Written Statement of Peter Cherouny, M.D.
Testimony before the Permanent Subcommittee on Investigations, United States Senate
Committee of Homeland Security and Governmental Affairs
Chairman Jon Ossoff, Presiding

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Thank you for the opportunity to serve your committee with this requested review of the obstetric and gynecologic medical care of immigrants in ICE custody at the Irwin County Detention Center in Georgia. All reviewed care was rendered by Mahendra G. Amin, M. D. Dr. Amin is a physician trained in India and at the University of Medicine and Dentistry of New Jersey. It is unclear what postgraduate training Dr. Amin received in New Jersey. He does not appear to be board certified in Obstetrics and Gynecology, nor boarded in any other medical speciality. My review is limited to this Committee's provided records from Irwin County Hospital (ICH), Irwin County Detention Center (ICDC) and U.S. Immigrations and Customs Enforcement (ICE) records of apparent on-site medical care and review of care.

I was not involved in the selection of patients and charts to be reviewed and I have no knowledge of Dr. Amin's accessibility to patients from the ICDC nor of the specific resources available to him in his office or through the Irwin County Hospital.

Summary

Over the last three decades, several imaging technologies and outpatient clinical strategies have been developed for the management of menstrual irregularities, which represent over half of outpatient visits to gynecologic care and the majority of the reviewed patients' concerns. Guidelines and tools for the evaluation of premenopausal, perimenopausal and postmenopausal bleeding have been developed that allow for outpatient assessment and avoid in hospital, surgical management for benign conditions, as appropriate. The provider appears unaware of these current options or does not have them available in his office or hospital. Due to this lack of knowledge or capability, the provider uses inpatient surgical options as diagnostic tools in order to manage predominantly benign conditions.

Concerns regarding specific therapies

The use of Depo-Provera as initial hormonal management of abnormal uterine bleeding in the premenopausal population. Many cases of abnormal uterine bleeding are responsive to medical management with nonsteroidal antiinflammatory medications (NSAIDs), or hormonal based therapies. The latter options recommended include a levonorgestrol containing IUD, a short course of oral progestins or combination birth control pills. Depo-Provera can be used but adequate time must be given to affect a clinical treatment response, usually considered at least six months. In most reviewed cases, the provider used Depo-Provera injections for initial management of menstrual complaints such as menorrhagia (heavy menstrual flow) and

metrorrhagia (irregular menstrual bleeding) and proceeds to surgical intervention after 2-6 weeks, siting failure of hormonal therapy for abnormal uterine bleeding. An additional issue with Depo-Provera is the side effect of irregular menstrual bleeding, up to 70% of patients within the first year, a common presenting complaint of the reviewed patients and compounding specific diagnoses.

Ovarian cystectomy or aspiration at laparoscopic evaluation of benign, functional cysts. The vast majority of ovarian cysts identified on transvaginal ultrasound and removed or aspirated during laparoscopy in these patients were benign, functional cysts. This is indicated in the surgical pathology reports for the patients. Forty patients underwent removal or aspiration of ovarian cysts. While they were benign in every case, the majority were functional ovarian cysts in normally cycling ovaries. These generally resolve without surgical intervention. Simple ovarian cysts up to 10 cm in diameter can be observed to resolution in most cases. These functional cysts do not require removal unless their appearance is concerning for malignancy or torsion (twisting), among other things. Aspiration is not recommended. Advanced imaging can, additionally, be used prior to surgery in order to identify cysts of concern and apply the appropriate surgery where needed, or follow them over time.

Perimenopausal leiomyomata management. Several perimenopausal patients presenting with irregular and painful menstrual bleeding were identified as likely having leiomyomas of the uterus. As these benign muscle tumors generally recede after menopause, one option of management, once identified and confirmed by imaging, is with observation and symptom management. Twenty to seventy percent of women develop these tumors during their lifetime and the vast majority are benign. A detailed assessment of the patient's symptoms is necessary in order to ascribe specific clinical complaints to fibroids because, as they are so common, other causes for the specific clinical symptoms of the patient need be excluded. This provider appears to use laparoscopy for confirmation of the diagnosis of leiomyomas and often removes them at surgery. These uterine muscle tumors can be evaluated by imaging techniques such as skilled ultrasonography or more advanced imaging like MRI and followed over time for clinically concerning changes.

IUD management. A patient presented with heavy bleeding and cramps with her menstrual cycle and a known IUD did not appear to have an attempt at removing the IUD until a D & C and laparoscopy were performed in the hospital. Of note, the surgical consent did not include removal of the IUD. The clincial note did indicate she received hormones, unsuccessfully, in an attempt to manage her symptoms. There was no attempt to remove the IUD as a possible cause of her symptoms prior to surgery.

Molar pregnancy follow up. A patient with an identified molar pregnancy underwent a uterine evacuation, which is the appropriate therapy. However, while initial management was appropriate with blood tests assessing pregnancy hormone levels (beta-HCG), there was no indication of longer term follow up for this patient who would have an approximate ten-percent chance of developing subsequent choriocarcinoma.

Pap smear management including colposcopy. The provider does not appear to follow the current recommendations regarding Pap smear management through colposcopy and further treatment. Examples include: 1) Pt 24 and 39 had inadequate tissue obtained at LEEP procedure making further diagnosis not possible. 2) Pt 38404 at 20 years old, the recommended followup for her Pap smear result of low-grade squamous intraepithelial lesion (LGSIL) with positive human papilloma virus (HPV) testing is repeat testing in one year. 3) Pt 60301 at 28 years old had a Pap smear result of atypical squamous cells of undetermined significance (ASCUS), the most common abnormal Pap smear finding, with positive HPV and a negative colposcopy. Dr. Amin performed cryosurgery (freezing destruction of cervical tissue) that does not appear to have been indicated. Recommended follow up from the available documentation would be retesting only. 4) Pt 48356 at 27 years old had a Pap smear read as ASCUS negative HPV. Again, recommended follow up is retesting, not colposcopy. Of the nine new patient reviews, only one had adequate documentation to indicate the care performed. Dr. Amin appears to have performed unindicated colposcopy and/or cryosurgery on six of these patients. The records reviewed suggest the provider has limited knowledge and/or skill in Pap smear management. The reviewer is not aware of how many patients the provider may have seen over this time period for a LEEP procedure making it difficult to assess overall skill and knowledge in performance of this procedure.

Condyloma acuminata management. Two patients had condyloma acuminata, or venereal warts, caused by human papilloma virus infection, excised in the hospital. There was no indication of timing of presentation of the warts on the clinical note. While there are several out patient management options for venereal warts, clinical observation alone can lead to resolution as patients clear the virus. It does not appear these options were reviewed or discussed with the patient.

Transvaginal ultrasound by Dr. Amin. Thirty-six patients underwent a transvaginal ultrasound by Dr. Amin. In general, the performance and documentation of these ultrasounds was limited and appeared incomplete. Guidelines regarding performance and documentation of female pelvic ultrasound can be found at the American Institute of Ultrasound in Medicine; (https://onlinelibrary.wiley.com/doi/10.1002/jum.15205).
An additional observation was the frequent ultrasound notation by Dr. Amin of a “thickened endometrium”, with this added to the indication for surgery (example, patients 31 and 44). Thickened endometrium is rarely helpful in the premenopausal population and a thickness less

than 4-5 mm is used in the post menopausal woman *with symptoms* to reliably exclude endometrial cancer.

Surgical observational diagnosis of endometriosis (documented in operative notes as postoperative diagnosis) In no case was there a tissue diagnosis (biopsy) performed to confirm endometriosis, as is recommended when first seen in a patient.

Surgical observational diagnosis of adenomyosis. Adenomyosis is usually a diagnosis by exclusion of other causes of the patient's symptoms. While it can be inferred on imaging, it is only confirmed by histologic evaluation on a hysterectomy specimen. This was not done in any cases where adenomyosis was added to the postoperative diagnoses.

The treatment of vulvovaginal infection by symptoms only. Recommendations for care of patients with vulvovaginal infections and discharges include microscopic evaluation of the discharge and/or culture. Dr. Amin frequently prescribes multiple treatments for a vaginal discharge complaint without an appropriate clinical evaluation. Not using microscopy or cultures for assessment in these patients, as seen frequently in these charts, results in patients receiving multiple treatments for the same complaints without improvement. In addition, one patient, patient 51, had a positive chlamydia test and the treatment prescribed was inadequate. Overall, compliance for the prescribed treatment in many cases of vulvovaginal infection is very poor at ICDC. This appears to be a significant process problem for the system.

Thank you again for allowing me to participate in the quality assessment of clinical care provided to this group of patients. I look forward to being helpful in improving the care as well.

Sincerely,

Peter Cherouny, M.D.