“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 Post-graduate, Research Programs, Faculty Development and Development of Educational Networks in women’s health care.
Letter from the Chair,
MEFACOOG Board Members

Mark Barbee, FACOOG (Hon.)

It is an honor to serve as Chair of MEFACOOG and to be involved with incredibly important projects that serve ACOOG. It is a privilege to serve with an outstanding Board that is dedicated to the mission of the foundation to foster continuing improvements in women’s health care. The goals of MEFACOOG are to support continuing medical education (undergraduate, graduate and post graduate research programs), faculty development and the creation of educational networks in women’s health care.

It has been a busy year for MEFACOOG and I would like to share with you some of the key activities that the Foundation has supported.

• Resident Reporter Scholarships - This program has been supporting residents for fifteen years to attend the ACOOG conference and to potentially have an article published. For many of you this program may have been your first exposure to ACOOG and the annual conference. To date approximately 250 residents have participated in this program. The 2012 Resident Reporter Program afforded 10 incredibly energetic and bright residents to attend the annual conference in Tucson, Arizona. These residents are the future of ACOOG and in improving the care of women.

• Resident and Postgraduate Fellow Research Awards - MEFACOOG Research Grants of up to $5,000 is open to all residents, fellows and junior faculty in osteopathic postdoctoral training institutions to support research efforts. This year the foundation supported one grant totaling $5000. We welcome even greater participation so submit your request before next November 1st.

• Resident Education Resources - The Foundation supports efforts to improve the education of residents. Resources that have been supported include the OMM Video Curriculum, Challenger Grants and L3 for Residents quarterly learning modules.

• Endowed Lectures - There is probably no better way to honor the great women and men who have graced the College than through endowing an annual lecture in their name. MEFACOOG currently supports three endowed lectures; Barbara Hawkes Honorary Fellows Lecture, Gail Goldsmith Memorial Lecture, MEFACOOG Distinguished Lecture, and the Past Presidents Honorary Lecture.

• Community Service Projects - This program was started 4 years ago with the recognition that there are many people in need within the communities where we hold our annual meeting. We wanted to give back to those communities guided by a local ACOOG member. Past projects include work at a youth community center in Chicago, home repairs in New Orleans for the Katrina recovery effort, blood drives, and support for a residential home for pregnant mothers in crisis. This year we supported “Safe Haven” which is program to help victims of domestic violence.

As you can see, the work of MEFACOOG is impacting the lives of women and the bright future of ACOOG. Fundraising is the cornerstone of much of what the Foundation does. In these lean times it is becoming much more difficult to achieve our fundraising goals. The support from industry continues to decline as regulatory and financial considerations are changing for those companies. MEFACOOG has been raising funds through several notable events such as the Annual Silent Auction, Golf Tournaments, ‘Evening with the Stars’ planetarium function and Cirque Du Soleil Mystere. The Silent Auction has become an annual event that is fun and entertaining and has raised significant revenue. This year we raised funds by selling ticket packages for members of ACOOG to attend Monday night football with the Dallas Cowboys playing the Chicago Bears. Bad night for the Cowboys!
The Board and I would like to thank all of you for your dedication and support to MEFACOOG and its mission to improve the care of women. Your support is critical to carry on the mission of the Foundation. Please consider supporting MEFACOOG. This support can take the form of donated items for the Silent Auction, funding endowments, philanthropy or just volunteering your time to help with projects. MEFACOOG is a 501c3 organization which means your donated items or monetary gifts qualify as a tax deduction. We all have so much more that we need to accomplish. I look forward to an even better 2013!

Sincerely,

Mark Barbee
MEFACOOG Chair

The **2011-2012 MEFACOOG Board members are:**

Mark Barbee, Chair
Robert Debbs, DO, Vice-Chair
Jeffrey Postlewaite, DO, Secretary-Treasurer
Lori Crites, RN, RDMS
Lisa Fritz, DO, Trustee
Deanah Jibril, DO, Trustee
Richard Polk, DO, Life Member
Teresa Hubka, DO, Trustee
ACOOG Immediate Past President
Steve Buchanan, DO, Ex-Officio
Valerie Brennan, CAE, Executive Director

MEFACOOG additional support by ACOOG Staff

Helen Oberbeck. . . . . . . . . . . . . . .
Director of Administration
Martha Prud’homme . . . . . . . . .
Project Administrator

**Dates to Remember**

**80th Annual Conference**
April 7-12, 2013
Clearwater, FL
Hilton Clearwater Beach

**2013 Fall Conference**
October 27-31, 2013
Chicago, IL
Chicago Mart Plaza Hotel

**81st Annual Conference**
April 6-11, 2014
Las Vegas, NV
Four Seasons Las Vegas

**2014 Fall Conference**
Grapevine, TX
Hilton DFW Lakes Hotel
Letter from the Executive Director

Valerie Brennan, CAE, Executive Director

The MEFACOOG Board of Trustees held a strategic planning retreat on September 30, 2012. Existing programs were evaluated, new programs considered, and the mission statement updated. They maintain that the priorities of MEFACOOG are education, research, and scholarships and have great plans for expanding roles of the National Student Society and Resident Reporter Programs.

Many thanks to everyone who contributed to the Safe Haven service project and Monday Night Football fundraiser during the ACOOG 2012 Fall Conference. Football fans not only enjoyed the game but some got to meet Chicago Bears players staying at our conference hotel! Also, we so appreciated meeting the people at Safe Haven who were extremely welcoming and grateful for the support provided by MEFACOOG.

Did you know? Donors have the ability to restrict their donation to any of the following programs/initiatives:
- National Student Society of ACOOG
- Resident Reporter Program
- Endowed Lectureships
- Osteopathic Graduate Medical Education
- Postgraduate Research Awards
- Silent Auction/Fundraising Events
- Community Service Project

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. Just make a selection on the MEFACOOG donation form or indicate your choice in the memo field of your donation check.

Continuing to provide educational opportunities for our members is crucial; beginning with medical students, through postgraduate training, continuing medical education, and osteopathic continuous certification.

Sincerely,

Valerie Brennan, CAE
Executive Director

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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 81st Annual Conference is November 1, 2013. Apply: Click here to download the application.

Authors of accepted abstracts will be notified by Research and Awards Committee by January 4, 2014.

If you have any questions please contact the ACOOG office at (800) 875-6360.
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 275, Fort Worth, TX 76116
Endometrial cancer is the most common gynecologic cancer of the female reproductive system. The vast majority of endometrial cancers are categorized as Type I and are the consequence of unopposed estrogen, either endogenous or exogenous without a correspondingly appropriate amount of progesterin. Endometrioid adenocarcinoma is the most common histologic cell type of endometrial cancer and arises from endometrial hyperplasia. Architectural changes induce glandular crowding which along with cellular hyperplasia leads to complex atypical hyperplasia progressing on to endometrial cancer.

**Endometrial cancer is the most common gynecologic cancer of the female reproductive system.**

In an often quoted longitudinal study, women with differing levels of endometrial hyperplasia and/or atypia were followed over time. Patients with a biopsied diagnosis of simple hyperplasia were found to progress to endometrial cancer on hysterectomy specimen at a rate of 1%. Whereas complex hyperplasia advanced to endometrial cancer in 3% of cases, simple atypical hyperplasia 8% progression and complex atypical hyperplasia in 29% of cases.

Many risk factors have been identified in conjunction with endometrial cancers including, but not limited to: early menarche, late menopause, nulliparity, obesity, postmenopausal estrogen therapy, diet high in animal fat, age greater than 40, Tamoxifen therapy, personal history of breast/ovarian cancer, family history of endometrial cancer or hereditary nonpolyposis colon cancer syndrome. An estimated 2.6% of American women will develop uterine cancer in their lifetime. The overall incidence of this disease is likely to increase with the obesity epidemic combined with an aging population.

Diagnosis of endometrial hyperplasia, atypia or endometrial cancer is achieved with tissue often via office-based endometrial biopsy (Pipelle®) or by dilation and curettage. Indications for endometrial biopsy which may yield such a diagnosis include postmenopausal bleeding, abnormal uterine bleeding or atypical glandular cells on Papnicolaou test.

Recent ACOG recommendations concerning abnormal uterine bleeding have given credence to the judicious use of ultrasound. Although the chance of malignancy with an endometrial stripe of less than 4 mm is quite small, it is worth noting that imaging modalities should not supplant one’s clinical suspicion.

Treatment of patients with atypical endometrial hyperplasia is typically surgical by total hysterec tomity and staging, if necessary. In patients with complex atypical hyperplasia or endometrial cancer who desire no further childbearing, medical treatment with progesterone can be used with favorable results from a recent study (77.7% response with 53% complete remission rate). Pregnancy rates were noted to be 41% in patients with complex atypical hyperplasia and 34% in patients with endometrial cancer. Although these results do give hope to those who desire further childbearing, persistence rates were 14-25% and recurrent disease rates were 23-35% in complex atypical hyperplasia and endometrial cancer, respectively.

Difficulties become apparent when considering treatment of patients with biopsy proven atypical endometrial hyperplasia as the reproducibility of tissue diagnosis between pathologists is poor. One study of over 300 tissue samples notes agreement between three pathologists 40% of the time. Furthermore both underestimating and overestimating the severity of the lesion has been found to be common with atypical endometrial hyperplasia. In addition to these findings, 40% of biopsied samples that were initially stated to be complex atypical hyperplasia either on endometrial biopsy or curettage were found to have
endometrial cancer on final pathology following hysterectomy. With this significant rate of endometrial cancer in patients with biopsy proven atypical endometrial hyperplasia, the general gynecologist serves her/his patient’s best interests by having a preoperative consultation with a gynecologic oncologist. Geographic constraints may limit access to an oncologic subspecialist. In such a case, one must weigh the availability of staff capable of full surgical staging and the potential for changes in treatment due to improperly staged patients.

According to the American College of Obstetricians and Gynecologist Practice Bulletin Number 65 which is supported by the Society of Gynecologic Oncologists, there are several situations when consultation with a gynecologic oncologist may be beneficial. These situations include:

• Lack of ability to completely and adequately surgically stage a patient with likely endometrial cancer at the time of the initial procedure.
• Preoperative histology suggests a high risk for extrauterine disease
• Endometrial cancer is present in pathology specimen when a hysterectomy is undertaken for benign disease
• Preoperative evidence of cervical involvement or extrauterine disease
• Pelvic washings are positive for malignant cells
• Recurrent disease is diagnosed or suspected
• Nonoperative therapy is contemplated.

Endometrial hyperplasia is a precursor lesion for endometrioid adenocarcinoma. When discovered prior to progression on to endometrial carcinoma, surgical treatment may be undertaken by a general gynecologist with the necessary surgical acumen. Any concern by the physician for the potential of a diagnosis of endometrial cancer should prompt a consultation from an oncologic specialist. No conflicts of interest were apparent in this lecture.

References

Table 1

<table>
<thead>
<tr>
<th>Patient</th>
<th>Initial Pathologic Dx</th>
<th>Medical management (type and total duration)</th>
<th>Interim End treatment history</th>
<th>Preinfertility treatment</th>
<th>Infertility outcome</th>
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</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>38 yo G0</td>
<td>FIGO grade 1</td>
<td>Megace 80 mg/day X 3 mos</td>
<td>proliferative endometrium @ 3 mos</td>
<td>No residual disease</td>
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<tr>
<td>Case 2</td>
<td>27 yo G0</td>
<td>FIGO grade 1</td>
<td>Megace 80 mg/day X 6 mos</td>
<td>proliferative endometrium @ 6 mos</td>
<td>No residual disease</td>
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<tr>
<td>Case 3</td>
<td>35 yo G0</td>
<td>CAH</td>
<td>Refused progestin, OCPx3mos ov induct 6 mos</td>
<td>CAH (3 mos)</td>
<td>Progesterone endometrium</td>
</tr>
<tr>
<td>Case 4</td>
<td>31 yo G0</td>
<td>CAH</td>
<td>High dose progestin not tolerated, low dose provera and progestin IUD (30 mos)</td>
<td>CAH (3 mos)</td>
<td>Progesterone endometrium</td>
</tr>
</tbody>
</table>
As osteopathic practitioners our role should be to facilitate the process of helping our patients’ body heal itself. This presentation truly embodied that central dogma of our profession. Dr. Showalter pleasantly presented how feasible it is to incorporate an osteopathic evaluation and treatment into the evaluation of our patients with the common complaint of chronic pelvic pain. With modern medicine’s abbreviated physician-patient encounters, we as gynecologists find ourselves quick to deliver a script for pain medication. Dr. Showalter was able to show how OMT can be used to minimize the pain medication requirements for many chronic pelvic pain patients. This is especially true in endometriosis patients that are treated on the first day of their menses at least 3 months in a row.

In the routine gynecologic exam it is important to note any erythema of the external genitalia which may be a visible manifestation of a somatic dysfunction in the patient. On speculum and bimanual exam, one should note if the cervix is deviated from midline and whether the uterus is ante/reverted. Although we are taught that a retroverted uterus is a normal variant, we now know that condition is associated with dysmenorrhea, miscarriage, and chronic pelvic pain. With minimal extra time during the physical exam, one can detect tender areas of the anterior and posterior aspect of the pelvis as well as intra-vaginal tender points that may need treatment. The current thinking revolves around how somatic dysfunction such as sacral torsion may result in distortion of blood supply to pelvic organs. By treating these somatic dysfunctions one can improve the perfusion to the pelvic organs and sometimes resolve the patient’s complaints without spending the time/cost/resources that you normally waste on diagnostic studies such as pelvic ultrasounds. It is also very important to remember that there can be multiple etiologies of pain that one may not consider such as fascial pain, levator ani issues, and pubic symphysia abnormalities among other things. Sometimes severe pelvic pain can result from psoas spasm which can sometimes be confused for pain from ovarian cysts and theoretical rupture.

The list of symptoms/conditions related to gynecologic pathology that can be treated with osteopathic manipulation is quite extensive and includes pelvic pain, coccydynia, dyspareunia, edema, endometriosis, endometritis, fibroids, mastodynia, galactorrhea, pubic shear, sciatica, vaginismus, vaginitis, vulvodynia, ovarian cysts, interstitial cystitis, and pelvic congestion.

In order to fully appreciate the treatment modalities I must direct you to the photo slides in Dr. Showalter’s powerpoint but in terms of her quick screen/treatment she recommends the following:

- With patient supine you rock iliac crest for restrictions of the sacroiliacs, check ASIS height, check for pubic shear in vertical and AP positions. Anterior findings can be treated with Dr. Eberly’s technique and Sacroiliac magic can be used for sciatica, pelvic pain, and asymmetry of visceral structures.
- A common anterior tender point is the psoas, which can easily be treated with counterstrain.
- In the prone position one can check for sacral torsion and treat with muscle energy, as well as check for lumbar rotation and treat with lumbar roll or soft tissue.
- Coccydynia can be treated intravaginally/rectally or with counterstrain to inferior gluteal folds. Axillary pump maneuver can be used for galactorrhea, mastitis, mastodynia, post-radiation pain, fibrocystic changes with breast tenderness.
- She commonly uses thoracic diaphragm release (doming of the diaphragm) to treat GERD, dyspnea of pregnancy, or vague abdominal pain.
- The pelvic diaphragm release done in lateral position can be used for pelvic pain, dysmenorrhea, or pelvic congestion (make sure to use gentle pressure because being too aggressive can make matters worse).
- When treating hemorrhoids, pelvic congestion/pain, or incontinence one can utilize the ischial tuberosity spread. Endometriosis patients typically get very good pain relief with sacral rocking especially when

(Continued on Page 9)
performed on first day of menses.

- Vaginal point tenderness and dyspareunia can be treated successfully using the counterstrain model with the internal vaginal technique (verbal consent should be sufficient).

The “Whoopie technique” from Dr. Millicien Tettambel has been used to treat postpartum blues/depression/psychosis as well as ‘fuzzy head’ symptom of menopause. The proposed mechanism is the alteration of the parasympathetic fibers in the sagging pelvic structures/tissues. Poor perfusion has also been cited as potential etiology for poor libido and/or anorgasmia, which have been shown to resolve with the above-mentioned OMT techniques.

In conclusion, it is very important to reevaluate the patient immediately after treatment as well as a follow up visit in 2 weeks. Patients need to be made aware that their symptoms may worsen for up to 2 days after treatment. All patients should be given exercise programs for their core, which could many times result in patients resolving their symptoms on their own. This presentation was a great reminder of how much magic we can all do with our hands.
The rates of preterm birth are very high in the US as compared with other developed nations. The cost of caring for preterm neonates is approximately $26 billion per year. Over the last ten years there has been a noticeable increase in survival of preterm neonates, especially in the extremely low gestational age neonate (ELGAN), i.e. less than 25 weeks gestation. However, additional endeavors can be made by the obstetrician to address morbidity and mortality associated with all neonates born before 39 weeks, including the ELGAN. These efforts include offering detailed patient counseling, exploring the use of antenatal corticosteroids, and delivering neonates only when medically necessary.

When counseling patients who are likely to deliver a preterm neonate, the standard method is to use the institution’s statistics for morbidity and mortality. Incorporating details of the circumstances with the information of the institution may support parents who must make difficult decisions regarding interventions. Another method to counsel patients is to use the general reference data as well as a risk calculation tool to predict outcomes, which is available on the National Institute for Child Health and Human Development (NICHD) website. The NICHD tool, for the extreme preterm birth of 22 to 25 completed weeks, bases outcomes on five factors: gestational age (being the most important factor), birth weight, sex, singleton birth, and steroid use. The outcome data incorporates these factors to provide a standardized estimation of survival and assessment of mental developmental index. The tool and information is available at http://www.nichd.nih.gov/about/cdbpm/pp/prog_epbo/index.cfm. Providing custom information may assist parents to prepare for the increased risks of death and neurodevelopmental disability as well as the role for interventions in extreme prematurity.

Patients may also want to be aware of the long-term complications that may affect all neonates born prior to 39 weeks. Complication risks related to prematurity continue to impact all neonates born preterm, including when the neonate is delivered during the late preterm and early term period. Most notably, mortality rises with each week lost in the gestation for neonates less than 39 weeks. Long term neurological complications, among many other complications, exist for the late preterm neonate including a three-fold increase in cerebral palsy, 37% increase in developmental delay, a 19% increase in kindergarten retention, and other delays documented in children up to the fifth grade. The recent literature states that these complications may relate to halted brain development secondary to early delivery. For example, at 36-37 weeks gestation, the brain volume is 65% of a neonate at 39 weeks. Additionally, the cerebellar growth stops at delivery. Because late preterm and early term birth rates are increasing, a concern exists for the related morbidity and mortality.

Interventions to improve outcomes for premature neonates continue to revolve around appropriate use of antenatal corticosteroids (ACS). The lowest threshold of gestational age to give ACS is unclear. In the ACOG Practice Bulletin Management of Preterm Labor, Number 127, ACS are indicated in the management of preterm labor. Currently, ACOG supports the practice of giving a single course of ACS from 24-34 weeks. A single course is recommended because a concern for decreased fetal growth exists if repeat courses are given. As Dr. Owen states, “If the body is not growing, then the brain is not growing.” Recent research is determining if antenatal exposure to corticosteroids in gestations less than 24 weeks is beneficial. In the JAMA December 2011 article, “Association of Antenatal Corticosteroids with Mortality and Neurodevelopmental Outcomes Among Infants Born at 22 to 25

(Continued on Page 11)
“Extremes of Prematurity: What’s New?”
(Continued from Page 10)

Weeks’ Gestation” Dr. Carlo et al, with the NICHD, present a study on use of ACS in the ELGAN. Their research is the largest cohort study of infants born during this gestational period and concludes that ACS use in infants born at each week from 23 to 25 weeks gestation lowers morbidity and mortality rate compared to those not given ACS. While no significant difference was made for infants born at 22 weeks gestation, the survival doubled in weeks 23 to 25 gestation for infants who received a course of ACS. At this time, research concludes that it is appropriate to consider ACS at 23 weeks and above if intensive care will be offered. Changes in the practice of antenatal steroid administration may reduce the severity of complications in the extremely preterm neonate.

Premature births are increasing because of increase in elective induction of labor. ACOG provides a list of appropriate indications in the Practice Bulletin Number 107, Induction of Labor. Medical indications, in accordance with ACOG guidelines, are acceptable for delivery of a neonate less than 39 weeks. These include placental abruption, chorioamnionitis, gestational hypertension, preclampsia, eclampsia, premature rupture of membranes, postterm pregnancy, maternal medical conditions, and fetal compromise. Currently, only 25% of late preterm deliveries (gestational age 34-36 weeks) have a medical indication. Strictly adhering to ACOG guidelines does not exclude indicated deliveries. In the medically indicated preterm birth outcomes are better as compared with elective early delivery.

Elective induction of labor contributes to the morbidity and mortality of neonates. Elective induction has become so prevalent that the average age of delivery in the U.S. has decreased from 40 to 39 weeks. Changes in culture standards may contribute to the increase in elective inductions. Accommodating for physician and maternal convenience may add to the induction rate. Also, emerging ideas of an elective cesarean because a woman is ‘too posh to push’ or desires ‘prevention’ from maternal complications of a vaginal delivery may contribute. In some instances, physicians feel pressured by the patient to agree to an elective induction or cesarean. ACOG Practice Bulletin Number 107 on Induction of Labor lists logistical difficulties as a reason for induction but includes a caveat that gestational age criteria must be met or fetal lung maturity (FLM) should be established. Additionally, the practice bulletin states that obtaining a FLM without an indication for induction is strongly discouraged. Testing for fetal lung maturity does not confirm overall fetal maturity. Accelerating the delivery date by even a short period may create lifelong difficulties for the child.

To reduce early deliveries that are not medically necessary, hospital policies must allow only ACOG approved indications for preterm delivery. In an effort for reform, some resistance may present. The speaker reminds us of “normalization of deviance”, which is the unsound practice that continues because of anecdotally derived favorable experience. Its application, along with the false perception that ‘being born a few weeks early doesn’t matter’, increases morbidity and mortality of neonates delivered early. Resources, such as the March of Dimes toolkit as well as their Healthy Babies are Worth the Wait® Program, are available to assist hospitals in modifying their current practices to make improvements. Hospitals that allow only medically necessary deliveries of neonates less than 39 weeks note a 66% decrease in scheduled cesareans and a reduction in elective inductions. These institutions are seeing the benefit of decreased morbidity and mortality of neonates. In conclusion, continued concern for the well-being of the pregnant woman and the neonate as well as adherence to guidelines by the obstetrician will improve outcomes.

References

Plan your research project now.

The MEFACOOG 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 Research Grant is November 1, of each year prior to our Annual Conference. The 2014 Research Grant has a deadline of November 1, 2013. Get your application and guidelines on the MEFACOOG website under Research Grant Award.

CALL FOR VOLUNTEERS

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, 2013.
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, 2011. As you can see, we were once again down in corporate contributions, but slightly up in individual and fundraiser contributions. Below are ongoing grants we hope to continue in the upcoming year.

- MEFACOOG 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 79th Annual Conference of the ACOOG hosted three ongoing funded lectureships. The fifteenth annual MEFACOOG Barbara Hawkes Memorial Lecture; also the college’s second memorial lectureship, was given by Stephen Corson, MD. The eleventh annual MEFACOOG Distinguished Lecture was presented by Gary Chapman, PhD. The annual MEFACOOG Gail Goldsmith Memorial Lectureship was presented this year by Robert Debbs, DO. This was the seventh annual lecture of the ten year endowment made possible by the friends and colleagues of Gail Goldsmith and Wyeth.

The seventh of a ten year endowment of the MEFACOOG Past President’s Honorary Lectureship was presented by Barbara Levy, MD at our 2012 Fall Conference in Grapevine, Texas.

The National Student Society of the ACOOG met for the sixth time in Grapevine at the ACOOG Fall Conference. The NSS-ACOOG officers are currently working on a quarterly newsletter for students. The officers also helped create a FaceBook page for the NSS-ACOOG. These projects would not be possible without the support of you, the donors. Thank you for your continuing support.

### Financial Review

#### Statement of Activities

<table>
<thead>
<tr>
<th>Year Ended December 31, 2011</th>
<th>Support</th>
<th>Expenses</th>
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<tr>
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<td>Corporate Contributions</td>
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<td>Total Support</td>
<td>$123,015</td>
<td>Total Expenses</td>
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**Dividend Income** $17,074  
**Unrealized/Realized Gains (Losses)** $(42,207)  
**Net Assets, Beginning of Year** $612,897  
**Change in Net Assets** $(55,877)  
**Net Assets, End of Year** $531,887

#### Statement of Financial Position

<table>
<thead>
<tr>
<th>Year Ended December 31, 2011</th>
<th>Assets</th>
<th>Liabilities and Net Assets</th>
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<td>Current Assets</td>
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<td>Total Assets</td>
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<td>Total Liabilities and Net Assets</td>
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**BACKGROUND**

Second Trimester serum screening using alpha-fetoprotein (AFP), unconjugated estriol (uE3), human chorionic gonadotropin (hCG), and inhibin A also known as the quad screen or quadruple test is used to identify pregnancies at increased risk for open neural tube defects and chromosomal abnormalities such as Trisomy 21 and 18.

Several studies have shown associations with elevated levels of maternal serum AFP or hCG and adverse pregnancy complications such as preeclampsia, Intrauterine growth restriction (IUGR), placental abruption, and fetal death when chromosomal abnormalities have been excluded.

Low maternal serum High uE3 defined as level < 0.5 MOM has been associated with IUGR and oligohydraminos. An increase level of High uE3 has not been associated with adverse perinatal outcomes.

Maternal serum inhibin- A levels > 2.0 MoM in the second trimester is associated with an increase risk to develop gestational hypertension with proteinuria. There is no association with low inhibin-A levels and adverse obstetrical outcomes. Maternal serum AFP levels > 2.5 MoM at higher risk of preterm delivery and persistent placental previa. Maternal AFP values are higher in women who develop gestational hypertension with proteinuria and adverse features before 32 weeks rather than after 32 weeks. Low maternal serum AFP defined as <0.25 MoM has been associated with spontaneous abortion, preterm birth, still birth, infant death, and increased macrosomia.

Increase levels > 2.0 MoM of hCG have a higher frequency of IUGR, gestational hypertension with proteinuria with or without adverse features, preterm labor or delivery. Low hCG is defined as a value <0.5 MoM has been associated with normal fetal anatomy and normal karotype. Low levels have higher incidence of birth weight below the fifth or tenth percentile and miscarriage. Extremely low levels < 0.25 MoM have been associated with an increase risk of spontaneous loss before 24 weeks.

**OBJECTIVE**

Compare the differences of adverse outcomes between women who had abnormal quad screen in the second trimester without fetal chromosomal or anatomy anomalies and women who had non-abnormal quad screen test.

The outcomes of interest are preeclampsia, IUGR and placental abruption. Abnormal quad screen is defined as AFP > 2.0 MoM, hCG > 2.0, uE3< 0.5 or Inhibin-A >2.0 MoM.

We hypothesized that in pregnant women even with a single marker of quad screen abnormality without fetal chromosomal or structural anomalies is associated with adverse pregnancy outcomes including preeclampsia, intrauterine growth restriction (IUGR), and placental abruption.

**DESIGN AND METHOD**

A case-control design will be conducted by a retrospective chart review of women noted to have quad Screen in second trimester between 15-20 wks, but amniocentesis and ultrasound showed no fetal chromosomal or structural anomalies between January 2005 and November 2010.

Cases were women with singleton gestations who were noted to have an Abnormal Quad Screen (total N=120). Controls will be randomly selected singleton pregnancies with a normal quad screen during the same time period (N=280).

Cases were defined as women who were noted to have at least a single marker of Abnormal quad screen. Controls were randomly selected from those who had no abnormal quad screen from a Quest laboratory database. Cases were randomly selected from R4 query database that had an indication of abnormal quad screen for amniocentesis.

(Continued on Page 15)
“Association Between Abnormal Quad Screen and Adverse Pregnancy Outcomes.”
(Continued from Page 14)

Abnormal quad screen is defined as AFP > 2.0 multiples of the median (MoM), or hCG > 2.0 MoM or uE3< 0.5 or Inhibin-A >2.0 MoM

All documented information regarding to outcome including age, weight, parity, results of quad screen, ethnicity, intrapartum complications, co- morbidities during pregnancy, gestational age at delivery, smoking in the current pregnancy, diabetes, prior history of abnormal quad screen without fetal chromosomal/ or structural abnormalities, intrapartum or delivery interventions, fetal weight on delivery and ultrasound were recorded from patient records.

Inclusion criteria include maternal Age >18, singleton pregnancies occurring from Jan 2005- Nov 2010 with antepartum care received from Maternal Fetal Medicine at Kennedy Memorial Hospital, Singleton pregnancies delivering at Kennedy Memorial Hospital with a quad screen obtained between 15-20 weeks, and all races.

Exclusion criteria include prior history of IUGR, placental abruption, and preeclampsia in previous pregnancies, multiple gestation pregnancy, history of fetal chromosomal abnormalities diagnosed by amniocentesis, history of fetal structural abnormalities diagnosed by targeted ultrasound, history of 1st trimester screening during pregnancy, abnormal quad screen in second trimester without amniocentesis, Inconclusive quad screen, neural tube defects and quad screen obtained > than 20 weeks.

Statistics and Analysis

General methods: T test was used to compare means for the continuous variables between cases and controls. Chi-square test was used for categorical variables for the comparison between cases and the controls.

Logistic regression analysis was performed to determine the association of abnormal quad screen on the risk of adverse outcomes where dependent variables are dichotomous. Odds ratios (OR), adjusted odds ratios (AOR) and their 95% confidence intervals (95% CI) from the logistic regression coefficients and their corresponding covariance matrices were computed. Potential confounding variables including maternal age, ethnicity, parity and smoking will be controlled in multivariable models for each dependent variable.

All statistical procedures were performed using SAS v.9.0 (SAS Institute, Inc., Cary, NC).

Results

Associations of positive quad screen with maternal / fetal outcomes were examined including IUGR, Preterm delivery (<37 completed week), Pre-eclampsia, Low birth weight (<2500g), Placenta abruption, and Delivery intervention (C-section or SVD).

Included 120 women who had a positive quad screen.

280 women who had a negative quad screen.

Women with a positive screen were significantly older (p<0.0001) and had a shorter gestational age at delivery (p<0.01) than those with a negative quad screen.

No difference on mother’s body weight and infant birth weight.

Summary

A positive quad screen was associated with an increased risk for preterm delivery, and c-section and IUGR.

A significant association was not found between a positive quad screen and preeclampsia, low birth weight or placenta abruption (p>0.05)

Conclusion

Our data showed that quad screen at the 2nd trimester can be a useful test for adverse pregnancy outcome prediction.

Our limitations are that we were unable to define the serum marker concentration values that defined the quad screen to abnormal, thus unable to evaluate the predictive value of each marker.

References


Kowalczyk, TD;Cabaniss ML; Cusmano. Association of Low Unconjungated Estriol in the Second Trimester and Adverse Pregnancy Outcomes. Obstetrics and Gynecology. 1998; 91. 319-483


Women with a positive quad screen had a more than 5-time increased risk for IUGR, 4-time risk for pre-term delivery and 2.5-time risk for delivery by C-section.

ANNUAL REPORT 2012  MEFA COOG 15
INTRODUCTION

A common saying that a woman is “eating for two” while pregnant implies that a mother should consume twice as much during pregnancy. In reality, this is not true. Conditions during pregnancy have been shown to have long term effects on adult health. Maternal nutritional and metabolic factors, which ultimately have an effect on the fetus, have been of particular interest because they may offer valuable intervention points for preventative programming in patient care.

Women are increasingly gaining weight during pregnancy beyond the thresholds set forth by Institute of Medicine (IOM) guidelines. These increases are pronounced among overweight and obese women and obesity levels among women of childbearing ages are rising dramatically. Many of these changes carry the added burden of chronic disease, which can put the mother and her baby’s health at risk. Because of this, review of outcomes of maternal weight gain is motivated by several trends in perinatal health that are of great public health concern.

IOM issued guidelines in 1990 to recommend optimal weight gain ranges for women based on their pre-pregnancy BMI. These guidelines have been validated by several studies demonstrating weight gain in accordance to the guidelines is associated with optimal birth weight and obstetric outcomes. Newer guidelines published in 2009 examines weight gain during pregnancy from the perspective that factors that affect pregnancy begin before conception and continue through the first year after delivery. These new weight gain guidelines are based on revised Body Mass Index (BMI) categories and now have a recommendation for obese women.

The relationship between high maternal pre-pregnancy BMI and adverse pregnancy outcomes has been examined in several studies. The purpose of this study was to determine if inadequate or excessive maternal gestational weight gain alone had any association with fetal outcomes regardless of pre-pregnancy BMI, overall body habitus, and other comorbidities.

HYPOTHESIS

Inadequate or excessive maternal gestational weight gain regardless of pre-pregnancy BMI or other variables can have adverse effects on pregnancy outcomes including small or large for gestational age fetuses as well as an increased risk of preterm delivery.

METHODS

A Retrospective Chart Review of records of patients delivered at Mount Clemens Regional Medical Center between January 1, 2009 to June 30, 2010 was performed on patients receiving prenatal care with MCRMC employee physicians. Inclusion criteria was singleton gestations that began prenatal care in the first trimester. Pre-pregnancy weight was defined as the documented pregravid weight at the first office visit which was compared to the weight obtained at the last documented office visit weight prior to delivery. The gestational age at delivery as well as birthweight of the infant was also recorded.

RESULTS

This study evaluated 477 singleton gestations that obtained prenatal care in the first trimester and were followed up until delivery. Values were available for 393 (82%). Weight gain greater than 25lbs was noted in 187 patients (48%). Of those patients 48 (26%) had a weight gain greater than 40lbs, which according to IOM guidelines is higher than the recommended weight gain for all pregnancies regardless of BMI. Weight gains of less than 25lbs were noted in 203 (52%). Of those, 73 (36%) were weight gains less than 15lbs.

29 women had a gestational birth-weight greater than 4000g (7.4%) while 31 had a gestational birth-weight less than 2500g (7.8%). Preterm delivery less than 37 weeks was noted in 40 (10%).

(Continued on Page 17)
“Is There a Correlation Between Maternal Gestational Weight Gain and Neonatal Outcomes”
(Continued from Page 18)

Of the patients reviewed, a modest relationship was made with the pre-pregnancy weight and overall weight gain. Women with higher pre-pregnancy weights tended to gain less weight throughout their pregnancy, while those with lower pre-pregnancy weights gained more. Gestational age at delivery was shown to be positively related to birth weights. Preterm infants were noted to have lower birth weights, while term infants had higher ones.

The study hypothesis was not supported by statistical analysis. The correlation is 0.074 for maternal weight gain and gestational weight and 0.059 for maternal weight gain and gestational age at delivery which is a non-zero at the statistically significant <0.05 level. When percent of initial weight gained during pregnancy was compared to both gestational age at delivery as well as gestational weight the correlation was .076 and .019 respectively with p=.1805 and p=.7304. A larger study group and a more diverse population would likely be needed to further evaluate the hypothesis.

CONCLUSION

IOM issued guidelines recommend optimal weight gain range for women based on their pre-pregnancy BMI. These guidelines have been validated by several studies demonstrating weight gain in accordance to the guidelines is associated with optimal birth weight and obstetric outcomes. The aim of this study was to review the outcomes of overall maternal weight gain regardless of pre-pregnancy BMI or other confounding variables.

According to the data reviewed, there was no true correlation noted between overall maternal weight gain regardless of prepregnancy BMI and preterm delivery nor was there a statistically significant correlation between overall maternal weight gain and birth weight.

Prepregnancy weight seems to play a role in overall weight gain during pregnancy. Women at either extreme of prepregnancy weight are likely to benefit the most from gaining weight within set guidelines. Because multiple variables need to be taken into account regarding maternal nutritional status and metabolic factors, further studies regarding lifestyle, culture, age, race, etc. may need to be performed to further evaluate the correlation. In the meantime, greater efforts should be made to educate patients about BMI appropriate weight gain in pregnancy in order to have optimal outcomes.

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.

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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 STATEMENT

The American College of Osteopathic Obstetricians & Gynecologists has requested that the AOA Council on Continuing Medical Education approve this program for 30 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.

PRESIDENTIAL CELEBRATION

Wednesday, April 10, 2013 join us for a Beachside Luau themed Presidential Celebration. Wear your best island attire, not mandatory. A ticket must be purchased to attend the reception. Tickets are no longer 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 black and white 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 syllabus will include all slides submitted prior to the print deadline. Printed copies will NOT be available on site. Check the ACOOG web site one week prior to the conference to download the digital 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 activities.
### Sunday (April 7, 2013) - 4 Potential Credits

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-11:00</td>
<td>ACOOG Board of Trustees meeting</td>
</tr>
<tr>
<td>Noon-5:00 PM</td>
<td>Early Registration</td>
</tr>
<tr>
<td>1:00-5:00</td>
<td>Subspecialty Pre-course in GYN-ONC</td>
</tr>
<tr>
<td>1:00-1:45</td>
<td>- Pearls to Diagnosis of Vulvar Cancer and Vaginal Cancer</td>
</tr>
<tr>
<td></td>
<td>Anthony Rakowski, DO</td>
</tr>
<tr>
<td>1:45-2:15</td>
<td>- Ovarian Cancer - Is It Really Silent?</td>
</tr>
<tr>
<td></td>
<td>Dirk Pikaart, DO</td>
</tr>
<tr>
<td>2:15-2:45</td>
<td>- Break</td>
</tr>
<tr>
<td>2:45-3:30</td>
<td>- Endometrial Cancer Diagnosis - Educating Your Patients</td>
</tr>
<tr>
<td></td>
<td>Anthony Rakowski, DO</td>
</tr>
<tr>
<td>3:30-4:15</td>
<td>- Cervical Cancer - Diagnosis and Prevention</td>
</tr>
<tr>
<td></td>
<td>Dirk Pikaart, DO</td>
</tr>
<tr>
<td>4:15-5:00</td>
<td>- Interactive Case Discussion - Gynecologic Malignancies</td>
</tr>
<tr>
<td></td>
<td>Dirk Pikaart, DO, Anthony Rakowski, DO, Glenn Bigsby, IV, DO</td>
</tr>
<tr>
<td>6:00-7:30</td>
<td>TBD Dinner Symposium (Tentative)</td>
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### Monday (April 8, 2013) - 6.75 Credits

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>6:30-7:30</td>
<td>Resident Reporter Orientation Breakfast</td>
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<tr>
<td>6:30-7:30</td>
<td>Registration/Breakfast/Exhibits</td>
</tr>
<tr>
<td>7:30-7:45</td>
<td>President’s Welcome Address</td>
</tr>
<tr>
<td>7:45-8:30</td>
<td>Gail Goldsmith Memorial Lecture</td>
</tr>
<tr>
<td></td>
<td>TBD</td>
</tr>
<tr>
<td>8:30-8:53</td>
<td>Updates in Cervical Screening-Cliff Note Version</td>
</tr>
<tr>
<td></td>
<td>Lois Ramondetta, MD</td>
</tr>
<tr>
<td>8:53-9:15</td>
<td>Cervical Dysplasia-Management Pearls</td>
</tr>
<tr>
<td></td>
<td>Lois Ramondetta, MD</td>
</tr>
<tr>
<td>9:15-9:38</td>
<td>Radiology Review of Adnexal Masses</td>
</tr>
<tr>
<td></td>
<td>Nicolas Feranac, MD</td>
</tr>
<tr>
<td>9:38-10:00</td>
<td>Radiologic Procedures in Gynecology</td>
</tr>
<tr>
<td></td>
<td>Nicolas Feranac, MD</td>
</tr>
<tr>
<td>10:00-10:45</td>
<td>BREAK with Exhibits</td>
</tr>
<tr>
<td>10:45-11:08</td>
<td>Training in the “Art of Dying”</td>
</tr>
<tr>
<td></td>
<td>Lois Ramondetta, MD</td>
</tr>
<tr>
<td>11:08-11:30</td>
<td>Spirituality and Cancer Management</td>
</tr>
<tr>
<td></td>
<td>Lois Ramondetta, MD</td>
</tr>
<tr>
<td>11:30-11:53</td>
<td>Endometrial Hyperplasia in the Premenopausal Setting</td>
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<tr>
<td></td>
<td>Giselle Ghurani, MD</td>
</tr>
<tr>
<td>11:53-12:15</td>
<td>Lymphadenectomy in Endometrial Cancer</td>
</tr>
<tr>
<td></td>
<td>Giselle Ghurani, MD</td>
</tr>
<tr>
<td>12:15-1:30</td>
<td>Lunch with Exhibits</td>
</tr>
<tr>
<td>1:30-1:53</td>
<td>Prevention of Thromboembolic Events After GYN Surgery</td>
</tr>
<tr>
<td></td>
<td>David Jaspan, DO</td>
</tr>
<tr>
<td>1:53-2:15</td>
<td>Management Paradigm for Dyspareunia and Pelvic Pain</td>
</tr>
<tr>
<td></td>
<td>David Jaspan, DO</td>
</tr>
<tr>
<td>2:15-2:38</td>
<td>Update on Sterilization Techniques</td>
</tr>
<tr>
<td></td>
<td>William Hood, DO</td>
</tr>
<tr>
<td>2:38-3:00</td>
<td>Endometriosis Management, Resection or Ablation</td>
</tr>
<tr>
<td></td>
<td>William Hood, DO</td>
</tr>
<tr>
<td>3:00-3:45</td>
<td>BREAK with Exhibits</td>
</tr>
<tr>
<td>3:30-5:00</td>
<td>MEFACOOG Corporate Partnership Council</td>
</tr>
</tbody>
</table>

### Monday Continued

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>3:45-4:08</td>
<td>The Annual Visit-Age Appropriate Checklist</td>
</tr>
<tr>
<td></td>
<td>David Jaspan, DO</td>
</tr>
<tr>
<td>4:08-4:30</td>
<td>Diagnosis of AUB in Reproductive Age Women</td>
</tr>
<tr>
<td></td>
<td>David Jaspan, DO</td>
</tr>
<tr>
<td>4:30-5:15</td>
<td>Prevention of Cardiovascular Disease in Women</td>
</tr>
<tr>
<td></td>
<td>David Shipon, DO</td>
</tr>
<tr>
<td>6:00-7:30</td>
<td>TBD Dinner Symposium (Tentative)</td>
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### Tuesday (April 9, 2013) - 6 Credits

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:00-7:30</td>
<td>Registration/Breakfast/Exhibits</td>
</tr>
<tr>
<td>7:00-7:30</td>
<td>Historian and Traditions Committee meeting</td>
</tr>
<tr>
<td>7:30-8:15</td>
<td>Computer Enhanced Fetal Monitoring</td>
</tr>
<tr>
<td></td>
<td>Arnold Cohen, MD</td>
</tr>
<tr>
<td>8:15-8:38</td>
<td>Chronic Hypertension in Pregnancy</td>
</tr>
<tr>
<td></td>
<td>Sherri Fair, DO</td>
</tr>
<tr>
<td>8:38-9:00</td>
<td>Managing the Hyperemesis Patient</td>
</tr>
<tr>
<td></td>
<td>Sherri Fair, DO</td>
</tr>
<tr>
<td>9:00-9:45</td>
<td>Free Fetal DNA Testing and Pre-Pregnancy Genetic Screening</td>
</tr>
<tr>
<td></td>
<td>Rachel Humphrey, MD</td>
</tr>
<tr>
<td>10:15-11:00</td>
<td>OMT in Pregnancy</td>
</tr>
<tr>
<td></td>
<td>Thomas Crow, DO</td>
</tr>
<tr>
<td>11:00-11:45</td>
<td>OMT in Women’s Health</td>
</tr>
<tr>
<td></td>
<td>Thomas Crow, DO</td>
</tr>
<tr>
<td>11:45-12:45</td>
<td>ACOOG Membership Meeting Luncheon</td>
</tr>
<tr>
<td></td>
<td>David Forstein, DO, President Presiding</td>
</tr>
<tr>
<td>12:45-1:30</td>
<td>The Use of Psychiatric Medications During Pregnancy and Lactation</td>
</tr>
<tr>
<td></td>
<td>Rachel Humphrey, MD</td>
</tr>
<tr>
<td>1:30-2:15</td>
<td>Managing Depression and Anxiety in Pregnancy</td>
</tr>
<tr>
<td></td>
<td>Rachel Humphrey, MD</td>
</tr>
<tr>
<td>2:00-5:00</td>
<td>AOBOG Recertification Exam</td>
</tr>
<tr>
<td>2:15-2:38</td>
<td>Prediction and Prevention of Preterm Birth</td>
</tr>
<tr>
<td></td>
<td>Eric Carlson, DO</td>
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<tr>
<td>2:38-3:00</td>
<td>Counseling the Patient with Multiple Pregnancy</td>
</tr>
<tr>
<td></td>
<td>Eric Carlson, DO</td>
</tr>
<tr>
<td>3:00-5:00</td>
<td>Exhibits Open</td>
</tr>
<tr>
<td>3:00-6:00</td>
<td>MEFACOOG Board of Trustees meeting</td>
</tr>
<tr>
<td>6:30-9:30</td>
<td>Parents Night Out/Kids Camp</td>
</tr>
<tr>
<td>6:30-7:30</td>
<td>New Fellows/Distinguished Fellows Reception (Invitation Only)</td>
</tr>
</tbody>
</table>

### Restaurants within walking distance...

- Bob Heilman’s Beachcomber (American)
- Mandalay Grill
- Captain’s Pizza
- Bob’s Bistro (French)
- Beach Shanty Cafe
**WEDNESDAY**

**PRESIDENT’S DAY (April 10, 2013) 6 Credits**

6:00-7:00 AM TBD Breakfast Symposium (Tentative)

6:30-7:00 Breakfast

7:00-7:45 CME Lecture

Norman Vinn, DO-AOA President-elect

7:45-8:30 CME Lecture

Jeanne Conry, MD-ACOG President-elect

8:30-9:15 MEFACOOG Distinguished Lecture

TBD

9:15-10:00 Barbara Hawkes Memorial Lecture

TBD

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, New Distinguished Fellows, and Inaugural Address of Michael Geria, DO, President-elect

Noon-1:00 ACOOG Farewell Reception and Roast for Joseph Bonanno, DO and Barbara Scott

1:00-4:15 Live Telesurgery

James Kendrick, MD

7:00-10:00 Presidential Celebration (Ticket required)

**THURSDAY (April 11, 2013) 5.25 Credits**

7:00-8:00 AM TBD Breakfast Symposium (Tentative)

7:30-8:00 Breakfast

8:00-8:45 Cervical Length Screening and Progesterone for Preterm Birth Prevention

Emily DeFranco, DO

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

8:45-9:30 Management of Stillbirth

Emily DeFranco, DO

9:30-9:53 Diagnosis and Management of Vulvar Skin Disorders

Maureen Conroy, DO

9:53-10:15 Management of GYN Issues in the Woman With Breast Cancer

Maureen Conroy, DO

10:15-10:30 BREAK

10:30-11:15 The Latest In Female Sexual Dysfunction

James Clark, MD

11:15-12:00 Dyspareunia, What’s New

James Clark, MD

12:00-1:00 TBD Lunch Symposium (Tentative)

1:00-1:45 Patient Care Act, What Does It Mean for the OBGYN!

Charles McNally, IV

**THURSDAY Continued**

1:45-2:30 Tips on Communicating With Potential Birth Mothers and Safe Haven Options

Patricia Strowbridge, JD

2:30-5:30 OMM Workshop

**FRIDAY (April 12, 2013) 6 Credits**

6:00-7:00 AM TBD Breakfast Symposium (Tentative)

7:30-8:00 Breakfast

7:30-8:15 Urogyn for the General OBGYN

Michael Coyle, DO

8:15-9:00 Urodynamics- Are They Really That Important?

Michael Coyle, DO

9:00-9:45 Voiding Dysfunction After a Sling-What Next?

UROGYN Expert Panel

9:45-10:00 BREAK

10:00-10:45 Expert Panel Discussion- Prolapse Repair; To Mesh or Not to Mesh

UROGYN Expert Panel

10:45-11:30 Surviving the Changing Payer Environment

Miguel Fernandez, DO

11:30-12:30 PM TBD Lunch Symposium (Tentative)

12:30-1:15 Ovulation Induction for the General OBGYN

Samuel Brown, MD

1:15-2:30 Reproductive Surgery in the Era of Assisted Reproductive Techniques

Samuel Brown, MD

2:30-3:15 Endocrine Disorders in Women-Update on PCOS

Angela Mazza, DO

3:15 Adjourn

**Things to do…**

Adventure Island
www.adventureisland.com

Busch Gardens (Tampa, FL) 33 miles
www.buschgardens.com

Clearwater Jolley Trolley Multiple locations
www.clearwaterjolleytrolley.com

Clearwater Marine Aquarium 1 mile
www.clearwatermarineaquarium.com

Grayhound Racing 96 miles
www.grayhound.com

Pier 60 .10 mile
www.pier60.com

Sea World (Orlando, FL) 96 miles
www.seaworld.com

Seminole Hard Rock Hotel and Casino 31 miles
www.seminoleshardrocktampa.com

St. Petersburg Pier 24 miles
www.stpete-pier.com

Universal Studios (Orlando, FL) 101 miles
www.universalstudios.com
ACOOG 80TH ANNUAL CONFERENCE

REGISTRATION FORM

Please print name for guest badge (ADULTS ONLY)

First Name* MI
Last Name*
AOA Number*
Degree* DO MD Other (PhD, RN, NP, RDMS,)
Address*
Apt. or Suite*
City*
State* Zip*
Contact Tel*
E-mail *
Guest Badge **

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

<table>
<thead>
<tr>
<th>GENERAL SESSION</th>
<th>Pre-Registration (payment received by March 20, 2013)</th>
<th>Late Registration (payment received after March 20, 2013)</th>
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<tbody>
<tr>
<td>Physician Member (Regular, Senior, Fellow, DF)</td>
<td>$800</td>
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<td>Non-Member Physician</td>
<td>$1,000</td>
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<td>Life Member</td>
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<tr>
<td>Affiliate Member (Non-physician member)</td>
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<td>Candidate (Resident member)</td>
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<td>Non-Member Resident</td>
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<tr>
<td>Non-Member Student</td>
<td>$250</td>
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<tr>
<td>Monday Only 6.75 credits April 8</td>
<td>$202</td>
<td>$252</td>
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<tr>
<td>Tuesday Only 6 credits April 9</td>
<td>$180</td>
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<td>Wednesday Only 6 credits April 10</td>
<td>$180</td>
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<tr>
<td>Thursday Only 5.25 credits April 11</td>
<td>$158</td>
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<td>Friday Only 6 credits April 12</td>
<td>$180</td>
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Pre-registrations will be accepted until March 20, 2013. All registrations received after this date will be processed at the late registration rate. Registrations received after March 27, 2013 will be accepted onsite at the registration desk only. A 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.

<table>
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<tr>
<th>SUPPLEMENTAL SESSIONS</th>
<th>Day</th>
<th>Time</th>
<th>CME</th>
<th>Limit</th>
<th>Fee</th>
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<tbody>
<tr>
<td>Subspecialty Pre-Course in GYN-ONC</td>
<td>Sun (April 7)</td>
<td>1:00-5:00 PM</td>
<td>4 hrs</td>
<td>100</td>
<td>$150</td>
<td>$75</td>
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<td>OMM Workshop</td>
<td>Thur (April 11)</td>
<td>2:30-5:30 PM</td>
<td>2 hrs</td>
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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.

<table>
<thead>
<tr>
<th>EVENT TICKETS</th>
<th>Day</th>
<th>Time</th>
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<tbody>
<tr>
<td>Parent’s Night Out (Snacks and a movie for the kids)</td>
<td>Tues (April 9)</td>
<td>6:30-9:30 PM</td>
<td>$15</td>
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<tr>
<td>ADULT Presidential Reception ticket</td>
<td>Wed (April 10)</td>
<td>7:00-10:00 PM</td>
<td>$60</td>
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<tr>
<td>CHILD Presidential Reception ticket</td>
<td>Wed (April 10)</td>
<td>7:00-10:00 PM</td>
<td>$25</td>
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<tr>
<td>DONATION of a Presidential Reception ticket for Resident or Student</td>
<td>Wed (April 10)</td>
<td>7:00-10:00 PM</td>
<td>$60</td>
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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.

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<th>MISCELLANEOUS</th>
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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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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.

<table>
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<th>PAYMENT &amp; POLICY</th>
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<td>□ Check (payable to ACOOG) □ Credit Card (complete below)</td>
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<td>Card #</td>
<td>Exp. Date</td>
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Refund Policy: Written cancellation of registration by March 20, 2013 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.
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

2012 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.

MEFACOOG would like to thank the former Corporate Partnership Council company for their past participation in the MEFACOOG CPC.

- NextGen Healthcare
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)

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<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>ZIP Code</td>
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<tr>
<td>Telephone (home)</td>
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<tr>
<td>Telephone (business)</td>
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Payment Information

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<td>Expiration date</td>
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<tr>
<td>Authorized signature</td>
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</table>

Acknowledgement Information

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

[ ] I wish to have our donation remain anonymous.

Signature
Date

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

MEFACOOG  
8851 Camp Bowie West, Suite 275  
Fort Worth, Texas 76116
Happy New Year from the ACOOG staff