Annual Report of the Medical Education Foundation of the ACOOG – 2006

Letter from the Chair –

Mark A. Kalchbrenner, D.O., FACOOG, (Dist.)

Due to a change in MEFACOOG leadership, there is a one year gap in the position of Chairperson. At the request of the ACOOG board, I will be fulfilling that responsibility.

The Corporate Partnership Council (CPC) is a group of representatives from industries that provide financial support to MEFACOOG. Representatives from Ortho, Wyeth, Berlex, and Matria contributed to a very successful meeting in Philadelphia on December 4th. Ortho-Women's Health and Urology pledged to continue support of the Visiting Professor Program. Wyeth chose to increase the number of participants in the Resident Reporter program from 16 to 25. Ortho and Wyeth decided to co-sponsor the new electronic logs for Residents. Two prospective members attended but have not yet committed to joining.

I must express gratitude to ACOOG membership as well. $20,000 in member contributions allowed me to inform the CPC that we had matched industry contributions. Please keep our college in mind as you decide on your end of year contributions.

Best wishes for a happy holiday season and New Year!

MEFACOOG/Wyeth Resident Reporter Scholarship Program 2006 –

June C. Murphy, D.O.

I am very pleased to announce that the Wyeth /MEFACOOG Resident Reporter Program at the 73rd Annual Convention was a great success. Fourteen Resident Reporters were involved and all provided excellent summaries of their assigned lectures. Wyeth Pharmaceuticals has graciously sponsored the Resident Reporter program for the past 10 years, which has allowed many residents to attend the Annual Conference, when they would have otherwise been unable to do so.

Dr. Christa Norlander did an excellent review of teen sexual education, based on Dr. Sulak's lecture at the annual conference. Dr. Annette Bombrys did an excellent comprehensive review of the risks and benefits of cervical cerclage based on one of Dr. Robert Debbs' presentations. Dr. April Hoffman also did an excellent review of Dr. Gill's lecture based on the prenatal and intra-partum care of twins. I am sure you will find their reviews as educational as I have. Thank you to all of our resident reporters as well as Wyeth and MEFACOOG for their support of the Resident Reporter Program.

June C. Murphy, D.O., Editor
Resident Reporter Program

Factual Sex Education –

73rd Annual Conference, San Antonio, TX

Resident Reporter: Christa Norlander, D.O.
Lecturer: Patricia Sulak, M.D., FACOG

More adolescents today than among previous generations are becoming involved in health-risk behaviors [1]. These behaviors include: consumption of alcohol, drugs and tobacco; leading a sedentary lifestyle and participation in sexual intercourse [1]. Engagement in these risk behaviors is also occurring at earlier ages when they may not possess the foresight to recognize the potential gravity of their behaviors [2]. As one of these important risk behaviors, sexual intercourse was the subject of a lecture given by Dr. Patricia Sulak M.D. at the 73rd Annual ACOOG Conference held earlier this spring. She gave a very entertaining yet informative talk on sex education as it pertains to the adolescent population.

Dr. Sulak discussed the differences between the two schools of thought behind most of the sexual education curriculums around the nation. These two philosophies are abstinence sex education and comprehensive sex education [3]. While both have their strengths, Dr. Sulak pointed out several deficiencies within these programs and most importantly the mixed message that has come across to our youth. Dr. Sulak also emphasized how influential the adolescent's parent, healthcare provider and community members can be over their choices in sexual behaviors. Finally a new model was proposed to better serve our adolescent population's need for sex education.

The first part of Dr. Sulak's talk addressed the differences between abstinence sex education and that of the comprehensive sex education model. Curriculums using the abstinence philosophy emphasize waiting until marriage to have sex as it is to be a "cherished" part of one's relationship [3]. This model also emphasizes that "all sex is sex," discouraging anal, oral and other alternative forms of sexual behavior sometimes practiced in place of vaginal intercourse [3]. On the other hand, comprehensive programs encourage adolescents to only postpone sexual activity until they are "ready/older" while placing most of their efforts on teaching risk behavior reduction, suggesting safer sex alternatives (anal sex unfortunately being one of them)[3]. Dr. Sulak pointed out that an abstinence model often does not provide discussion on contraceptive methods nor does it address sexual activity among teens that are already having sex. This is a serious problem given the earlier ages at which adolescents are engaging in sexual behaviors, potentially having not yet been informed of the potential consequences of their sexual behaviors. The abstinence model does not appear to be the only one lacking a clear message. Dr. Sulak also addressed the deficiencies within the comprehensive curriculums which fail to provide factual information on contraceptive effectiveness or the health risks of sexual activity. For instance, teens are often left with a false sense of security with regard to the effectiveness of condoms, unaware that contraception failures occur with operator error playing a major role [3]. Both sex education curriculums seem to have their faults.

Dr. Sulak suggested another model that she called "Factual Sex Education" [3]. This sends a clear message to our youth that abstinence is the expected standard. Abstinence has been shown to decrease the number of sexual experiences had by adolescents. The birth rates among adolescents ages 15-19yrs has fallen from 62 per 1000 in 1991 to 41.7 per 1000 in 2003 in part result from encouraging abstinence [3,4]. According to Dr. Sulak's talk, 53% of the decline in teen pregnancy rates can be attributed to the fall in sexual experience (47% to improved contraceptive use) [3].

This message, however, addresses the clear dangers that adolescents face in contracting sexually transmitted diseases and becoming pregnant if they choose to practice risky sexual behaviors. The Centers for Disease Control and Prevention (CDC) estimates that more than 1 in 10 sexually active female adolescents have chlamydial infections [5]. Adolescents who have sex at an earlier age are more likely to have multiple partners and are less likely to use barrier protection, particularly as the relationship progresses [5]. This puts them at significant risk of contracting sexually transmitted diseases. Furthermore, adolescents who become

Factual Sex Education – continued

73rd Annual Conference, San Antonio, TX

Resident Reporter: Christa Norlander, D.O.

Lecturer: Patricia Sulak, M.D., FACOG

pregnant are less likely to receive a high school diploma and more likely to live in poverty, requiring public assistance for longer periods of time [6]. Dr. Sulak's model of "Factual Sex Education" provides realistic and factual information on the failures and limitation of contraceptive/condom use, attempting to limit the number of adolescent STD infections and pregnancies.

According to our distinguished lecturer, a good education program requires more than just an improved curriculum to assist adolescents in their risk behavior assessments. It also requires reinforcement of the curriculum through parental, civil and healthcare provider involvement [3]. Adolescents with a strong support system are better informed and tend to be more confident in their decision making thus less likely to give into peer pressures swaying them towards more health risk behaviors [3].

At the foundation of this support system is the parent/guardian. They play a critical role in the adolescent's life, setting limits and expectations for their children [3]. Knowing where their teen is, who they are with and what they are doing is key to minimizing exposure to opportunities that promote risky behaviors [3]. No amount of supervision however can replace judgment. Adolescents are constantly making their own decisions and having a good role model in a parent to emulate can help them to make the correct choices.

Finally, the community and healthcare providers can optimize the sexual health of adolescents. The American College of Obstetricians and Gynecologists recommends that all adolescents should receive annual health guidance regarding sexuality [7]. This includes counseling about what constitutes responsible, consensual sexual behavior and emphasizing that abstinence is the only definitive practice to avoid sexually transmitted diseases and prevent unintended pregnancy [7]. Adolescents are often apprehensive about visiting their physician, mostly fearing the discomfort of a pelvic exam. The American Cancer Society recommends that cervical cancer screening should begin approximately 3 years after the onset of vaginal intercourse or no later than 21 years of age [8]. Thus, adolescents can visit an obstetrician-gynecologist before or early on in their sexually active lives without the stress of having to face a pelvic exam. Newer technology for urine-based STD screening, also provides alternative screening for gonorrhea and chlamydia should the adolescent be reluctant to undergo a speculum/pelvic exam [5]. The roles of these early visits with the healthcare provider are to dispel any misconceptions about pelvic exams, and counsel the adolescent accurately on STD exposure/pregnancy prevention.

According to Dr. Sulak's data, encouraging abstinence has shown to decrease sexual experiences [3]. Pregnancy rates have continued to decrease across all races [3]. Still the age of first intercourse has decreased from approximately 19 years of age in 1970 to 17 years of age in 2002 [3]. Only through a clear and factual message on sexual education does it appear that an improvement in teen awareness and risk behavior modification can occur.

Acknowledgement

Thank you to Dr. Patricia Sulak M.D. for her enlightening talk on sex education.

References

1. Ozer, Em, et al. America's Adolescents: Are They Healthy? National Adolescent Health Information Center, Department of Pediatrics and Institute for Health Policy Studies, University of California School of Medicine, San Francisco 1998.
2. Sells, CW, et al. Morbidity and Mortality Amony US Adolescents: An overview of data and trends. Am J Public Health 1996; 86:513.
3. Sulak M.D., Patricia. Sex Education Lecture @ 73rd Annual ACOOG Conference, 2006.
4. Martin, JA. Births: Final data for 2003. Natl Vital Stat Rep 2005; 54:1.
5. American College of Obstetricians and Gynecologists. Committee Opinion No. 301. Sexually Transmitted Diseases in Adolescents. Washington, DC: ACOG; 2004.

6. Chacko MD, Mariam R. Pregnancy in Adolescents. Up to Date review article, 2006.
7. American College of Obstetricians and Gynecologists. Health Care for Adolescents. Washington, DC: ACOG; 2003.
8. Saslow D, et. Al. American Cancer Society Guidelines for the Early Detection of Cervical Neoplasia and Cancer. American Cancer

Cervical Cerclage: To Stitch or Not to Stitch, That is the Question! An Evidence Based Review –

73rd Annual Conference, San Antonio, TX
Resident Reporter: Annette Bombrys, D.O.
Lecturer: Robert Debbs, D.O., FACOOG (Dist.)

There is much debate in obstetrical practice regarding cerclage placement and management of pregnancies complicated by a previous history of second trimester loss from presumed cervical insufficiency. The purpose of this review is to evaluate the current literature available on cervical insufficiency and cervical cerclage placement.

Cervical insufficiency, previously called cervical incompetence, is painless cervical dilation leading to recurrent second trimester losses.1 The current theory of cervical insufficiency uses cervical length as a marker of cervical competence operating as a continuum with different levels of competency.[1] Cervical insufficiency would represent the lowermost point of the continuum.[2]

The incidence of cervical insufficiency is ~1% and usually occurs between 16-28 weeks of gestation.

Risk factors for cervical insufficiency include cervical trauma, DES exposure, surgical procedures of the cervix including loop electrosurgical excision procedure (LEEP) and cold knife conization (CKC), mullerian anomalies, and obstetrical laceration. [1,2] There appears to be no increased risk for cervical insufficiency with a LEEP, if the depth is < 1.5cm, or CKC, if the height is <1.0cm and overall volume of tissue is <4cc.[2,3,4]

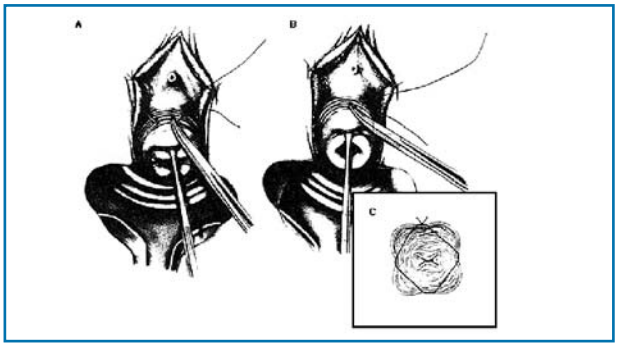
There are no standardized diagnostic criteria for diagnosing cervical insufficiency. It is difficult to identify the point in the continuum of cervical competence that defines incompetence and requires surgical intervention. History remains the mainstay diagnostic criteria but history with concurrent transvaginal ultrasound (TV US) assessment of cervical length is emerging as the standard of care.[2] Also, there are no good tests in the nonpregnant state to predict which women are at increased risk of cervical insufficiency. Tests used during pregnancy include cervical changes detected by digital exam, changes detected by ultrasound, and functional tests (transfundal pressure and cervical changes with posture).[2]

TV US cervical measurement is superior to manual examination and considered gold standard for determination of cervical length.[2] TV US cervical length is most predictive of perinatal outcome: the shorter the cervix in midtrimester, the higher the risk for spontaneous preterm labor or delivery.[5] Normal cervical length is 25mm- 45 mm between 16-30 weeks. Cervical length prior to 14 weeks is not beneficial. An abnormal cervical length is <25 mm between 14-24 weeks.[2]

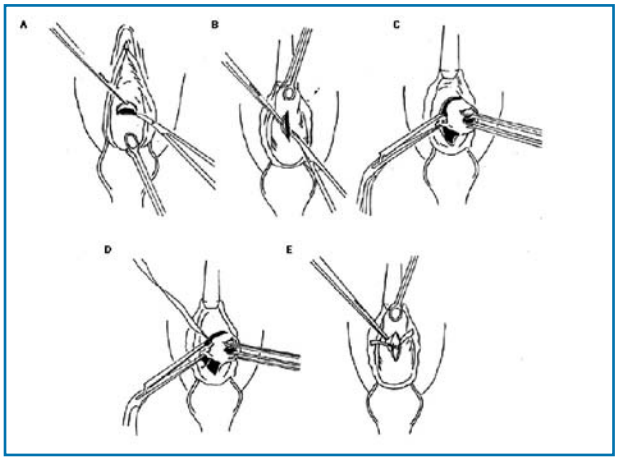
The mainstay in treatment of cervical insufficiency has been the application of a cervical cerclage. Shirodkar performed the first cerclage in 1955, followed by McDonald in 1957, and finally the introduction of abdominal cerclage in 1965 by Benson.[2] Cerclages can be placed electively or as prophylaxis, in an emergency, or as a rescue cerclage. The preferred terminology of the 3 situations is history-indicated cerclage, ultrasound- indicated cerclage, and manual- indicated cerclage.[6] The different surgical techniques to place a cerclage include: McDonald's cerclage (simple purse string suture), Shirodkar cerclage (bladder mucosa is

Cervical Cerclage: To Stitch or Not to Stitch, That is the Question! An Evidence Based Review – continued

73rd Annual Conference, San Antonio, TX
Resident Reporter: Annette Bombrys, D.O.
Lecturer: Robert Debbs, D.O., FACOOG (Dist.)



McDonald operation
In order to make a purse-string suture, four bites are made at the junction between the rugose vaginal mucosa and the smooth cervix. If a purse-string suture is placed at 14 weeks of gestation before the cervix starts to dilate (A) rather than after, (B) a better success rate (80 percent) will be obtained. (C) A cross-section of the cervix after purse-string suture is made. Adapted from TeLinde's Operative Gynecology. Richard F. Mattingly, 5th Edition. J.B. Lippincott Company. Philadelphia, copyright 1977. Copyright 1977 Lippincott Williams & Wilkins.



Simplified approach to Shirodkar cerclage procedure
A, Incision at vesicocervical reflection. B, Vertical posterior incision. C, Use of a clamp to coapt anterior and posterior incisions to facilitate needle placement. D, Needle placement, anterior to posterior. E, Posterior knot and anchoring silk structure. Reproduced with permission from Druzin, ML, Berkeley, AS. A simplified approach to Shirodkar cerclage procedure. Surg Gynecol Obstet 1986; 162:375. Copyright © 1986 Journal of the American College of Surgeons.

dissected anteriorly and the suture is placed higher on the cervix), and the cervicoisthmic cerclage (transabdominal or laproscopically placed suture at the cervicoisthmic junction).[6] Alternative treatments for cervical insufficiency include bedrest, progesterone supplementation, antibiotics, anti-inflammatory drugs, and pessaries.[2]

Complications of cerclage placement include bleeding, infection, cervical trauma, preterm premature rupture of membranes, suture displacement and evulsion, and death. Contraindications to cerclage placement at any gestation of pregnancy include ruptured membranes, cervical or intrauterine infection, major congenital fetal anomalies, vaginal bleeding of unknown etiology, and active labor.[2]

The following is the available recommendations based on available evidence:

- Antibiotics and tocolytics: No randomized trials to make final recommendations regarding use of antibiotics and tocolytics for elective cerclage. No evidence that antibiotics and tocolytics are needed for elective cerclage placement.[8,9]
- Efficacy of McDonald vs. Shirodkar cerclages: There are no randomized studies comparing the efficacy of the 2 vaginal cerclage modalities. Technique used should be based on operator's comfort.
- Cerclage and preterm rupture of membranes: No randomized prospective studies. Evidence is conflicting regarding retention of cerclage and duration of latency. There does not appear to be increased perinatal morbidity with retention of the cerclage.[10,11,12] Care needs to be individualized.
- Transvaginal vs. transabdominal cerclages in patient with previous failed transvaginal cerclage: No randomized control trails addressing this issue. Transabdominal cerclage may be associated with lower risk of perinatal death or delivery a <24 weeks of gestation.[14]

Cervical Cerclage: To Stitch or Not to Stitch, That is the Question! An Evidence Based Review – continued

73rd Annual Conference, San Antonio, TX
Resident Reporter: Annette Bombrys, D.O.
Lecturer: Robert Debbs, D.O., FACOOG (Dist.)

A retrospective study showed transabdominal cerclage to be associated with lower incidence of preterm delivery and preterm premature rupture of membranes.[13]

- Abdominal cerclage vs. laproscopic cerclage: There is insufficient data on laproscopic cerclages to compare outcomes with abdominal cerclages.
- Multiple gestations: Routine history- indicated cerclage placement is not recommended for twin or triplet gestations.[15,16] There is no benefit to ultrasound- indicated or manual-indicated cerclage placement in twin gestations.[17,18] Ultrasound-indicated cerclage is associated with a statistically significant higher rate of preterm birth when placed in twin gestations.[18]
- History- indicated cerclage: Beneficial in patients with history of ≥3 preterm births or second trimester losses.[1] Probably beneficial in patients with history of 2 second trimester losses if no prior preterm births. Cerclage does not appear to be helpful in patient with history of 1 prior preterm birth.[1,15,19,20,21,22]
- Manual-indicated cerclage: No randomized prospective trials performed to date. In a single study, cerclage placement with indomethacin administration appeared to reduce the rate of preterm delivery.[5,26]
- Ultrasound-indicated cerclage: The effectiveness of cerclage in a patient at high risk for preterm delivery and short cervix on ultrasound is unclear. Based on uncontrolled studies, it is reasonable to follow patients at high risk for preterm delivery with serial ultrasound assessment and cerclage placement in those with a shortened cervix.[5,7,19,23]

In summary, cervical insufficiency is a syndrome with multiple etiologies. Every patient needs individualized treatment. Treatment options include cerclage placement, pessary, bedrest, progesterone supplementation, and expectant management. Depending on the clinical situation, there is evidence that shows a beneficial effect for history-indicated and ultrasound-indicated cerclage placement. Transabdominal cerclage is a reasonable option for patients with a previously failed transvaginal cerclage. Reviewing the technique utilized is also important. Many patients have appreciated success with well placed Shirodkar cerclage rather than abdominal cerclage. Future studies need to focus on effectiveness of manual-indicated cerclage placement, the efficacy of antibiotics and tocolytic therapy with elective cerclage placement, and the efficacy of laproscopic cerclage placement versus the gold standard abdominal approach.

References

1. ACOG. Cervical Insufficiency. Compendium of Selected Publications. Practice Bulletin 48. Nov. 2003.
2. Creasy RK, Resnik R. Maternal Fetal Medicine Principles and Practice. Philadelphia, PA: Saunders Company 2004.
3. Ferenczy A, Choukroun D, Falcone T, Franco E. The effects of cervical loop electrosurgical excision on subsequent pregnancy outcome: North American Experience. Am J Obstet Gynecol. 1995 Apr;172(4 Pt 1):1246-50.
4. Leiman G, Harrison NA, Rubin A. pregnancy following conization of the cervix: complications related to cone size. Am J Obstet Gynecol. 1980 Jan 1;136(1):14-8.
5. Romero R, Espinoza J, Erez O, Hassan S. The role of cervical cerclage in obstetric practice: Can the patient who could benefit from this procedure be identified? Am J Obstet Gynecol. 2006. 194:1-9.
6. UptoDate. Cervical Cerclage: technique. 2006
7. Hassan SS, Romero R. Does cervical cerclage

Cervical Cerclage: To Stitch or Not to Stitch, That is the Question! An Evidence Based Review – continued

73rd Annual Conference, San Antonio, TX

Resident Reporter: Annette Bombrys, D.O.
Lecturer: Robert Debbs, D.O., FACOOG (Dist.)

prevent preterm delivery in patients with a short cervix? Am J Obstet Gynecol 2001;184: 1325-31.

8. Novy MJ, Gupta A, Wothe DD. Cervical cerclage in the second trimester of pregnancy: a historical cohort study. Am J Obstet Gynecol. 2001 Jun;184(7):1447-54.
9. Kessler I, Shoham Z, lancet M. Complications associated with genital colonization in pregnancies with and without cerclage. Int J Gynaecol Obstet. 1988 Dec;27(3): 359-63.
10. Jenkins TM, Berghella V, shlossman PA. Timing of cerclage removal after preterm premature rupture of membranes: Maternal and neonatal outcomes. Am J Obstet Gynecol. 2000;183:847-52.
11. McElrath TF, Norwitz ER, Lieberman ES. Management of cervical cerclage and preterm premature rupture of membranes: Should the stitch be removed? Am J Obstet Gynecol. 2000;183:840-6.
12. McElrath TF, Norwitz ER, Lieberman ES. Perinatal outcome after preterm premature rupture of membranes with in situ cervical cerclage. Am J Obstet Gynecol. 2002;187:1147-52.
13. Davis G, Berghella V. patients with prior failed transvaginal cerclage: A comparison of obstetric outcomes with either transabdominal or transvaginal cerclage. Am J Obstet Gynecol. 200;83:836-9.
14. Zaveri V, Aghajafari F. Abdominal versus vaginal cerclage after a failed transvaginal cerclage: A systemic review. Am J Obstet Gynecol. 2002;187:868-72.
15. Vidaeff AC, ramin SM. From concept to practice: The recent history of preterm delivery prevention. Part I: cervical competence. American Journal of Perinatology. 2006;23: 3-13.
16. Michaels WH, Schreiber FR. Ultrasound surveillance of the cervix in twin gestations: Management of cervical incompetency. Obstet Gynecol. 1991 Nov;78(5 Pt1)739-44.
17. Newman RB, Krombach S, Myers MC. Effect of cerclage on obstetrical outcome in twin gestations with a shortened cervical length. Am J Obstet Gynecol. 2002;186:634-40.
18. Berghella V, Odibo AO, To MS. Cerclage for short cervix on ultrasonography: meta-analysis of trails using individual patient-level data. Obstet Gynecol. 2005 Jul;106(1):181-9.
19. Dor J, Shaley J, Mashiach S. Elective cervical suture of twin pregnancies diagnosed ultrasonically in the first trimester following induced ovulation. Gynecol Obstet Invest.1982;13(1):55-60.
20. Lazar P, Guequen S. Multicentred controlled trial of cervical cerclage in women at moderate risk of preterm delivery. Br J Obstet Gynaecol. 1984 Aug;91(8)731-5.
21. Rush RW, Isaacs S, McPherson K. A randomized controlled trial of cervical cerclage in women at high risk of spontaneous preterm delivery. Br J Obstet Gynaecol. 1984;91(8):724-30.
22. Medical Research Council/Royal College of Obstetricians and Gynaecologists. Final Report of the Medical Research Council/Royal College of Obstetricians and Gynaecologists multicentre randomized trial of the cervical cerclage. MRC/RCOG Working Party on Cervical Cercalge. Br J Obstet Gynaecol. 1993 Jun;100(6):516-23.
23. Cockwell HA, Smith GN. Cervical Incompetence and the role of emergency cerclage. J Obstet Gynaecol Can. 2005 Feb;27(2):123-9.

Twin Pregnancy: Prenatal and Intra-partum Care –

73rd Annual Conference, San Antonio, TX

Resident Reporter: April Taggie Hoffman, D.O.
Lecturer: Prab Gill, M.D.

Between 1996 and 2002, the multiple birth rate in the United States increased more than 20% to 33.0 per 1,000 live births in 2002. The increased obstetric risks for preterm labor, fetal growth restriction, abruption, preeclampsia and anemia are 5.0x, 2.0x, 3.0x, 2.5x and 2.5x respectively.[1]

The effect of corticosteroids on respiratory distress syndrome (RDS) in preterm infants decreases with increasing plurality, suggesting that higher doses of corticosteroids may be necessary in multiples to achieve the desired preventive effect for RDS. However, a complete course of antenatal corticosteroids did significantly reduce the incidence of RDS, whereas partial treatment had the same effect as no treatment.[2] By comparison, the current standard dosing of antenatal corticosteroids appears adequate to prevent intraventricular hemorrhage in multiples to the same extent as in singletons.[3]

The chorionicity, amnionicity and zygosity must be determined as these will have prognostic implications and allow attention to be focused on specific risks. While dizygotic twins have a perinatal mortality of 3%, which is twice that of singletons and is associated with age, race and assisted reproductive technology (ART), monozygotic twins have significantly higher perinatal mortality, ranging from 9% for dichorionic, diamniotic twins to 50% for monoamniotic, monochorionic twins.[1] Chorionicity continues to play a role as the number of multiples increases. Dichorionic triplets have an eight times higher perinatal mortality rate than trichorionic triamniotic pregnancies.[4]

ART is an independent risk factor in most studies,[5] although one review found a 40% lower perinatal mortality rate in twin pregnancies conceived after ART compared with natural conception.[6] Despite a 40-50% rate of singleton pregnancies with ART, these pregnancies are still at a higher risk for birth defects, intrauterine growth restriction and preterm birth. Some of this may be attributed to the finding that 8-10% of males with oligospermia have deletions which are passed on to the fetus making them more genetically vulnerable. Zona manipulation leads to approximately 17% of the multiple gestation pregnancies being monoamniotic.[1]

Genetic screening in twin pregnancies is problematic with the quad test having an approximately 15% false positive rate compared to 5% in singleton pregnancies. Careful discussion will need to be individualized to the patient in regard to what testing will be done and what actions will be taken if an anomaly is detected as selective reduction of the affected twin results in a 10% loss of the unaffected twin. Ultrasound works well for screening since it is fetus specific and can be used in the first trimester to measure nuchal translucency. Targeted ultrasound after serum MSAFP detects 99% of neural tube defects.[1]

With a shared placenta the outcomes vary depending on how the vasculature is shared, with equal sharing being optimal. With uneven sharing there is the risk of twin-twin transfusion syndrome (TTTS) with one fetus being much too small and at risk of demise. An important distinction is when the placental mass is equally shared but the vasculature is not.[1] Unequal placental sharing, which is associated with peripheral cord insertion, appears to be the primary contributor to birth weight discordance and monochorionic diamniotic twins with birth weight discordance are delivered an average of three weeks earlier than those without birthweight discordance.[7] TTTS occurs in around eight to fifteen percent of all monochorionic multiples and carries an 80% risk of perinatal morbidity and mortality.[7 Ref in 8] There is an almost six-fold increase in antenatally acquired severe cerebral palsy in monochorionic twins with TTTS compared with monochorionic twins without TTTS.[9] While intrauterine laser treatment for severe twin-twin transfusion has demonstrated better long term neurologic development, likely due in part to the greater gestational age at birth relative to a group undergoing serial amnioreduction.[10],close

Twin Pregnancy: Prenatal and Intra-partum Care – continued

73rd Annual Conference, San Antonio, TX

Resident Reporter: April Taggie Hoffman, D.O.
Lecturer: Prab Gill, M.D..

follow-up is necessary and failures often develop reverse unidirectional blood flow.[11] More significantly, intrauterine fetal demise (IUFD) following laser treatment in TTTS is 38% (and previously cited as high as 60%) although this is superior to the IUFD rate in TTTS managed by serial amnioreduction.[8]

Several abnormalities are seen only in monozygotic twin conceptions including about 1 in 35,000 that produces an acardiac twin. In the case of twin-reversed arterial perfusion (TRAP), superficial anastamoses on the chorionic plate of the placenta cause the placenta to be bypassed with one fetus becoming a parasite and getting reversed blood flow. The parasitic fetus will be non-viable with absent fetal heart beat and head, cervical spine and upper limb development are usually absent. In these pregnancies there are an excess of female acardiac twins and at least 20% of the monozygotic co-twin can be expected to have congenital anomalies and 55% die in the newborn period.[12] It is essential to properly identify this by assessing any non-viable fetuses for blood flow as this will affect the prognosis of the surviving twin.[1] The overall perinatal survival for patients undergoing surgical occlusion of the umbilical cord was 65% compared to 42.9% for expectantly managed patients in one study.[13]

Twins are at significant risk of spontaneous preterm delivery and cervical length should be assessed at 23 weeks with a cervical length of greater than 25mm having a significant negative predictive power for PTD.[1] The best single predictor of preterm delivery is cervical length between 22 and 24 weeks. While the rate of preterm delivery is strongly influenced by obstetric history, such that a previous preterm birth makes the risk of preterm delivery twice that of a nulliparous woman and a previous term delivery halves the risk, the addition of obstetric history does not significantly improve the risk assessment based on cervical length alone.[14] Furthermore, there is a significantly higher rate of preterm birth associated with cerclage usage in twins.[15]

It is also essential to determine the placental location and recommended that when the placenta is <20mm from the internal os that it be considered "critically low-lying" and these patients should be treated like those with placenta previa. Caution should be used to identify velamentous cord insertions. When low-lying placentas resolve with advancing gestational age, multifetal pregnancies with velamentous cord insertions remain at significant risk for vasa previa.[1]

While monitoring fetuses for discordant growth is important, it must be realized that not all discordant growth has the same implications and when one fetus is large for gestational age and the other is appropriate for gestational age this is less of a cause for worry than when one of the fetuses is small for gestational age. The chorionicity must also be taken into consideration.[1] To complicate this monitoring, at least one study determined that sonographic measurement of either abdominal circumference or of estimated fetal weight is not adequately sensitive to accurately assess a 25% difference in twin growth.[16]

When delivering twins, the presentations must be evaluated. If external cephalic version of the second twin fails, a cesarean section should be performed and a breech extraction should not be done as a rescue strategy. When planning to do a total breech extraction of a second twin, one should be well prepared will full anesthesia back-up, effective epidural anesthesia, plan delivery in the operating room with 500mcg of nitroglycerin available. There must be at least three people, one of whom controls the ultrasound and then is prepared to give suprapubic pressure. Drain the bladder when the first twin is crowning and be prepared to do an episiotomy. A Hollister cord clamp is recommended. Do not manipulate the fetus excessively and do not rotate for delivery of the arm until the scapula is becoming visible. Have piper forceps available in the event of head entrapment.[1] The American College of Obstetricians and Gynecologists and the Society of Obstetricians and Gynecologists of Canada currently recommend cesarean delivery when the first twin is breech and vaginal delivery for nonvertex second twins weighing 1500-4000g as long as criteria for vaginal breech delivery are met.[17, 18]

Twin Pregnancy: Prenatal and Intra-partum Care – continued

73rd Annual Conference, San Antonio, TX

Resident Reporter: April Taggie Hoffman, D.O.
Lecturer: Prab Gill, M.D.

References

1. Gill, Prabhcharan P. M.D., FRCOG (London), FACOG "Multiple Pregnancy: Prenatal and Intrapartum Care" American College of Osteopathic Obstetricians and Gynecologists 73rd Annual Conference.
2. Blickstein, I et al "Plurality-Dependent Risk of Respiratory Distress Syndrome among Very-Low-Birth-Weight Infants and Antepartum Corticosteroid Treatment" Am J OB Gyn 2005; 192:360-4.
3. Blickstein, I et al "Plurality-Dependent Risk of Severe Intraventricular Hemorrhage among Very-Low-Birth-Weight Infants and Antepartum Corticosteroid Treatment" Am J OB Gyn 2006; 194: 1329-33.
4. Bajoria, R et al "Comparative Study of Perinatal Outcome of Dichorionic and Trichorionic Iatrogenic Triplets" OB Gyn 2006; 194: 415-25.
5. McDonald, S et al "Perinatal Outcomes of in vitro Fertilization Twins: A Systematic Review and Meta-Analyses" Am J OB Gyn 2005; 193: 141-52.
6. Helmerhorst, F et al, "Perinatal outcome of singletons and twins after assisted conception: a systematic review of controlled studies" BMJ 2004; 328: 261-
7. Flick, A et al " Unequal Placental Sharing and Birth Weight Discordance in Monochorionic Diamniotic Twins" Am J OB Gyn 2006; 195: 178-83.
8. Cavicchioni O et al "Intrauterine Fetal Demise following Laser Treatment in Twin-to-Twin Transfusion Syndrome: BJOG 2006; 113: 590-4.
9. Lopriore, E et al "Incidence, Origin, and Character of Cerebral Injury in Twin-to-Twin Transfusion Syndrome Treated with Fetoscopic Laser Surgery" Am J OB Gyn 2006; 194: 1215-20.
10. Graef, C et al "Long-Term Neurodevelopmental Outcome of 167 Children after Intrauterine Laser Treatment for Severe Twin-Twin Transfusion Syndrome" Am J OB Gyn 2006; 194: 303-8.
11. Robyr, R et al "Prevalence and Management of Late Fetal Complications following Successful Selective Laser Coagulation of Chorionic Plate Anastomoses in Twin-to-Twin Transfusion Syndrome" Am J OB Gyn 2006; 194: 796-803.
12. Hall, J "Twinning" Lancet 2003; 362:735-43.
13. Quintero, R et al, "Surgical Management of Twin Reversed Arterial Perfusion Sequence" Am J OB Gyn 2006; 194: 982-91.
14. Meekai, S et al "Maternal Characteristics and Cervical Length in the Prediction of Spontaneous Early Preterm Delivery in Twins" OB Gyn 2006; 194: 1360-5.
15. Berghella, V et al: "Cerclage for Short Cervix on Ultrasonography: Meta-Analysis of Trials Using Individual Patient-Level Data" Am Col OB Gyn 2005; 106(1): 181-189
16. Caravello, J et al "Sonographic Examination Does not Predict Twin Growth Discordance Accurately" OB Gyn 1997; 89:529-33.
17. American College of Obstetricians and Gynecologists. "Multiple Gestation" 1989 Technical Bulletin No. 131.
18. Barrett J, Bocking A. "The SOCG Consensus Statement on Management of Twin Pregnancies (Part I)" J SOCG 2000; 91: 519-32.

MEFACOOG/Berlex Awards for Excellence in Poster Presentation 2006

We gratefully acknowledge the ongoing support for this program by Berlex through a restricted educational grant.

Posters were presented at the 73rd Annual Conference of the ACOOG in San Antonio, Texas. The Annual Poster Presentation Awards are judged by the ACOOG Research and Awards Committee under the direction of George Davis, D.O., Chair.

The first place poster is reproduced here for your review.

Congratulations to:

Michelle Tartaglia, D.O. First Place - $1,000.
FALLOPIAN TUBE RECONSTRUCTION USING A PORCINE SMALL INTESTINE SUBMUCOSA GRAFT IN A RABBIT MODEL – INTERIM REPORT
Philadelphia School of Osteopathic Medicine
Philadelphia, PA

Lisa Barden, D.O., Resident Second Place - $750.
SOFT TISSUE EFFECT ON THE INCIDENCE OF SHOULDER DYSTOCIA - METHODS OF INDUCTION
Arrowhead Regional Medical Center,
Colton, California

Monica Valenzuela-Gamm, D.O., Third place- $500.
MAJOR MATERNAL TRAUMA IN PREGNANCY AND MATERNAL/PERINATAL OUTCOMES AT HOSPITAL DISCHARGE
Arrowhead Regional Medical Center,
Colton, California

Fallopian Tube Reconstruction Using a Porcine Small Intestine Submucosa Graft in a Rabbit Model – Interim Report

M. Tartaglia D.O., J.W. Taveau M.S. D.O., B. Hooks D.O., R. Lopez B.S., L. Drohan D.O., J. Rakitt D.O., C. Greene Ph.D.

ABSTRACT

Tubal pathology is one of the most common causes of infertility and is the primary diagnosis in 30-35% of infertile couples. Recent clinical practice has focused infertility treatment on circumventing the diseased tube using methods such as in-vitro fertilization. However, treatment options do exist which involve the repair and reconstruction of the fallopian tube. This report will explore a novel method of tubal reconstruction that utilizes a graft material derived from porcine small intestinal submucosa. The graft replaces the missing or diseased portion of tube, facilitates regrowth of the inherent tissue, and then is resorbed by the body. The New Zealand White rabbit is being used as the model due to the fact that its uterine horn is nearly histologically identical to the human fallopian tube. As the project has evolved, more and more has been learned about small-intestinal submucosa as a graft material and the surgical implications of tubal reconstruction using a graft. The progress of the study and the interim findings shall be reported here.

BACKGROUND

Greater than one third of all infertile couples are diagnosed with tubal factor infertility. This is no surprise as the incidence of infections such as N. gonorrhea and C. trachomatis continue to rise and as thousands of women undergo tubal sterilization each year. Many of these women with tubal scarring seek advice on their medical and surgical options. This ongoing study has explored one possible new

Fallopian Tube Reconstruction Using a Porcine Small Intestine Submucosa Graft in a Rabbit Model – Interim Report – continued

M. Tartaglia D.O., J.W. Taveau M.S. D.O., B. Hooks D.O., R. Lopez B.S., L. Drohan D.O., J. Rakitt D.O., C. Greene Ph.D.

surgical option – a novel graft material that replaces a portion of resected, scarred tube in order to aid in the regeneration of innate healthy tissue, thereby restoring normal tubal architecture and length.

The study has undergone many evolutions over the years. The first focus was merely to prove that our graft material would successfully regenerate tissue histologically similar to the human fallopian tube. Once electron microscopy had proven that it was possible, we attempted place longer grafts in order to replace longer segments of scarred tube. Though we even built and tested multiple stents, the longer grafts continued to fail. We regrouped and reconsidered our clinical applications and a new direction has been undertaken.

The incidence of post sterilization regret is not insignificant. Twenty percent of women less than 30 years old at the time of sterilization express regret about their decision. Surgical reanastomosis of the fallopian tube has been shown to be a successful option for these women. However, the length of reanastomosed tube has been shown to directly correlate with successful pregnancy rates. The final phase of this study will explore the possibility of using our graft material to successfully add one additional centimeter of length to a reanastomosed tube in order to increase overall surgical success rates.

New Zealand White Rabbit as a Model

The New Zealand White rabbit was chosen for its anatomic and reproductive characteristics. The histology of the human fallopian tube and the rabbit uterine horn are almost identical (Fig. 1) Further, rabbits are induced ovulators – they only ovulate when they copulate - therefore, they have no menstrual cycle and can be mated at any time. And as the rabbit gestational period is only 30 days and pregnancy can be detected by day 10, the New Zealand White is an excellent model for fertility studies.

Small Intestinal Submucosa as a Graft Material

Small intestinal submucosa (SIS) is a Type I collagen matrix imbedded with natural heparin and numerous growth factors such as FGF2, TGF beta, and VEGF. When SIS is placed in proximity to tissue in vitro and in vivo, it has been shown to induce neoplasia of that tissue – a multitude of tissues have been studied such as bone, tendon, cornea, urinary bladder, esophagus, and skin. The SIS is comprised of intestinal submucosa with attached muscularis mucosae and stratum compactum (Fig 2). It is harvested simply by peeling off the serosa and scraping away the mucosa of small bowel. It is quite inert as it is collagen based and relatively acellular. Porcine jejunum was used to harvest the SIS – many animal models have been studied and porcine SIS was noted to be the most durable and the least thrombogenic. (Fig 3)

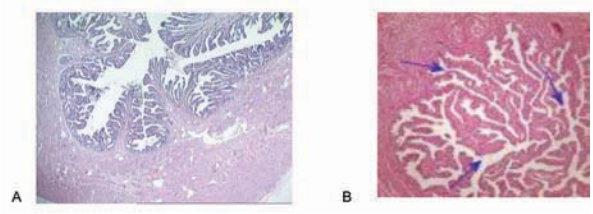


Fig. 1 A. Rabbit uterine horn B. Human fallopian tube

Fig. 2 Rabbit reproductive system. Pictured are the ovaries (black arrows) and the bilateral uterine horns (white arrows) with surrounding fatty tissue.

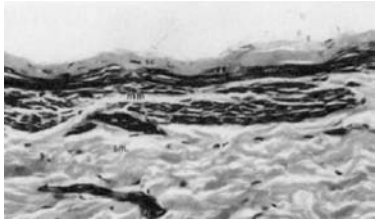


Fig. 3
Small intestinal submucosa
Stratum Compactum (sc)
Muscularis Mucosa (mm)
Submucosa (sm)

Fallopian Tube Reconstruction Using a Porcine Small Intestine Submucosa Graft in a Rabbit Model – Interim Report – continued

M. Tartaglia D.O., J.W. Taveau M.S. D.O., B. Hooks D.O., R. Lopez B.S., L. Drohan D.O., J. Rakitt D.O., C. Greene Ph.D.

Fig. 4. SIS is a thin, highly durable collagen matrix

PHASE ONE

* note: JW Taveau MS DO was the primary investigator of this phase *

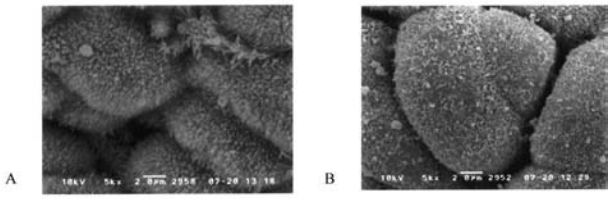


Fig. 5. A. Native uterine horn (5000x)
B. Uterine horn at the graft site suture line (5000x)

HYPOTHESIS

To show that porcine SIS grafts would successfully regenerate rabbit uterine horn.

MATERIALS AND METHODS

Porcine SIS was used to fashion tubular grafts 0.5, 1, and 2cm in length and two grafts of each length were placed - New Zealand White rabbit was anesthetized, a laparotomy performed, and a 0.5-2cm portion of one uterine horn was resected and the tubular SIS graft sewn into place using standard microsurgical technique. The contralateral uterine horn was resected and the abdomen was closed in layers.

The rabbit was mated approximately 28 days later and pregnancy was evaluated via behavioral method at day 4 and by palpation on day 10. The rabbit was then euthanised and the uterine horn and graft were harvested. The specimen was examined using both light and electron microscopy

RESULTS

Light and electron microscopy revealed complete regeneration of all tissue layers – epithelium with cilia, muscularis, and serosa – though they were somewhat dysmorphic after 52 days of healing time (Fig 4). Three of the six rabbits in the study became pregnant – both of the rabbits with 0.5cm grafts and one of the rabbits with the 1cm graft. Upon necropsy, it was found that some of the longer, 1-2cm, grafts had collapsed and the uterine horn was found to be dilated and fluid, or in one case, pus filled.

DISCUSSION

Though there was no significant difference in postoperative premating times (p=0.284) or graft length (p=0.6) the results do suggest that shorter graft lengths and increased healing times could improve outcomes.

PHASE TWO

HYPOTHESIS

Tubular SIS uterine horn grafts longer than one centimeter will require a stent to maintain patency

MATERIALS AND METHODS

Gore-Tex and surgical steel stents were hand made and affixed to the tubular SIS grafts (Fig 5). The SIS was also wrapped on itself 8 times to form a multilayer graft which proved to have more inherent stability in the tubular form than a single layer graft. Each of the three types of stent materials were used with 2cm of SIS and placed in the uterine horn of at least 2 rabbits using microsurgical technique. Rabbits were mated after approximately 28 days and the grafts were harvested approximately 10-15 days later.

RESULTS

No pregnancies were observed in the Gore-Tex or surgical steel stent rabbits. The only pregnancy noted was with the multiwrap graft (Fig 6).

Fallopian Tube Reconstruction Using a Porcine Small Intestine Submucosa Graft in a Rabbit Model – Interim Report – continued

M. Tartaglia D.O., J.W. Taveau M.S. D.O., B. Hooks D.O., R. Lopez B.S., L. Drohan D.O., J. Rakitt D.O., C. Greene Ph.D.

DISCUSSION

The multiwrap graft proved to have inherent stability and patency preoperatively and proven fecundability in the postoperative period. No microscopy studies were done at this time as the purpose of this phase was merely to determine fecundability rates with different stent types.

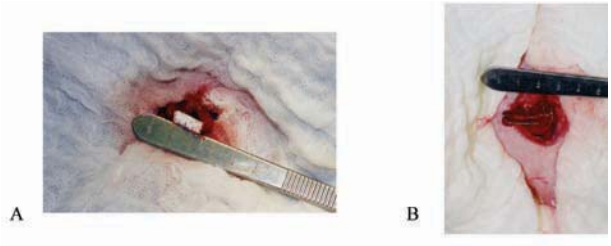


Fig. 6. Gore-Tex stent (left) and surgical steel stent (right)

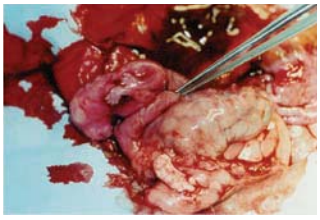


Fig. 7. Pregnancy after placement of a multiwrap graft (distal to forceps)

PHASE THREE

HYPOTHESIS

The multiwrap graft would remain patent in the postoperative period at varying lengths and improve fecundability rates.

MATERIALS AND METHODS

Multiwrap SIS grafts ranging from 1-5cm in 1cm increments were fashioned. Two grafts of each length were created, with the exception of the 1cm grafts – one was a single layer graft and one was a multilayer graft. All grafts were placed and harvested as in Phase One.

RESULTS

One of the 4cm graft rabbits succumbed to wound dehiscence and was euthanized. Eight of the study rabbits were noted to have graft collapse or torsion upon necropsy. One successful pregnancy was noted in the 1cm single-wrap graft rabbit.

DISCUSSION

Once the multilayer graft was further studied it was revealed to have the same inherent flaw at greater lengths as the single layer graft – collapse.

PHASE FOUR - THE FUTURE

After careful review of all prior data, it was decided to focus the next phase of the study on the one centimeter single wrap graft. The shorter, single wrap grafts had proven to be the most consistent in producing successful pregnancies.

This fourth phase of the study will focus on two major parameters. First, increasing the total number of 1cm single wrap SIS grafts that are to be studied to help better understand the patency and fertility rates of such a graft. The second focus of the study will be healing times. The amount of postoperative healing time allowed will be varied among subjects to help elucidate the most effective postoperative period before mating.

MATERIALS AND METHODS

One centimeter single wrap SIS grafts will be placed in the New Zealand White rabbit uterine horn using microsurgical technique as previously described. Postoperative recovery times before mating will be either 4, 6, 8, or 12 weeks. Six rabbits will be placed in each sequential recovery time group for a total of 24 rabbits in the protocol. Necropsy will be performed approximately 10 days after mating to confirm pregnancy and harvest the graft for further microscopic evaluation of tissue regeneration and organization.

Fallopian Tube Reconstruction Using a Porcine Small Intestine Submucosa Graft in a Rabbit Model – Interim Report – continued

M. Tartaglia D.O., J.W. Taveau M.S. D.O., B. Hooks D.O., R. Lopez B.S., L. Drohan D.O., J. Rakitt D.O., C. Greene Ph.D.

RESULTS

Study currently in progress

REFERENCES

1. Miller JH, Weinberg RK, Canino NL, Klein NA, Soules MR. The pattern of infertility diagnoses in women of advanced reproductive age. Am J Obstet Gynecol 181:952, 1999.
2. Hills SD, Marchbanks PA, Tylor LR, Peterson HB. Poststerilization regret: findings from the United States Collaborative Review of Sterilization. Obstet Gynecol 93:889, 1999.
3. Rock J, Jones H. TeLinde's Operative Gynecology. Ninth Ed. 2003. Philadelphia: Lippincott Williams & Wilkins. p 454.
4. Speroff L, Fritz M. Clinical Gynecologic Endocrinology and Infertility. Seventh Ed. 2005. Philadelphia: Lippincott Williams & Wilkins. p 1046.
5. Voytik-Harbin SL, et al. Identification of extractable growth factors from small intestinal submucosa. J of Cellular Biochemistry. 67:4. p 478-91, 1997.
6. Robotin-Johnson MC, Swanson PE, Johnson DC, Schuesslez RB, Cox JL. An experimental model of small intestinal submucosa as a growing vascular graft. J of Thoracic and Cardiovascular Surgery. 116:5 p 805-11, 1998.
7. Lantz GC, et al. Small intestinal submucosa as a vascular graft: a review. Journal of Investigative Surgery. 6:3. p 297-310, 1993.
8. Badylak SF, et al. Small intestinal submucosa as a large diameter vascular graft in the dog. Journal of Surgical Research. 47:1. p 74-80, 1989.
9. McPherson TB, et al. Galalpha(1,3)Gal epitope in porcine small intestinal submucosa. Tissue Engineering. 6:3. p 233-9, 2000.
10. Taveau J. Tartaglia M. Buchannan D. Smith B. Koenig G. Thomfohrde K. Stouch B. Jeck S. Greene CH. Regeneration of uterine horn using porcine small intestinal submucosa grafts in rabbits. Journal of Investigative Surgery. 17:2 p 81-92, 2004

2007 Medical Education Silent Auction Information

Thank you for your kind consideration of a donation to the 5th Annual Silent Auction of the Medical Education Foundation of the American College of Osteopathic Obstetricians and Gynecologists. This event will take place during the 74th Annual Conference of the ACOOG in Palm Springs, CA on Wednesday, March 28, 2007.

This important fund raiser has helped MEFACOOG accomplish its mission which is to foster continuing improvements in women's healthcare. Your donation will be acknowledged in the Silent Auction Program and in the MEFACOOG Annual Report published in December 2007 and on the MEFACOOG web site, www.mefacoog.org .

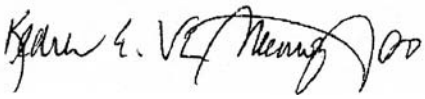
Items vary from gift certificates to national chain restaurants and hotel and condominium getaways to autographed sports memorabilia and handmade craft gift items. The Silent Auction takes place as part of the Welcome Reception at the Annual Conference and each year it concludes with a few select live auction items of large value.

Please be generous in your donation. MEFACOOG is a 501c3 not for profit and donations are federally tax deductible to the full extent of the law. Please consult your tax advisor.

MEFACOOG was founded in 1999. The members of the ACOOG have to date matched every corporate corpus gift dollar for dollar. This shows how the medical industry/medical education collaboration can be successful to the benefit of patient care. MEFACOOG has grown to an organization that is sponsoring medical education activities for osteopathic Ob/Gyn residents and practicing Ob/Gyn physicians. Help us continue to improve our patients' health with support for educational programs that challenge, validate, and set the highest standards in women's health.

Fraternally,

Mark A. Kalchbrenner, D.O., FACOOG (Dist.)
MEFACOOG Chair



Kedrin Van Steenwyk, D.O., FACOOG (Dist.)
Silent Auction Chair

MEFACOOG Calendar of Events - 2007

March 28th	MEFACOOG Corporate Partnership Council Meeting
March 28th	MEFACOOG 4th Annual Silent Auction
March 31st	MEFACOOG Board of Trustees Meeting

MEFACOOG 5th Annual Silent Auction Donation Form

74th Annual Conference of the ACOOG

Wednesday, March 28, 2007 - Palm Springs, CA

Donor Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

E-mail _____ Fax _____

Contact Person _____

Donation Description: Please provide a description of your item for the website and event program _____

_____

_____

_____

Estimated Value $_____ Starting Bid $_____

If this item requires shipping, the purchaser is responsible for paying shipping costs.

OPTIONAL CASH DONATION TO THE FOUNDATION

❑ Yes! In place of an item, I would like to make a cash donation.
❑ Check (Please make payable to the MEFACOOG)
❑ VISA ❑ MasterCard

Credit Card # _____ Exp. Date _____

Name on Card _____ Date _____

Signature _____

Mail or fax this form to:
MEFACOOG
2615 Merrick Street • Fort Worth, Texas 76107 or
FAX 817-377-0439
Questions 800-875-6360

Year 2005 Support

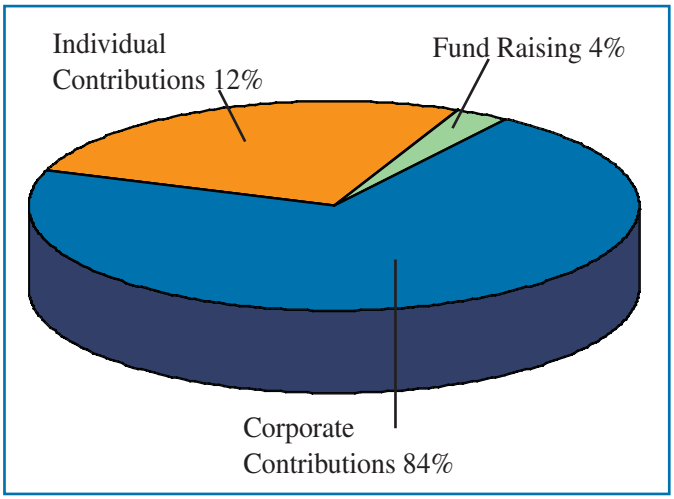
We are pleased to report that the financial review for 2005 reflected an increase in assets for MEFACOOG. As you can see, the corporate contributions are channeled into programs that benefit education, research and faculty development:

• MEFACOOG/Wyeth Resident Reporter Scholarship Program-educating osteopathic ob/gyn residents at the ACOOG Annual Conference

• MEFACOOG/ Ortho Women's Health Visiting Professor Program- educating osteopathic medical students and promoting career choices in obstetrics and gynecology

• MEFACOOG/ Berlex Awards for Excellence in Poster Presentation- encouraging research and rewarding dissemination via poster presentation at the ACOOG Annual conferences

• MEFACOOG/Ortho Women's Health Resident Research Grant- encouraging research in osteopathic ob/gyn residency programs



This was the first year of a ten year Endowment in which ACOOG members received the benefits of the Gail Goldsmith Memorial Lecture at the 73rd Annual Conference. To date friends and colleagues of Gail have donated $14,855 toward the goal of a ten year $50,000 endowment. Wyeth generously provided the balance of over $35,000 to assure an outstanding women's health lecture at each of the next ten ACOOG Annual Conferences.

This Endowment, like the other programs, shows the successful model of philanthropy in the medical education and industry partnership that helps foster continuing improvements in women's healthcare.

Thank you for your support. Please keep MEFACOOG in mind when you look for worthy causes and organizations to nurture.

We cannot be successful without you.

MEFACOOG Financial Review

MEFACOOG Statement of Activities

Year Ended December 31, 2005

Support	
Corporate Contributions	$174,645
Individual Contributions	63,677
Fund Raising	8,390
Total Support	**$246,712**
Expenses	
Program Services	115,443
Support Services	73,674
Total Expenses	**$189,117**
Other Income (Expenses)	14,628
Change in Net Assets	72,223
Net Assets, Beginning of Year	530,205
Net Assets, End of Year	**$602,428**

MEFACOOG Statement of Financial Position

December 31, 2005

Assets	
Current Assets	
Cash	$436,773
Investments	177,119
Unconditional Promises to Give	7,400
Total Assets	**$622,334**
Liabilities and Net Assets	
Due to ACOOG	19,906
Liabilities	19,906
Net Assets	602,428
Total Liabilities and Net Assets	**$622,334**

Medical Education Foundation News

Donations received as of press time, November 29, 2006. Any received after this date will be acknowledged in the next Annual Report. Cumulative donations since inception, October 1999 to November 29, 2006.

ACOOG Membership Matching Grantors

Founding Corporate Grantors	ACOOG Board of Trustees	Past President's Club
Platinum	***Millennium***	***Millennium***
Ortho-McNeil Pharmaceutical	Patricia Arnett, D.O.	David L. Wolf, D.O.
Wyeth Pharmaceuticals	Robert Debbs, D.O.	Paul M. Krueger, D.O.
Warner Lambert/Parke-Davis	Carl R. Della Badia, D.O.	Sheryl A. Bushman, D.O.
Berlex Laboratories	Gary L. Doublestein, D.O.	W. Lee Irving, D.O.
Matria Healthcare	Laura Dalton, D.O.	Kedrin E. Van Steenwyk, D.O. ★
Organon, Inc.	Cathy & Michael Geria, D.O.	Joseph M. Kaczmarczyk, D.O.
Pfizer Pharmaceuticals	Mark A. Kalchbrenner, D.O.★	Richard R. Polk, D.O.
Eli Lilly & Company	Jeffrey Postlewaite, D.O.	Anthony Cortese, D.O.
(listed in order of grants received)	Anita Showalter, D.O.	Jerry Polsinelli, D.O.
	David Boes, D.O.	Ronald Librizzi, D.O.
	William Bradford, D.O.	Steve P. Buchanan, D.O.
	Teresa A. Hubka, D.O.	Richard Tucker, D.O.
		Jewell Malick. D.O.
		Gary S. Packin, D.O.
		Ronald E. Ayres, D.O.
		Joseph P. Bonanno, D.O.
		Kenneth P. Glinter, D.O.
		Simon Lubin, D.O.
		Bernard Billman, D.O. ★
		Lee J. Walker, D.O.
		Margaret Jones, D.O. (1934-1936)✣
Gold	***Gold***	***Gold***
3M Pharmaceuticals	Thomas Alderson, D.O.	Harvey Orth, D.O.
	David Forstein, D.O.	William Hole, D.O.
	Peter S. Konchak, D.O.	Saul Jeck, D.O.
Bronze	***Century***	***Century***
Solvay Pharmaceuticals		Edward Slotnick, D.O.
		J. Dudley Chapman, D.O.

Corporate Grantors:
Platinum - $25,000 +
Gold - $10,000 - $24,999
Bronze - $5,000 - $9,999

ACOOG Membership Matching Grantors
Millennium - $1,000 +
Gold - $500 - $999
Century - $100 - $499
Supporter $1 - $99
★MEFACOOG Board Member Pledging $1,000 each year per three year term

	Benefitting students of:	*Through restricted grants by:*
MEFACOOG Student Scholar Program	UHS-COMFall Conference 2002	
Inaugural Grant (In Memoriam ✣)	UNTHSC-TCOM Fall Conference 2003	*an anonymous donor couple*
MEFACOOG Student Scholar Program	AZCOM 70th Annual Conference	*Sidney Semrad, D.O.*
David Wolf, D.O. (In Honor of)	PCOM Fall Conference 2004	*John Stevens, Jr., D.O.*
MEFACOOG Student Scholar Program	COMP 71st Annual Conference	*Kedrin E. Van Steenwyk, D.O.*
MEFACOOG Student Scholar Program	UMDJNJ Fall Conference 2004	*Paul M. Krueger, D.O.*
MEFACOOG Student Scholar Program	PCSOM Fall Conference 2004	*Steve P. Buchanan, D.O.*
	Pikeville College School of Osto. Med.	*Mark A. Kalchbrenner, D.O.*
		Kedrin E. Van Steenwyk, D.O.
		David L. Wolf, D.O.

To Honor the office staff of the ACOOG
by Richard R. Polk, D.O.

In Honor of David Wolf, D.O.
by John Stevens, Jr., D.O.

In Honor of graduating chief residents, Jeffrey Hantes, D.O. and Lynn Speaks, D.O.
by Anny & Steve P. Buchanan, D.O.

In Memoriam of George Russian, D.O.
by David L. Wolf, D.O.

In Memoriam of Harry Ludwig, D.O.
by
Valerie Payne-Jackson, D.O.
David L. Wolf, D.O., FACOOG, (Dist)
Todd Moyerbrailean, D.O.
David Boes, D.O.
ACOOG

In Honor of graduating chief residents, Karen Benz, D.O. and Trisha Parks-Beakley, D.O.
by Anny & Steve P. Buchanan, D.O.

In Memoriam of Randy Collins, D.O.
by ACOOG

In Memoriam of James Matthews, D.O.
by
David L. Wolf, D.O.
Monica Bachamp, D.O.
Harvey Orth, D.O.
Lee Walker, D.O.
ACOOG

In Memoriam of Herb Scolnick
by Michael D. Weiss, D.O.

In Memoriam of Marie A.K. Weiss
by
Ethan, Emma and Megan Weiss
Michael D. Weiss, D.O.
Kathy and W. Lee Irving, D.O.

In Honor of Ernest Thompson
by Johnson and Johnson

In Memoriam of Christopher Hubka
by David L. Wolf, D.O.

In Memoriam of James Emme, D.O.
by
Thomas Losure, D.O.
Mark Kalchbrenner, D.O.
Jeffrey Postelwaite, D.O.
Edward Newman, D.O.
ACOOG

In Memoriam of Harvey Orth, D.O.
by
Joseph Bonanno, D.O.
David L. Wolf, D.O.
ACOOG

In Memoriam of Pat Guyton, D.O.
by David L. Wolf, D.O.

In Memoriam of Gwyneth Royer, D.O.
by ACOOG

In Honor of graduating chief residents, Erin Westerholm, D.O. and Leslie Hardick, D.O.
by Anny & Steve P. Buchanan, D.O.

ACOOG General Membership Donations

Millennium $1000 +

Patricia F. Arnett, D.O.
Ronald E. Ayres, D.O.
Bernard D. Billman, D.O.
David J. Boes, D.O.
Joseph Bonanno, D.O.
William Bradford, D.O.
Steve Buchanan, D.O.
Sheryl A. Bushman, D.O.
Dennis M. Carden, D.O.
Eric J. Carlson, D.O.
Stuart Chesky, D.O.
Randy Collins, D.O.
Anthony J. Cortese, D.O.
Laura Souders Dalton, D.O.
Robert H. Debbs, D.O.
Douglas C. Dedelow, D.O.
Raymond W. Deiter, D.O.
Carl Della Badia, D.O.
Gary L. Doublestein, D.O.
Jeannemarie Durocher
Kenneth Finkelstein, D.O.
William J. Gall, D.O.
Michael Geria, D.O.
Daniel D. Gilman, D.O.
Craig Glines, D.O.
Kenneth P. Glinter, D.O.
Teresa Ann Hubka, D.O.
Jeanie Huynh, D.O.
Lee W. Irving, D.O.
Joseph M. Kaczmarczyk, D.O.
Mark Kalchbrenner, D.O.
Howard Kaufman, D.O.
Jeffrey C. Koszczuk, D.O.
Paul Krueger, D.O.
Sue Leasure, R.N.
Robert S. Lee, D.O.
Ronald J. Librizzi, D.O.
Steven Lown, D.O.
John J. Maceluch, D.O.
Jewell E. Malick, D.O.
Carol Markiewicz, D.O.
Steve McCarus, D.O.
Thomas E. McCurdy, D.O.
John V. McInerney, D.O.
Melissa McNett
Craig L. Mechelke, D.O.
Mary O'Connor, J.D.
Betty Orange, D.O.
Gary Packin, D.O.
James J. Perez, D.O.
Richard R. Polk, D.O.
Jerry Polsinelli, D.O.
Jeffrey Postlewaite, D.O.
Frank Raymond, D.O.
Edward O. Reece II, D.O.
Amelia K. Roush, D.O. ★
George W. Russian, D.O.
Mary Beth Sandin
Larry E. Seals, D.O.
Sidney E. Semrad, D.O.

Millennium $1000 + Continued

Stacy L. Sensor, D.O.
Anita L. Showalter, D.O.
William Stanley,Jr., D.O.
John S. Stevens Jr., D.O.
Ernest Thompson
Richard Tucker, D.O.
Parveen Vahora, M.D.
Kedrin Van Steenwyk, D.O.
Lee J. Walker, D.O.
Paul Whitham, D.O.
Gregory Willis, D.O.
David L. Wolf, D.O.
George J. Zobel, D.O.

Gold $500 - $999

Thomas Alderson, D.O.
Roxanna Aldstadt, D.O.
Monica Bachamp, D.O.
Glen Bigsby IV. D.O.
William Bradford, D.O.
Christoff Coutifarous, D.O.
Zane G. Craig, D.O.
Sylvia S. Cruz, D.O.
Stephanie Cunninghan, D.O.
John J. Eberhart
David Forstein, D.O.
Ferio J. Francois, D.O.
Lisa Gilbert, D.O.
June A. Goldsmith
Saul Jeck, D.O.
John Jonesco, D.O.
Marilyn J. Kindig, D.O.
Thomas Lee, D.O.
Tracey S. Linden, D.O.
Simon Lubin, D.O.
Cynthia A. Mace-Motta, D.O.
Douglas Neal MacGregor, D.O.
Karen Matus
Mark E. Melton, D.O.
Beth H. Mulvihill, D.O.
Jeffrey C. Northup, D.O.
Harvey Orth, D.O.
Douglas E. Pugmire, D.O.
Carolyn Quist, D.O.
Michael W. Rochowiak, D.O.
Sidney D. Rubinow, D.O.
Jerrold M. Snyder, D.O.
James David Spencer, D.O.
Suzanne Steinbaum, D.O.
Berm Studios
Hovik Taymoorian, D.O.
Lorie A. Thomas, D.O.
Leopoldo E. Valdivia, D.O.
Marcy D. Verplanck-Kanitz, D.O.
Bruce Wang, D.O.
Michael Weiss, D.O.
Patricia Wilhelm, D.O.

Century $100 - $499

Diane A. Adams, D.O.
David S. Adelstein, D.O.
William Anderson II, D.O.
Diane Aslanis, D.O.
Terry King Badzinski, D.O.
Daniel R Barkus, D.O.
Bill Barnes, D.O.
Katherine Barrett-Avendano, D.O.
Michelle L. Becher, D.O.
William Beuchat, D.O.
Peter Bianco, D.O.
David E. Biats, D.O.
Carrie Bolander, D.O.
Teresa Borchers, D.O.
Patricia C. Borthwick, D.O.
Carolyn A. Braithwaite
Christopher Buckley, D.O.
Nancy J. Bucy, D.O.
Lisa A. Bukovac, D.O.
Gerald V. Burr
Peter J. Cabala, D.O.
Daniel J. Cain, D.O.
Joni S. Canby, D.O.
Wallace Champlain Jr., D.O.
Craig W. Chandler, D.O.
Dudley J. Chapman, D.O.
Kenneth H. Chen, D.O.
Lisa Chobanian
Max A. Clark, D.O.
Kenneth R. Clayton, Jr., D.O.
Thomas Connolly, D.O.
Fred Couts, D.O.
Stephen A. D'Abreau, D.O.
Michelle M. D'Almeida, D.O.
Lee W. Davis, D.O.
Melissa L. Delaney, D.O.
Mark DeMasi, D.O.
Michelina DeSanti, D.O.
Terry J. Dierdorff, D.O.
Gina Dietrich, D.O.
Marianne DiGiovanni, D.O.
Walter Dodard, D.O.
James T. Dodge, D.O.
Stephen Downey
Liam Duggan, D.O.
Stephen F. Dyke, D.O.
Rinda P. Ellis, D.O.
Arlene England, D.O.
Jacaueline Evans, D.O.
Salvatore Finazzo, D.O.
Sheldon H. Fisher, D.O.
Ronald Fitch, D.O.
Stephanie Fitzgerald, D.O.
Judith Florido, D.O.
Kateryn G. Foss, D.O.
Macy Fox, D.O.
Ralph G. Frank, D.O.
John Gelinas, D.O.
Justine Gelinas, D.O.
Christian Geltz, D.O.
Brent W. Gillum, D.O.
William J. Goldsmith Jr.
Christina Goldstein - Charbonniau, D.O.
Stephen B. Graham, D.O.
Becky Graham, D.O.
Mitchell G. Greenbaum, D.O.
Jan C. Gromada, D.O.
John R. Guerra, D.O.
Reproductive Gynecologists
Travis K. Haldeman, D.O.
William V. Hamilton, D.O.
Kurt D. Harrison, D.O.
Lynne A. Haspedis, D.O.

Century $100 - $499 continued

Jennifer S. Hayes, D.O.
Daira Hertel
William Hole, D.O.
David W. Jackson, D.O.
Carol L. Jane
Margaret Jaskowski-Lutsic, D.O.
Deanah A. Jibril, D.O.
Rosanna Johnson, D.O.
Kim Johnson, D.O.
Sarah Jones, D.O.
Gloria Jue, D.O.
Kenneth S. Kacenga, D.O.
Peter E. Kaczkofsky, D.O.
Andre Kasko, D.O.
Deborah G. Kauffman, D.O.
Karen Kemp-Glock, D.O.
Michael F. Kenner, D.O.
David M. Keuchel, D.O.
Joseph Keuchel, Jr., D.O.
Nazafarine Keyvani, D.O.
Talaksoon Khademi, D.O.
Hyuk Kim, D.O.
Robert S. Kinsella, D.O.
Rhonda Kobold, D.O.
James Koerner, D.O.
Maria Kossak, D.O.
Susan Kroener, D.O.
Rosanna Kulisz, D.O.
David B. Land, D.O.
Michele J. Lapayowker, D.O.
Bruce Lastra, D.O.
Troy R. Lehman, D.O.
Geoffrey Levitt
Laura A. L'Heureux, D.O.
James Lindemulder, D.O.
Paul Loeb, D.O.
Azieb Lofton, D.O.
William M. Long, D.O.
William P. Long, D.O.
Jack Ludmir, D.O.
Harry A. Ludwig, D.O.
Rosie Lynch
Jerold M. Lynn, D.O.
Cecil Lyttle
Scott MacGregor, D.O.
Lou E. MacManus, D.O.
Louis Manara, D.O.
Edward M. Marici, D.O.
Jerome Markowitz, D.O.
Richard Markwood, D.O.
Robert J. Marotz, D.O.
Debra L. Marshall
Francis J. Martinez, D.O.
Lorraine Martinez, D.O.
William & Mary McDevitt
Jeannie M. McMahon, D.O.
Dennis William McNally, D.O.
Robert Meinzer
James E. Merrill, D.O.
George D. Methven, D.O.
Joseph L. Milio, D.O.
Gene W. Miller, D.O.
Michael Miller, D.O.
Stephen A. Miller, D.O.
Kate Eby Moore
William Moors, D.O.
James Morgan, D.O.
Cynthia Morris, D.O.
Samer Mossallam, D.O.
Todd A. Moyerbrailean, D.O.
Scott D. Muir, D.O.
James Murray, D.O.
Wendy K. Neininger
Jeffrey R. Nelson, D.O.
Edward M. Newman, D.O.
Barbara Newman, D.O.
Joseph Novi, D.O.
Michael L. Nowak, D.O.
Tanja K. O'Connor, D.O.
Andrew J. Ogden, D.O.
Andrew Panagy
Trisha Parks-Beakley, D.O.
James P. Parshall, D.O.
Steven T. Patterson, D.O.
Paul J. Pawlosky, D.O.
Valerie Payne-Jackson, D.O.
Robert Pearl, D.O.
Fiorina Pellegrino, D.O.
Edward S. Perkins, D.O.
Alice H. Perrone
Harvey L. Raimi, D.O.
Adolfo Rapaport, D.O.
Constantine Raphtis, D.O.
Martin Raskin, D.O.
Marydonna Ravasio, D.O.
Norman Raymond, D.O.
James Reilly, D.O.
Elizabeth M. Reinoehl, D.O.
Maureen A. Ribail, D.O.
Joann Richichi, D.O.
Joseph Riley, D.O.
Matthew A. Roberts, D.O.
John T. Robinett, D.O.
Avery Rosen, D.O.
Harvey Roth, D.O.
James Roukema, D.O.
Jeanie L. Rowe, D.O.
William J. Saks, Jr., D.O.
George A. Saleh, D.O.
Joann Sansone, D.O.
John & Julie Saunders
Patrick Sayavong, D.O.
Paul Schneider, D.O.
Valerie Schulte, D.O.
Rosanna Shayeghi
Steven Sheppard, D.O.
Michael Sinapi
Jerome Siudara, D.O.
Edward A. Slotnick, D.O.
Michael Sobel, D.O.
Candace Steele
Gary W. Stephens, D.O.
Elizabeth Stevenson, D.O.
Donna Sweets, D.O.
Scott C. Syndergaard, D.O.
Joseph P. Sypniewski, D.O.
Gerard W. Szczygiel, D.O.
Joseph P. Talcott, D.O.
Joe Talvacchia, D.O.
Donald R. Taylor, D.O.
Joseph H. Tedesco, D.O.
Mary Testa, D.O.
Robert Thiele, D.O.
Mark C. Torres, D.O.
Stephens Triplett, D.O.
Robert L. Tripp, D.O.
Nan Troiano, R.N.
Linda R. Tucker, D.O.
Mary Jo Urso, D.O.
Peter Vienne, Jr., D.O.
Rick A. Visci, D.O.
Robert T. Walsh, D.O.
Kimberly Warren, D.O.
Lisa R. Waterman, D.O.
Arnold Wechsler, D.O.
Lori W. Weinstein, D.O.
Herbert G. Wendelken, D.O.
Gehred D. Wetzel, D.O.
Benjamin White, D.O.
Elaine Wilson

Century $100 - $499 continued

Chris Wirsing, D.O.
Anita Wolf
Mark Woodland, D.O.
Janet L. Zurovchak, D.O.
Mary T. Zygmunt, D.O.

Supporter $1 - $99

Edwin W. Abbott, D.O
Carol Arnett, D.O
Kimberly Belsky
Catherine Bernardini, D.O.
James S. Betoni, D.O.
Angela Breckenridge, D.O.
Joseph Camardo
Jeffrey Carver
Wesley Chodos, D.O.
D. J. Clow, D.O.
Catherine A. Coats, D.O.
Marcia J. Coleman, M.D.
Stephen Dalm, D.O.
Dipak Delvadia, D.O.
Robert DiGregorio, D.O.
Bernardita Druhan, D.O.
Stephanie Parsons Eckert, D.O.
Peter Edinburg
Rosemary Fadool, D.O.
Ellen D. Faucett, D.O.
Kristen Fernandez, D.O.
Miguel Fernandez, D.O.
Joseph Flynn, D.O.
Jeffrey V. Fowler, D.O.
Patricia Gabig
Edna M. Garcia, D.O.
Gary S. Grubb, M.D.
Tom Guyton
Jeffrey Hantes, D.O.
Heather Harris
Ron Hayden
Teresa Ann Hubka, D.O.
Juanita K. Huggins, D.O.
Mary Joy Hyde, D.O.
Connie Januzelli, D.O.
Eileen Kampf
Linda M. Karbonit, D.O.
Mark T. Karnes, D.O.
James Koerner, D.O.
Sherri Lilifeld
Debra Littlejohn
Margaret C. Mader
Jerome Markowitz, D.O.
James K. Matheson, D.O.
Joseph Meunier, D.O.
Aubrey Narke
Mary Ellen O'Donnell
Tracy Papa, D.O.
Vanna M. Powell, D.O.
Lawerance Rogina, D.O.
Brunilda Rosario, D.O.
Janet L. Salvina
Robert Saretsky, D.O.
Howard Saul, D.O.
Michael Shaheen, D.O.
Stuart Shalit, D.O.
Rosanna Shayeghi
Thomas A. Sipprell, D.O.
Becky Jo Smith, D.O.
James Smith, D.O.
Kathline Smith
Lynn Speaks, D.O.
Leonard J. Staszak, D.O.
George Stefennelli, D.O.
Karen Stellabotte
Angelo Stoyanovich, D.O.
Stephanie Swan, D.O.
Brian Thomas
Terry Tressler, D.O.
Lisa Lynn Vendeland, D.O.
Richard Vitali
Doug Wells, D.O.
White Rose OB/GYN
Elaine Wilson
Rosanna Winchester, D.O.
Jeffrey C. Wong, D.O.
Debra Zwerlein

Mission Statement of the Corporate Partnership Council (CPC) of the Medical Education Foundation of the American College of Osteopathic Obstetricians and Gynecologists

The mission of the CPC of the MEFACOOG is to enhance and improve the quality of women's healthcare through collaborative partnerships. We will accomplish our mission by:

- Education of:
  - Physicians
  - Residents, and other related
  - Healthcare provider
- Increasing industry awareness of the uniquely osteopathic education model
- Improving industry access to physicians and the patients they serve
- Collaboratively, identifying, developing, and implementing educational programs in women's healthcare, thereby,
- Improving the lives of women through education.

Members of the Corporate Partnership Council of the MEFACOOG

Many thanks for the ongoing support of the Corporate Partnership Council of MEFACOOG

Ortho Women's Health & Urology - Platinum - Mark Szymanski
Wyeth Pharmaceuticals - Platinum - Mark Barbee
Berlex Laboratories - Platinum - Tom LiVecchi
Matria Healthcare, Inc. - Platinum - John Miller
Organon, Inc. - Platinum - Aimee DeBlasis
Eli Lilly and Company - Platinum - Sharron Stewart
Pfizer, Inc. - Platinum - George Roberts
3M Pharmaceuticals - Gold -Kent Taylor
Solvay Pharmaceuticals - Bronze - Loretta Goodwin

Mission of the Medical Education Foundation of the American College of Osteopathic Obstetricians and Gynecologists

As approved by the ACOOG Board of Trustees, March 25, 1999.

The Mission of the ACOOG Foundation is to foster continuing improvements in women's healthcare.

The goals of the ACOOG Foundation are to support:

- Continuing medical education at the
  - Undergraduate
  - Graduate
  - Postgraduate level
- Research Programs
- Faculty Development
- Development of educational networks in women's healthcare

MEFACOOG Donation Form

__Yes, I wish to be recognized as a donor on the web site and in the Annual Report of the MEFACOOG.

__No, I prefer my gift to remain anonymous.

__I wish to have my donation placed in the general foundation fund.

__I wish to have my donation placed in the Gail Goldsmith Memorial Lectureship Endowment.

__I wish to have my donation in Honor of _____ or

In Memory of _____ .

Please provide name, address information here if in honor or memory of an individual so we may inform the honoree or family that a gift has been received by MEFACOOG.

Name _____

Address _____

City,State,Zip_____

Your gift is tax deductible according to the IRS Regulations. MEFACOOG is a non-profit 501(C)3 Corporation chartered under the laws of the State of Michigan. MEFACOOG Tax ID Number is 38-3499619.

Amount of my Gift $_____

Make checks payable to MEFACOOG and return this form with your donation.

Visa/MC: _____ Exp.Date: _____

Signature: _____

Printed Name: _____

Address: _____

City _____ State _____ Zip _____

E-Mail _____

The Foundation does not share donor information.

Mail to: MEFACOOG
2615 Merrick Street
Fort Worth, TX 76107

FAX: (817) 377-0439

A receipt will follow by U.S. Mail

Thank you for assisting the MEFACOOG in accomplishing its mission and to foster continuing improvements in women's healthcare