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.
The Fall Conference for ACOOG was recently held in beautiful Philadelphia at the Hyatt Regency at Penn’s Landing. This was an unusual conference for us because we joined with ACOG District III, which resulted in an excellent educational program, fellowship and just plain fun. The total meeting attendees for both the college and ACOG was over 500. This is another excellent example of ACOOG and MEFACOOG looking for creative ways to minimize our costs while maximizing the educational benefit for everyone.

As in the past, MEFACOOG participated in another service project at this meeting. We believe that we should give back to the city and the community where we hold our meetings. This year Mother’s Home was our selected project. Mother’s Home is a residential shelter which provides a safe haven for vulnerable, pregnant women in crisis. Attendees donated shampoo, deodorant, toothpaste and other toiletries for the shelter. At our reception, someone began a contest to see which organization would donate the most to the shelter. Total monies collected from attendees from the ACOOG and ACOG District III was given to Mother’s Home to help support its residents. Thank you to all who supported and donated to this very worthwhile project.

The support from industry continues to decline so MEFACOOG must seek ways to support your Foundation. The Silent Auction is an event that has proven fun, entertaining and profitable. In the past we have auctioned off gold watches, vacation getaways, sports memorabilia, a South African Safari, crafts, gift baskets, hotel stays and many other desirable items. It’s not too soon to identify an item or two that you wish to donate. Don’t forget to look in your attic, safe or safety deposit box for that watch, ring or other valuable item that you never use and would like to donate.

We will inform you prior to the Tucson meeting as to the procedure for registering your donated items. Don’t forget that your donated item qualifies for a tax donation because MEFACOOG is a 501c3 organization.

We, the committee members of the MEFACOOG Board, are committed to our mission of continuing improvements in women’s health. Thank you to all who have supported and encouraged us in this endeavor this year.

Sincerely,

Ernest Thompson, FACOOG (Hon.)
Letter from the Executive Director

Valerie Brennan, CAE, Executive Director

Many thanks to everyone who contributed to the Philadelphia service project. The residents, administration, and volunteer staff of Mother’s Home were extremely welcoming and grateful for the support provided by MEFACOOG.

Thinking ahead to the 79th Annual Conference in March, we hope you will participate in the MEFACOOG Golf Tournament on Sunday, March 11th from 1-5 p.m. Get your mul- ligans early and join us for a great afternoon of fun and fellowship!

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.

Sincerely,
Valerie Brennan, CAE
Executive Director

MEFACOOG additional support by ACOOG Staff

Helen Oberbeck.......................... Director of Administration
Sherry Halm................................. Membership and Communications Manager
Jenny Mathis, CPA ..................... Director of Finance

Employees from the Hyatt Regency Philadelphia at Penn’s Landing donating toiletries to The Mother’s Home MEFACOOG Service Project.
October 17, 2011

Medical Education Foundation of the ACOOG
8851 Camp Bowie West, Suite 120
Fort Worth, TX 76116

Dear MEFACOOG:

Thank you for your donation.
On behalf of the residents at Mothers’ Home I would like to sincerely thank you for the donations. The money will come in handy to help replace a refrigerator that recently stopped working. The toiletries are much sought after items (especially the umbrellas, baby monitors and breast pumps). We just had two babies born this week and expect ten more babies to be delivered by Christmas week. All the donated items will come in handy!

Over the summer we have been serving 18 residents but expect to serve 24 women by the end of the year. This is the maximum number of residents allowed by Darby Borough for our site. Your financial donation will enable two more residents to be here as it is necessary that one refrigerator be shared by two residents. We need help to replace the broken refrigerator before we can admit the additional two women. We are able to obtain a good, refurbished refrigerator from a local dealer for $500. Your donation means so much to us!

Please extend to every member of the American College of Osteopathic Obstetricians and Gynecologists our gratitude for their generosity to us. May they be richly rewarded for sharing their treasure with our moms and their infants. We are blessed to see a transformation during the year or two that our mothers are with us from women who are uncertain and failing to women who can begin to take some control of the direction of their lives and be on their way to gaining some success in life.

Sincerely,

Helen McBlain
Executive Director
Medical Education Foundation
of the
American College of Osteopathic Obstetricians and Gynecologists

RECURRING GIFT FORM

Name: _____________________________________________________________________________________

Address: ___________________________________________________________________________________

City: _______________________________________ State:  ____________________  Zip: ________________

Phone Number:  _____________________________________ Email: __________________________________

Option #1 Direct Debit

☐ Please draft my bank account*  ☐ monthly ($25 minimum) or  ☐ quarterly ($75 minimum)

Enclose a voided check for accuracy ★

Bank Draft Start Date (circle one):  15th  25th

Scheduled Draft Amount (if different from above):  $ ____________________________

Signature: ___________________________________________ Date: ___________________________

Option #2 Credit Card

Type of Credit Card (circle one): Visa MasterCard American Express

☐ Please charge my credit card  ☐ monthly ($25 minimum) or  ☐ quarterly ($75 minimum)

Credit Card Charge Start Date (circle one):  15th  or  25th  Scheduled Charge Amount:  $ ____________________________

Acct. No.: ___________________________________________ Expiration Date: __________________________

Signature: ___________________________________________ Date: ___________________________

Please designate to help support the following programs:

☐ MEFACOOG General Support
☐ Gail Goldsmith Memorial Lecture (Annual Conference)
☐ Barbara Hawkes & Honorary Fellows Address (Annual Conference)
☐ MEFACOOG Distinguished Lecture (Annual Conference)
☐ Past President’s Honorary Lecture (Fall Conference)
☐ National Student Society of the ACOOG Scholarship grant
☐ Visiting Professor Program
☐ MEFACOOG Fall Service Project

* This agreement will remain in effect until MEFACOOG receives written notification of termination.
Quarterly donations will occur every three months after the first gift.

Return this form to:  8851 Camp Bowie West, Suite 120, Fort Worth, TX 76116
Preterm delivery (PTD), defined as births occurring prior to 37 weeks gestation, accounted for 12.8% of all births in 2006. Since 1980, the incidence of PTD has increased 36%. With the current advancements in obstetrics and neonatology, survival rates for these infants has improved, yet the risk of a complicated neonatal course and long term morbidity remains. Therefore, it is imperative that all physicians involved understand the survival rates and morbidities associated with preterm infants as determined by birth weight and gestational age. This knowledge will help physicians convey the consequences of these births to the families.

Many factors are considered when determining survival rates for each individual patient. Current data shows factors which significantly impact survival; gestational age, birth weight, sex of the fetus, antenatal steroid use, and single vs. multiple gestations. Currently the National Institute of Child and Health Development (NICHD) offers an online tool to calculate risks for extremely preterm infants using the data listed above. This tool is provided to give the best available information regarding each case; however each physician should tailor information for their individual patient.

Extremely preterm infants include those born between 22 0/7 weeks and 25 6/7 weeks of completed gestation. The current survival rate for infants born at 22 weeks gestation is 6%. At 23 and 24 weeks survival rates improve to 26% and 65% respectively according to the national data. Infants delivered between 26 0/7 weeks to 31 6/7 weeks have significantly improved survival when compared to these born prior to 26 weeks of completed gestation. Current survival statistics for this group are as follows: 86% at 26 weeks, 89% at 27 weeks, 94% at 28 weeks, and 97% at 29 weeks or greater. This data varies by region, and regional data should be taken into consideration when counseling those at risk.

Survival rates for extremely premature infants are also influenced by the infant’s birth weight. In recent years, the survival rate of extremely low birth weight infants has increased by approximately 3%. Despite this slight increase, mortality rates among this group remain high. Infants born at less than 1500gm were one hundred times more likely to die in the first year of life than an infant born weighing more than 2500gm. According to the National Vital Statistics Report, survival designated by birth weight is as follows: <500gm is 15%, 500-749gm is 51.5%, 750gm-999gm is 84.4%. Infants born weighing more than 1000 grams have increased survival rates. Current survival rates by birth weight are 1000-1249gm=94%, 1250-2499gm=98% and >2500gm=99%.

Although infants of extremely premature delivery may survive the first year of life, it is important to counsel parents regarding the risk of morbidity associated with delivery at each gestational age. Morbidities include: bronchopulmonary dysplasia, stage III retinopathy of prematurity (ROP), and severe brain injury. The percentage of infants with at least one diagnosed morbidity is between 80% to 87% between 23 weeks and 24 weeks. By
two years of age it is has been observed that 33% of infants diagnosed with one morbidity are developmentally normal. If the infant was diagnosed with 2 or more morbidities, only 12% were developmentally normal at 2 years of age. As noted with survival rates, the risk of morbidity greatly decreases for each week of completed gestation. The risk of at least one diagnosed morbidity decreases from 38% at 26 weeks to only 2% at 32 completed weeks of gestation. Although survival rates have been steady for this group since 1990, neonatal morbidity has shown improved outcomes.

Eighty four percent of PTD occurs between 32 0/7 and 36 6/7 weeks of gestation and is defined as late preterm deliveries. The rate of late preterm delivery has increased by 31% since 1985 and accounts for 70% of all NICU admissions. Survival is not a concern in these infants but they have a six-fold increase of death within the first week of life, and a three-times higher rate of mortality than a full –term newborn.5

Within the first 48 hours of life, preterm newborns must be monitored for respiratory distress, hypothermia, poor feeding, hypoglycemia, and apnea. Often no morbidities are diagnosed within the first 48 hours of birth, but these children must be kept under close observation for their neonatal period into childhood. They are at risk for poor feeding, weight loss, jaundice, SIDS, and adverse neurological outcomes. At 6 years of age, infants born between 32 and 36 6/7 weeks gestation are two to three times more likely to have an IQ less than 85, and have two times the risk of attention and internalizing problems when compared to infants born at 37 weeks.6 As reported by the March of Dimes, an infant’s brain at 35 weeks gestation is only two thirds the size of the brain of a 39 week or 40 week newborn.5 Of late preterm infants that require NICU admission, data shows that morbidities diagnosed by gestational age are as follows: 34 weeks 51%, 35 weeks, 25.6%, 36 weeks 12.1%.7

When counseling families, it is imperative to keep in mind that time can be critical. We must be mindful of the knowledge available to us as healthcare providers and tailor it to each specific patient. As we give advice based on current data it is important to convey this information to patients in terms that they can understand. Medical terminology must be broken down into an easily understood language for the patient so they can process the information to make an informed decision. Currently, there is no consensus on the best approach to explain complex medical information and convey statistics to parents.

The neonatologist should be consulted for management of the infant’s resuscitation and medical care. Additionally, the obstetrician should be included in conversations regarding upcoming treatment decisions for the newborn because of the rapport they have with their patient. Often there is little time for the NICU team to build that relationship.

Upon meeting with each individual family, it is important to review the demographic information, prenatal and obstetrical history, and past medical history for each individual case as these

(Continued on Page 8)
factors will play a role in potential outcomes. This information will help clinicians tailor counseling and treatment course for each individual patient.

Patients will look to others for support, and it is important to assist in the decision making process. These supportive figures may include; family members, chaplains or clergy members, and pediatric hospice services. After discussing options—ideally with both the obstetrician and neonatologist present to provide consistent information to the patient—time should be allowed for parents to discuss all options after considering the information that has been presented. If the decision of resuscitation is unknown, undecided or variable among parents at the time of delivery, full resuscitation should be initiated.

It is important to remind family members that the decision is not final. If an initial decision for resuscitation is made, continuation of care may be revisited depending on upcoming findings. They must be aware of the potential for catastrophic events such as intracranial hemorrhage, necrotizing enterocolitis, and nosocomial infections. If one of these events occurs it may be necessary to readdress the decision for care. With today’s interventions and available technology it is appropriate to offer selective resuscitation on a case by case basis starting at 22 weeks gestation. Full resuscitation should be offered to each patient at 24 weeks of completed gestation.

Challenges continue for these infants and their providers throughout their childhood. Initially, it is important for the child to receive breast milk if possible to improve outcomes. Once a child has received intensive care services and is discharged, it is important to stress to parents and caregivers that close observation on an outpatient basis is crucial. Not only is it important for the child’s physical health, but there must also be follow-up for developmental assessment. These children may require extra care and have home health needs requiring increased manpower and involvement of caregivers.

In review, when preparing for a preterm delivery, it is important to keep the basic key points in mind when counseling families and determining the course of treatment. First, we must be able to apply current statistics to each individual patient and tailor care depending on individual demographics and risk factors. Second, communication must be encouraged between all physicians, parents, and supporting family members. It is important to deliver critical information and changes in status in an understandable manner to non-medical personnel. Third, during this period of decision making, time can be of the essence. It is important to allow family members time to consider all the options necessary to make an informed decision. If the clinical information, family, communication among medical staff, and statistical knowledge are all combined in the decision making, difficult decisions can be made thoughtfully in these times of high stress.

REFERENCES
Endometriosis is a benign disease of endometrial glands and stroma that are located outside of the uterus. Multiple theories exist to explain the development of endometriosis. The retrograde menstruation and implantation theory is shedding of endometrial tissue during menstruation which implants on the pelvic organs after being transported by the fallopian tubes. The vascular dissemination theory is the transportation of endometrial cells to extra pelvic and pelvic regions via the vascular or lymphatic systems. The coelomic metaplasia theory suggests that endometriosis results from metaplastic changes in the mesothelial cells derived from coelomic epithelium. Finally, the direct implantation theory is the seeding of endometrial tissue at the time of pelvic surgery which may give rise to implants found at incision sites or in subcutaneous tissues. Despite these theories, the cause of this disease still remains unknown.

Several factors have been implicated in the pathogenesis of the disease. Abnormalities in cellular and humoral immunity may contribute to the development of endometriosis. Studies have analyzed the peritoneal fluid of women with endometriosis and found alterations in immunomodulators such as macrophages and lymphocytes. These changes promote the disease by inhibiting apoptosis and enhancing angiogenesis, rather than responding in their normal fashion to scavenge and eliminate the foreign tissues. This in turn, promotes the survival, attachment, and proliferation of endometrial tissue and results in chronic inflammation that may affect the fallopian tubes, ovum, sperm, or even the embryo. Estrogen and prostaglandin production by the endometrial tissue may induce a chronic inflammatory response that promotes endometriosis. The hormonal abnormalities may be responsible for disruptions in ovulation due to adhesions secondary to the inflammatory response which may prevent ovum capture and ovulation.

A thorough history and physical can arouse suspicion of endometriosis. Clinical signs and symptoms include dysmenorrhea, dyspareunia, chronic fatigue, infertility, abnormal bleeding, chronic pelvic pain, and cyclic bowel and bladder symptoms. The degree of symptoms does not always correlate well with the severity of disease. Women with severe disease may have minimal to mild symptoms, while women with mild disease may have incapacitating pain. A family history may also be elicited from the patient. Frequently, the physical exam is unremarkable; however, the clinician may palpate induration or nodularity on the uterosacral ligaments or palpate an adnexal mass. Imaging is only helpful in women with advanced endometriosis. Ultrasound and MRI can detect ovarian endometriosis but not pelvic adhesions or small peritoneal lesions. CA-125 is often elevated in women with endometriosis, as it is a cell surface antigen secreted by derivatives of coelomic epithelium. However it can also be elevated during early pregnancy, normal menstruation, in women with acute pelvic inflammatory disease, fibroids, and in epithelial ovarian cancer. The decreased sensitivity of CA-125 has limited its use as a screening test for endometriosis.

Diagnosing and staging endometriosis can only be accomplished by laparoscopy or laparotomy. The American Society of Reproductive Medicine (ASRM) has developed a classification for endometriosis based on surgical staging that was revised in
Endometriosis and Infertility”.
(Continued from Page 9)

1996 to acknowledge the varying morphology of endometriosis. It provides a method to clearly document the location and extent of the disease. Endometriosis is classified as Stage I (minimal), Stage II (mild), Stage III (moderate), and Stage IV (severe) based on a numerical value. The values are calculated according to the size, depth, and location of the endometriosis; quality of adhesions; and degree of posterior cul-de-sac obliteration.

Many prior studies have shown a strong correlation between endometriosis and infertility. Fecundity is the probability of a woman achieving a live birth for each month of unprotected intercourse. The range of fecundity in normal women is 0.15 to 0.2 per month. Treatment to increase live births in women with endometriosis has centered on two modes of therapy, medical and surgical.

Treatment of endometriosis is dependent on the stage of the disease. For Stage I and Stage II endometriosis, medical therapy, including non-steroidal anti-inflammatory drugs (NSAIDs), estrogen-progestin contraceptives, or gonadotropin-releasing hormone (GnRH) agonists have had beneficial effects on symptomatology. But none of these therapies have proven effective in enhancing fertility.

Surgical therapies include laparoscopy or laparotomy to excise or ablate endometriosis using diathermy, laser or ultrasound. The goal is to restore normal anatomy, destroy all visible disease, and to prevent or delay recurrence. Surgery can be used to treat all stages of endometriosis and has been shown to result in a small increase in the live birth rate. Two randomized controlled studies have been done comparing outcomes in fecundity following expectant management versus laparoscopic ablation of endometriosis. A multicenter, Canadian trial compared women with minimal to mild disease on laparoscopy randomized to ablation versus expectant management. The treated group had twice the fecundity rate compared to the expectant management group. However, an Italian study of similar design observed no difference in the treated versus untreated groups in term of successful pregnancy. A meta-analysis comparing the two studies concluded that the surgical treatment of minimal to mild endometriosis may improve fertility. No studies have been performed to compare surgical treatment versus expectant management on fertility in women with Stage III and Stage IV endometriosis. If surgical treatment is performed, the choice between expectant management and active treatment after surgery must take into account the patient’s age and duration of infertility. GnRH therapy post operatively does not enhance fertility and can cause unnecessary delays in treatment. Assisted therapy is the treatment of choice in older patients with a longer duration of infertility.

Ovulation induction has been studied in women with surgically treated endometriosis. Higher rates of conception have been documented in women treated with clomiphene and IUI (intrauterine insemination) and gonadotropins/ IUI. However, IVF is the best option for infertility in women with advanced endometriosis, especially with today’s ability to achieve higher pregnancy rates with fewer embryos transferred. Luteal phase GnRH treatment in an IVF cycle may enhance embryo quality.

The FASTT (Fast track and standard treatment) trial studied different therapies in women with unexplained infertility and is the basis for many treatment models. The FASTT trial was a randomized control trial to determine the value of FSH/IUI therapy for infertile women aged 21-39. Woman with Stage III and Stage IV endometriosis were excluded from the study. Five hundred and three women participated in the study. Two hundred and forty seven were treated with clomiphene and IUI for three cycles, FSH and IUI for three cycles, and IVF for six cycles. Two hundred and fifty six women were randomized to the “fast track.” The women in this group underwent three cycles of clomifene and IUI and then immediately started IVF rather than three cycles of FSH and IUI before starting IVF. The women in the fast track had an increased pregnancy rate, fewer treatment cycles, decreased rate
of multiple births, and a decreased cost incurred. The estimated median time to pregnancy was 8 months in the accelerated arm and 11 months in the conventional arm, with an average savings of $9,800/delivery.

Proper management of endometriosis must take into account the patient’s age, duration of infertility, and stage of disease. Appropriate treatment options can be individualized to help the patient achieve her goal of a successful pregnancy. In review, the approach to those women less than 35 years old with Stage I/II disease can be expectant management or ovulation therapy. If the patient is older than 35 with Stage I/II disease aggressive treatment with gonadotropins/IUI or IVF should be recommended. In Stage III/IV disease conservative surgery can be done but if no pregnancy follows and the patient is 35 years of age or older, IVF is the treatment of choice.

REFERENCES

Least function scores. (A) Ovary = 3: not normal, but only minor trauma to the surface. Fimbria = 3: slight blunting. (B) Ovary = 2 (high): large endometrioma cleanly resected, good volume of ovary remaining, but more than minor damage. (C) Tube = 2 (high): distal tubal endometriosis moderately significant, cleanly vaporized by CO2 laser. Could be associated with postoperative adhesions and loss of function. (D) Fimbria = 2 (high): clear intrafimbrial adhesions, treated with some damage to fimbria, still some reasonable architecture and function, but more than minor damage. (E) Ovary = 2 (low): large endometrioma has been removed, suture required for ovarian reconstruction, some damage to ovarian surface, and relatively small ovarian volume. (F) Tube = 2 (low): extensive resection and vaporization of tubal endometriosis seen in tube at 12 o’clock with resultant reduction in tubal function. Ovary = 2 (low): small endometrioma removed with loss of ovarian volume, and extensive invasive ovarian surface endometriosis vaporized, with postoperative high risk of adhesions. (G) Fimbria = 2 (low): fimbrioplasty has been performed in obviously damaged tube, but with good patency expected. Very close to a score of 1. (H) Tube = 1: both tubes have extensive salpingitis isthmica nodosa.
INTRODUCTION
Intrahepatic cholestasis of pregnancy (IHCP) is a transient or reversible form of hormonally triggered cholestasis that develops in genetically predisposed women in the second half of pregnancy, resolves after delivery, and may recur in subsequent pregnancies. This condition is characterized by pruritis and elevated serum bile acids in the absence of other maternal liver disease. Although these symptoms have little risk to the mother, risks are increased for fetal complications such as placental insufficiency, premature labor, and sudden fetal death. Historically, IHCP has been described as jaundice in pregnancy, idiopathic jaundice of pregnancy, obstetric hepatotitis, hepatosis gestationalis, and obstetric cholestasis (1). The etiology of IHCP is poorly understood, and research currently focuses on the contributing hormonal and genetic factors. Treatment is largely symptomatic, but management should include close surveillance and possible delivery by 37-38 weeks to reduce the risk of intrauterine fetal demise.

CLINICAL FEATURES AND DIAGNOSIS
Maternal Disease Pruritis is the most common presenting symptom of IHCP, typically presenting in the third trimester. The pruritis can be defined as an unpleasant sensation that evokes the desire to scratch, beginning on the soles of the feet and palms of the hand and generalizing to other regions quickly, including the extensor surfaces of the extremities, buttocks, and abdomen. There are no specific dermatoses in IHCP; the skin lesions observed are actually excoriations secondary to the pruritis, not a specific rash. The severity of the excoriations is related to the duration of symptoms, as skin lesions progress from subtle excoriations to prominent prurigo nodules (2). Symptoms also commonly become more severe at night, with insomnia and suicidal urges also reported.

Occasionally the cholestasis may be accompanied by diarrhea or steatorrhea (3), and jaundice secondary to IHCP occurs in only 10-25% of patients and usually does not manifest until after 2-4 weeks in severe prolonged cases. During pregnancy, the motility of the gall bladder decreases, and this factor is thought to increase the likelihood of IHCP. Cholelithiasis and cholecystitis are more common in women with a history of IHCP and in their first degree relatives (4). Women with IHCP may also report anorexia, fatigue, epigastric pain and steatorrhea, although these symptoms are less common.

The diagnosis of IHCP is made with the combination of pruritis with no rash that begins in the third trimester of pregnancy and an elevation of serum bile acids above the level of 10μmol/L. If bile acid salts become elevated above 40 μmol/L, adverse fetal outcomes are observed (described below). AST and ALT may also be elevated, typically less than twice the upper limit of normal, although levels as high as twenty times the normal level have been reported. These changes in transaminases are seen in approximately 60% of cases and are not required for the diagnosis of IHCP. Serum levels of GGT are normal or only slightly elevated. Alkaline phosphatase may increase up to 7-10 times normal, but these findings are less definitive due to the elevation of the placental isoenzyme during pregnancy.

Maternal outcome is good, as symptoms typically resolve within 48-72 hours after delivery. Women should be screened postpartum for other underlying chronic liver diseases also associated with pruritis during late pregnancy such as primary biliary cirrhosis and chronic hepatitis C. Recurrence of IHCP in subsequent pregnancies is common, with varying degrees of severity, and cases of IHCP with the use of oral contraceptives have been reported.

Fetal Disease
Maternal morbidity in IHCP is low, but fetal outcomes may be compromised by the chronic placental insufficiency of IHCP. The elimination of bile acids by the fetus is decreased, and this causes vasoconstriction of the placental chorionic veins. As a result, fetal distress may occur, manifested by pre term birth, meconium stained fluid, and stillbirth. Fetal bradycardia, tachycardia, and decreased fetal heart rate variability have also been reported. The risk

(Continued on Page 13)
of adverse fetal outcomes increases with the levels of serum bile acids; for every umol/L of bile acid above 40umol/L, risk to the fetus increases by 1-2% (5). Postnatally, respiratory distress syndrome may occur in infants born to mothers with IHCP.

ETIOLOGY
The incidence of IHCP is less than 0.1% to 1.5%, but the recurrence rate is 40-70% in subsequent pregnancies. Pregnant women are more likely to have IHCP in multifetal gestations, and if they have had a prior history of cholestasis prior to pregnancy or cholestasis with the use of oral contraceptives. A family history of cholestasis disease also makes the occurrence of IHCP more likely; 50% of cases of IHCP have a positive family history of cholestasis. In fact, the abnormal biliary function observed in IHCP can be traced to mutations of the bile salt transport system, with ten different mutations known to date. Only heterozygotes for the mutations display the transporter dysfunction.

The higher incidence of IHCP in multifetal gestations also suggests a role for hormones in the pathogenesis of this disease, and altered progesterone and bile acid metabolism have been reported (9). Vitamin D is important for metabolism of bile acid and steroid hormones. Women with IHCP have lower levels of Vitamin D and were more likely to have meconium stained amniotic fluid if their levels of Vitamin D were low (7). The role of the fetal stress-response system may mediate some of the fetal effects of IHCP. In women with IHCP, the fetal cortisol levels were higher in mild IHCP but lower in severe cases of IHCP, suggesting that the fetal response system is activated with the onset of IHCP but suppressed in prolonged or severe cases and may contribute to intrauterine fetal demise (9). Although the precise etiology remains unclear, hormonal and genetic factors remain the leading causes of IHCP.

TREATMENT
Early recognition of IHCP is important, and if diagnosed prior to 34 weeks, referral to a tertiary care center is preferred. Daily kick count records and twice weekly fetal surveillance should be initiated. Treatment of IHCP includes the use of ursodiol which decreases the concentration of bile acids by stimulating the export pump activity. The use of ursodiol at the dose of 10-15 mg/kg (450 to 1200 mg/day) usually improves the pruritis and neonatal outcomes with in 1-2 weeks. Other less effective treatments include cholestyramine, adenosylmethionine, guar gum, and activated charcoal. Emollients, antipruritics, and antihistamines may give limited temporary relief of the pruritis. The ultimate treatment is delivery, as the condition usually resolves by 48 hours postpartum. The risk of stillbirth secondary to IHCP is increased at 38 weeks, and retrospective studies have suggested that mortality is decreased if delivery occurs at 37 weeks.

REFERENCES
5. Glantz A, Marschall HU, Mattson LA. Intrahepatic cholestasis of pregnancy:
Things to Know...

Plan your research project now.

The MEFACOOG Research Grant is open to all residents, fellows, and junior faculty in Osteopathic Postdoctoral Training Institutions. The deadline for the MEFACOOG Research Grant is November 1, of each year prior to our Annual Conference. The 2013 Research Grant has a deadline of November 1, 2012. Get your application and guidelines on the MEFACOOG website under Research Grant Award.

CALL FOR VOLUNTEERS

MEDICAL EDUCATION FOUNDATION OF ACOOG

Are you looking for a new way to be involved? Do you enjoy developing innovative educational programs or social philanthropy? Being a MEFACOOG Board Member could be for you! MEFACOOG volunteer leaders can be physicians, educators, non-physician clinicians, spouses/family of ACOOG members, health care industry supporters…anyone with a passion for women’s health!

Several positions will be open for nomination this year and we need your expertise. The MEFACOOG Board of Trustees meets twice per year with one meeting usually conducted by phone or web conference. The primary, in-person meeting of the MEFACOOG Board coincides with the ACOOG Annual Conference.

Key MEFACOOG activities include:

- Community Service Projects—past projects include work at a youth community center in Chicago, home repairs in New Orleans for Katrina recovery effort, blood drives, and support for a residential home for pregnant mothers in crisis.
- Resident and Postgraduate Fellow Research Awards and Grants
- Resident Reporter Scholarships provide an opportunity for residents to attend an ACOOG conference and potential article publication
- Resident Education Resources (OMM video curriculum, Challenger grants, L3 for Residents quarterly learning modules)
- Endowed lectureships for CME (Lifelong Learning for attending physicians)
- Support for Osteopathic Continuous Certification (Lifelong Learning, Practice Performance Improvement for attending physicians)
- Annual Silent Auction and Golf Tournament
- Fundraising events such as the ‘Evening with the Stars’ planetarium function and Cirque Du Soleil Mystere

This is just an overview of the potential that exists with MEFACOOG. We welcome new opportunities, new leaders, and new ideas! If you are interested in MEFACOOG Board of Trustees service, please forward a statement of interest and a brief bio or CV to Valerie Brennan, CAE by email to vbrennan@acoog.org or by fax to (817)377-0439 by February 13, 2012.

ACOOG NEWS

IN ACOOG’S CONTINUED EFFORT TO GO GREEN, THIS WILL BE THE LAST PRINT VERSION OF THE ACOOG NEWSLETTER.

WE WILL CONTINUE TO PRINT AND MAIL THE MEFACOOG ANNUAL REPORT.

ALL FUTURE ACOOG NEWSLETTERS WILL BE AVAILABLE ONLINE ONLY.
Unfortunately, our economic status has remained relatively the same the past few years. The Medical Education Foundation relies more and more on its members to support its mission. 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, 2010. As you can see, we were once again down in both individual and corporate contributions. We were extremely fortunate to receive another grant from Pfizer to continue the Resident Reporter Program for 2011. This is an excellent tool for our residents. We hope to continue it for the 2012 year. Below are ongoing grants we hope to continue in the upcoming year.

- MEFACOOG/Pfizer 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 Awards for Excellence in Poster Presentation encouraging research and rewarding dissemination via poster presentation at the ACOOG Annual conference.
- MEFACOOG Resident Research Grant encouraging research in osteopathic OB/GYN residency and fellowship programs.

The 78th Annual Conference of the ACOOG hosted three ongoing funded lectureships. The fourteenth annual MEFACOOG Barbara Hawkes Memorial Lecture; also the college’s first memorial lectureship, was given by Joseph Kaczmarczyk, DO. The tenth annual MEFACOOG Distinguished Lecture was presented by Martin Levine, DO. The sixth annual MEFACOOG Gail Goldsmith Memorial Lectureship was presented this year by Paul Krueger, DO. This was the sixth annual lecture of the ten year endowment made possible by the friends and colleagues of Gail Goldsmith and Wyeth.

The sixth of a ten year endowment of the MEFACOOG Past President’s Honorary Lectureship was presented by Anthony Johnson, DO at our 2011 Fall Conference in Philadelphia, Pennsylvania.

The National Student Society of the ACOOG met for the fifth time in Philadelphia at the joint ACOOG Fall Conference/ACOG District III Annual Meeting. The Osteopathic Manipulative Medicine Guidelines for Osteopathic OB/GYN Residencies in video format is complete. These projects would not be possible without the support of you, the donors. Thank you for your continuing support.
**BACKGROUND**

Infection and inflammation are the only pathologic processes for which both a firm causal link with preterm birth has been established and a molecular pathophysiology has been defined (1). Normal pregnancy is also a proposed state of physiologic activation of the immune system response, specifically cytokine activation of prostaglandin synthesis pathways (2).

Numerous inflammatory markers have been investigated. Elevated levels of HS-CRP in pregnancy have been associated with adverse outcomes such as preeclampsia and Intrauterine Growth Restriction (IUGR) as well as doubling the risk of preterm delivery at levels greater than eight (3,4). In addition, intraamniotic injection of TNF-a induced preterm labor in rhesus monkeys (5) and TNF receptor antagonists in combination with intravenous immunoglobulin (IVIG) improved live birth rates in recurrent pregnancy loss (6).

Standardized serum levels of TNF may possibly guide preterm labor treatment using TNF-a antagonists once studied. Normal levels of TNF-a in normal pregnancy and labor have not been evaluated to date.

Do the serum markers HS-CRP and TNF-a correlate with the inflammatory changes of labor?

Do the less expensive results of HS-CRP correlate with the expensive TNF-a levels?

**METHODS**

Study population:
- pregnant women
- singleton gestation
- age greater than 18
- ability to understand and read English
- no history of cesarean section

HS-CRP and TNF-a levels were obtained at two different intervals:
1. In the absence of labor and contractions beyond 24 weeks
2. During documented labor (contractions and cervical change)

**RESULTS**

51 consented participants
49 non-labored labs
18 with both sets in entirety

**CONCLUSION**

- HS-CRP and TNF-a increase in labor
- Did not reach statistical significance
- Preterm labor not evaluated in current study and future studies looking specifically at preterm labor are under way

- Theory of inflammatory state of labor supported
- Elevation of WBC in labor state
- TNF-a correlated significantly with WBC suggesting a possible linear relationship

- Sample size may have precluded association of HS-CRP and WBC
- TNF-a antagonists may have a role in the treatment of preterm labor
- TNF-a is an expensive test whereas HS-CRP is inexpensive
- If HS-CRP and TNF-a behave similarly, perhaps HS-CRP can be used to screen for potential intervention
- Standardized values for HS-CRP limited and TNF-a not available to date
- Study limitations
  - Sample size

- Many obstacles despite study revisions such as: fear of missing anesthesia, fear of second needle stick, precipitous labor and need for cesarean section
- Induction vs spontaneous labor
- 67% of labors were induced
- Previous studies show stronger association with HS-CRP and spontaneous labor

(Continued on Page 17)
“Prospective Cohort Study of High Sensitivity HS-CRP and TNF-a Serum Markers in Normal Pregnancy Labor (Continued from Page 16)

Bibliography

Funds graciously provided by the following grant sources:
MSU/Resident-led Research Mini-Grant ($1000)
MEFACOOG Ortho Women’s Health and Urology Research Committee Grant ($5,000)
Blue Cross Blue Shield Foundation Physician Investigator Research Award ($10,000)

Results

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
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<th>N</th>
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<tbody>
<tr>
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<td>12.726</td>
<td>19</td>
<td>3.871</td>
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<td>CRP</td>
<td>5.531</td>
<td>4.635</td>
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<tr>
<td>Labor TNF</td>
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Table 2: T-Test for HS-CRP and TNF-a.

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Table 3: Descriptive Statistics (significant at p < 0.500).

Dates to Remember

ACOOG 79th Annual Conference
March 11-15, 2012
Tucson, AZ
Loews Ventana Canyon

ACOOG 2012 Fall Conference
September 30-October 4, 2012
Grapevine, TX
Hilton DFW Lakes

ACOOG 80th Annual Conference
April 7-11, 2013
Clearwater, FL
Hilton Clearwater Beach
ABSTRACT

This study is designed as a prospective, observational study comparing the accuracy of the “new test” vs. conventional clinical tests of ROM. (Clin-Asses) This study is designed to assess the reliability, sensitivity and specificity of a new point of care test for rupture of membranes. The test we are using is a rapid qualitative immunochromatographic test for the detection of in-vitro amniotic fluid in cervico-vaginal secretions of women with suspected rupture of membranes (ROM). Our hypothesis is that this new point of care test will be more sensitive and specific than current methods of detecting rupture of membranes.

OBJECTIVES

Premature rupture of membranes (PROM), defined as spontaneous ROM before the onset of labor, is a common diagnostic dilemma in obstetrical practice today. Early and accurate diagnosis of PROM would allow for appropriate gestational interventions designed to optimize perinatal outcome and minimize serious complications including preterm delivery, and infections such as chorioamnionitis, and neonatal sepsis. Conversely a false-positive diagnosis of PROM may lead to unwarranted obstetric interventions including hospitalization, administration of medications and even labor induction. Hence accurate and timely diagnosis of ROM is of critical importance to clinicians. This test detects a specific combination of proteins present in amniotic fluid of pregnant women during all trimesters of pregnancy. This combination is unique to amniotic fluid, and is not found in significant concentrations in blood, urine or semen; and may prove to be a valuable biomarker of ROM. Our objective is to assess the reliability of this point of care test and its ability to detect this unique combination of proteins.

METHODS

This study was designed as a prospective, observational study comparing the accuracy of the “ROMPlus” vs. conventional clinical tests of ROM. Conventional clinical testing is positive for ROM if: 1.) amniotic fluid is seen leaking from the cervical os on speculum examination 2.) if at least two of the following three clinical signs are present: (a) visual pooling of fluid in the posterior fornix, (b) positive nitrazine test, (c) microscopic evidence of ferning. After informed consent and a detailed history were obtained, the patient underwent standard clinical examination and a sample of the cervic-vaginal fluid was collected using a vaginal swab to perform the “ROMPlus”. The reading of the “ROMPlus” was be performed by the same investigator once the standard examination has been completed. If two of the three control procedures were positive for ROM, this was considered positive for the control. After an initial assessment for ROM all patients were managed by standard gestational age specific clinical algorithms. Once the patient delivered, the clinical record was reviewed to assess whether the patient had ROM, PROM, or PPROM (PROM prior to 37 weeks of gestation). The study data was collected, analyzed and stored by study personnel in a fashion which ensured patient anonymity and confidentiality. The “ROMPlus” specimens were individually assessed for sensitivity, specificity, and positive and negative predictive values rates for ROM, PROM, and PPROM. Any discrepancies between the
“Diagnosing PROM with Combination Monoclonal/Polyclonal Immunologic Protein Detection”
(Continued from Page 18)

“ROMPlus” and the control method were addressed in a thorough review of the patients clinical course by the local investigator.

RESULTS

<table>
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</tr>
<tr>
<td>Negative</td>
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**Sensitivity:** 86/(86+0) = 100%
**Specificity:** 24/(24+2) + 92%
**PPV:** 86/(86+2) = 98%
**NPV:** 2/(24+0) = 100%

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**Sensitivity:** 73/73 = 100%
**Specificity:** 10/11 = 91%
**PPV:** 10/(10+0) = 100%

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</table>

**Sensitivity:** 13/13 = 100%
**Specificity:** 14/15 = 93%
**PPV:** 13/14 = 93%
**NPV:** 14/14 = 100%

CONCLUSION
Based on the current data the “ROMPlus” has proven itself to be an excellent test for consistently and accurately determining ROM at all gestational ages. It has proven itself easy to understand, convenient, and easy to use in a clinical setting.

REFERENCES:

MEFACOOG Award for Excellence in Poster Presentations

The MEFACOOG Award for Excellence in Poster Presentations is meant to encourage scientific writing, research and presentation at the Annual ACOOG meeting. It is open to all AOA approved OB/GYN residency programs.

Deadline to submit a Poster Presentation for the 80th Annual Conference is November 1, 2012. Apply: Click here to download the application.

Authors of accepted abstracts will be notified by Research and Awards Committee by January 4, 2013.

If you have any questions please contact the ACOOG office at (800) 875-6360.
INTRODUCTION

Obesity has become a worldwide health crisis increasing the prevalence of diabetes from 2.8% in 2000 to an anticipated 4.4% in 2030. Diabetes affects 8% of pregnancies making it the most common problem of pregnancy. Studies show that half of the women diagnosed with gestational diabetes later develop overt diabetes in the 20 years following gestation. For this reason, diagnosis must be accurate, patient education must be sound, and the disease appropriately treated to ensure long term diet and lifestyle modifications for our female patients and their infants.

Hyperglycemia in pregnancy is linked to long term outcomes of obesity and diabetes in children. Recent publications show hyperglycemia, even at levels less than those seen in overt diabetes, is associated with adverse pregnancy outcomes including neonatal hyperinsulinemia, macrosomia, large-for-gestational age, and pre-eclampsia. It is also clear, that proper treatment with diet modifications, home glucose monitoring, and anti-hyperglycemic therapy reduces these risks. Accurate diagnosis has been confounded by conflicting screening recommendations from expert groups with recommendations based on retrospective diagnosis of diabetes following pregnancy and no fetal outcomes assessment.

In 2010, the International Association of Diabetes and Pregnancy Groups (IADPSG) consensus proposed that the diagnosis of gestational diabetes should be established if a fasting venous plasma glucose is greater than 92mg/dL but less than 126mg/dL, a 75 gram oral glucose tolerance test fasting value greater than 92mg/dL, a one hour value of greater than 180mg/dL, or a two hour value greater than 153mg/dL. Overt diabetes should be diagnosed if a fasting venous plasma glucose is greater than 126mg/dL, a hemoglobin A1c greater than 6.5%, or a random glucose greater than 200mg/dL. These guidelines are based on incidence of adverse perinatal outcomes as assessed in the Hyperglycemia and Adverse Outcome Study (HAPO).

HYPOTHESIS

An elevated random blood glucose at less than 20 weeks gestation predicts abnormal glucose tolerance testing between 26 and 28 weeks. An elevated random glucose is defined as a value greater than or equal to 100 mg/dl.

METHODS

Mount Clemens Regional Medical Center employee physicians obtain a random glucose as part of their initial prenatal laboratory screening panel. Evaluating the predictive value of the practice was accomplished by identifying pregnancies delivered by this group of employee physicians between January, 1st 2009 and June 30, 2010 by the official delivery log. A chart review was then performed identifying gestational age and random glucose at initial visit. Glucose values for all standard screening diabetes labs including a 50 gram oral glucose tolerance test at 26 weeks gestation were then recorded. Failure was defined by a value greater than 135mg/dl and then the 100 gram challenge results were recorded. 341 pregnancies were reviewed and multiple regression analysis was performed.

RESULTS

This study evaluated 341 gestations of which random glucose values were available for 241 (70%). Twenty five patients (10%) had random glucose greater than 100mg/dL. Six of these women (24%) were classified as diabetic.

(Continued on Page 21)
Eighty-five 3 hour OGTT were performed in this study population. A total of 30 patients (9%) were classified as gestational diabetics. Of the 30 patients diagnosed with gestational diabetes, 25 (83%) had an available random glucose value. Of the 25 women with an available random glucose, twenty (80%) had a random glucose between 50mg/dL and 100mg/dL, and five had a value between 100mg/dL and 121mg/dL. One patient had a random glucose of 206mg/dL that was diagnostic for pre-existing diabetes mellitus.

The study hypothesis was not supported by statistical analysis. The correlation is 0.177 which is a non-zero at the statistically significant <0.05 level. Random blood glucose have no predictive value of the diagnosis of gestational diabetes in this study population.

CONCLUSION

The findings of this study are consistent with previously published data suggesting no correlation between random blood sugar and the diagnosis of gestational diabetes. Based on this study population 241 random blood glucose tests were performed to identify one woman with pre-existing diabetes mellitus. The total laboratory cost of the 241 random glucose tests was $5061. Therefore the cost to diagnose one pre-existing diabetic in this practice was more than five thousand dollars. A fasting glucose test costs the same amount as the random at the hospital laboratory and has known predictive value therefore should be the test of choice.

This study suggests that the current practice among employed physicians to collect a random blood glucose should be abandoned. The initial visit prenatal laboratory profile should instead include a fasting blood glucose.

Acknowledgements:
Special thanks to Michigan State psychologist David Harley Ph.D. for his expertise with statistical analysis and graphical data representation and Mount Clemens Women’s Health Associates physicians.

References:
Lindsay, R.S, Gestational diabetes: cost and consequences. Diabetologia. DOI 10.1007/s00125-010-1979-2
Leeuwen, M. Accuracy of the random glucose test as screening test for gestational diabetes mellitus; a system review. Eur J of Obstet Gynecol (2010) doi, 10.1016/ j.ejorg.2010.11.02
Barbieri, R. Consensus panel proposes new diagnostic criteria for gestational diabetes
American College of Osteopathic Obstetricians and Gynecologists

79th Annual Conference

March 11-15, 2012
Tucson, Arizona
Loews Ventana Canyon Hotel

Catherine Bernardini, DO, Co-Program Chair
Jeffrey Koszczuk, DO, Co-Program Chair
79TH ANNUAL CONFERENCE
March 11-15, 2012

WELCOME & CONFERENCE OVERVIEW
It is our pleasure to invite you to the 79th 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 year’s schedule provides you an opportunity to participate in a Pre-Course in REI. Thank you for supporting ACOOG through your membership. We hope you will register for the 79th Annual Conference.

LOCATION & LODGING
Loews Ventana Canyon
7000 North Resort Drive
Tucson, AZ 85750
520-299-2020

Welcome to the breathtaking Loews Ventana Canyon. If you can tear yourself away from spectacular views of the Catalina Mountains, consider one of the many activities the resort has to offer:

Complimentary wireless internet in the meeting room in order to facilitate interactive educational content.

Gaze in awe at the natural beauty of the Catalina Mountains or at Mother Nature’s nightly star show from the luxury of your private Tucson hotel room terrace. From cozy, inviting standard Tucson accommodations all the way up to our sumptuous suites, we can accommodate you – in ultimate comfort.

Two championship golf courses traverse the canyon: both were designed to take full advantage of the beautifully rugged natural landscapes, including cascading waterfalls and plunging ravines. New to Golf? Take a lesson from one of our professional golf instructors and learn to putt like a pro in no time.

Visit www.acoog.org for a direct link to the hotel. Don’t forget to reserve early. Hotel block cutoff date is February 17, 2012. ACOOG Rate: Double/Double $293. To make reservations call 800-234-5117, 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.

MEFACOOG GOLF TOURNAMENT
The MEFACOOG Golf Tournament will be held on Sunday, March 11, 2012 from 1:00-5:00 PM. Ticket includes cart rental, boxed lunch, and bottled water. The golf course is spikeless and adheres to a strict dress code.

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 25.5 credits of AOA Category 1-A 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 at the conference during Exhibit Hours for the return of MEFACOOG Silent Auction. Bids will be accepted throughout the day on Monday and Tuesday. Winning bids will be posted on Wednesday, March 14, 2012.

PRESIDENTIAL CELEBRATION
Wednesday, March 14, 2012 join us for a Denim and Diamonds themed Presidential Celebration. Black tie, boots and cocktail attire suggested but not required. A ticket must be purchased to attend the reception. Tickets will no longer be included in the CME registration fee. Children are welcome at the reception with a ticket.

DO NOT FORGET...
In an 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 $45 and must be pre-ordered with your registration. Printed copies will NOT be available on site. Check the ACOOG web site one week prior to the conference to download the syllabus.

CONSENT TO USE OF PHOTOGRAPHIC IMAGES
Registration and attendance at, or participation in ACOOG meetings and other non-CME activities constitutes an agreement by the registrant to ACOOG’s use and distribution of the registrant’s or attendee’s image or voice in photographs, videotapes, electronic reproductions and audiotapes of such and activities.
**SUNDAY (March 11, 2012)**

8:00 AM-Noon  ACOOG Board of Trustees meeting

Noon-5:00  Early Registration

1:00-5:00  Subspecialty Pre-course in REI

1:00-5:00  MEFACOOG Golf Tournament

6:00-7:30  TBD Dinner Symposium

**MONDAY (March 12, 2012)**

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  MEFACOOG Gail Goldsmith Memorial Lecture

Robert Debbs, DO

8:30-9:15  Pap Today, Gone Tomorrow-Discussion of new American Cancer Society Recommendations

Joseph Kaczmarczyk, DO

9:15- 10:00  VIN: One Disease or Two?

Alan Waxman, MD

10:00-10:45   BREAK with Exhibits

10:45-11:30   Colposcopy in Pregnancy-When, How and Follow Up

Alan Waxman, MD

11:30-12:15 PM  Prophylactic BSO Recommendations Based on the Risk of Ovarian CA Tumor Markers-Assesment of Risk

DeEtte Vasques, DO

12:15-1:30  Lunch with Exhibits

1:30-2:15  Endometrial Hyperplasia, Cancer Diagnosis and Treatment Recommendations Update-Role of the Generalist

DeEtte Vasques, DO

2:15-3:00  Surgical Management of Vaginal and Uterine Anomalies

Paul Miller, MD

3:00-3:45  BREAK with Exhibits

3:45-4:30  Contraception Update

Laura Dalton, DO

4:30-5:00  ERT and Breast Cancer-Continued Data from the WHI

Paul Miller, MD

6:00-7:30  TBD Dinner Symposium

**TUESDAY (March 13, 2012)**

7:00-7:30 AM  Registration/Breakfast/Exhibits

7:30-8:15  Habitual Pregnancy Loss

Robert Debbs, DO

8:15-9:00  Extremes of Prematurity: What’s new?

Lisa Owens, DO

9:00-9:45  VBAC vs. RLTCS Risks and Benefits to Mother and Baby

Robert Debbs, DO

9:45-10:15  BREAK with Exhibits

10:15-11:00  Fetal Monitoring and ACOG Recommendations/Management Part I

David Miller, MD

11:00-11:45  Fetal Monitoring and ACOG Recommendations/Management Part II

David Miller, MD

11:45-12:15 PM  ACOOG Membership Meeting Luncheon  
(Dues must be current to participate)

12:45-1:30  The Floppy Newborn-What’s an Obstetrician To Do?

Eric Carlson, DO

1:30-2:15  Minimally Invasive Surgical Approach to Myoma

Carl Della Badia, DO

2:00-5:00  AOBG Recertification Exam

2:15-3:00  Endometriosis

Bruce Lessey, MD, PhD

3:00-3:30  BREAK with Exhibits

3:00-6:00  MEFACOOG Board of Trustees meeting

3:30-4:15  Tricks for Laproscopic Hysterectomy

James Perez, DO

4:15-5:00  Mastering the Difficult Vaginal Hysterectomy

Joseph Novi, DO

5:30-6:00  Love Languages (non-CME, for attendees and spouses)

Gary Chapman, PhD

6:00-7:00  New Fellows/Distinguished Fellows Reception  
(Invitation Only)

**TUESDAY CONTINUED**

**WEDNESDAY PRESIDENT’S DAY (March 14, 2012)**

6:00-7:00 AM  TBD Breakfast Symposium

6:30-7:00  Breakfast

7:00-7:45  AOA Update

Raymond E. Stowers, DO, AOA President-elect

7:45-8:30  ACOG Update

James T. Breeden, MD, ACOG President-elect

8:30-9:15  MEFACOOG Distinguished Lecture

5 Languages of Apology-Applications in Medical Practice

Gary Chapman, PhD

9:15-10:00  MEFACOOG Barbara Hawkes Memorial Lecture

Medical Publishing-Help for Fledgling Authors

Stephen Corson, MD

10:00-10:30  BREAK (New Fellows, Distinguished Fellows, Boards and Past Presidents assemble for entrance)

10:30- Noon  Awards Ceremony, Presentation of New Fellows, Distinguished Fellows, President’s Inaugural Address

11:15-12:15  The FDA Mesh Statement and Its Impact on Practice

Betsy Greenleaf, DO

12:15  Adjourn

**THURSDAY (March 15, 2011)**

6:15-7:15 AM  TBD Breakfast Symposium

6:30-7:15  Breakfast

7:15-8:00  Pre-Conceptional Planning From a Genetic Perspective

Temi McHugh, DO

8:00-10:00  ACOOG Re-organizational Board meeting

8:00-8:45  Light Years Better than Chromosomes-Prenatal Diagnosis at the DNA Level

Alan Donnenfeld, MD

8:45-9:30  Customizing Hormones for Women

Anna Cabeca, DO

9:30-9:45  BREAK

9:45-10:30   Vulvodynia and Vaginismus

Terri McHugh, DO

10:30-11:15  Sexual Dysfunction: Women’s Health and Revitalizing the Libido

Anna Cabeca, DO

11:15-12:15  The FDA Mesh Statement and Its Impact on Practice

Betsy Greenleaf, DO

12:15  Adjourn
REGISTRATION FORM

**ACOOG 79TH ANNUAL CONFERENCE**

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* Required  ** Adults only; includes entrance to Exhibit Hall only. Daily meals not included. Please call the ACOOG office for daily meal ticket prices.

### GENERAL SESSION

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<td>$149</td>
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</tr>
</tbody>
</table>

Pre-registrations will be accepted until February 22, 2012. All registrations received after this date will be processed at the late registration rate. Registrations received after February 28, 2012 will be accepted on site at the registration desk only. Presidential Reception ticket is not included with any of the CME registration fees or the daily rates. Payment must be received in full to process registration. Faxed registrations without payment information will not be processed.

### SUPPLEMENTAL SESSIONS

<table>
<thead>
<tr>
<th>Session</th>
<th>Day</th>
<th>Time</th>
<th>CME</th>
<th>Limit</th>
<th>Fee</th>
<th>Residents</th>
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<tbody>
<tr>
<td>Subspecialty Pre-Course in REI</td>
<td>Sun</td>
<td>1:00-5:00</td>
<td>4 hrs</td>
<td>100</td>
<td>$150</td>
<td>$75</td>
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</table>

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.

### EVENT TICKETS

<table>
<thead>
<tr>
<th>Event</th>
<th>Day</th>
<th>Time</th>
<th>Cost Per Ticket</th>
<th>Quantity</th>
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</thead>
<tbody>
<tr>
<td>MEFACOOG Golf Tournament</td>
<td>Sun</td>
<td>1:00-5:00</td>
<td>$350</td>
<td></td>
</tr>
<tr>
<td>ADULT Presidential Reception ticket</td>
<td>Wed</td>
<td>7:30-10:30</td>
<td>$60</td>
<td></td>
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<tr>
<td>CHILD Presidential Reception ticket</td>
<td>Wed</td>
<td>7:30-10:30</td>
<td>$25</td>
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<tr>
<td>DONATION of a Presidential Reception ticket for Resident or Student</td>
<td>Wed</td>
<td>7:30-10:30</td>
<td>$60</td>
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### MISCELLANEOUS

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<tr>
<td>Black and white syllabus and color CD (PRE ORDER ONLY - available for pickup at the registration desk)</td>
<td>$45</td>
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</table>

If you plan to attend the Presidential Reception you must purchase a ticket. There is not a ticket included with registration. Children are allowed to attend. Golf includes cart rental, boxed lunch, and bottle water. **Handicap** Please note the golf course is spikeless and adheres to a strict dress code.

### PAYMENT & POLICY

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<td>Card #</td>
<td>Exp. Date</td>
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Refund Policy: Written cancellation of registration by February 22, 2012 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.

American College of Osteopathic Obstetricians and Gynecologists
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www.acoog.org
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Cumulative October 1999 through November 1st, 2011

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- Valerie Brennan, CAE
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- Nancy J. Bucy, DO

* Bold reflects new donations in 2011
* Thank you for moving up a level
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Cumulative October 1999 through November 1st, 2011

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Mary Jo Urso, DO
Peter Vienne, Jr., DO

(Continued on Page 20)

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Kimberly Belsky
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Angela Breckenridge, DO
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Jeffrey Y. Fowler, DO
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Daniel Gabrielson, DO
Linda Gallen
Edna M. Garcia, DO

Shannon Gilham, DO
Barbara Melican Gleason, DO
Sherri L. Graf, DO
Ray S. Greco, II, DO
Gary S. Grubb, MD
Tom Guyton
Sherry M. Halm
Heather Harris
Ron Hayden

Mickey Hooper, DO
Connie Januzelli, DO
Eileen Kampf

(Continued on Page 20)
MEMBERSHIP DONATIONS

OTHER DONATIONS TO THE MEDICAL EDUCATION FOUNDATION OF ACOOG

SUPPORTER LEVEL $1-99
CONTINUED

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Mark T. Karnes, DO
Sherri Littlejohn
Margaret C. Mader
James K. Matheson, DO
Joseph Meunier, DO
Lauren Michelson, DO
Aubrey Narke
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Tracy Papa, DO
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Lawerance Regina, DO
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Stuart Shalit, DO
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William E. Trent, DO
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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
Archie Barrett, DO, FACOOG
1951-2011
ACOOG
* Daniel Barkus, DO, FACOOG
(Dist.) 2010
ACOOG
* Simon Lubin, DO, FACOOG
(Dist.) 2010
ACOOG
* MEFACOOG regrets that the In Memory donation did not appear in the 2010 Annual Report

MEFACOOG SERVICE PROJECT

The Medical Education Foundation of ACOOG conducts a service project in conjunction with each ACOOG Fall Conference. Mother’s Home of Philadelphia was selected as our service project during the Fall 2011 Conference. We took donations through Friday of the conference. There were many that gave much needed items and monetary donations. Thank you to all that gave. We were able to present Mother’s Home with a check for $500 and were also able to use some of the money that was given to purchase items like baby monitors, breast pumps and umbrellas for the residents of Mother’s Home. The MEFACOOG Service Project has been a wonderful way for ACOOG and MEFACOOG to give back to the city where our Fall Conferences are held. Please watch your email for information about our next Service Project.

Sincerely

Jenny Mathis, CPA
Director of Finance

Welcome Back the MEFACOOG Silent Auction
Sunday, Monday and Tuesday, March 11-13, 2012 during registration hours.

Winning bids will be announced on Wednesday, March 14, 2012.

Suggested donation items:
Theme park tickets
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
Gift baskets

Supporter Level $1-99 Continued
It’s not too early to donate to the 2012 MEFACOOG Silent Auction! This year’s theme is Entertainment. The Medical Education Foundation of the ACOOG is pleased to bring back the silent auction during registration hours at the 79th Annual Conference, Sunday, Monday and Tuesday, March 11-13, 2012 at the beautiful Loews Ventana Canyon Hotel in beautiful Tucson, Arizona. This key fundraiser 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 Ernest Thompson, FACOOG (Hon.), MEFACOOG Chair 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
Winning bids will be announced on Wednesday, March 14, 2012

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, NextGen Healthcare. MEFACOOG would like to thank NextGen Healthcare 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

2011 Corporate Partnership Council (CPC) Members are:

**Platinum $25,000+**
- Barr Laboratories /TEVA Pharmaceuticals
- Bayer HealthCare Pharmaceuticals
- Pfizer Pharmaceuticals

**Bronze $5,000 - $9,999**
- Hologic, Inc.
- NextGen Healthcare

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

- Boehringer Ingelheim Pharmaceuticals
- Ortho-Women’s Health & Urology
- Solvay Pharmaceuticals
### MEFACOOG Donation Form

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>
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#### Payment Information

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<td>Authorized signature</td>
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#### Acknowledgement Information

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

___ I wish to have our donation remain anonymous.

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<tbody>
<tr>
<td>Date</td>
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</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
Happy New Year from the ACOOG staff