

saving"³ and suggested measures for "conserving [the] endangered species".⁴ An ecologic niche⁵ is now believed to exist for this species. Because of this "revival in obstetrics"⁶ academic physicians are calling for a "new direction"⁷ and new "decisions"⁸ concerning the training of family physicians to deliver babies — even suggesting that family physicians be the primary instructors of family physicians learning to deliver babies.⁹ Your data would indicate that the future for family practice obstetrics is indeed "bright".¹⁰

Without doubt, "obstetrics is too important to be left to the obstetricians"¹¹ and "just too darned important to leave to the technologists."⁵ The specialty of family practice and the academic community in family medicine is beginning to awaken to the fact that family medicine without birthing is not family medicine — it's just medicine.

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Transvaginal Ultrasound and Surveillance on Estrogen Therapy

To the Editor: In their review of the recently published guidelines for postmenopausal preventive hormone therapy,¹ Drs. Moy and Realini lend support to the recommendation that transvaginal ultrasound might be an acceptable option to direct tissue sampling as an approach to surveillance of women receiving estrogen therapy. This support is unwarranted.

When compared with the reference standard, transvaginal ultrasound has a sensitivity of 80 percent and a specificity of 60 percent.² Given the consequence of a missed mitotic lesion, this modality is

too insensitive to support its use as a substitute for periodic direct endometrial sampling in women on unopposed estrogen therapy.

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The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: Thanks to Dr. Kiser, et al. for their letter with regard to transvaginal ultrasound as an evaluative technique for surveillance of women receiving estrogen therapy.

In our policy review we noted that this technique "appears to be quite useful in distinguishing endometrial hyperplasia and carcinoma." We also noted that this procedure is less invasive than endometrial biopsy. We do mention that experience with this technique is still relatively limited and its performance should be monitored.

We appreciate this new reference provided by Dr. Kiser, et al. At the time the American College of Physicians guidelines were published, no cases of endometrial malignancy were known to have been present with an endometrial thickness less than 5 mm on vaginal ultrasound. This new study suggests that the ability of vaginal ultrasonography to rule out endometrial hyperplasia and cancer might be less than previously thought.

We encourage family physicians whose interests include this topic to continue to study vaginal ultrasonography, office endometrial biopsy, and other techniques so that the optimal technique can be determined and used in clinical practice. The sensitivity, specificity, and predictive value of transvaginal ultrasound should be compared with those of endometrial biopsy in the office, as well as with those of dilation and curettage in the operative setting. Comparative evaluations can only enhance our knowledge and ability to provide appropriate care for patients.

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