The mission of the MEFACOOG is to foster continuing improvements in women's health care. The goals of the MEFACOOG are to support Continuing Medical Education – Undergraduate, Graduate and Postgraduate, Research Programs, Faculty Development and Development of Educational Networks in women’s health care.
Greetings from the MEFACOOG Chair!

The Medical Education Foundation of ACOOG recently held a meeting in beautiful downtown Chicago in conjunction with the excellent mid-year educational program chaired by Laura Dalton, DO and Teresa Hubka, DO. MEFACOOG once again sponsored a community service project where approximately 40 participants, including ACOOG members, spouses, staff, friends, and family, participated in general labor services for Benton House located on the south side of Chicago. Benton House is a volunteer organization, founded in 1907, which strives to provide an array of social services to improve the health, educational, social, recreational, and cultural opportunities for individuals and their families. We painted, cleaned, built projects for the upcoming Halloween event and worked on their stage. Everyone seemed to have a great time enjoying the fellowship and fun of the project, knowing that their hard work was benefiting the community. Thanks to all those who supported, organized, and participated in this project. If you would like more information on the Benton House, go to www.benton-house.org.

Last Spring MEFACOOG organized a community service project in New Orleans where we worked on several homes devastated by hurricane Katrina. I wrote about this in the last newsletter and told about one of the women that had touched our hearts. Recently, I seized the opportunity to organize a follow-up community service project involving Steeler fans joined with Saints fans for an afternoon of cleaning and landscaping. I had the opportunity to visit with Amelia and see the improvement in her home. She is still living in the FEMA trailer, but significant improvements have been made. She now has electricity and water and hopefully she will qualify for some help from the Saint Bernard Project. St. Paul’s Homecoming Center is still trying to get assistance for her. One little step at a time. Donations for Amelia can be made through St. Paul’s Homecoming Center at http://www.stpaulschurchno.org/spc_news_saintsational.htm.

With the continuing decline of support from industry, fund-raising is becoming more of a challenge. In response, the MEFACOOG approved to resurrect the SILENT AUCTION!!!!!! After many requests, we have decided to host an evening of fellowship and fun at the Annual conference in Orlando, Florida. Start now, thinking, plotting and planning to donate your time, talent, and/or auction items for this fund-raising project. Proceeds from the silent auction will benefit MEFACOOG projects such as student scholarships, community service events, and educational opportunities. Thanks to the generous donation of Dr. Gregory Willis, a South African safari has already been donated and Dr. John Maceluch has donated some Dallas Cowboys memorabilia for all you sports fans!! Some suggested items: hand-made gifts, sports memorabilia, autographed items, vacation getaways, savings bonds, gift baskets, art, coins, jewelry, cigars, golf packages, steaks, spa certificates, gift cards, Club of the Month (flowers, wines, beer, etc.), cars, horses, donated services (such as an hour of OMM), dinner with the ACOOG president or past president! Suggestions are greatly appreciated! Use your imagination! All donations are tax-deductible! I look forward to seeing you in beautiful Orlando for another exciting Annual conference!

Respectfully,

Patricia Arnett, DO, FACOOG (Dist.), Chair
Did you know?
Donors have the ability to restrict their donation to any of the following programs/initiatives:

- Visiting Professor Program
- National Student Society of ACOOG
- Resident Reporter Program
- Endowed Lectureships
- Osteopathic Graduate Medical Education
- Postgraduate Research Awards
- Silent Auction
- Community Service Project

Just make a selection on the MEFACOOG donation form or indicate your choice in the memo field of your donation check. This is a great opportunity if you’ve been a recipient of a particular award or scholarship and want to support the participation of another young ACOOG member.

Continuing to provide educational opportunities for our members is crucial; beginning with medical students, through postgraduate training, continuing medical education, and on the horizon osteopathic continuous certification. On that note, I would like to invite your ideas for future educational initiatives as well as creative fund-raising suggestions. I believe that member and donor involvement in program development is the key to continued support for MEFACOOG. Please contact me at vbrennan@acoog.org.

Sincerely,

Valerie Brennan, CAE
Executive Director

ACOOG Participants at the 2010 Fall conference service project at Benton House.

Our MEFACOOG Board of Trustee members for 2010-2011 include:

Patricia Arnett, DO ............ Chair
Ernest Thompson ............ Vice Chair
Carolyn Quist, DO ............... Secretary-Treasurer
Robert Debs, DO ............ Trustee
Sue Leasure, RN ............ Trustee
Martin Pernoll, MD .......... Trustee
Rhonda Kobold, DO ........ Century Member Trustee
Kathryn Saponaro, DO ........ Life Member Trustee
Mark Barbee .... CPC Member Trustee
Valerie Brennan, CAE ........ Executive Director
Steve Buchanan, DO ........ Ex-officio

Additional support by ACOOG Staff

Helen Oberbeck ........ Director of Administration
Sherry Halm ........ Membership and Communications Manager
Jenny Mathis, CPA ........ Accounting Manager
Maria Ortiz ........ Board and Committee Coordinator
Endometrial hyperplasia is defined as the histological proliferation of endometrial glands resulting in a larger ratio of endometrial glands to stroma. The primary causative factor leading to this proliferation is largely due to estrogen effect on the endometrium. The WHO (World Health Organization) classification system identifies two factors in the assessment of risk for progression to cancer: glandular complexity and nuclear atypicality.

In the classic study done by Kurman et al published in Cancer 1985, progression to malignancy as noted by the pathological diagnosis from endometrial sampling and the actual pathological diagnosis at hysterectomy using the glandular/stromal architecture and the presence or absence of atypical cells for classification purposes. The progression rates for simple hyperplasia without atypia, complex hyperplasia without atypia, simple hyperplasia with atypia, and complex hyperplasia with atypia were determined to be 1, 3, 8, and 29% respectively. These differences suggested that endometrial hyperplasia should be classified on the basis of cytologic atypia due to its usefulness in predicting progression to endometrial cancer. The WHO adopted this criterion in the 1994 WHO classification system for endometrial hyperplasia.

However, Kendall compiled data published in 1998 on 100 endometrial biopsy and curettage specimens evaluated separately by 5 pathologists and determined the interobserver agreement between surgical pathologists was only 69% for the spectrum of proliferative endometrium to endometrial cancer, and 47% agreement between the diagnosis of complex hyperplasia and Grade 1 endometrial cancer. The most problematic areas highlighted by this study were distinguishing simple from complex hyperplasia and atypical complex hyperplasia from well differentiated endometrial carcinoma. This study began to question the accuracy of the WHO classification system due to the non-reproducibility of histopathologic criteria.

The Endometrial Collaborative Group composed of 19 gynecologic pathologists then convened in 1999 to create a classification system based on new information as a more accurate means to diagnose hyperplasia. This classification system includes 3 subgroups: endometrial hyperplasia (EH), endometrial intraepithelial neoplasia (EIN), and adenocarcinoma. The pathological factors evaluated include the stromal to tissue volume, glandular proliferation, and a D-score, which helps evaluate the risk for disease progression. A score of >1 signifies a low risk for progression, whereas a score of <1 signifies EIN, which carries a greater risk for progression to cancer.

Baak compared the WHO and EIN classification systems in 2001 and determined that the EIN system more accurately predicted progression to cancer, with a progression rate of 17, 22, and 38% for atypical hyperplasia without atypia, complex hyperplasia without atypia, and complex hyperplasia with atypia respectively. These percentages were then compared to the actual number of diagnoses of malignancy and the EIN classification system more accurately predicted benign and malignant pathological diagnoses with a 92% sensitivity compared to 67% sensitivity with the WHO classification system. Mutter suggested that “implementation of this proposal will bring diagnostic terminology into agreement with current concepts of premalignant endometrial disease and facilitate more uniform patient management.” Despite these noted advantages of the EIN classification system, the WHO classification system for endometrial hyperplasia remains the most widely used classification system by pathologists today.

Risk factors for endometrial hyperplasia are unopposed estrogen replacement therapy, late menopause and nulliparity, diabetes mellitus, anovulation or PCOS, which leads to chronic estrogen stimulation from decreased sex-hormone binding globulin (SHBG), estrogen-producing ovarian tumors, especially granulosa cell tumors, and obesity, with increased peripheral tissue conversion to estrogen. Age is not considered a risk factor; in fact, 25% of endometrial cancers occur in premenopausal females, with the youngest documented patient being 14 years old. Hereditary Nonpolyposis Colorectal Cancer (HNPPC) is an independent risk factor, in that individuals with these gene mutations carry a higher risk for certain cancers, including colon, ovarian, and endometrial cancers. Current screening guidelines for women with HNPPC include annual endometrial sampling and transvaginal ultrasonography beginning at the age 30 to 35 years. Tamoxifen use has also been identified as a risk factor in that the medication causes glandular enlargement and hypertrophy which can lead to hyperplasia. It is not currently recommended to perform routine endometrial sampling on asymptomatic patients using Tamoxifen.

The workup for a woman with menorrhagia, metrorrhagia, postmenopausal bleeding, or vaginal bleeding while using Tamoxifen should include an assessment of risk factors for endometrial hyperplasia and endometrial sampling. Ultrasound has shown to be helpful in postmenopausal

(Continued on Page 5)
vaginal bleeding to direct endometrial sampling with an endometrial thickness >
4mm; however, there is no correlation of endometrial thickness on ultrasound and
endometrial hyperplasia in the premeno-
pausal age group.[12, 13]. Pippelle endometrial
sampling has been shown to be as accurate
as dilation and curettage for the evaluation of abnormal uterine bleeding and the
diagnosis of endometrial hyperplasia and carcinoma, although the accuracy is
higher for postmenopausal compared to premenopausal females[1, 18]. This
procedure is less invasive and more cost
effective than dilation and curettage for the routine evaluation of abnormal uterine
bleeding. When dilation and curettage is performed, studies have confirmed that
hysteroscopy may be performed at the time
of the dilation and curettage to evaluate the endometrium in patients with a diagnosis of
endometrial hyperplasia without negative
consequences[14].

A pathological diagnosis of
endometrial hyperplasia should prompt a
slide review by the pathologist to
confirm the diagnosis. If the diagnosis of
endometrial hyperplasia was diagnosed with office biopsy, a dilation and curettage
is recommended due to the high prevalence of concurrent endometrial cancer[17]. With
a confirmed diagnosis of endometrial hyperplasia in a premenopausal female, the
determination of the patient’s desire and ability to pursue fertility should be
discussed. Hormonal treatment of
endometrial hyperplasia has been evaluated by
numerous studies. The mainstay of
 treatment is progesterone, and it has been
noted that the regression rate for females
with endometrial hyperplasia treated with medroxyprogesterone acetate (MPA) is as
high as 80%[19]. Many various regimens
have been evaluated using MPA, oral
natural progesterone, vaginal micronized
progesterone and the levonorgestrel
intrauterine device (Mirena IUD).

The recommended treatment for
premenopausal women with endometrial
hyperplasia without atypia is MPA 10
mg daily for 12 to 14 days each month
for three to six months. Micronized
progesterone 100-200mg in a vaginal
cream or the Mirena IUD, which has been
shown to be equally effective as oral MPA, are also effective treatments[15, 16]. They
should also have a risk factor assessment
and correction of any underlying modifi-
able risk factors. Premenopausal women
with endometrial hyperplasia with atypia
should be treated with either MPA 600mg,
oral megestrol acetate 80mg twice daily,
or the Mirena IUD with repeat biopsies in
3-6 months to determine regression or
progression, or hysterectomy if the patient is unwilling or unable to comply with the
therapy.[17, 18]. Postmenopausal women diag-
nosed with endometrial hyperplasia without
atypia should again have re-evaluation of
their pathologic slides followed by MPA
10mg daily treatment and repeat biopsy in
3-6 months if the patient prefers medical
therapy.[19]. However, hysterectomy is the
preferred treatment in the postmenopausal
age group. For postmenopausal women
diagnosed with endometrial hyperplasia
with atypia, the preferred treatment is
hysterectomy, but medical treatment with
MPA and reassessment via D&C at 3-6
months would be an option for women
who are poor surgical candidates or refuse
hysterectomy[20].

REFERENCES
1. Berek JS, Neville FH. Practical Gynecologic Oncol-
ogy. Philadelphia: Lippincott Williams & Wilkins,
2. Baak, JPA, Mutter, GL. EIN and WH094. J of
3. Kurman RJ, Kaminski PF, Norris HJ. The behav-

our of endometrial hyperplasia. A long-term study
of untreated hyperplasia in 170 patients. Cancer.
1985;56:403-412.
Reproducibility of the diagnosis of endometrial
hyperplasia, atypical hyperplasia, and well-dif-
5. Mutter GL. The Endometrial Collaborative
Group. Endometrial intraepithelial neoplasia
(EIN): will it bring order to chaos? Gynecol Oncol
6. Baak, UP, Mutter, GL, Robboy, S et al. The
molecular genetics and morphometry-based endometrial intraepithelial neoplasia classification system predicts disease progression in endome-
trial hyperplasia more accurately than the 1994
WHO classification system. Cancer. 2005 Jun
1;103(11):2304-12.
Docs/EM%20Collaborative%20Group.htm
old female patient with FIGO stage IB endometrial
9. Meyer LA, Broadus RR, Lu KH. Endometrial
cancer and Lynch syndrome: clinical and pathologic
considerations. Cancer Control. 2009 Jan;16(1):14-
22.
10. Vogel VG, Costantino JP, Wickerham DL.
Effects of tamoxifen vs raloxifene on the risk of
developing invasive breast cancer and other disease
outcomes: the NSABP Study of Tamoxifen and
Raloxifene (STAR) P-2 trial. JAMA. 2006 Jun
11. Fung MF, Reid A, Faught W et al. Prospective
longitudinal study of ultrasound screening for
endometrial abnormalities in women with breast
cancer receiving tamoxifen. Gynecol Oncol. 2003
sound replace dilation and curettage? A longitudinal
evaluation of postmenopausal bleeding and trans-
vaginal sonographic measurement of the endometri-
um as predictors of endometrial cancer. Am J Obstet
13. Dikhuizen FP, Brömmlmann HA, Potters AE et al.
The accuracy of transvaginal ultrasonography in the
follow-up of patients with endometrial carcinoma
after preoperative fluid hysteroscopy. Int J Gynecol
15. Dikhuizen FP, Mol BW, Brömmlmann HA et al.
The accuracy of endometrial sampling in the
diagnosis of patients with endometrial carcinoma
15;89(8):1765-72.
16. Fakhur S, Saeed G, Khan AH et al. Validity of
pippelle endometrial sampling in patients with
17. Trimbile CL; Kauderer J; Zaino R et al. Concur-
rent endometrial carcinoma in women with a biopsy
diagnosis of atypical endometrial hyperplasia: a
Gynecologic Oncology Group study. Cancer. 2006
18. Ferencycz A, Gelland M. The biologic signifi-
cance of cytologic atypia in progestogen-treated
19. Vereide AE; Arnes M; Straume B; Maltau JM;
Orbo A. Nuclear morphometric changes and therapy
monitoring in patients with endometrial hyperplasia: a
study comparing effects of intrartereine levonorg-
estrol and systemic medroxyprogesterone. Gynecol
Oncol 2003 Dec;91(3):526-33.
20. Ushijima K; Yahata H; Yoshikawa H et al. Mul-
ticenter phase II study of fertility-sparing treatment
with medroxyprogesterone acetate for endometrial
carcinoma and atypical hyperplasia in young women.
CASE PRESENTATION
Shelly is a 35 y/o Caucasian female, G1P1 who presents to your office with the complaint of fatigue and “hormone problems”. She also would like help with PMS symptoms and weight gain. Her medical history is negative except for “some bladder infections” since her vaginal delivery one year ago. In her review of systems she comments on multiple urinary complaints: nocturia (3-4 times per night) and daytime urgency from every 30 minutes to 4 hours. Additionally, she reports progressively worsening dyspareunia and poor libido. Her physical exam is unremarkable and no pain was reproduced with pelvic exam. The urinalysis is negative for infection. What now?

DEFINITION
Included in this patient’s differential diagnosis must be interstitial cystitis/painful bladder syndrome (IC/PBS). Definitions of IC/PBS have been numerous and ever changing over the past two decades. Criteria for diagnosis of IC/PBS developed by NIDDK (1990), however, it was felt to be too constritive for application to the general population. Therefore, the International Continence Society (ICS) in 2002 published recommendations for definitions of bladder pain disorders. ICS defined PBS as “suprapubic pain related to bladder filling, accompanied by other symptoms, such as increased daytime and nighttime frequency in the absence of proven infection or other obvious pathology.” Overall, the name IC is reserved for PBS with cystoscopic and histologic features. For the remainder of this review, this disorder will be referred to as IC/PBS.

EPIDEMIOLOGY
With the variability in nomenclature, the exact prevalence of IC/PBS is not well known and much of the data is from population based studies. Recent data from a study conducted in a primary care office demonstrated a prevalence rate of 12,600 per 100,000. IC/PBS is more common in women with a 4.5-9 male to female ratio with the mean age of diagnosis is 42-45 years of age. On average, from the initial symptom presentation of IC/PBS to the time of diagnosis is 5 years, however, many women have experienced symptoms since childhood. Furthermore, patients with IC/PBS are more likely to have other co-morbidities, specifically 100 times more likely to have IBS and 30 times more likely to have SLE. Other associated chronic illnesses include: migraine, asthma, fibromyalgia, depression, vulvodynia and chronic fatigue syndrome. In regards to depression and IC/PBS, suicidal thoughts are 3-4 times more likely when compared with the general population and 70-94% of women with IC/PBS report severe disruption of their activities of daily living and adverse affects on their personal relationships.

PATHOPHYSIOLOGY
The underlying pathophysiology of IC/PBS is largely unknown but is likely multifactorial. The main considerations include the disruption of the GAG (glycosaminoglycan) layer leading to altered bladder epithelium, activation of underlying muscle and nerve cells, and generation of an immune response. Mast cells are then released and produce a generalized bladder inflammation and damage. Other inflammatory agents are released including histamine which then sensitizes bladder nerve cells hence, causing pain. With the nervous system over-sensitized, previously non-noxious bladder stimuli will now produce bladder and/or pelvic pain. For instance, many food items, such as coffee, tea, carbonated beverages, citrus, alcoholic beverages, etc can exacerbate a patient’s symptoms. Additionally, it is speculated that other generators of pelvic pain (i.e. Fibromyalgia, endometriosis, depression, IBS, etc) can lead to inflammation and sensitization of nerve cells and bladder pain. Chronic activation of inflammatory responses will lead to hormonal imbalances, specifically decreased levels of cortisol. Low cortisol levels lead to increased histamine activity and immune responses again leading to multi-system inflammation. It is evident that the underlying etiology of IC/PBS likely involves more than one system of the body to produce symptoms, hence, the clinical manifestations of IC/PBS will vary.

CLINICAL PRESENTATION
The clinical manifestations of IC/PBS vary among the affected women and many times overlap with common urologic or gynecologic disorders. The diagnosis can be challenging especially early in the disease process because 90% of the women only experience one symptom. The diagnosis can be challenging, especially early in the disease process because 90% of women they experience only one symptom. Another complicating factor is that many times these symptoms are episodic allowing for misdiagnosis and delay in treatment to occur. In regards to symptomatology, the most common presenting symptoms are urinary urgency, frequency, nocturia and pain with bladder filling. Pelvic pain is another symptom and its pattern can vary in presentation. Often pelvic pain presents as suprapubic, flank, low back, upper thigh...
and even as vulvar pain. Additionally, vulvodynia and vaginismus can also be manifestations of IC/PBS. Many times women experience exacerbations or “flares” from everyday life events including co-morbid conditions, stress, food, menses, intercourse, etc, which again complicates the diagnosis of IC/PBS.

DIAGNOSIS

Lack of an adequate consensus in diagnostic criteria, variability in symptom presentation and existence of co-morbid conditions make the diagnosis of IC/PBS difficult to ascertain. The physician must have strong clinical suspicion to aid in the diagnosis and without the physician’s astuteness; many women continue to live undiagnosed and untreated for years. The diagnosis of IC/PBS can be straightforward based on symptoms but if it is not at the forefront of the physician’s attention it may be missed. One of the most common screening tools utilized is the PUFF questionnaire, which if used routinely can facilitate the identification of patients who may have IC/PBS. Moreover, a comprehensive focus on the woman’s symptoms, voiding habits, PUFF questionnaire results, allergies and food intolerance are to be reviewed with the patient. Physical examination findings can be useful in the diagnosis as well. For instance, if tenderness is produced with gentle palpation or if the woman’s symptoms are reproduced with examination of the following areas, then IC/PBS is likely: suprapubic, bladder neck, levator ani, or posterior wall tenderness. Of course, a physician must complete diagnostic testing (urinalysis, urine culture, etc) to exclude additional underlying pathology causing the patient’s symptomatology. In years past, the diagnosis was based purely on cystoscopic findings; however, many studies have demonstrated this procedure is no better than an extensive history and physical examination. Potassium sensitivity testing (PST) is also controversial for the diagnosis of IC/PBS; however, recent studies have demonstrated routine PST is not recommended because the findings are non-specific for IC/PBS. This diagnosis involves multiple organ systems and produces variable symptoms therefore, treatment options need to reflect these facts.

TREATMENT OPTIONS

Once the diagnosis of IC/PBS is made, there are multiple treatment avenues to provide alleviation of symptoms. Essential to a patient’s treatment plan is education on the diagnosis and her specific treatment plan. First, she must understand her diagnosis and there is hope in treating her symptoms. LIFESTYLE MODIFICATIONS

Optimization of nutrition and adherence to the “IC diet” is imperative; initially eliminating all bladder-aggravating foods for 2 weeks and slowly re-introduce each individual item with special attention to specific foods causing recurrence or exacerbation of symptoms. Treatment of co-morbid conditions such as IBD/IBS, endometriosis, depression and endometriosis, is imperative to reduce sensitization of the bladder thus reduce pain. Addressing the psycho-social aspect, specifically stress management, restoration of sleep-wake cycle, behavioral therapy, and avoidance of activities causing flares can improve quality of life. Pelvic floor rehabilitation is an important component in treating hypertonic and dysfunctional muscles because it can be a source of persistent pain even if the bladder symptoms are well-controlled.

ALCAT TESTING

A tool that is useful in aiding diagnosis and treatment for IC/PBS is ALCAT testing. This form of testing is a blood test that identifies food allergy or intolerance tests as it measures leukocyte cellular reactivity. ALCAT testing can identify a patient’s intolerance for hundreds of foods, herbal supplements, and environmental exposures. By identifying a patient’s intolerances, leading to hypersensitive immune and neurologic systems, they can be eliminated or have limited exposure in a patient’s life, hence reducing a patient’s symptoms. PENTOSAN POLYSULFATE SODIUM

Pentosan polysulfate sodium (PPS), sold under the brand name Elmiron, is the first oral drug approved by the FDA for the treatment of IC/PBS. Its mechanism of action is thought to be in the restoration of the integrity of the uroepithelial lining specifically the GAG layer. PPS has a delayed response so before concluding a patient unresponsive, a trial for 6-12 months is necessary.

AMITRIPTYLINE

Amitriptyline is another commonly used medication in the treatment of IC/PBS. Its underlying mechanism of action is multifaceted. It is thought to be a neuromodulating therapy to reduce neuropathic pain as well as anti-cholinergic properties to reduce urinary urgency/frequency, nocturia and improve sleep patterns. Multiple studies confirm Amitriptyline is well tolerated, effective and requires doses lower than those used for the treatment of depression.

GABAPENTIN

Gabapentin is a commonly used anti-convulsant to treat neuropathic pain. Anecdotal reports suggest successful symptom reduction with Gabapentin, however, no official studies have demonstrated these results. To address the inflammatory nature of IC/PBS, Hydroxyzine has been utilized specifically in patients with a history of significant allergy.

HYDROXYZINE

Hydroxyzine is felt to stabilize and reduce mast cell activation, hence, decreasing the inflammatory response and reduction in symptoms. This drug must also be administered for several months before symptoms significantly improve. A Hydroxyzine failure is considered after 3-6 months without improvement.

INTRAVESICAL INSTILLATIONS

Finally, there are combinations of intra-
**The Painful Bladder “The Sterile UTI”.**
(Continued from Page 7)

vesical instillations or “cocktails” used to alleviate symptoms. Many of these “cocktails” include heparin, lidocaine and PPS. Patients may utilize these instillations as “rescue” interventions at home for severe exacerbations.

**ELECTRICAL STIMULATION THERAPY**

On the frontier of treating IC/PBS, is electrical stimulation therapy with an implanted sacral neuromodulation (InterStim device). The FDA has approved this device for treatment of urinary urgency and frequency but not specifically for IC/PBS. Considering that many IC/PBS patients suffer from these urinary symptoms, considerations can be made to proceed with the device implantation in these patients for refractory cases.

**CASE CONCLUSION**

Upon a follow-up appointment, Shelly elected to proceed with testing: PST, PUFF score (16) and self-confirmation of IC/PBS. She selected to start PPS, Amitriptyline and Hydroxyzine in addition to adherence to “IC diet” and rescue infusion when necessary. She has undergone food sensitivity testing and has had complete resolution of her pelvic pain.

**SUMMARY**

A diagnosis of IC/PBS is complex, easy to overlook and must not be considered a “wastebasket” diagnosis. However, the diagnosis must consist of obtaining an accurate history and physical examination, education of the patient and exclusion of confounding medical conditions. Finally, a key component to the treatment plan is recognizing the wide variability in patient symptom presentation. Identifying a patient’s physiologic, psycho-social and physical triggers can allow for a comprehensive treatment plan that includes: nutrition management, medication therapy and possibly pelvic rehabilitation; all of which will lead to a reduction in the over-sensitization of a patient’s immune system.

Overall, IC/PBS is not a simple diagnosis that is treated conventional therapies and thus must be individualized in order to provide the most effective treatment regimen for the patient and her symptoms.

Dr. Wright comments: Osteopathic physicians have the great benefit of visualizing the patient from a comprehensive integrated perspective. Gynecologists can choose to treat symptoms and attempt to suppress them; or, they can ask “why?” and seek to restore normal physiology, thereby satisfying the key osteopathic tenant: “the body will heal itself.” Shelly is not an anomaly. Through restoration of nutrient and mineral depletions (key to igniting the body’s restorative enzymatic systems and hormonal systems) and temporary hormone supplementation she was able to achieve dramatic improvement in quality of life and weight loss. By identifying and removing foods that cause activation of the immune response, she was able to be healed of her bladder pain. In her case, the bladder pain was a symptom of underlying disease and inflammation, largely coming from the gastrointestinal system.

**REFERENCES**

8. Ottem, D.P. and Teichman, JMH. What is the value of cystoscopy and hydrodistension for interstitial cystitis. Urology; Sept 2005:66-3
Vulvar Cancer

Jacob Moore, DO

Inspired by a lecture by Glenn Bigsby, IV, DO, FACOOG

There are an estimated 2,500 new cases of vulvar cancer each year, and of these new cases approximately 500 deaths per year occur from vulvar cancer. Vulvar cancer represents five percent of all female genital cancers and one percent of all malignancies in women. The incidence of vulvar cancer has increased from five percent, in 1927 to 1961, to around eight percent now. There are numerous reasons for the increased incidence of vulvar cancer. The reasons for this elevated incidence have been theorized as, increasing age of the female population, increase in the prevalence of human papilloma virus (HPV), increase incidence of HPV related dysplasias in younger females, smoking, prior abnormal paps, chronic immunosuppression, hypertension, diabetes, and obesity. Vulvar cancer is best managed by gynecologic oncologists. Therefore, it is imperative that every effort is made to diagnose vulvar cancer early and that it is treated appropriately. The typical symptoms of vulvar cancer are pruritis, a palpable mass, pain, ulcerations, bleeding, and discharge. When viewed histologically the majority of vulvar cancers are squamous cell carcinomas. Vulvar cancers typically spread to adjacent pelvic organs, e.g. urethra, vagina, and anus, lymphatically to regional lymph nodes, and hematogenous spread. This article will highlight four other reports discussing vulvar cancer and the management options.

Chu et al (1) performed a review of 38 women with stage 1 epidermoid carcinoma of the vulva. They attempted to illustrate criteria for microinvasion of vulvar cancer, with microinvasion being defined as a lesion that is predominately intraepithelial with superficial invasion into the underlying stroma. Of these 38 women, 23 met all the criteria for early invasive carcinoma of the vulva. In this group there was no metastatic nodal disease. In addition, the depth of stromal invasion correlated strongly with the degree of tumor differentiation and the presence of carcinoma in situ (CIS) (1). Invasion of the stroma less than 3 mm and the presence of CIS were predictive of no nodal involvement or endothelial space (1). This fist case helps illustrate the point that depth of invasion is directly linked with nodal invasion.

Hacker et al (2) investigated the management of regional lymph nodes and their prognostic influence in vulvar cancer. One hundred thirteen patients with invasive vulvar cancer underwent radical vulvectomy and bilateral inguinal-femoral lymphadenectomy, and eighteen patients had unilateral pelvic lymphadenectomy between 1957 and 1978 (2). Of these, thirty-one (27.4%) had positive lymph nodes. The five year survival for patients with negative nodes was 96%, whereas it was 94% for patients with one positive node, 80% with two positive nodes, and 12% for those with three or more positive nodes (2). All patients with positive nodes or recurrence had three or more positive groin nodes, and palpable nodes preoperatively (2). Recurrences occurred in 2.9 and 3.8% of patients with fewer than three positive nodes, as compared with 33 and 66% of patients with three or more positive nodes (2). This data illustrates that there is no need for routine pelvic lymphadenectomy in patients who have no palpable nodes and fewer than three positive nodes on histologic exam (2).

Levenback et al (3) inspected intraoperative lymphatic mapping for vulvar cancer. Isosulfan blue was injected intradermally at the junction of tumor and normal skin in nine patients (3). Next an attempt was made to identify the dye in the superficial lymphatic vessels and in a superficial groin node (3). The sentinel node was identified in seven of 12 groins in seven of nine subjects studied (3). Six cases had unilateral lesions. In patients whose sentinel node was not identified was a midline lesion and one who appeared to have direct drainage to the deep pelvic nodes (3). In conclusion, intraoperative lymphatic mapping is technically feasible in patients with vulvar cancer, especially those patients with unilateral disease (3).

In our last study, Shanbour et al (4), compared clinical versus surgical staging systems in vulvar cancer. One hundred six women with prior untreated squamous cell carcinoma of the vulva who underwent radical vulvectomies and inguinal lymph node dissections at the University of Oklahoma from 1971-1990 (4). Next a retrospective chart review was undertaken to assign surgical stage (4). The overall 5 yr survival was 64% (4). There was a 5 yr survival rate of 38% in patients with inguinal and femoral node metastasis versus 87% in patients without nodal metastasis (4). The more nodes that were positive the poorer the prognosis. Thirty-one patients had tumors of 2 cm or less in

(Continued on Page 10)
Vulvar Cancer
(Continued from Page 9)

diameter with zero recurrences, versus 52% 5-year survival in the remaining patients (4). In 24 patients there was perineal involvement, however, it did not influence survival. In summary, the authors felt that the new classification system revised by FIGO for vulvar cancer staging places patients into more accurate categories (4).

In conclusion, Stage I is defined by lesions less than 2 centimeters in size, stage II greater than two centimeters, stage III spread to lower urethra, vagina, anus, and unilateral nodes, stage IV bilateral nodes, distant metastasis. The five year survival rates for stage I is around 90%, 70% for stage II, 50% for stage III, and less than 20% for stage IV. The five year survival rates for lesions with negative nodes is around 90-95%. Survival rates for lesions with positive nodes is around 35-45%. The traditional surgical treatment has been radical vulvectomy or “longhorn” resection. The five year survival of this approach is around 60%, and there is a high incidence of wound breakdown and lower extremity edema. There are now modifications to management surgically, which include separate groin incisions and unilateral lymphadenectomy.

Contraindications to this approach are clitoral involvement or positive nodes. Studies have shown a 0.4-2% incidence of a positive node with a lateralized lesion. The description of sentinel nodes were described by DiSaia in 1979. The use of technetium 99 in lymphoscintigraphy offers the potential of decreasing morbidity associated with lymphadenectomy. If a superficial lymph node dissection is used there is a higher incidence of groin recurrences. However, less than six percent of vulvar cancers have metastasis to pelvic lymph nodes. Treatments of stages I, II, and selected III involve modified radical vulvectomy, bilateral groin node dissection through separate incisions.

Treatments for stages III, and IV involve preop chemotherapy with cisplatin (cis) and radiation therapy (RT) followed by more limited surgical resection.

In summary, vulvar cancer is best managed by gynecologic oncologists. It is imperative that every effort be made to diagnose vulvar cancer early and that it is treated appropriately. These newer approaches to vulvar cancer might help to improve quality of life without sacrificing survival that is a result of more radical surgery.

REFERENCES

Things to Know...

Plan your research project now.

The MEFACOOG/Ortho Research Grant of up to $5,000 is open to all residents, fellows and junior faculty in Osteopathic Postdoctoral Training Institutions to support research efforts. The deadline date for the MEFACOOG/Ortho Research Grant is November 1, of each year prior to our Annual Conference. The 2012 Research Grant has a deadline of November 1, 2011. Get your application and guidelines on the MEFACOOG website under Research Grant Award.

The MEFACOOG/Bayer Research Grant of up to $5,000 is open to all residents, fellows and junior faculty in Osteopathic Postdoctoral Training Institutions to support research efforts. The deadline date for the MEFACOOG/Bayer Research Grant is November 1 of each year prior to our Annual Conference. The 2012 Research Grant has a deadline of November 1, 2011. Get your application and guidelines on the MEFACOOG website under Research Grant Award.
We can all agree that not much has changed with our economic situation from last year. Even more of a reason to thank all those of you who helped support the MEFACOOG mission with your donations. The mission of the MEFACOOG is to foster continuing improvements in women’s health care. The financial review below reflects the year ending December 31, 2009. As you can see, we were once again down in both individual and corporate contributions. We were extremely fortunate to receive another grant from Wyeth to continue the Resident Reporter Program for 2010. We hope to continue it for the 2011 year. Below are ongoing grants we hope to continue in the upcoming year.

- MEFACOOG/Wyeth Resident Reporter Scholarship Program-educating osteopathic OB/GYN residents at the ACOOG Annual Conference and reporting back to their programs and to the profession.
- MEFACOOG/Bayer Awards for Excellence in Poster Presentation-encouraging research and rewarding dissemination via poster presentation at the ACOOG Annual conference.
- MEFACOOG/Ortho Women’s Health Resident Research Grant- encouraging research in osteopathic OB/GYN residency and fellowship programs.

The 77th Annual Conference of the ACOOG hosted four ongoing funded lectureships. The thirteenth annual MEFACOOG Barbara Hawkes Memorial Lecture; also the college’s first memorial lectureship, was given by Mark Kalchbrenner, DO. The ninth annual MEFACOOG Distinguished Lecture was presented by Karen Nichols, DO. The fifth annual MEFACOOG Gail Goldsmith Memorial Lectureship was presented this year by Steve McCarus, MD. This was the fifth annual lecture of the ten year endowment made possible by the friends and colleagues of Gail Goldsmith and Wyeth.

The fifth of a ten year endowment of the Past President’s Honorary Lectureship was presented by Jack Ludmir, MD at our 2010 Fall Conference in Chicago, Illinois.

The ACOOG Historian Committee completed “History of the ACOOG, The First 75 Years”. Please call the ACOOG office to order yours today. The National Student Society of the ACOOG met for the fourth time in Chicago, Illinois at the ACOOG Fall Conference. The Osteopathic Manipulative Medicine Guidelines for Osteopathic OB/GYN Residencies in video format is reaching completion. These projects would not be possible without the support of you, the donors. Thank you for your continuing support.

**MEFACOOG Annual Report - Year 2009 Support**

---

### Statement of Activities

<table>
<thead>
<tr>
<th>Year Ended December 31, 2009</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support</strong></td>
<td></td>
</tr>
<tr>
<td>Corporate Contributions</td>
<td>$105,000</td>
</tr>
<tr>
<td>Individual Contributions</td>
<td>$30,274</td>
</tr>
<tr>
<td>Fund Raising</td>
<td>$18,590</td>
</tr>
<tr>
<td><strong>Total Support</strong></td>
<td><strong>$153,864</strong></td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
</tr>
<tr>
<td>Program Services</td>
<td>$93,379</td>
</tr>
<tr>
<td>Support Services</td>
<td>$110,725</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$204,104</strong></td>
</tr>
</tbody>
</table>

### Statement of Financial Position

<table>
<thead>
<tr>
<th>Year Ended December 31, 2009</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>$497,0841</td>
</tr>
<tr>
<td>Investments</td>
<td>$154,659</td>
</tr>
<tr>
<td>Unconditional Promises to Give</td>
<td>$15,000</td>
</tr>
<tr>
<td>Due from ACOOG</td>
<td>$1,395</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$668,138</strong></td>
</tr>
<tr>
<td><strong>Liabilities and Net Assets</strong></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>$0</td>
</tr>
<tr>
<td>Deferred Revenue</td>
<td>$50,000</td>
</tr>
<tr>
<td>Net Assets</td>
<td>$618,138</td>
</tr>
<tr>
<td><strong>Total Liabilities and Net Assets</strong></td>
<td><strong>$668,138</strong></td>
</tr>
</tbody>
</table>

---
OBJECTIVE

The purpose of this project was to assess whether intensive management of weight during prenatal care could impact maternal weight gain, infant birth weight, and neonatal comorbidities.

INTRODUCTION

The prevalence of obesity is increasing at a rapid rate in the United States and around the world. Studies have shown that maternal obesity correlates with a host of adverse pregnancy outcomes including pre-gestational and gestational diabetes, chronic hypertension and pre-eclampsia, fetal macrosomia, increased Cesarean section rate and infections, and increased thromboembolic disease or events. [1,3] There may also be an association with increased number of fetal anomalies, fetal morbidity and mortality, and preterm delivery. [2]

In our county hospital, serving a lower socioeconomic class, roughly 50% of our obstetrical patient population can be classified as overweight or obese by their body mass index (BMI) according to the definitions set forth by the World Health Organization (WHO). Starting in 2008, we placed these obese patients into a specialty obesity clinic to receive intensive therapy.

MATERIALS AND METHODS

We identified sixty patients whose BMI was over 40 who delivered at > 37 weeks gestation at our county hospital from November 2008 to November 2009.

We collected data on maternal age, gravida, parity, pre-existing medical complications, development of medical complications during pregnancy, history of a previous cesarean section, maternal weight and birthweight, type of delivery and complications associated with them for each patient. For the purposes of our study, those patients with pre-existing diabetes or hypertension were not included in our study as they could not be matched equally to our controls. This left 25 non-randomized patients who presented to our specialty obesity clinic (first entry, first served). We collected similar data in a group of 18 patients (BMI > 40), matched for age, gravida and parity, who did not receive intensive therapy because of no opening in the intensive management clinic.

DISCUSSION

As we expected, our patients did not decrease their weight during the pregnancy. The objective of our intervention was to see if intensive therapy could decrease maternal weight gain in pregnancy, and consequently, decrease the appearance of diabetes mellitus and fetal weight.

The present findings are encouraging because we found a decrease in
Effect of Intensive Management in Pregnant Women with a BMI >40 kg/m² (Continued from Page 12)

Birthweight even though it was not statistically significant. These results suggest that goals should be made to reduce maternal weight prior to pregnancy to prevent the appearance of neonatal comorbidities.

REFERENCES

RESULTS

<table>
<thead>
<tr>
<th></th>
<th>Intervention (N=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>26.9 ±4.8</td>
</tr>
<tr>
<td></td>
<td>28.4 ±6.4</td>
</tr>
<tr>
<td><strong>BMI</strong></td>
<td>45.7 ±4.7</td>
</tr>
<tr>
<td></td>
<td>48.9 ±6.9</td>
</tr>
<tr>
<td><strong>Weight Gain</strong></td>
<td>27.1</td>
</tr>
<tr>
<td></td>
<td>27.1</td>
</tr>
<tr>
<td><strong>Birth Weight</strong></td>
<td>3456.5 ±452</td>
</tr>
<tr>
<td></td>
<td>3415.1 ±562</td>
</tr>
<tr>
<td><strong>% Diabetes</strong></td>
<td>16.6</td>
</tr>
<tr>
<td></td>
<td>16.6</td>
</tr>
<tr>
<td><strong>% Previous CS</strong></td>
<td>39.0</td>
</tr>
<tr>
<td></td>
<td>20.8</td>
</tr>
<tr>
<td><strong>% Cesarean</strong></td>
<td>58.</td>
</tr>
<tr>
<td></td>
<td>58.3</td>
</tr>
</tbody>
</table>

Discrete variables were calculated by t-test and significance was defined as p<0.05 (Prism, 4th version). Categorical variables were examined by Chi-square (p<0.05) utilizing the same software.

<table>
<thead>
<tr>
<th>60 patients (delivered at term from Nov 2008-2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 excluded for pre-existing medical conditions</td>
</tr>
</tbody>
</table>

| 25 patients with intensive therapy | 18 matched patients no intensive therapy |

**Dates to Remember**

**ACOOG 78th Annual Conference**
March 27-31, 2011
Orlando, FL
Loews Portofino Bay Hotel at Universal Studios

**ACOOG 2011 Fall Conference**
October 12-16, 2011
Philadelphia, PA
Hyatt Regency at Penn’s Landing

**ACOOG 79th Annual Conference**
March 12-15, 2012
Tucson, AZ
Loews Ventana Canyon Hotel
78TH ANNUAL CONFERENCE
AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS

March 27-31, 2011
Orlando, FL
Loews Portofino Bay Hotel
at Universal Studios

Thomas Enyart, DO, Program Chair
Michelle McElroy, DO, Program Chair
WELCOME & CONFERENCE OVERVIEW
It is our pleasure to invite you to the 78th Annual Conference of the American College of Osteopathic Obstetricians and Gynecologists. This conference has been carefully designed to meet the unique educational needs of ACOOG members, offering thorough scientific assessment of a variety of clinical topics and controversial issues that OB/GYNs face on a daily basis. In addition to cutting-edge presentations and debates, this years schedule provides you an opportunity to participate in hands-on workshops. Thank you for supporting ACOOG through your membership. We hope you will register for the 78th Annual Conference.

LOCATION & LODGING
Loews Portofino Bay Hotel at Universal Studios
5601 Universal Boulevard
Orlando, FL 32819
888-430-4999

Experience the sights and sounds of the Italian Riviera at Loews Portofino Bay Hotel at Universal Orlando®. Inspired by the picturesque Mediterranean seaside resort, our Orlando hotel is a romantic getaway reminiscent of sunny days on the Italian Riviera. Every guest room features authentic Italian furnishings and marble accents. Families will appreciate special themed kids’ suites with an adjoining entrance for parents and plenty of room for everyone at our Universal Orlando hotel. As an on-site hotel guest, you’ll skip the regular lines at participating rides and attractions with free Universal Express access in both Universal Orlando theme parks. It’s the fastest way to ride – enjoy unparalleled access all day long, as often as you’d like, just by showing your hotel room key card at each express entrance.

Visit www.acoog.org for a direct link to our hotel home page. Don’t forget to reserve early. Hotel block cutoff date is March 4, 2011.

ACOOG Rate: Deluxe King $298, Deluxe Double/Double $298
Reservations: 800-235-6397, group ID ACOOG

LEARNING OBJECTIVES
Those participating in this activity will receive information that should allow them to...

- Enhance the skills needed to diagnose and manage common and uncommon clinical challenges faced in a modern OB/GYN practice.
- Address current and future OB/GYN practice issues.
- Apply advances in technology and therapeutics to facilitate improved patient care and outcomes.

ACCREDITATION
The American College of Osteopathic Obstetricians & Gynecologists is accredited by the American Osteopathic Association to award continuing medical education to physicians. This activity has been planned and implemented in accordance with the Policies of the Council on Continuing Medical Education of the American Osteopathic Association.

CREDIT STATEMENTS
The American College of Osteopathic Obstetricians & Gynecologists has requested that the AOA Council on Continuing Medical Education approve this program for 25 credits of AOA Category 1A CME. Approval is currently pending.

Physicians should only claim credit commensurate with the extent of their participation in the activity.

A completed attestation form and post-course evaluation are required to receive CME credit and a certificate of attendance.

MEFACOOG SILENT AUCTION
(Medical Education Foundation of the ACOOG)
Please join us on Sunday, March 27, 2010 for the return of MEFACOOG Silent Auction during the Welcome Reception with Exhibitors.

PRESIDENTIAL BANQUET AND RECEPTION
On Wednesday, March 30, 2011 join us for a Casa Blanca themed Presidential Reception and Banquet by dressing in BLACK AND WHITE. Black tie or cocktail attire suggested but not required. One ticket is included with purchase of the General Session. Please make sure to sign up for table assignments on site at registration.

NEW FOR THIS YEAR...
In a continued effort to go green there will not be a printed syllabus; however if you would like to order a printed copy of the syllabus make sure to indicate on the registration form. The cost is $40 and must be pre-ordered with your registration. Printed copies will NOT be available on site. Check the acoog website one week prior to the conference to download the syllabus.
SATURDAY (March 26, 2011)
1:30 PM-6:00  ACOOG Board of Trustees meeting

SUNDAY (March 27, 2011)
7:00 AM-Noon  Subspecialty Pre-course in MFM
Anthony Johnson, DO, Giancarlo Mari, MD, Mark Neerhof, DO, Joshua Copel, MD

Noon-5:00  Early Registration
1:00-5:00  Nuchal Translucency Quality Review Course
Anthony Johnson, DO, Beryl Benacerraf, MD, Joshua Copel, MD

3:00-6:00  Exhibit Hours
5:00-6:00  Welcome Reception with Exhibitors
and MEFACOOG Silent Auction

MONDAY (March 28, 2011)
6:30-7:30 AM  Resident Reporter Orientation Breakfast
6:30-7:30  Registration/Breakfast/Exhibits
7:30-7:45  President’s Welcome Address
7:45-8:30  Gail Goldsmith Memorial Lecture
Paul Krueger, DO

8:30-9:30  Sonographic Evaluation of the Patient with Pelvic Pain
Beryl Benacerraf, MD

9:30-10:30  AIUM Certification: What You Need to Know
Joshua Copel, MD

10:30-11:15  BREAK with Exhibits
11:15-12:15 PM  Obstetrical Ultrasound: What Needs to be Imaged/Trimester for SOC
Anthony Johnson, DO

12:15-1:0 Lunch with Exhibits
1:00-1:45  The Management of the Pelvic Mass in all Phases of the Female Life Cycle
Timothy McGuinness, DO

2:15-3:00  OMT in the Gravid Patient
Thomas Crow, DO

3:30-3:45 BREAK with Exhibits
3:30-5:00  MEFACOOG Corporate Partnership Council meeting
3:45-4:30  HPV-What DO the New Recommendations Mean? What is the Rationale for Management?
Timothy McGuinness, DO

4:30-5:15  OMT in the GYN Patient: Dysmenorrhea, Pelvic Pain, and other Indications
Thomas Crow, DO

TUESDAY (March 29, 2011)
7:00-7:30 AM  Breakfast
7:30-8:15  Preexisting Diabetes Mellitus in Pregnancy
Margarita de Veciana, MD

8:15-9:00  Maternal Cardiac Disease for the Generalist
David Stoh, DO

9:00-9:45  Evaluation and Management of the OB Patient with Thrombophilia
Margarita de Veciana, MD

9:45-10:00 BREAK
10:00-10:45  IHCP Update/Chorioamnionitis Update
Emily DeFranco, DO

10:45-11:30  Neonatal Morbidities Following PTD: Counseling the Parents At Risk
William Driscoll, DO

11:30-12:30 PM  ACOOG Membership Luncheon
(Dues must be current to participate)

TUESDAY CONTINUED
12:45-1:30  Genetic Issues Concerning the Gynecologist
David Jaspan, DO

1:30-2:15  What’s New in Contraception
James Clark, MD

2:00-5:00  AOBG Recertification Exam
2:15-3:00  Approach to the Patient with AUB
David Jaspan, DO

3:00-3:15  MEFACOOG Board of Trustees meeting
3:00-6:00  Female Sexual Dysfunction
James Clark, MD

4:00-4:45  Checklist for the Gynecologist Caring for the Menopausal Patient
Laura Dalton, DO

6:00-7:00  New Fellows Reception

WEDNESDAY (March 30, 2011)  PRESIDENT’S DAY
7:00-8:00 AM  Breakfast
7:00-8:00  Distinguished Fellows Breakfast (Invitation Only)
William Bradford, DO

8:00-8:15  Resident Thesis Award Winner
8:15-8:30  MEFACOOG Research Grant Winner
8:30-8:45  AOA President Elect - AOA Update
Martin Levine, DO

8:45-9:30  MEFACOOG Distinguished Lecture
Martin Levine, DO

9:30-9:45  ACOG President
Richard N. Waldman, MD

9:45-10:15  BREAK (New Fellows, Boards and Past Presidents assemble for entrance)
10:15-11:00  Barbara Hawkes Memorial Lecture
Joseph Kaczmarczyk, DO

11:00-Noon  Awards Ceremony and Presentation of New Fellows
Noon-1:00 Lunch on your own
1:00-5:00  Medicolegal Seminar
James Triona, Esq., Nicholas E. Bunch, JD

6:30-7:30  Presidential Reception
7:30-10:30  Presidential Banquet

THURSDAY (March 31, 2011)
7:15-8:00 AM  Pelvic Organ Prolapse and Robotic Sacrocolpopexy
Michael Coyle, DO

8:00-10:00  In-Vitro Fertilization
Steven Ory, MD

4:30-5:15  OMT in the GYN Patient: Dysmenorrhea, Pelvic Pain, and other Indications
Thomas Crow, DO

8:45-9:30  Sacral Neuromodulation (Interstim) for the Treatment of Bladder Dysfunction
Michael Coyle, DO

9:30-9:45  Medicolegal Seminar
James Triona, Esq., Nicholas E. Bunch, JD

8:00-8:45  ACOOG BOT Re-organizational meeting

10:30-11:15  Review of SUI and Treatment of ISD
Michael Coyle, DO

11:15-Noon  Fibroids: When and How to Treat for Infertility
Ellen Wood, DO

Noon  Adjourn
REGISTRATION FORM

PLEASE PRINT

First Name*  
MI  
Last Name*  
AOA # *  
Degree*  DO MD Other  
Address*  
Apt. or Suite  
City*  
State*  Zip*  
Contact Tel*  
E-mail *  
Guest Badge **  

* Required  ** Adults only and includes entrance to Exhibit Hall and Welcome Reception only, food not included. Please call the ACOOG office for meal ticket prices.

√ GENERAL SESSION  

<table>
<thead>
<tr>
<th>Pre-Registration</th>
<th>Late Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>(payment received by March 4, 2011)</td>
<td>(payment received after March 4, 2011)</td>
</tr>
<tr>
<td>Physician Member</td>
<td>$ 750</td>
</tr>
<tr>
<td>Non-Member Physician</td>
<td>$ 950</td>
</tr>
<tr>
<td>Life Member</td>
<td>$ 375</td>
</tr>
<tr>
<td>Affiliate Member</td>
<td>$ 375</td>
</tr>
<tr>
<td>Resident</td>
<td>$ 375</td>
</tr>
<tr>
<td>Non-Member Resident</td>
<td>$ 475</td>
</tr>
<tr>
<td>Student Member</td>
<td>$ 0</td>
</tr>
<tr>
<td>Non-Member Student</td>
<td>$ 150</td>
</tr>
<tr>
<td>Monday Only 6.75 hours</td>
<td>$ 223</td>
</tr>
<tr>
<td>Tuesday Only 7.50 hours</td>
<td>$ 248</td>
</tr>
<tr>
<td>Wednesday Only 6.50 hours</td>
<td>$ 215</td>
</tr>
<tr>
<td>Thursday Only 4.50 hours</td>
<td>$ 149</td>
</tr>
</tbody>
</table>

Pre-registrations will be accepted until March 4, 2011. All registrations received after this date will be processed at the late registration rate. Registrations received after March 16, 2011 will be accepted on site at the registration desk only. President Reception and Banquet ticket is not included with any of the daily rates. Payment must be received in full to process registration. Faxed registrations without payment information will not be processed.

√ SUPPLEMENTAL SESSIONS

| Subspecialty Pre-Course in MFM | Sun | 7:00-12:00 | 5 hrs | 100 | $ 150 | $ 75 |
| Nuchal translucency Quality Review Course | Sun | 1:00-5:00 | 4 hrs | 100 | $ 350 | $ 350 |
| Inspector Training Seminar (for those interested in becoming Residency Program Inspector) | Sun | 5:00-6:00 | 1 hr | 15 | Free | Free |

Workshops and supplemental sessions are space limited. Your registration will be returned if a session has reached maximum capacity. Medical students may audit workshops free of charge if space is available.

√ ADDITIONAL EVENT

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Cost Per Ticket</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Additional Presidential Reception and Banquet ticket</td>
<td>Wed</td>
<td>7:30-10:30</td>
<td>$ 125</td>
</tr>
</tbody>
</table>

* One banquet ticket is included with the purchase of a the full General Session. Ticket is not included in with daily rates.

√ MISCELLANEOUS

<table>
<thead>
<tr>
<th>Amount</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black and white syllabus in 3 ring binder and color CD (will be available for pickup at the registration desk)</td>
<td>$ 40</td>
</tr>
</tbody>
</table>

PAYMENT & POLICY

<table>
<thead>
<tr>
<th>Total Due</th>
<th>Payment Method</th>
<th>Check (payable to ACOOG)</th>
<th>Credit Card (complete below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Card Type</td>
<td>Visa</td>
<td>MasterCard</td>
<td>Amex</td>
</tr>
<tr>
<td>Card #</td>
<td>Exp. Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Refund Policy: Written cancellation of registration by March 4, 2011 will be subject to a $50 processing fee. No refunds will be given after this date.

Special Needs: In accordance with the Americans with Disabilities Act, every effort has been made to make this conference accessible to people of all capabilities. Please list any ADA-compliant accommodations you may require below.
Membership Donations
Cumulative October 1999 through November 1st, 2010

DIAMOND LEVEL $10,000
Patricia F. Arnett, DO
Steve Buchanan, DO
Eric J. Carlson, DO
Mark Kalchbrenner, DO
Paul Krueger, DO
Kedrin Van Steenwyk, DO

RUBY LEVEL $5,000-9,999
William Bradford, DO
Sheryl A. Bushman, DO
Anthony J. Cortese, DO
Robert H. Debs, DO
Carl J. Della Badia, DO
Jeannemarie Durocher
Kenneth Finkelstein, DO
Michael Geria, DO
Bernard D. Billman, DO
Glen Bigsby IV , DO
Ronald E. Ayres, DO
David Adelstein, DO *

SILVER LEVEL $3,000-4,999
George J. Zobel, DO
Gregory Willis, DO
Paul Whitham, DO
Bruce Wang, DO
Lee J. Walker, DO
Parveen Vahora, MD
Richard Tucker, DO
Mary Testa, DO
Melicent Tettamnel, DO
Lorie A. Thomas, DO
Jeffrey C. Northup, DO
Karen Nichols, DO

GOLD LEVEL $500-999
Roxxena Aldstadt, DO
Lisa M. Allen, DO
Monica Bachamp, DO
Corinne Bell, DO
Robert Bonaminio, DO
Patricia C. Borthwick, DO
Joseph Bottalico, DO
Rainna Brazil, DO
Lisa A. Bukovac, DO
Richard J. Burns, Jr., DO
Octavia M. Cannon, DO
Sharon K. Cathcart, DO
Christoff Coutiforous, DO
Sylvia S. Cruz, DO
Stephanie Cunningham, DO
Stephen A. D’Abreu, DO
George Davis, DO
Marianne DiGiovanni, DO
Stephen F. Dyke, DO
June A. Goldsmith

BOLD reflects new donations in 2009
* Thank you for moving up a level
Mark DeMasi, DO
Michelina DeSanti, DO
Terry J. Dierdorff, DO
Gina Dietrich, DO
Walter Dodar, DO
James T. Dodge, DO
Stephen Downey
Liam Duggan, DO
Sherman Dunn, DO
Rinda P. Ellis, DO
Arlene England, DO
Leo. H. Eschback, Jr., DO
Jacqueline Evans, DO
Ellen Faucett, DO *
Sheldon H. Fisher, DO
Ronald Fitch, DO
Stephanie Fitzgerald, DO
Judith Florida, DO
Kateryn G. Foss, DO
Macy Fox, DO
Ralph G. Frank, DO
Regen Gallager, DO
John Gelasas, DO
Justine Gelias, DO
Christian Gelz, DO
Brent W. Gilliam, DO
William J. Goldsmith Jr.
Christina Goldstein-Charbonniau, DO
Stephen B. Graham, DO
Becky Graham, DO
Mitchell G. Greenbaum, DO
Jan C. Gromada, DO
Travis K. Haldeman, DO
William V. Hamilton, DO
Lynne A. Haspedis, DO
Jennifer S. Hayes, DO
Daira Hertel
William Hoke, DO
Mary Joy Hyde, DO
Petre Itzhak, DO
David W. Jackson, DO
Carol L. Jans
Margaret Jaskowski-Lutsic, DO
Joseph Johnson, DO
Kim Johnson, DO
Margaret Jaskowski-Lutsic, DO
Rosanna Kulisz, DO
David B. Land, DO
Bruce Lastra, DO
Troy R. Lehman, DO
Geoffrey Levitt
Laura A. L’Heureux, DO
James Lindeinulder, DO
Paul Loeb, DO
Aziz Ellof, DO
William M. Long, DO
William P. Long, DO
Thomas A. Loesure, DO
Jack Ludmire, DO
Harry A. Ludwig, DO
Rosie Lynch
Yerdon M. Lynn, DO
Cecil Lytle
Scott MacGregor, DO
Lou E. MacManus, DO
Louis Manara, DO
Gregory Mann, DO
Edward M. Marici, DO
Jerome Markowitz, DO
Richard Markwood, DO
Robert J. Marotz, DO
Debra L. Marshall
Ranette Marshall, DO
Francis J. Martinez, DO
Lorraine Martinez, DO
William & Mary McDevitt
Robin McGuire, DO
Jeanne Mcmahon, DO
Dennis William McNally, DO
Robert Meirzer
James E. Merrill, DO
George D. Methven, DO
Joseph L. Milio, DO
Gene W. Miller, DO
Michael Miller, DO
Stephen A. Miller, DO
Kate Eby Moore
William Moors, DO
James Morgan, DO
Cynthia Morris, DO
Samer Mossallam, DO
Todd A. Moyerbrailean, DO
Scott D. Muir, DO
James Murray, DO
Wendy K. Neininger
Jeffrey R. Nelson, DO
Edward M. Newman, DO
Barbara Newman, DO
Joseph Novi, DO
Michael L. Nowak, DO
Tanja K. O’Connor, DO
Andrew J. Ogden, DO
Karen Olesen, DO
J. Brent Oliver, DO
Andrew Panagy
Trisha Parks-Beakley, DO
James P. Parshall, DO
Steven T. Patterson, DO
Paul J. Pawlosky, DO
Valerie Payne-Jackson, DO
Robert Pearl, DO.
Fiorina Pellegrino, DO
Edward S. Perkins, DO
Alice H. Perrone
Harvey L. Raimi, DO
Adolfo Rapaport, DO
Constantine Raphis, DO
Martin Raskin, DO
Norman Raymond, DO
James Reilly, DO
Elizabeth M. Reinoehl, DO
Maureen A. Ribail, DO
Joseph Riley, DO
Matthew A. Roberts, DO
John T. Robinett, DO
Brunilda Rosario, DO
Avery Rosen, DO
James Roukema, DO
Jeanie L. Rowe, DO
William J. Saks, Jr., DO
George A. Saleh, DO
Joann Sansone, DO
Robert Saretsky, DO
John & Julie Saunders
Patrick Sayavong, DO
Paul Schneider, DO
Valerie Schulte, DO
Rosanna Shayeghi
Steven Sheppard, DO
Michael Sinapi
Jerome Siudara, DO
Edward A. Slotnick, DO
James Smith, DO *
Michael Sobel, DO
Candace Steele
Gary W. Stephens, DO
Elizabeth Stevenson, DO
Donna Sweats, DO
Scott C. Syndergaard, DO
Joseph P. Sytpiernski, DO
Gerard W. Szczegiel, DO
Joseph P. Talcott, DO
Joe Talacch, DO
Stephens Triplett, DO
Robert A. Trierre, DO
Mark C. Torres, DO
Phillips Triplett, DO
Robert L. Tripp, DO
Nan Troiano, DO
Linda R. Tucker, DO
Mary Jo Ursen, DO
Peter Vienhe, Jr., DO
Rick A. Visic, DO
Kimberly Warren, DO
Lisa R. Waterman, DO
Arnold Wechsler, DO
Lori W. Weinstein, DO
Herbert G. Wendelken, DO
Gehred D. Wetzel, DO
Benjamin White, DO
Elaine Wilson
Chris Wirsing, DO
Anita Wolf
Bonita Wong, DO
Mark Woodland, DO
Lee Yang, DO
Mary T. Zygmunt, DO
SUPPORTER LEVEL $1-99
Edwin W. Abbott, DO
Carol Arnett, DO
Kimberly Belsky
Catherine Bernardini, DO
James S. Betoni, DO
Angela Breckenridge, DO
Joseph Camardo
Jeffrey Carver
Wesley Chodos, DO
D. J. Clow, DO
Catherine A. Coats, DO
Marcia J. Coleman, MD
Stephen Dalm, DO
Davis Dalton, DO
Dipak Delvidia, DO
Bernadita Druhan, DO
Stephanie Parsons Eckert, DO
Peter Edimburg
Rosemary Fadool, DO
Kristen Fernandez, DO
Miguel Fernandez, DO
Joseph Flynn, DO
Jeffrey C. Fowler, DO
Patricia Gabig
Daniel Gabellino, DO
Linda Gallen
Edna M. Garcia, DO
Barbara Melican Gleason, DO
Sheri L. Graf, DO
Ray S. Greco, II, DO
Gary S. Grubb, MD
Tom Guyton
Sherry M. Halm
Heather Harris
Ron Hayden
Juanita K. Huggins, DO
Connie Januzzelli, DO
Eileen Kampf
Linda M. Karbonit, DO
Mark T. Karnes, DO
Sherri Lilifeld
Debra Littlejohn
Margaret C. Mader
James K. Matheson, DO
Joseph Meunier, DO
Lauren Michelsohn
Audrey Parke
Mary Ellen O’Donnell
Charlene Okoms, DO
Tracy Papa, DO
Vance Powell, DO
Vanna M. Powell, DO
Shawn Ramsey, DO
Lawrence Regino, DO
Janet L. Salvina
BOLD reflects new donations in 2009
* Thank you for moving up a level

(Continued on Page 20)
MEMBERSHIP DONATIONS

OTHER DONATIONS TO THE MEDICAL EDUCATION FOUNDATION OF ACOOG

SUPPORTER LEVEL $1-99
CONTINUED

Howard Saul, DO
Michael Shaeen, DO
Stuart Shalit, DO
Thomas A. Sipprele, DO
Becky Jo Smith, DO
Kathline Smith
Lynn Speaks, DO
Leonard J. Staszak, DO
George Stefanelli, DO
Karen Stellabotte
Angelo Stoyanianich, DO
Renee Sundstrom, DO
Stephanie Swan, DO
Brian Thomas
William C. Tindall, DO
William E. Trent, DO
Terry Tressler, DO
Lisa Lynn Vendeland, DO
Richard Vitali
Doug Wells, DO
White Rose OB/GYN
Rosanna Winchester, DO
Jeffrey C. Wong, DO
Debra Zwerlein

IN MEMORY OF SIMON LUBIN, DO, FACOOG (DIST.)
AGOOG

MEFACOOG SERVICE PROJECT

Lisa Allen, DO
David Boes, DO
Amy and Steve Buchanan, DO
Robert Debbys, DO
Jennifer Glance, DO
Becky Graham, DO
Joseph Kaczmarczyk, DO
Joseph Kingsbury, DO
Carol Markiewicz, DO
Ranette Marshall, DO
Jenny Mathis, CPA

PARTICIPANTS IN THE FALL CONFERENCE
MEFACOOG SERVICE PROJECT

Michelle Auerbach, DO
Valerie Brennan, CAE
Sharon Carthart, DO
Catherine Coats, DO
Laura Dalton, DO
Stephanie Fitzgerald, DO
Becky Graham, DO
Kurt Harrison, DO
Maz Izbicki, DO
Holly Jaskierny, DO
Kendra Johnson, DO
Jeffrey Kosczuck, DO
David Land, DO
Stacey McEwen, DO
Carolyn Quist, DO
Lawrence Rogina, DO
James Smith, DO
Gregory Willis, DO

Suggested donation items:
Hand-made gifts
Sports memorabilia
Autographed items
Vacation giveaways
Jewelry
Cigars
Golf packages
Gift cards
Steaks
Spa certificates
Club of the Month (flowers, fruit, wines, beer etc.)
Cars
Horses
Savings Bonds
Art
Coins
Gift baskets
It's not too early to donate to the 2011 MEFACOOG Silent Auction! The Medical Education Foundation of the ACOOG is pleased to bring back the silent auction in conjunction with the Welcome Reception with the exhibitors at the 78th Annual Conference on Sunday, March 27, 2011 at the beautiful Loews Portofino Bay Hotel at Universal Studios in Orlando, Florida. This key fund raiser for the foundation promotes fellowship and support for the mission of MEFACOOG, which is to foster continuing improvements in women’s health care.

Leading the efforts this year will be Patricia Arnett, D.O., FACOOG (Dist.), MEFACOOG Board of Trustees and Marydonna Ravasio, FACOOG, Chair of the ACOOG Membership and Promotion Committee.

Cash contributions or item donations are now being accepted. Just follow the directions on the form below and either mail to the address provided or fax back to ACOOG at (817) 377-0439.

We thank you for your continuing support. MEFACOOG is a charitable foundation, a 501c3 not for profit organization; Federal Tax Identification number 38-3499619.

---

**MEFACOOG Silent Auction Donation Form**

78th Annual Conference of ACOOG – Sunday, March 27, 2011 from 6-7pm – Orlando, Florida

Donor Name ___________________________________ Phone _______________________________

Address ______________________________________________________________________________

City ___________________________ State _______________ Zip ________________

E-mail _________________________ Fax _________________________

Contact Person __________________________________________________________________________

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. (Please make payable to MEFACOOG)

(Circle one) VISA American Express MasterCard $ ____________________ AMOUNT

Credit Card # ___________________________________________ Expiration Date ______________________

Name on card ___________________________________________ Date _________________________________

Signature ____________________________________________

8851 Camp Bowie West, Suite 120 * Fort Worth, Texas 76116
(817) 377-0421 * (817) 377-0439 Fax
MEFACOOG welcomes the newest Corporate Partnership Council member, Hologic, Inc. MEFACOOG would like to thank Hologic, Inc. for joining at the Bronze Level.

Our thanks to these companies for their valuable assistance in partnering with the MEFACOOG to foster continuing improvements in women’s health care.

The Corporate Partnership Council of the Medical Education Foundation of the American College of Osteopathic Obstetricians and Gynecologists Mission Statement is:

_The mission of the CPC of the MEFACOOG is to enhance and improve the quality of women’s health care through collaborative partnerships._

We will accomplish our mission by:

1. Education of:
   • Physicians
   • Residents and other related
   • Health care professionals
2. Increasing industry awareness of the uniquely osteopathic educational model
3. Improving industry access to physicians and the patients they serve
4. Collaboratively identifying, developing and implementing educational programs in women’s health care and thereby,
5. Improving the lives of women through education

2010 Corporate Partnership Council (CPC) Members are:

**PLATINUM $25,000+**
- Barr Laboratories /TEVA Pharmaceuticals
- Bayer HealthCare Pharmaceuticals
- Boehringer Ingelheim Pharmaceuticals
- Ortho-Women’s Health & Urology

**BRONZE $5,000 - $9,999**
- Hologic, Inc.
- Solvay Pharmaceuticals

MEFACOOG WOULD LIKE TO THANK THE FORMER CORPORATE PARTNERSHIP COUNCIL COMPANIES FOR THEIR PAST PARTICIPATION IN THE MEFACOOG CPC.

- Astellas
- Endo Pharmaceuticals
- Ther-Rx Pharmaceuticals
I would like to donate $__________ to help support the following program:

- MEFACOOG General Support Donation
- MEFACOOG/Wyeth Gail Goldsmith Memorial Lecture (Annual Conference)
- Barbara Hawkes and Honorary Fellows Address (Annual Conference)
- MEFACOOG Distinguished Lecture (Annual Conference)
- Past President’s Honorary Lecture (Fall Conference)
- National Student Society of the ACOOG
- Visiting Professor Program
- MEFACOOG Fall Service Project
- In Honor or In Memory of ____________________________________________

Donor Information (please print or type)

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Telephone (home)</td>
<td></td>
</tr>
<tr>
<td>Telephone (business)</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>E-mail</td>
<td></td>
</tr>
</tbody>
</table>

Payment Information

<table>
<thead>
<tr>
<th>Credit card type</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Credit card number</td>
<td></td>
</tr>
<tr>
<td>Expiration date</td>
<td></td>
</tr>
<tr>
<td>Authorized signature</td>
<td></td>
</tr>
</tbody>
</table>

Acknowledgement Information

Please use the following name(s) in all acknowledgements:

____ I wish to have our donation remain anonymous.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Please make checks, corporate matches, other gifts or in honor or in memory gifts payable to:

MEFACOOG
8851 Camp Bowie West, Suite 120
Fort Worth, Texas 76116
mefacoog.org
Happy Holidays from the ACOOG staff