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6/8/84471

Reply

To the Editors: Mishell misquotes me in each of his first two sentences. In my article, I did not speculate as to which of the two general mechanisms of action of IUDs, prevention or fertilization versus prevention of implantation, was the "main" mechanism. This question has not been directly or conclusively addressed in the literature. What I did conclude is that inhibition of implantation remains a major mechanism of action of IUDs. Whether the relative proportion of importance of the two mechanisms is 60:40, 50:50, 40:60 or some other proportion, and whether that proportion changes with time, is unknown.

As have others, Mishell has chosen to ignore the evidence I present. The disproportionate protection against intrauterine versus ectopic pregnancy noted in several clinical trails of IUDs, the studies of ectopic pregnancy among IUD users, and the virtual 100% effectiveness of the IUD when used as an emergency contraceptive compel the conclusions I reached.

Mishell misses the point. In two of his publications,[1, 2] when addressing the mechanism of action of IUDs, he states it to be exclusively spermicidal with no mention of a postfertilization mechanism. I believe these publications to be erroneous on this point and therefore might mislead both the providers and recipients of IUDs.

I am more than willing to concede to Mishell that the spermicidal effect of IUDs might be the "main" mechanism of action. (All this requires is that its proportion of action exceeds 50%.) However, the available evidence requires Mishell to concede a major postfertilization mechanism as well and adjust his future publications to reflect this change. How about it, sir?

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2. Mishell DR. Intrauterine devices. Fertil Control Rev 1992;3: 3-12.

6/8/84470

Povidone-iodine and abdominal hysterectomy

To the Editors: The use of intravaginal povidone-iodine gel as reported by Eason et al. (Eason EL, Sampalis JS, Hemmings R, Joseph L. Povidone-iodine gel vaginal antisepsis for abdominal hysterectomy. Am J Obstet Gynecol 1997;176:1011-6) demonstrates a useful antiinfective technique. We have been using a somewhat similar but easier technique for the past 26 years. In our procedures we complete a standard abdominal preparation and use a single dose of preoperative cefazolin (2.0 gm) but do not "prep" the vagina. On opening the vagina at the time of hysterectomy, we place a sponge, dripping with povidone-iodine liquid, on top of the cuff and then push the sponge (an opened 4 × 4 gauze) in the vagina, complete the surgery, close the abdomen, and remove the sponge from the vagina before the patient leaves the operating room. Although I do not have comparative statistics, I can state that my own infection rate over this time period is <5%. The only real difference with our procedure is not taking the time to place the patient in the lithotomy position and taking the time to "prep" the vagina.

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6/8/84472

Reply

To the Editors: It is interesting to learn that, although Amstey abandoned the vaginal "prep" long ago, he does value vaginal antisepsis. His novel technique of "immediate postexposure antisepsis" may indeed lower bacterial counts at the appropriate time better than the usual preoperative wash with povidone-iodine solution. I would look forward to seeing more rigorous comparative data on this approach.

Incidentally, we do not use stirrups or the lithotomy position to prepare the vagina. We simply abduct and flex the thighs, keeping the heels resting together on the operating table mattress in the "frog-leg" position.

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6/8/84473