk about risks and benefits, if one of the benefits that we’re talking about is nutritional value and it’s not really adding to the nutritional value for the women, I wonder if it’s even worth taking the risk of possibly neonatal GBS sepsis.

Dr. Joe Chappelle: We talk about this a lot, and we’re going to talk about it in one of the other topics today, but you get into number needed to treat. If your number needed to treat for benefit is, say, 50, and your number needed to treat for a bad outcome is 100,000, well sure. If the risk is really bad, that’s probably a good tradeoff. However, no matter what your risk is, even if it is one in a million, let’s say that this only happens once a year in the United States, but there’s no benefit, well then we shouldn’t do it.

Dr. Sara Kim: Right.

Dr. Joe Chappelle: And there are many people who’ll listen to this who are going to say, “well there are probably other benefits than just nutritional.” Maybe it’s hormonal, there are people who say you can eat the placenta for oxytocin, for uterine contraction and things that maybe we don’t understand yet. And I am willing to accept that we don’t know everything, because I don't know everything, and I don't know how common this particular risk is, and I’m not saying we should change anything necessarily, but I think it’s a great time to step back and say, women are doing this more, let’s start devoting some research to it and find out if it’s good and give women the data they need to make an informed decision.

Dr. Sara Kim: Right. And I wonder how much of this is up to us as Ob/Gyns to counsel or talk about the risks with the patients. When patients ask to take their placenta home, I’ll be honest, I don’t usually go in the room to tell them, “Here are the risks of placenta encapsulation, and there’s not really a study that shows the benefits.” I just say, “Okay,” and I let them take them home. But I wonder if it’s something that maybe we need to think about, do we need to have a discussion with the patients and at least let them know so they can make a more informed decision. Although I agree, we don’t have big data to give them the best counseling at this point, but maybe that’s something that we need to think about as well.

Dr. Joe Chappelle: Yeah. I think for right now, all we can really do is ask… I’d like to ask the patient, “Why are you doing it? What do you feel that you’re getting out of it?” Because they may say, “Well, I heard it’s good for my iron levels.” Well, at least I can say with that, “Doesn’t seem to be.” But if they have a different goal and I have no data go for or against it, I think what you’re saying is the least we can do is say, “Well, there’s no really good data here, and there is some data that maybe there’s a risk. So, think it through and ask the woman or person who’s going to be encapsulating for you what their process is.”

Dr. Sara Kim: Right. So that at least they’re thinking about it. Yeah, I agree. Instead of just saying, “Okay, you can take it home,” I think maybe we need to make it a habit to just at least ask the patient to say what their motivation is, I agree.

Dr. Joe Chappelle: Alright. Well, I think we’ve… and there’s not much we can say about that, because there isn’t a whole lot of data, but I think we’ve raised the topic and I hope that we come back to this one in maybe a future episode podcast or maybe even another discussion down the road as we get more information.

Dr. Sara Kim: Right. I think it would be good to just have awareness at least of the issues, because not everybody knows about even placenta encapsulation and even the risks of it, possibly, so, agreed.

Dr. Joe Chappelle: Exactly. Alright. We’re going to move on. This topic was actually brought to us by Dr. Kim, so I’m going to let her give us a brief synopsis of how she came across it and what it says.

Dr. Sara Kim: Okay. The paper that I decided to talk about that I thought was interesting is basically a study that was actually done in Canada, and made me think about what are some of the things that we do that we don’t really think… some of the things, some guidelines that we adopt that may have other indirect consequences. As many of you know, in 2012, the ASCCP, which is I basically the American Society for Colposcopy and Cervical Pathology changed its guidelines that lengthen the time interval between Pap smears, so women aged 21 to 29, cytology is basically done every three years, or that’s the recommendation, and women aged 30 to 64, cytology with HPV testing, which is known as co-testing is done every five years and that’s the preferred method, although you could do a cytology every three years. That’s a change from before when we used to do Pap smears basically on a yearly basis. From my personal experience, I’ve heard many women say that they don’t need to go to the annual exam since Pap smears are not done annually anyway, and some simply get lost to follow up and they forget when their last Pap smear was or even to remember to go to their Ob/Gyns because they will come and not get their Pap smears, and they will just say, “I don’t need to go for annuals anymore.”

I think the argument was that, because of the progression of disease of cervical cancer and HPV disease, that it’s such a long progression and it takes a lot of time to develop, that the potential benefits of continuously testing is not worth the cost and unnecessary base to diagnostic testing with a colposcopy. One of the things that this paper brought up is that with this change, they’ve noticed a decrease in detection and treatment of chlamydia, and basically the paper is published in the Annals of Family Medicine, and it’s a study done by Naimer et al. and the paper looks at the impact of chlamydia incidents in light of this change in screening guidelines.

So, basically they started to look at data two years prior to and two years after the implementation of the change and found a reduction in chlamydia testing in females. Ironically enough, the incidence in the male population did not decrease during this time. So, I thought it was kind of interesting to see that, although… and again, the data is not there right now to show whether the change in these guidelines from the ASCCP, what impact it has had on cervical dysplasia and the detection and the incidence of cervical cancer in general, but it goes to show that there are other areas that have been impacted by this guideline and changes.

Dr. Joe Chappelle: Yeah. Before we get into the cervical screening stuff and the unintended consequences, I just want to stop for a second and talk about, what they found here is that they showed a decrease incidence from 26 to 18 or something like that, right?

Dr. Sara Kim: Yes.

Dr. Joe Chappelle: We’ll assume that the actual incidence didn’t change, it was just the number that were picked up. And we already talked about in, I would say a little bit too exhaustive discussion on PID that we did in the Fall of last year, that each one of those women that you don’t pick up is a woman who could end up with PID, who could end up with infertility, who could pass it on to somebody else, and all the costs that are downstream of that can be huge. So, this is not something we… “Okay, so we missed a few women with a chlamydia.” I just want to make the point for all the listeners that, to me at least, that is a huge deal.

But going back to the cervical screening and its effect, I found this fascinating. It really comes down to unintended consequences but also public health versus personal health. This is a discussion we have all the time, especially in Pap smears and mammograms, is that public health applies to a large population of women, but each individual woman’s health is her own. Especially with Pap smears, agreed that, at least we think that by decreasing the interval between Pap smears, that we’re going to decrease all these unnecessary tests and maybe preterm labors and all that kind of stuff, incompetent cervix, which will be good. At the same time, there’s a woman out there who you didn’t Pap this year who has cervical cancer.

Dr. Sara Kim: Agreed, and I see some patients in the clinic who actually say that. They say, “How come three years ago this wasn’t there? Maybe if I had gotten annually, you guys would have picked up this cervical dysplasia earlier.” And to be honest, I don’t have an argument, it’s just that… Luckily so far, most of them have been CIN1s or CIN2s, but who knows? Maybe that one-year difference made a huge difference in that person’s life.

Dr. Joe Chappelle: Statistically, it will. Eventually, you’ll find that woman who would have benefited. But that’s how population health works. The other thing I found interesting… Before I get there, you brought it up, but a lot of people, Ob/Gyns, were… I don’t want to say upset, but they definitely were worried about this change from yearly to three years or whatever, for this exact reason, that women wouldn’t come for their annual exams. And at the time, I kind of poopooed that, to be honest with you. I mean, most of what we do in an annual exam is actually not helpful. If Pap smears every year don’t help, okay. We already know that clinical breast exams are essentially useless at picking up meaningful breast cancers, and we have no screening test for ovarian cancer, so what are we really doing? Well, I mean, we are doing things, we’re talking to the patients, we’re asking about menopausal stuff, new sexual partners, and I think to me, this highlights why the annual… I don’t even call an exam, but the annual discussion with your patient is so important because it gives you the opportunity to talk about things like this.

Dr. Sara Kim: I agree. And I think that’s another impact of having this decrease interval between Pap smears, is that I think sometimes the rapport with your patients could be affected as well, because I think when they come in, having some type of expectation and you say you’re not going to do it and that also affects how they’re going to view their annual exam the next year as well as the fact that if they don’t think it’s necessary, they’re just going to stop coming altogether to annuals.

Dr. Joe Chappelle: Right. To me this… I’m thinking, alright, I don’t think we should change the way we do our cervical screening, because that’s evidence based, and as people who listen to this podcast on a regular basis will have figured out by now, I am an evidence-based person. I try to live my life by that. So, I don’t think we should change our cervical screening criteria just to affect something else. But it gives us the opportunity, or it makes us have the opportunity to say, okay, so how can we do, for example, chlamydia screening better?

Dr. Sara Kim: Right.

Dr. Joe Chappelle: Right? How can we change the way we do it, because before, we were already in there doing this Pap, so might as well do GC chlamydia testing. So, is there a different way to go about screening that doesn’t include a Pap smear that we can implement? How do we get the best of both worlds?

Dr. Sara Kim: Right. And I know there’s some papers that show that… One recently published chlamydia testing, that started looking at vaginal swab versus urine chlamydia testing and they show that they’re pretty sensitive in detecting chlamydia in patients.

Dr. Joe Chappelle: Yeah. The one paper I found on that showed a sensitivity for the endocervical, which is what we traditionally do when we do a Pap smear, of basically 92% with the urine being similar at 92%. What was interesting to me though, is the vaginal swab was actually 97.2%. The vaginal swab was better, and that was, by the way done either by the physician or by the patient herself, right?

Dr. Sara Kim: Yeah. I think… I’m not sure if it’s the same paper. I think that was in the New England Journal of Medicine, that’s the one I looked at that showed that vaginal swabs are better. And if the patient herself could do it and if it’s that sensitive, then that’s another way for us to test for chlamydia instead of subjecting patients to another speculum exam, which sometimes if you say, “I’m only going to be doing speculum exam just to do a GC swab,” some people do refuse that.

Dr. Joe Chappelle: Yeah. I mean, I think honestly, if we could eliminate the speculum exam from our routine practice, we would have a lot more women who wouldn’t hate going to the gynecologist.

Dr. Sara Kim: I agree. That’s the worst part of going to a gynecologist.

Dr. Joe Chappelle: Right. For some things you need it. You want to look… whatever. You need it sometimes. But for routine screening, if we could… with the HPV testing instead of Pap smear testing, if we could get rid of it, that would be wonderful. But at least for GC chlamydia, it seems like we can get rid of it. But the question isn’t to me so much how we test but it’s how do we prompt ourselves to ask the patient to test? When you lose that annual appointment with you to come in and talk about all these things, then you miss that opportunity to say, “Hey, do you want to get tested for gonorrhea and chlamydia? Because you’re at risk.” So, how do we recreate that connection with our patients when we eliminate the Pap smear.

Dr. Sara Kim: Right. And I guess that goes back to us having this relationship and rapport with patients to try to show that the annuals are needed and I think that’s something that we need to work on as Ob/Gyns to also say, okay, annuals are not just for Pap smears, and even for STD testing, that we have to look at the woman as a whole and, when we think about a well woman visit, that there are some things that we need to address with them on a more personal level. And I agree that even if you have very effective testing and a very sensitive test for chlamydia, if they’re not coming in, then we’re not going to detect it.

Dr. Joe Chappelle: Right. What you just said… I was thinking this today, as a matter of fact. Annuals for a gynecologist can easily devolve into breast exam, Pap, gonorrhea/chlamydia, contraception, alright, thank you that’s it, come back next year. And when we start removing those items, the breast exam, the Pap smear, what are we left with? Well, there are a whole host of things, and ACOG has this up in their bulletins, of things that we can do for these patients, because a lot of times, we’re the only doctor they see. We can do screening for domestic violence, we can do hypertension screening, we can do lipid screening. But all of that takes a lot longer than Pap and a pill. And so, we have to… reorganizing the entire way we approach our office session, because counseling takes way longer than just doing a Pap smear. But that, we have to give the patients some value to that yearly exam, and if we’re not doing these other, basically easy procedures, we have to do the harder stuff. And I think, for me personally, that’s the challenge, to reorient myself towards the annual exam in order to give that patient some value.

Dr. Sara Kim: Right. And part of that is just the nature of what we do. We see a lot of patients in clinic, sometimes you can’t really devote a lot of time, and some patients also have a PCP, but not everyone does. They do look at their Ob/Gyns as their primary care physician and I think it is our responsibility in some ways to at least screen for things and ask the patients questions that look at the woman as a whole, but I’m not going to lie, that’s something that I don’t always do when I see a patient for their annuals. And sometimes, patients come in to their Ob/Gyns with the thought of, I’m only here to just get a refill on my OCPs. And so, even if I try to go into a discussion about, “How are you doing in school?” Or, “How are you doing in life? Everything going okay at home? Do you feel safe?” It’s just shrugged off as, “Can I just get a refill on my OCPs?” And I feel like maybe in the public eye, they view Ob/Gyns as people who are going to be there for STD testing, Pap tests and breast exam and just contraception.

Dr. Joe Chappelle: Yeah, well, you’re actually getting to the heart of an argument that happened well before you were an Ob/Gyn and, to a degree myself, when ACOG decided that we were going to be primary care providers, and that had to do, I think mostly, with reimbursement and things like that in the U.S., but there was this big push for us to be primary care providers and now it’s kind of come back the other way. But that’s right at the heart of that. Some women don’t come to us for that. They just want what they want, and they want to go, to get out. And it’s amazing how I have some women who I feel like I do absolutely nothing for them when they come for their annual, and it’s like they checked off a box, that they did that for the year and they’re happy. That’s all they want, they don’t want to talk to me, they just want to get their Pap and their breast exam and their mammo prescription and then they can, “Check, I did that for the year and I can move on.” And other women, they want more than that, which is challenging.

We’ve definitely completely gone away from where we started on this conversation about chlamydia screening. But I think it all does come together. We have this population health point of view, we have this relationship with our patients and how do we get them to come back, and then also, how do we incentivize women to get chlamydia screening? And those are all hard questions which neither you or I are going to answer on this podcast, but I’m happy that someone wrote this paper so that we could bring it up to our audience.

Dr. Sara Kim: Right. And I think that’s a good way to sum up the paper, that although they found this, the fact that we have now decreased incidence of chlamydia because maybe we’re not screening them with Pap smears, is that the only reason? Is it because maybe women are not coming for STD testing in general because they’re not coming to their annuals because they’re not due for their Pap smears? I think it’s a paper that has multiple layers and highlights some other issues, not just the effect of Pap tests on chlamydia screening.

Dr. Joe Chappelle: Yeah. And again, I think that we have beat that one to death. Now, for all you listeners, all of these papers and everything are going to be in the show notes so you can read them yourselves. Also, some of these other papers that we mentioned or quoted here, we’ll put those in the show notes if we can as well, so you can all read through them.

So that gives us time to get into one last article. This one is actually not a scientific paper, which I kind of liked. This is from a website called Timeline, although I think it was other places as well, and it was titled “The inventors of the Pill decided women should still bleed every month.” We talked about contraception, again, ad nauseum not that long ago, and I spent an entire episode on the pill. And what I really found interesting about this is, part of it is how do you allow women to accept a new medication and a new way of thinking about their fertility? And then the second thing is, what do you do when that mentality is no longer needed?

Essentially, what this paper was saying, and absolutely correctly, is that the pill was designed with this monthly bleeding for no purpose other than to allow women to have a period because they were comfortable having a period every month knowing that they weren’t pregnant. There’s no physiologic reason if you’re on the pill to have a menstruation, because there’s no real lining to come out, and that’s done on purpose, it’s the way the whole pill works, we’ve already discussed that. And again, back in the 1950s and 1960s, when the pill was a new thing, women had to be convinced that this was safe, and they had to be convinced that it was natural or normal, and so having that withdrawal bleed every month, mimicking their non pregnant state was comforting to them and allowed more women to accept it culturally, or at least that’s what the men who designed it thought. Women might have actually been just fine not having periods, but that’s a whole different discussion about men’s place in medical history. But in any case, that’s what the men thought, and we have no real contemporaneous female commentary on that, so for the moment we’ll assume that that was true. But in any case, now we’re here in 2017, 1957 was when it came out, so we’re a good long ways after the pill was manufactured and yet we’re still making pills so that most women have a period every month. Do we need that anymore?

Dr. Sara Kim: And I wonder if… Actually, when I read that article, I found it very, very interesting. Part of it was, I am a woman, so I personally have menstrual cycles as well, and it’s just interesting to look at that the pill was designed to mimic normalcy and naturalness, but it’s not natural. And they thought that having that would make the women more amenable and agreeable to taking the pill. But what’s surprising is that, although that was back in the day, when it was made, created by John Rock, that a lot of women even now sometimes ask me, “If I take it continuously, is that safe for me? Is that normal? Am I okay? Am I supposed to have some bleeding either way…” And that goes to show that that idea of having a menstrual cycle and saying that the pill is normal has percolated even now and trickled down to how women view menstrual cycles today. Granted, not everyone thinks that, but it’s an effect, and that big decision that was made when the pill was initially made, I think that idea has permeated even our culture today.

Dr. Joe Chappelle: Yeah. I would agree. In my practice, I have a very… few percentage of women who want the extended cycle or amenorrhea. With the IUD it seems to be okay. Women are okay with that concept. But when taking pills, they really want that monthly bleed. And I don't know how much of that is… Actually, I’m pretty sure most of that is the reassurance every month that you are not pregnant.

Dr. Sara Kim: Right.

Dr. Joe Chappelle: Right? So, there’s something to be said for that culturally. Now, is that because that’s the way it’s been for the last 60 years or 70 years? Or is that something inherent in the… Oh, God, I’m going to kill myself for saying this later, but the female psyche. Which is ridiculous. Please don’t write me and tell me that was ridiculous, I know.

Dr. Sara Kim: Yeah. You might regret saying that later.

Dr. Joe Chappelle: I’m going to regret saying that. Because I don’t think that’s true. I think it is more of a cultural this is normal, and even on the pill this is normal. This is what your mother and your grandmother, this is what they had, and so this is what you have. But there’s certainly, I hear a lot of women say exactly that, “Well, how do I know I’m not pregnant if I don’t have my period?”

Dr. Sara Kim: Right. Even though that’s not your period.

Dr. Joe Chappelle: Correct. And obviously, there are Seasonale and Seasonique and there are these brand name… some of them are generic now, but most of them still brand-name methods for extended cycles. And they do decent business, but nowhere near what the regular monthly pill does. Now, one of the things I wanted to just bring up on this is, okay, just because we think there’s no reason to have it, is there a downside to not having your period? Is there any evidence that, if you don’t have a period for nine months or a year when you’re taking the pill continuously, are you at risk for endometrial hyperplasia? Are there other risks there? I looked it up a little bit. There isn’t a whole lot there, but it seems to be the answer is no.

Dr. Sara Kim: Yeah. So, if there’s no risk, and I wonder if that’s also something that we need to tell patients, when we’re giving the pill and they’re… And it’s a personal choice. I think at the end of the day, it’s their choice. They really want to not be on the extended or be on the continuous, they could definitely have this withdrawal bleed, as we call it. I think it’s a matter or a discussion with patients to tell them that there really is no risk about it, but I wonder if that’s even going to change how people view the pill, even if they know that there is no risk about it.

Dr. Joe Chappelle: What do you mean by that?

Dr. Sara Kim: Even if, let’s say, we tell patients that there’s really no risks of you taking it continuously and not bleeding for nine months, would that convince patients to opt not to have that placebo week?

Dr. Joe Chappelle: Well, I don't know. This is one of the things that I talk about a lot with residents and even patients sometimes, is most women – it changes a little bit in the last few years – but most women come to us because we’re the experts. So, if you go to an accountant or a lawyer and you say, “This is my situation, give me your advice,” well, you want their advice, because they’re experts. So, you’re already primed to do what they tell you to do because you went to them to begin with.

Dr. Sara Kim; That’s true.

Dr. Joe Chappelle: Right? And I think, for us providers, we don’t recognize how much that’s true for us sometimes. Women come to us wanting a recommendation. Now, some people, and this is not just women, it could be any field of medicine, go to the doctor already knowing what they want. “I have an ear infection I want amoxicillin.” Okay. So, I can spend the next 25 minutes talking to you, trying to convince you, you don’t need amoxicillin, but at the end of the day, if you don’t walk out with amoxicillin, you’re going to be upset. But for birth control at least, I think most women come wanting our opinion and our recommendation.

Dr. Sara Kim: That’s true.

Dr. Joe Chappelle: And so, I think if we, again, spend the time to explain the rationale and the reasoning behind continuous or extended birth control, I think that a lot of women would go for that, but that takes time. So, how much time do we want to spend, when you have four patients waiting to see you. And I hate to bring things into that level of money and time, but a lot of it, that’s what we do on a daily basis, is how much time do I have to spend with each one of these women to explain something like this.

Dr. Sara Kim: Right. And it has nothing to do with the paper, but I wonder how much of it is cultural in a way too, because I know in some countries, they sell birth control over the counter, and they don’t require any counseling in the office, they go out to a regular CVS-like place in their country and are able to buy OCPs over the counter, and there are directions in the back and they just take it as is. Some of them take it continuously and they’re happy about not bleeding, but it’s not a discussion in an office with the gynecologist as to how do they take it and what are the different options that are available. So, I wonder if there’s some component of how, depending on the role, I guess, that Ob/Gyns have in different cultures and maybe different countries, what the expectations are of the patients who go in, when they see their Ob/Gyns, what kind of discussions they’re expecting to have in the office.

Dr. Joe Chappelle: Yeah. That’s a rabbit hole that we can dive down a little bit, but not too long because we’re running out of time here. First of all, you have to remember that Ob/Gyns like we have in the U.S. are kind of a U.S. construct. Most of the world does not work like we work. In most of the world, Europe and other places, the Ob/Gyn is more of a specialist as opposed to your general practitioner. And so, that is a difference. To go on your thing about buying pills over the counter, again, those who listened to the contraception episodes know that I am a strong proponent of easy access to contraception, and I think that I’d pretty much be okay with women being able to buy contraception over the counter. However, I think it goes back to our last conversation, is what are the unintended consequences of that?

Dr. Sara Kim: That’s true.

Dr. Joe Chappelle: Right? Now, if they don’t even need to come to us for birth control, we’re never going to screen them for chlamydia, right?

Dr. Sara Kim: That’s right.

Dr. Joe Chappelle: Amongst other things. So, I think there’s some unintended consequences there we don’t want to overlook. But again, I firmly believe that cheap and easy access to contraception makes the entire society better. And surprisingly, there actually aren’t that many countries that allow you to buy it over the counter. There are a lot that make it easier than we do here in the U.S., but very few countries actually allow you to buy it over the counter, probably for similar reasons. Although in California, there’s an app that you can go on, log in, give your medical information, it goes to a doctor and then that doctor prescribes the birth control for you, so you never have to go to the office. And it costs money, I forget how much it costs, but it’s not too much. But you never have to go to the office. You can just go on the app and do it. It only works in a few states right now, but I think that’s an interesting approach as well.

Dr. Sara Kim: An interesting approach, but going back to what you said, I wonder how that’s going to change with our role and patients in their visits, because it might be interesting to you see how… and I agree, in countries that have OCPs over the counter, what their Ob/Gyn visit rates, I guess, are, and how those people and those patients view Ob/Gyns. Maybe they don’t even have a gynecologist, maybe they’ve never even gone to see one, and they’re just buying OCPs over the counter. So, it is one of those things where it probably has other consequences down the road that we don’t necessarily see here because we don’t necessarily sell it over the counter.

Dr. Joe Chappelle: Yeah. It definitely is a good idea to look at other places who do something different than us and see what the rates are, but again, you’re comparing two different cultures that go along with that, so it’s hard to draw too many conclusions. But at least we can get some idea.

Anyway, I think that we definitely raised some interesting thoughts with all three of these papers. These are all, as you would say, ripped from the headlines, so I hope that you all enjoyed listening to them, and maybe you had already come across them in your own reading, but if not, well here you go, some good reading material for the weekend. Thank you, Dr. Kim for sitting in with me and going through these papers, I really appreciate your time.

Dr. Sara Kim: Thank you for having me.

Dr. Joe Chappelle: And we should be back in the next week or so with a journal club episode. I know that’s a little delayed from this earlier month, but as it turned out we took a little unanticipated summer holiday here to do some vacations amongst the three of us, but anyway, we should be back with that. And then Dr. Kim has an episode coming up in the near future on cholestasis, and then I’ll be back, hopefully soon, with a new series on polycystic ovarian syndrome, which I think should be interesting.

So, in any case, thank you all for listening. I hope you really enjoyed it. As always, please remember we have the Slack open for anybody who wants to join. Just send me an email at feedback@obgyn.fm and Dr. Kim will be there to greet you as well, when you come in the door to the Slack. You can send any other feedback also to that same email. And please, if you have a moment, consider dropping at review in iTunes, I really much appreciate it and it does help other people find the podcast. And with that, I say, thank you very much and until next time.