“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.
Message from the Chair

Eric John Carlson, DO, FACOOG (Dist)

As an obstetrician-gynecologist and maternal-fetal medicine subspecialist I have spent my professional life working with a wide spectrum of pregnant patients. I’ve worked with healthy moms and sick moms. I’ve worked with moms with no recognizable risk factors for pregnancy complication, as well as with moms having significant comorbidity that substantially increases their risk for pregnancy mortality. I’ve seen both healthy and sick moms have uneventful pregnancies, as well as each having complicated pregnancies with tragic outcome. I have learned that pregnancy is unpredictable, and that it is imperative to have a healthy respect for the possibility for untoward processes to occur at a moment’s notice. To prepare for the unexpected requires continued learning. Continuing medical education is the basis for osteopathic continuous certification, and I’ve come to the realization that continuing medical education is ACOOG’s foundation for enhancing and promoting public safety.

The mission of the MEFACOOG is to foster continuing improvements in women’s healthcare. The goals of the MEFACOOG are to support continuing medical education, including undergraduate, graduate and postgraduate research programs. In addition, MEFACOOG supports faculty development and promotes the development of educational networks in women’s healthcare. My message is concerned specifically with graduate education…teaching our residents.

I am inspired by MEFACOOG’s commitment to continuing medical education and take this opportunity to promote MEFACOOG’s campaign to fund the resident reporter program, to impress on the members of the American College of Osteopathic Obstetricians & Gynecologists (ACOOG) how important this program is for our residents in training, and to implore all of us to support this program by donating to the MEFACOOG.

The resident reporter program promotes resident education by subsidizing the expenses of a resident to attend the annual ACOOG conference. Funding includes travel, lodging and conference registration. The resident is responsible for collaborating with one of the conference speakers to write an article based upon that speaker’s lecture. The article is written and edited in a journal “peer-review” format for ultimate publication in the MEFACOOG Annual Report. For many of the resident reporters this is their first opportunity to write a referenced, evidence-based article…as well as their first publication.

The Resident Reporter Program was initiated in 1996, and at that time was primarily funded by grants provided by the pharmaceutical industry. This enabled MEFACOOG to confer many resident reporter scholarships that otherwise wouldn’t have been able to be funded. The first class of resident reporter scholarships in 1996 included 21 residents who attended the annual conference in San Antonio, Texas. The

(Continued on Page 4)
largest group of resident reporters included 25 scholarship recipients who attended the ACOOG Annual Conference in Palm Springs, California, in 2007.

In 1997, I was fortunate to be one of the 21 resident reporter scholarship recipients included in the second year of the program. This enabled me to attend the ACOOG 64th Annual Conference in La Jolla, California. In collaboration with Timothy McKinney, MD, based upon his lecture, I wrote the following article:


This scholarship was a special opportunity and event in my life that I treasure, and still reflect on with appreciation and pride. I attended the conference lectures…I befriended the other resident reporters…I attended the Presidential Banquet…I reveled in the resorts’ opulent accommodations as a financially-strapped resident… the alumni from my medical school who attended the conference invited me to attend their alumni banquet, which was held on a moored yacht in San Diego—it made quite an impression on me…I met many ACOOG members attending the conference and conversed with them about their practices…I met with the ACOOG staff and leaders, which helped me gain insight with the inner workings of the College…I was able to publish an article for publication that I could list on my curriculum vitae…and I was even able to visit Mexico while in southern California.

Over the past 10 years subsidies have become less available secondary to funding constraints applied to the pharmaceutical industry regarding grants for medical education, and as a result the MEFACOOG has assumed the primary responsibility for funding the Resident Reporter Program. The number of resident reporter scholarships has dwindled significantly, and in 2016 there were only three resident reporter scholarships granted for the annual conference in Fort Lauderdale, Florida…and only five scholarships were awarded for the 2017 conference in Palm Springs, California. Over the past three years a temporary arrangement has been forged between the MEFACOOG and ACOOG to share the cost of subsidizing the resident reporter program to increase the number of scholarships awarded. In 2018 there were 9 scholarships awarded for the conference in Orlando, Florida, and there are currently 9 scholarship recipients for the 2019 conference in New Orleans, Louisiana.

There is now a fundraising campaign to raise awareness to the ACOOG members about the Resident Reporter Program with the goal that the MEFACOOG, through member donations and possibly with some select Industry funding, can once again grant significant numbers of resident reporter scholarships to benefit our residents. It is with this in mind that I ask all of our ACOOG colleagues to remember some act of kindness afforded to you during your training…and to please consider how impactful this kindness was at that time in your life, and then “pay it forward” by reaching out to the residents of our College—your future colleagues.
As the Chair of the Medical Education Foundation of the American College of Osteopathic Obstetricians & Gynecologists (MEFACOOG) I wish to recognize those resident reporters whose articles are published in this edition of the ACOOG Annual Report. They are:

Erica Zaworski, DO-Mercy Health, Muskegon, MI
“Collegiate, Elite, and Professional Female Athlete Health, Medical Care to the Retired Athlete”
-this article is based upon the lecture given by Dr. Rebeccah Rodriguez Regner.

Jillian Kurtz, DO-OUCOM/Doctors Hospital-Columbus, OH
“Transgender Fertility Options.”
-this article is based upon the lecture given by Jennifer Nichols, DO.

David Doyle, DO-Garden City Hospital-Township, MI
“Hybrid Fractional Laser Treatment of Genitourinary Syndrome in Menopause.”
-this article is based upon the lecture given by Michael Coyle, DO.

Donations to the MEFACOOG earmarked for the resident reporter program are entirely tax-deductible. The approximate full cost of one resident reporter scholarship is $2,500.00, but you can donate any amount toward the program. I also ask our members that when they register for any ACOOG Annual Conference, that they consider donating 1-4 tickets for medical student or resident conference attendees for admission to that conference’s “special event,” which is listed on the conference program, or you can inquire how to do this with on-site ACOOG staff.

So, it is with deep respect and humility, I ask that you please heed the call to support our residents in training by donating to the MEFACOOG for the Resident Reporter Program…and the next time you attend the ACOOG Annual Conference please take some time to meet with these amazing young doctors. You’ll be inspired by their goals, optimism and knowledge.

Sincerely yours,
Eric

Eric Carlson, DO, MPH, FACOOG (Dist.)
Resident Reporter Scholarship Recipient, 1997

Our MEFACOOG Board of Trustees members for 2018-2019:

Eric J. Carlson, DO..........................Chair
James J. Perez, DO..........................Vice-Chair
Kimberlee Perkins, DO......................Secretary Treasurer
David J. Boes, DO.............................Trustee
Lori A. Crites-Perez, RN, RDMS............Trustee
F. Miguel Fernandez, DO...........................Trustee
Stephanie L Fitzgerald, DO..................Trustee
Corinna Muller, DO............................Trustee
John Orris, DO.................................Trustee
Michael J. Geria, DO..........................Ex-Officio
Valerie Bakies Lile, CAE......................Executive Director
Message from the Executive Director

Valerie Bakies Lile, CAE, Executive Director

Dear Members of the Osteopathic OBGYN Community,

The Medical Education Foundation has welcomed many changes in 2018. New officers were Eric Carlson, DO-Chair, James Perez, DO-Vice Chair, and Kimberlee Perkins, DO-Secretary Treasurer. New trustees were David Boes, DO. Please welcome them and share your ideas.

I wish to express my appreciation for our new donors and those that consistently support the mission of the foundation on an annual basis. I would also like to highlight an extremely easy way for anyone to support MEFACOOG. Simply visit www.smile.amazon.com and select Medical Education Foundation of the Amer Coll of Osteopathic Ob-Gyn as your preferred charity. (search exactly as listed here)

Think about how many times a month, week, or even daily that you order on Amazon. If a majority of our 2,500 members make this simple change, it could really add up quickly!

Engaging young osteopathic physicians is more important than ever in this new GME environment. Another way we hope to impact education in the single accreditation transition is by continuing to recognize excellence in osteopathic research. MEFACOOG research awards and grants will provide the foundation for bringing osteopathic education principles to the greater OBGYN community and create scholarly activity opportunities for residency and fellowship programs.

Providing excellent educational experiences is our priority; beginning with medical students, through postgraduate training, continuing medical education, and osteopathic continuous certification.

Sincerest Thanks,

Valerie Bakies Lile, CAE, FACOOG(Hon)
Executive Director

As we look at MEFACOOG programs past and present, the Resident Reporter Scholarship Program alone has benefited more than 300 residents, many of whom have gone on to serve in ACOOG leadership roles. Continued support of the Resident Reporter program is the major fundraising campaign of MEFACOOG this year. If you are a former recipient, please consider paying forward this experience by investing in our future leaders.
Objectives: Hypertensive disease in pregnancy is the second leading cause of morbidity and mortality and a common clinical disorder in pregnant women. Population studies highlight the severity of the problem and estimate that 5-6000 maternal deaths a year worldwide are attributable to hypertensive disorders. Overall in the United States, these disorders affect as many as 5-10% of pregnancies. From 1998 to 2006, the number of hospitalizations for hypertensive disorders has increased from 67.2 per 1000 deliveries to 81.4 in 1000 deliveries. A trend that is matched by the increased risk of severe obstetric complications including acute renal failure, disseminated intravascular coagulation syndrome, ventilation complications, pulmonary edema, respiratory distress syndrome and cerebrovascular disorders related to eclampsia/preeclampsia as well as gestational and chronic hypertension.

After delivery and in the postpartum period, preeclampsia and other hypertensive disorders are known risk factors for future chronic metabolic and cardiovascular disease so repercussions and impacts are long-term and ongoing. Serious health consequences related to preeclampsia and other hypertensive disorders can persist and present days to even weeks after delivery. At the author’s institution, patients with hypertensive disorders were in general, appropriately diagnosed and managed in the antenatal setting and during labor and delivery. However, in the postpartum period, there was not an established standard of practice for scheduling follow up blood pressure checks prior to their postpartum visit at 2 or 6 weeks depending on the mode of delivery.

Material and Methods: The FADE model (Focus, Analyze, Develop and Execute) was followed for this project. The institution focused on inconsistent follow up postpartum blood pressure checks for patients with hypertensive disorders. The analysis included reviewing timeliness or existence of follow up appointments prior to implementation of the task force protocol. The development phase was a retrospective review of all inpatient labor and delivery patients with hypertensive disorders managed during this study period. Comparison of the timeliness to follow up blood pressure checks will assist in executing standardized policies for postpartum patients with hypertensive disorders.

A retrospective electronic healthcare record was performed using ICD-9 and ICD-10 codes to isolate hypertensive diagnoses admitted to Metro Health University of Michigan Health Hospital Childbirth Center from January 2013 through December 2016 for analysis of follow up postpartum blood pressure check prior to protocol implementation. Data from January 2017 through May 2017 was analyzed for follow up after protocol implementation. Charts for the study were based on inclusion and exclusion criteria.
Inclusion criteria included diagnoses for chronic hypertension in pregnancy, gestational hypertension, preeclampsia, preeclampsia with severe features, chronic hypertension with superimposed preeclampsia or chronic hypertension with superimposed preeclampsia with severe features and eclampsia, patients admitted to the labor and delivery floor for delivery and also included patients readmitted for any above diagnosis within six (6) weeks of delivery. Exclusion criteria included patients admitted for observation or antenatal care that did not deliver during their admission.

Results: Total sample of 394 postpartum patients 284 (72.1%) of total sample patients delivered before the implementation of the F/U protocol

- 110 (27.9%) delivered after protocol implementation. 91 (23.1%) of patients had a prior history of chronic, gestational hypertension or preeclampsia
- 299 (75.9%) patients had a new documented preeclampsia or hypertensive disorder diagnosis
- 96 (24.4%) patients were prescribed some form of antihypertensive medication during their pregnancy
- 60 (15.2%) patients received some form of magnesium during labor
- 81.8% of these patients had already received a new antihypertensive medication order
  - A smaller number of 18 (4.6%) of these patients receiving antihypertensive medications had some type of documented medication changes made during their inpatient stay

In the total sample
- 85 (21.6%) of patients had a scheduled postpartum follow up office visit
- Of the 299 patients with a new preeclampsia or hypertensive disorder diagnosis
- 69 (23.1%) presented for a blood pressure check within three to 14 days postpartum.

Pearson product-moment bivariate correlation procedures were completed between \{0,1\} postpartum follow up office visit events and other patient characteristic factors. Three pertinent statistically significant factors were found:

- Whether the patient’s delivery had occurred before, or after the implementation of the follow up protocol. (Pearson r = 0.403, n = 394, p < 0.001)
- Whether the patient had been started on any new type of antihypertensive medication (Pearson r = 0.170, n = 394, p = 0.001) It was notable that the correlation between a new antihypertensive medication order and whether patient had been prescribed some form of magnesium during their labor was highly collinear (Pearson r = 0.302, n = 394, p < 0.001).

In the predictive model using data from 391 sample mothers pre-protocol vs. post-protocol delivery status was found to be a significant predictor on scheduling of a postpartum follow up office visit. Receiving a new antihypertensive medication prescription during pregnancy was found to be a significant predictor on office visit events

Conclusions:

In the author’s institution, few women were scheduled for followed up blood pressure checks prior to the implementation of the preeclampsia task force recommendations. The
data show that pre-protocol vs post-protocol delivery status was a significant predictor of scheduling a postpartum follow up visit and also demonstrated improved compliance with scheduling within the recommended timeline for the clinical situation. Another strong predictor of follow up scheduling was if a patient had received a new anti-hypertensive medication in both the pre and post-protocol study groups, indicating that those at highest risk were followed appropriately and closely.

The author concludes that prior to implementation, follow up for postpartum blood pressure checks was inconsistent. Statistically significant results showed that the protocol did improve follow up and established much needed follow up timelines. Using real-time tracing now that the protocol is in place, the data can be used to improve continued compliance with the protocol recommendations. A reasonable goal would be to improve from 55% to 80% compliance of the policy with timely blood pressure checks by January of 2018.

Limitations to the protocol implementation could be assessed more in depth to see if further education is needed for staff members, physicians and patients alike. Ideally, additional data concerning other factors (e.g., maternal age, number of prior pregnancies, number of perinatal office visits (if any), etc.) could be inserted into predictive models to influence final study results.

A future direction of study could be to perform a prospective analysis to determine if this protocol is improving quality health indicators of maternal outcomes such as repeat admissions for preeclampsia on neonatal outcomes including decreasing rates of preterm delivery or length of stay in the NICU.

References


8. Vittinghoff, E, Shiboski, SC, Gildden DV, McCulloch CE. Regression Methods in Biostatistics:

MEFACOOG/Resident Reporter Scholarship Program

The Resident Reporter Program at the 85th Annual Conference in Orlando, FL received commendable contributions from the residents who participated. The top three papers given monetary awards and publication in the MEFACOOG Annual Report were:

**Erica Zaworski, DO** - Mercy Health - Muskegon, MI

“Collegiate, Elite, and Professional Female Athlete Health, Medical Care to the Retired Athlete”
Article based upon a lecture by lecture by: Dr. Rebeccah Rodriguez Regner.

**Jillian Kurtz, DO** - OUCOM/Doctors Hospital - Columbus, OH

“Transgender Fertility Options”
Article based upon a lecture by Jennifer Nichols, DO.

**David Doyle, DO** - Garden City Hospital - Township, MI

“Hybrid Fractional Laser Treatment of Genitourinary Syndrome in Menopause”
Article based upon a lecture by Michael Coyle, DO.

---

**Did You Know?**

Plan your research project now!

The MEFACOOG Research Grant of up to $5,000 is open to osteopathic physicians in AOA accredited programs, ACGME programs or any resident or fellow of an osteopathically recognized ACGME residency or fellowship training program.
Elite athletes dedicate their lives to their careers and the pursuit of the win. To achieve their exceptional level of athletic success, these young women eat, drink, sleep, train, race, and recover on a carefully strategized schedule. Regardless of reason for retirement from elite competition, unique needs exist which must be addressed to provide complete, comprehensive medical care to former collegiate, elite, and professional female athletes.

The lifestyle of the collegiate, elite, and professional athlete must be appreciated in order to fully understand medical care needs unique to the retired female athlete. Women at this level of competition have nearly every aspect of their lives scheduled around their sport. These women are supported by multidisciplinary teams ($^{11,12}$) who work tirelessly together toward the shared goal of maximizing athletic performance at critical events such as the Olympic Trials or international competition. Nutritionists guide diet choices, micronutrient supplementation, and ensure adequate energy is being consumed to meet the demands of a rigorous training schedule. Activities including mealtimes, workouts, schoolwork, recovery, conditioning, competitions, sleep, and travel are carefully planned to the minute by coaches or team managers. Physicians work alongside chiropractors, physical therapists, athletic trainers, and massage therapists to prevent and promptly address injuries and illness, prioritizing structural alignment for the maintenance of optimal function. Sports psychologists address the mental health and wellness of each athlete. This multifaceted team is critical for care of the elite athlete ($^{11,12}$), as achievement does not come without a cost. These women test the limits of their bodies on a daily basis, taking action to enhance their peak performance in ways which have potential to negatively impact their future bone health, reproductive health, and psyche.

Several common medical concerns faced by elite female athletes include unbalanced energy state, family planning and fertility considerations, and ensuring anti-doping compliance is maintained with any therapeutic regimen. Relative Energy Deficiency Syndrome of Sports, (RED-S), is a newly-recognized expanded conceptualization of the female athlete triad of low energy availability, oligomenorrhea/amenorrhea, and osteopenia/osteoarosporosis ($^{5,8}$). This expansion accounts for the adverse effects of energy deficiency which precede the menstrual abnormalities and osteopenia of the female athlete triad, encouraging earlier recognition and intervention. Screening with a 12-question screening tool for female athlete triad (LEAF-Q) recommended by the NIH is performed annually on elite athletes or more frequently if patient is at high risk or has a history of disordered eating habits. Further assessment and management then follows the International Olympic Committee’s RED-S clinical assessment tool (RED-S CAT), a red-/

(Continued on Page 12)
yellow-/ green-light approach for intervention and training modification\(^{(9,11)}\). Appropriate energy availability is vital for maximizing performance\(^{(11)}\). It is arguably even more important for protecting these young women from progression to the female athlete triad and other complications of a negative energy balance including depression, impaired immunity and recurrent infection, increased risk of injury, decreased muscle strength, and decreased endurance performance\(^{(5, 6, 8, 9, 11)}\). Low energy availability may occur either in the presence or absence of disordered eating habits. The provider must take time to obtain a detailed history of both diet and exercise behaviors. In females with disordered eating habits, “over-exercising” was the variable most strongly associated with suicidal behaviors” \(^{(12)}\).

Multiple biomarkers for low energy availability have been validated, including triiodothyronine (T3), cortisol, insulin-like growth factor-1 (IGF-1), and fasting glucose levels\(^{(6)}\). However, these are not currently incorporated into clinical screening practices for patients at-risk for low energy availability.

Female athletes may misunderstand the importance of regular menstruation as a signal of estrogen levels sufficient for bone health and future fertility. The limited window in a young woman’s life for significantly building lifelong bone density\(^{(7)}\) must be stressed to encourage her to consider beyond the short-term convenience of amenorrhea. The temptation to prescribe oral contraceptives to induce menstruation should be avoided\(^{(12)}\). Instead, increasing energy availability and weight gain should be emphasized as shifting toward a positive energy balance has proven the most sensitive indicator of return of menses in collegiate athletes \(^{(1, 12)}\). To accomplish this weight gain, protein and carbohydrate intake should be increased\(^{(1)}\), especially in liquid form\(^{(6)}\). Patients should be counseled on the risks of unintended pregnancy as ovulation may continue even in the presence of menstrual cycle dysfunction\(^{(12)}\). However, bleeding due to cyclic contraception withdrawal may provide a false sense of improved energy balance\(^{(12)}\). As such, athletes may be offered hormonal contraception for birth control purposes, but should not delay nutrition and exercise modification and contraceptives should not be used as a treatment for amenorrhea\(^{(12)}\).

Family planning and future fertility may not be on the forefront of the elite athlete’s mind at the peak of her career, but should not be overlooked. Conversations regarding the effect of negative energy balance and amenorrhea on future fertility should be incorporated into the care of the elite athlete. High-intensity exercise for at least 60 minutes/day is known to adversely affect ovulation in normal and underweight women, however the long-term effects of chronic ovulation suppression have not been well-studied\(^{(3)}\). If the patient desires contraception, specific performance-related side effects such as potential weight gain or impact on bone density associated with available contraception methods should be discussed.

Finally, when caring for the elite level athlete therapeutic regimens must always be compliant with WADA regulations to ensure avoidance of prohibited medications. If a banned substance is erroneously prescribed and taken by the athlete, the athlete must abstain from competition until the substance can be cleared.
“Collegiate, Elite, and Professional Female Athlete Health, Medical Care to the Retired Athlete”

(Continued from Page 12)

from her body. A comprehensive listing of banned substances is available at globaldro.org, and providers and patients alike should familiarize themselves with the website and both hold themselves accountable to verify new prescriptions are acceptable to avoid accidental exposure to banned substances. Additionally, fluoroquinolones must be avoided due to the intensity of training and increased risk of tendon rupture, which would be devastating to the career of a promising young elite athlete.

As athletes make the transition from the elite spotlight to retirement, they often maintain an active lifestyle with many of the same concerns as those actively engaging in elite competition, but now without the safety net of an extensive support team. It is in this period that Ob/Gyn providers have a profound opportunity to help these women navigate one of the most pivotal transition periods they will face in their lives. Instead of a singular goal of athletic performance consuming every facet of their daily lives, retired female athletes must seek balance in their lives as they begin to consider new careers, plan for childbearing or long-term contraception, and develop lifetime preventative healthcare strategies. As they learn to create their own schedules and manage their healthcare needs in the community beyond their training centers, retired athletes will benefit greatly from being provided with printed educational materials to read and a specific timeline with recommended routine screening and testing interventions. Their sports medicine physician, who previously filled the role of primary care physician (PCP), now steps into a consultant role and retired athletes must obtain primary care elsewhere in the community. For many women, their Ob/Gyn serves as their PCP which creates an opportunity for the Ob/Gyn to become a lifelong care provider for these retired female athletes. During this transition, PCPs are encouraged to embrace the opportunity to carefully explore the patient’s family history for risk factors for chronic disease which may have been previously overlooked on her pathway to elite athletic performance.

In treating the retired athlete, her former career and associated medical risks should be addressed. This may provide an opportunity for building rapport if her PCP can communicate their own interest in fitness and lifelong wellness. Depression screening should not be overlooked. “Post-Olympic blue” have been documented in limited, but consistent studies highlighting the need for mental health support as athletes transition back to a daily routine from “celebrity status”(4). Screening for disordered eating habits should be continued on an annual basis or more frequently if at increased risk. A thorough history of bone density testing and interventions should be obtained. Women who participate in non-weight bearing sports or those with decreased bone mineral density should incorporate resistance training and high-intensity interval training (HIIT) at least 2-3 days/ week(7,12). Bisphosphonates should not be prescribed to women of childbearing age without the specific recommendation of an endocrinologist due to the prolonged storage in bone and known teratogenic effects(7). However, supplemental calcium (1000-1300mg/d) and vitamin D3 (sufficient to maintain serum 25-hydroxyvitamin D between 32 and 50 ng/mL) are recommended(2,12). Additionally, in

(Continued on Page 14)
preliminary studies pulsed electromagnetic therapy shows promise for increasing bone mineral density in female athletes(2). Bone broth is a currently popular intervention which has yet to be supported by evidence. The American College of Sports Medicine (ACSM) recommends weight bearing endurance and plyometric exercises 3-5x / week and resistance exercises at moderate to high intensity 2-3x/ week, for 30-60 min/day total(7). These recommendation should be communicated to patients to encourage continued activity and avoid an unintentional transition to a morbidly sedentary lifestyle.

In conclusion, female athletes have unique medical needs and concerns which must be specifically addressed for health optimization, even after their retirement from elite-level competition. However, they tend to be a highly motivated, health-oriented demographic with whom the Ob/Gyn physician has the opportunity to build a close, long-term doctor/patient relationship. Through compassionate, holistic care these women will continue to have active, fulfilling lives far beyond their careers as elite athletes.

Reference:
5. Kroshus, E., J.D. DeFreese, and Z. Y. Kerr. Collegiate Athletic Trainers’ Knowledge of the Female Athlete Triad and Relative Energy Deficiency in Sport. 2018; J Athletic Train 53:1
Transgender issues are an increasingly relevant topic and have received quite a bit of media attention in the last few years. Laverne Cox appeared on the cover of TIME (the first openly transgender person to make it on the cover or win an Emmy). In 2015, Caitlyn Jenner came out in a TV interview and helped bring transgender issues to the forefront. Both ACOG and ASRM have published committee opinions stating that obstetrician-gynecologists should be prepared to assist in the medical care for these patients\(^1,2\). Dr. Nichols started her lecture polling the audience with the following question: **Have you ever seen or cared for a transgender patient?** 61% reported yes, and 39% reported no.

The term transgender describes anyone who lives their life identifying as and expressing a different gender than their biological sex assigned at birth. An estimated 1.4 million transgender people living in the US\(^3\). In 2014, Nerdwallet came out with the top friendliest LGBT communities. San Francisco is #1, Portland, Oregon #2 and Philadelphia, where Doctor Nichols practices ranks #6\(^4\). Dr. Nichols went on to poll the audience again: **If you have ever seen/cared for a transgender patient please click on your practice location.** Not surprisingly, most were in California or the East/NE United States.

While there are many individuals who identify as transgender, surveys have consistently shown that this patient population are either denied care or receive suboptimal care. A survey conducted in New York found that 51.9% of transgendered individuals were concerned they would be denied care, compared to only 20% of HIV positive individuals. 73% thought that medical personnel would treat them differently, compared to only 35% of HIV positive individuals and 28.5% of LGB people\(^5\). More than 70% have stated that they have experienced serious discrimination in health care\(^6\).
When caring for LGBTQ community it is important to understand who LGBTQ people are. The following are some important definitions:

- **Transgender**: an umbrella term, used by people whose gender identity and/or gender expression differs from what is typically associated with their sex assigned at birth.
- **Gender queer/non-binary**: people who do not identify with the binary of man/woman, and/or people who do not express gender in binary terms.
- **Cisgender**: People who identify as or live as a gender that is the same as what they were assigned at birth (people who are not transgender or gender queer).

The following definitions are from ACOG committee opinion.

- **Transsexual**: an individual who strongly identifies with the other sex and seeks hormones or gender-affirmation surgery or both to feminize or masculinize the body.
- **Crossdresser**: an individual who dresses in clothing of the opposite sex for reasons that include a need to express feminity or masculinity, artistic expression, performance or erotic pleasure, but do not identify as that gender.
- **Bigendered**: individuals who identify as both or alternatively male and female, as no gender or as a gender outside the male or female binary.
- **Intersex**: Individuals with a set of congenital variations of the reproductive system that are not considered typical for either male or female. This includes newborns with ambiguous genitalia, a condition that affects 1 in 2,000 in the US.

- **Female-to-Male**: Someone who was identified as female at birth but who identifies and portrays his gender as male. This term is often used after the individual has taken some steps to express his gender as male, or after medically transitioning through hormones or surgery FTM or Transman.
- **Male-to-Female**: someone who has identified as male at birth but who identifies and portrays her gender as female. This term is often used after the individual has taken some steps to express her gender as female, or after medically transitioning through hormones or surgery MTF or Transwoman.

The documented history of gender transformation goes back at least 80 years. In the 1940’s UK surgeon, Sir Harold Gillies, performed the first sex reassignment surgeries on transman, Michal Dillon and transwoman, Roberta Cowell. In the 1960’s, in London, John Randall created the first gender identity clinic. And, in 1972, Sweden became the first country in the world to allow legally changing your gender after sex reassignment surgery. Today in the US, 3-9 million people have had gender confirmation surgery. There are very few genital operations due to cost. In France, there is a waitlist up to 5 years.

Some controversy surrounds the issue of whether to label transgendered individuals as having gender dysphoria or gender identity disorder. Many transgender activists advocate removing gender identity disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Proponents argue that being labeled as having a “mental disorder” can be
The term *transition* refers to the time during which a person begins to live as or express themselves as the gender they identify with versus the one they were assigned at birth. It is a unique experience for each individual and is important to recognize that while many transgender people use hormones and/or desire surgery, others will not be interested in medical transition services. Have a conversation with your patients about their goals and desires during transition.

The term *Ally* is someone who supports the LGBTQ people in being treated equally, respectfully and with dignity. As health care professionals we have a responsibility to be allies to our patients, their families and our colleagues. Only 8% of Americans are personally acquainted with a transgender person. This means many of us might have difficulty with using the appropriate pronouns (she/her/hers vs He/Him/His vs They/Them/Their – gender neutral option). Some people may use pronouns that you may be unfamiliar with. Some people prefer to sue pronouns not associated with masculine or feminine terms, such “ze” or “hir.” If you don’t know, just ask!

- **Important Tip!**
  During your next meeting, try asking everyone to introduce themselves using their name and preferred pronoun. This will help staff get in the habit of asking for this information, including from patients.

ACOG recommends non-discriminatory practices to facilitate quality health care for transgendered individuals. Examples of non-discriminatory language include:

- Do you have a Significant Other? (instead of do you have a wife/husband)
- What gender do you identify as?
- What is your transition history?

In a survey of transgendered men, the majority of those surveyed (64%) were involved in a relationship and about half (54%) desired to have children. About a third (37.5%)
had considered freezing their germ cells. It is therefore recommended by most recent Standards of Care of the World Professional Association for Transgender Health to clearly discuss fertility and fertility preservation before any treatment. Studies have consistently shown that children of LGBT homes are well-adjusted, healthy, demonstrate secure attachment to their parents and do not demonstrate gender variant behaviors.

Case presentation:
29 yo G0 transman presents to Dr Nichols’ office desiring for his female partner to conceive using his eggs. He was on testosterone x12 years (since age 18). Uterus and ovaries still present. PMHx: healthy, prior HTN (no meds) PSHx: bilateral mastectomy (aka “Top” surgery) Meds: Testosterone injections weekly since age 18, managed by endocrinology Soc Hx: non-smoker, no drugs/EtOH use Plan: Donor Sperm, stop testosterone. Followed by IVF with plans to resume testosterone ASAP.

He stopped testosterone with a goal level <100 ng/dL and underwent ovarian stimulation with FSH/LH, followed by oocyte retrieval and fertilization with donor sperm. On day 5, the embryos were biopsied and for pre-implantation genetic screening. Out of 11 embryos, 5 were euploid and one was transferred into his Cis-Female partner. Unfortunately, this resulted in an early biochemical pregnancy.

Prior to transition, all transgender persons, including children and adolescents, should be counseled on the effects of medical and surgical intervention on their future fertility. Fertility preservation options are similar to options available to men and women undergoing gonadotoxic cancer therapies and include oocyte cryopreservation, ovarian tissue cryopreservation, sperm freezing, testicular tissue cryopreservation and embryo cryopreservation. In children who have initiated natal puberty, fertility preservation options include sperm and oocyte cryopreservation.

While testosterone therapy usually leads to an anovulatory state and amenorrhea, the effect of prolonged treatment with exogenous testosterone on ovarian function is unclear. Menses and ovulation will usually resume upon discontinuation of testosterone therapy and pregnancies have been reported in transmen following prolonged treatment with testosterone. In a survey of transgender men who became pregnant 80% resumed menses within 6 months of stopping testosterone and 70% used fertility medications. Obstetric outcomes were similar in testosterone and non-testosterone users. Many expressed a desire for more supportive resources and reported a lack of provider awareness and knowledge regarding fertility in transgender patients.

While assisted reproductive technology has greatly expanded family building options, they are rarely covered by insurance. Below are some estimates of what this would cost to the patient.

- Donor sperm: $500-900/vial
- Sperm banking and FDA testing: $1000
- Intrauterine Insemination: $400
- Oocyte/embryo cryopreservation: $7000-10,000
- In Vitro Fertilization: $10,000-12,000
- Pre-implantation Genetic Screening: $3000-5000
- Donor egg IVF: $7000-10,000 + FDA testing/carrying screening + IVF cost + meds: $25,000
- Gestational surrogacy + IVF: $50,000 – 100,000
To wrap up the lecture Dr Nichols asked everyone to type in their thoughts. The following words were provided: important, informative, enlightening, great, wow, empowering, needed, awesome, interesting, educational, compassionate, fabulous, different, real.

References:
7. WHY GENDER DYSPHORIA SHOULD NO LONGER BE CONSIDERED A MEDICAL DISORDER. It does more harm than good. Alice Dreger. October 18, 2013
MEFACOOG/Resident Reporter Scholarship Program

“Hybrid Fractional Laser Treatment of Genitourinary Syndrome in Menopause”

David Doyle, DO

Article based upon a lecture by Michael Coyle, DO

**Introduction:**
Genitourinary Syndrome in menopause (GSM) is a condition that affects many women. It is a frustrating condition for the patient, and can be a frustrating condition for a gynecologist to treat due to the nature of the condition and the somewhat limited treatment options that are currently available. Dr. Coyle’s lecture presents a new method for treating GSM using a hybrid fractional laser.

The vaginal epithelium is made up of non-keratinized stratified squamous epithelial cells. These cells make the tissue well suited for constant abrasion, and the layers can be easily sluffed off and replaced before the basal membrane is exposed. The vaginal epithelium is permeable to water, soluble proteins, cellular mediators of immune defense, and helps create a microenvironment that fosters normal vaginal flora while deterring invasive bacteria. The lamina propria of the vaginal tissue is a layer of dense irregular connective tissue that provides support and nutrition to the overlying epithelium. Its collagen fibers are key for compressibility and elasticity, and are also rich in blood vessels, lymphatic channels, and nerve endings. During reproductive years, estrogen induces the cells of the lamina propria to fill with glycogen which causes a thickening of the vaginal epithelium, which reaches maximum thickness right before ovulation. After menopause, the lack of estrogen causes glycogen stores to diminish, which then causes the epithelium to dry, thin, and become less elastic.

The reduction of estrogen production by the ovaries that eventually leads to the thinning and drying of the vaginal walls can also lead to inflammation, shortening and narrowing of the vagina, and a smooth appearance. These physical changes are what lead to the complaints that encompass GSM. The most common complaints are vaginal dryness, poor lubrication during intercourse, dyspareunia, orgasmic disorders, burning or irritation of the genital area, vaginal constriction, prolapse, incontinence, bleeding after intercourse, and frequent urinary tract infections. For many women, these issues significantly decrease their quality of life.

Current treatment options for GSM with medication fall into one of three categories; non-hormonal therapy, vaginal estrogen, and systemic estrogen therapy. Non-hormone therapies consist of vaginal lubricants and vagina moisturizers that can be purchased over the counter. Vaginal estrogens consist of rings, creams, suppositories, and tablets. They are considered safer than systemic estrogens due to their effects being mostly local acting. Systemic estrogens are administered orally, vaginally, or transdermal. Caution must be given to long term use due to possibility of developing breast or uterine cancer, and additional consideration must be given for women with cardiovascular disease or previous history of estrogen sensitive cancers.

The prevalence of vagina atrophy and associated dryness is approximately 50% in postmenopausal women, and as high as 61%
in breast cancer survivors. Sexual dysfunction, which includes dyspareunia, exceeds 30% in pre-menopausal women, 50% in post-menopausal women, and exceeds 60-70% in women that have urogynecologic issues and/or are breast cancer survivors. These issues are largely under reported and go untreated due to their sensitive and private nature.

Laser therapy works by using thermal energy to break the intermolecular bonds of water inside the tissue that is being targeted. The proposed method of action for laser therapy of the skin and mucosa has three different effects. It causes the immediate contraction of collagen, immediate collagen remodeling and elasticity, and causes long term stimulation in producing new collagen. In reference to using laser therapy on the vagina, the laser causes thermal injury to the vaginal epithelium, which stimulates thickening with glycogen filled cells, which increases vaginal lubrication and decreases pain with intercourse. In similar fashion, thermal injury by the laser directed at the lamina propria increases the collagen density, elastin, and causes neovascularization, which then results in increased vaginal tightness, elasticity, sensation, and improved urinary control.

There were two types of fractional lasers that were discussed in the lecture. The first was fractional erbium YAG laser. This laser is very efficient for ablation, and has been used effectively to treat stress urinary incontinence and vaginal laxity without and adverse effects. One draw back to this laser is that it is considered a long pulse laser and lacks the ability for deep penetration. This requires pulse stacking which increases treatment time.

The second type of fractional laser that was discussed is the CO2 laser. This laser has been shown to effectively treat atrophic vaginitis, dyspareunia, and stress urinary incontinence. Draw backs to this laser are the lack of depth of penetration that may not appropriately stimulate the lamina propria, and the probe works by manual rotation, which causes a greater margin of error due to lack of control for depth and percent of surface treated.

Hybrid fractional laser uses two different wavelengths to stimulate the tissue it is being directed at. The Erbium wavelength is used for ablation of the tissue, and the diode wavelength is used for coagulation. This combination of wavelengths works together to effectively stimulate the tissue in different ways to promote healing and regeneration. This also allows for different controls so that the treatment can be customized to each individual patient, and it also allows the treatment settings to be adjusted as successive treatments may not require the same intensity. The addition of a single use dilator to the laser assembly has allowed for the expansion of the vaginal canal which increases the treatment area. It also means the laser is not directly touching the tissue, which increases effectiveness and is more hygienic.

In his lecture, Dr. Coyle shared some of the research that he and his colleagues from around the country are in the process of completing regarding hybrid fractional use for the treatment of GSM. The study enrolled 50 peri-menopausal and post-menopausal patients, ages ranging from 40-70, from 5 different centers that underwent 3 hybrid fractional laser treatments 4 weeks apart. The average of age of the patients enrolled in the study was 58 +/- 7 years. Selection criteria for admission to the study were 2 self-reported symptoms of GSM. Results have shown significant improvement in sexual desire, arousal, satisfaction, orgasm, vaginal lubrication, and decrease pain at 1,
“Hybrid Fractional Laser Treatment of Genitourinary Syndrome in Menopause”

(Continued from Page 21)

3, and 6 month follow up visits. The results have also shown significant histologic improvements in maturation of the vaginal tissue. One specific example from a patient in the study showed an initial epithelial thickness of 0.23mm before treatment, and 0.35mm after 3 months of treatment. Adverse events that have been associated with this study have been reported, and are considered to be very minimal.

Perhaps even more so than GSM, lichen sclerosis is an incredibly difficult and troublesome condition to treat. Unlike GSM, lichen sclerosis is of unknown etiology, but causes similar pain, inflammation, and discomfort to the female genitalia. As physicians, we are often times limited to steroidal treatments that have a low success rate. At the end of his lecture, Dr. Coyle shared some of his current research on the same technology in the treatment lichen sclerosis. Patients that receive this treatment experience slightly more discomfort than those receiving the treatment for GSM, and this is primarily due to the anatomical location of the treatment. Preliminary results have shown similar success as with treatment of GSM. The physical manifestations of the condition are noticeably reduced at each successive treatment session, and histologically the scleroused tissue has been noted to be lacking scar tissue and is even showing regenerating healthy tissue. The study is its early stages, but is very promising in treating this challenging condition.

Dr. Coyle’s lecture on GSM and his current research in the treatment of GSM appears to be a giant step forward in how this condition is treated. This new approach to the treatment of GSM has already shown to have significantly improved the lives of the patients that are treated with this modality. Hopefully, the research will continue to prove these early results and this will eventually become a mainstream treatment option that can improve quality of life for suffering patients, and provide another method of treatment that physicians can use to combat this condition.

References:
The Medical Education Foundation relies 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, 2018. 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 Prostgraduate Research Grant encouraging research in osteopathic OB/GYN residency and fellowship programs.

The 85th Annual Conference of the ACOOG hosted four ongoing funded lectureships. The Barbara Hawkes Memorial Lecture; also the college’s first endowment memorial lectureship, was given by Saundra Wall Williams, EdD. The MEFACOOG Distinguished Lecture was presented by Tiffany Lowe-Payne, DO. The Distinguished Fellows Lecture was presented by Mark Levine, MD. The 2017 Past President’s Honorary Lectureship was presented by Stuart Rothenberg, MD.

The 2018 Fall Conference included the 2018 Past President’s Honorary Lectureship, by Lisa Thiel, DO.

The National Student Society of the ACOOG met for the tenth time in Fort Worth, Texas at the ACOOG Fall Conference. 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, 2018</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Corporate Contributions $15,000</td>
</tr>
<tr>
<td></td>
<td>Individual Contributions $51,276</td>
</tr>
<tr>
<td></td>
<td>Interest &amp; Dividends $18,013</td>
</tr>
<tr>
<td></td>
<td>Realized &amp; Unrealized $(46,482)</td>
</tr>
<tr>
<td></td>
<td>In-Kind Contributions $44,256</td>
</tr>
<tr>
<td></td>
<td>Fundraising Income $690</td>
</tr>
<tr>
<td></td>
<td>Restrictions Satisfied $15,990</td>
</tr>
<tr>
<td>Total Support</td>
<td>$98,743</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th>$128,107</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Services</td>
<td>$28,433</td>
</tr>
<tr>
<td>Support Services</td>
<td>$99,676</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$128,107</td>
</tr>
</tbody>
</table>

Net Assets, Beginning of Year $618,543
Change in Net Assets $573,187
Net Assets, End of Year $573,187

### Statement of Financial Position

<table>
<thead>
<tr>
<th>Year Ended December 31, 2018</th>
<th>Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current Assets</td>
</tr>
<tr>
<td></td>
<td>Cash and Equivalents $36,738</td>
</tr>
<tr>
<td></td>
<td>Investments $536,106</td>
</tr>
<tr>
<td></td>
<td>Due from ACOOG $343</td>
</tr>
<tr>
<td>Total Assets</td>
<td>$573,187</td>
</tr>
</tbody>
</table>

Liabilities and Net Assets

<table>
<thead>
<tr>
<th>Accounts Payable $0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to ACOOG $0.00</td>
</tr>
<tr>
<td>Deferred Revenue $0.00</td>
</tr>
<tr>
<td>Net Assets $573,187</td>
</tr>
<tr>
<td>Total Liabilities and Net Assets $573,187</td>
</tr>
</tbody>
</table>
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, 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 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 Bakies Lile, CAE by email to vblile@acoog.org or by fax to (817)377-0439 by February 1st.
ACOOG Calendar of Events

2019 Fall Conference
October 3-6, 2019
Hyatt Regency Downtown Columbus, OH

87th Annual Conference
March 29-April 2, 2020
Hilton La Jolla Torrey Pines
San Diego, CA

88th Annual Conference
April 11-16, 2021
Hyatt Regency Coconut Point
Bonita Springs, FL

89th Annual Conference
April 3-8, 2022
Grand Hyatt San Antonio Riverwalk
San Antonio, TX

90th Annual Conference
March 26-31, 2023
Manchester Grand Hyatt
San Diego, CA
# Membership Donations
Cumulative October 1999 through December 31st, 2018

<table>
<thead>
<tr>
<th>CHAIRMAN LEVEL $50,000+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eric Carlson, DO *</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIAMOND LEVEL $40,000+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patricia Bauer</td>
</tr>
<tr>
<td>Catherine Bernardini, DO</td>
</tr>
<tr>
<td>Glenn Bigby IV, D.O.</td>
</tr>
<tr>
<td>Bernard D. Billman, DO</td>
</tr>
<tr>
<td>Annette Bombrrys, DO</td>
</tr>
<tr>
<td>Joseph Bonanno, DO</td>
</tr>
<tr>
<td>Joseph Bottalico, DO</td>
</tr>
<tr>
<td>Kathie K. Boyd, DO</td>
</tr>
<tr>
<td>Rainna Brazil, DO</td>
</tr>
<tr>
<td>Draxon Burch, DO *</td>
</tr>
<tr>
<td>Richard J. Burns, Jr., DO</td>
</tr>
<tr>
<td>Dennis M. Carden, DO</td>
</tr>
<tr>
<td>Sharon K. Cathcart, DO</td>
</tr>
<tr>
<td>Stuart Chesky, DO</td>
</tr>
<tr>
<td>Randy Collins, DO</td>
</tr>
<tr>
<td>Michael J. Coyle, DO</td>
</tr>
<tr>
<td>Zane G. Craig, DO</td>
</tr>
<tr>
<td>Lori Crites-Perez, RN, RDMS</td>
</tr>
<tr>
<td>Stephanie Cunningham, DO</td>
</tr>
<tr>
<td>Stephen A. D’Abreo, DO</td>
</tr>
<tr>
<td>Raymond W. Deiter, DO</td>
</tr>
<tr>
<td>Andrew Demasi, DO</td>
</tr>
<tr>
<td>Gary L. Doublestein, DO</td>
</tr>
<tr>
<td>Rebecca Dresser, J.D.</td>
</tr>
<tr>
<td>Sherman Dunn, DO</td>
</tr>
<tr>
<td>Stephen F. Dyke, DO</td>
</tr>
<tr>
<td>Fernando M. Fernandez, DO *</td>
</tr>
<tr>
<td>Salvatore Finazzo, DO</td>
</tr>
<tr>
<td>William J. Gall, DO</td>
</tr>
<tr>
<td>Norman Gan, MD</td>
</tr>
<tr>
<td>Lisa Gilbert, DO</td>
</tr>
<tr>
<td>Craig Glines, DO</td>
</tr>
<tr>
<td>Kenneth P. Glinter, DO</td>
</tr>
<tr>
<td>Becky Graham, DO *</td>
</tr>
<tr>
<td>Robert Gray</td>
</tr>
<tr>
<td>John R. Guerra, DO</td>
</tr>
<tr>
<td>Kurt D. Harrison, DO</td>
</tr>
<tr>
<td>Kathleen Heer, DO</td>
</tr>
<tr>
<td>William Ashley Hood, DO</td>
</tr>
<tr>
<td>Teresa Ann Hubka, DO</td>
</tr>
<tr>
<td>Rachael Humphrey, MD</td>
</tr>
<tr>
<td>Jeanie Huynh, DO</td>
</tr>
<tr>
<td>Brad Irving, DO *</td>
</tr>
<tr>
<td>Mohammed Kabir, DO</td>
</tr>
<tr>
<td>Howard K. Kaufman, DO</td>
</tr>
<tr>
<td>Karen Kemp-Glock, DO</td>
</tr>
<tr>
<td>Nasreen M. Khan, DO</td>
</tr>
<tr>
<td>Marilyn J. Kindig, DO</td>
</tr>
<tr>
<td>Joseph Kingsbury, DO</td>
</tr>
<tr>
<td>Peter Konchak, DO</td>
</tr>
<tr>
<td>Jeffrey C. Kosczucz, DO</td>
</tr>
<tr>
<td>Sue Leasure, RN</td>
</tr>
<tr>
<td>Robert S. Lee, DO</td>
</tr>
<tr>
<td>Marty Levine, DO</td>
</tr>
<tr>
<td>Steven Lown, DO</td>
</tr>
<tr>
<td>Cynthia A. Mace-Motta, DO</td>
</tr>
<tr>
<td>John J. Maceluch, DO</td>
</tr>
<tr>
<td>Douglas Neal MacGregor, DO</td>
</tr>
<tr>
<td>Scott MacGregor, DO</td>
</tr>
<tr>
<td>Jewell E. Malick, DO</td>
</tr>
<tr>
<td>Carol Markiewicz, DO</td>
</tr>
<tr>
<td>Steve McCaray, MD</td>
</tr>
<tr>
<td>Thomas E. McCurdy, MD</td>
</tr>
<tr>
<td>Michael McKenna, MD</td>
</tr>
<tr>
<td>Jeannine M. McMahon, DO</td>
</tr>
<tr>
<td>Melissa McNett</td>
</tr>
<tr>
<td>Craig L. Meechelke, DO</td>
</tr>
<tr>
<td>Mark E. Melton, DO</td>
</tr>
<tr>
<td>Joseph L. Milio, DO</td>
</tr>
<tr>
<td>Todd A. Moyerbraillean, DO *</td>
</tr>
<tr>
<td>Moses T. Mukai, Jr., DO *</td>
</tr>
<tr>
<td>Corrina Muller, DO</td>
</tr>
<tr>
<td>Beth H. Mulvihill, DO</td>
</tr>
<tr>
<td>Arax Nazarian, DO *</td>
</tr>
<tr>
<td>Fred Nichols, DO</td>
</tr>
<tr>
<td>Jennifer Nichols, DO</td>
</tr>
<tr>
<td>Mary O’Connor, J.D.</td>
</tr>
<tr>
<td>Kaaren Olesen, DO</td>
</tr>
<tr>
<td>Betty Orange, DO</td>
</tr>
<tr>
<td>John J. Orris, DO *</td>
</tr>
<tr>
<td>Tracy Papa, DO</td>
</tr>
<tr>
<td>Jennifer L. Papp, DO *</td>
</tr>
<tr>
<td>Trisha Parks, DO</td>
</tr>
<tr>
<td>Kimberly Perkins, DO *</td>
</tr>
<tr>
<td>Jerry Polsinelli, DO</td>
</tr>
<tr>
<td>Douglas E. Pugmire, DO</td>
</tr>
<tr>
<td>Marydonna Ravasio, DO</td>
</tr>
<tr>
<td>Frank Raymond, DO</td>
</tr>
<tr>
<td>Edward O. Reece II, DO</td>
</tr>
<tr>
<td>Joel B. Rose, DO</td>
</tr>
<tr>
<td>George W. Russian, DO</td>
</tr>
<tr>
<td>Mary Beth Sandin</td>
</tr>
<tr>
<td>Larry E. Seals, DO</td>
</tr>
<tr>
<td>Stacy L. Sensor, DO</td>
</tr>
<tr>
<td>Erik J. Smith, DO</td>
</tr>
<tr>
<td>William Stanley, Jr., DO</td>
</tr>
<tr>
<td>John S. Stevens Jr., DO</td>
</tr>
<tr>
<td>Hovik Taymoorian, DO</td>
</tr>
<tr>
<td>Mary Testa, DO</td>
</tr>
<tr>
<td>Melicen Tettambel, DO</td>
</tr>
<tr>
<td>Lisa Thiel, DO</td>
</tr>
<tr>
<td>Lorie A. Thomas, DO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SAPPHIRE LEVEL $30,000+</th>
</tr>
</thead>
<tbody>
<tr>
<td>David L. Wolf, DO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMERALD LEVEL $20,000+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patricia F. Arnett, DO</td>
</tr>
<tr>
<td>Anita L. Showalter, DO *</td>
</tr>
<tr>
<td>Ernest Thompson</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLATINUM LEVEL $10,000+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patricia F. Arnett, DO</td>
</tr>
<tr>
<td>Anita L. Showalter, DO *</td>
</tr>
<tr>
<td>Ernest Thompson</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOLD LEVEL $5,000+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patricia F. Arnett, DO</td>
</tr>
<tr>
<td>Anita L. Showalter, DO *</td>
</tr>
<tr>
<td>Ernest Thompson</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SILVER LEVEL $1,000+</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACOOG *</td>
</tr>
<tr>
<td>David S. Adelstein, DO</td>
</tr>
<tr>
<td>Thomas Alderson, DO</td>
</tr>
<tr>
<td>Roxanna Aldstadt, DO</td>
</tr>
<tr>
<td>Ronald E. Ayres, DO</td>
</tr>
<tr>
<td>Monica Bachamp, DO</td>
</tr>
<tr>
<td>Valerie S. Bakies-Life, CAE</td>
</tr>
<tr>
<td>Patricia Bauer</td>
</tr>
<tr>
<td>Catherine Bernardini, DO</td>
</tr>
<tr>
<td>Glenn Bigby IV, D.O.</td>
</tr>
<tr>
<td>Bernard D. Billman, DO</td>
</tr>
<tr>
<td>Annette Bombrrys, DO</td>
</tr>
<tr>
<td>Joseph Bonanno, DO</td>
</tr>
<tr>
<td>Joseph Bottalico, DO</td>
</tr>
<tr>
<td>Kathie K. Boyd, DO</td>
</tr>
<tr>
<td>Rainna Brazil, DO</td>
</tr>
<tr>
<td>Draxon Burch, DO *</td>
</tr>
<tr>
<td>Richard J. Burns, Jr., DO</td>
</tr>
<tr>
<td>Dennis M. Carden, DO</td>
</tr>
<tr>
<td>Sharon K. Cathcart, DO</td>
</tr>
<tr>
<td>Stuart Chesky, DO</td>
</tr>
<tr>
<td>Randy Collins, DO</td>
</tr>
<tr>
<td>Michael J. Coyle, DO</td>
</tr>
<tr>
<td>Zane G. Craig, DO</td>
</tr>
<tr>
<td>Lori Crites-Perez, RN, RDMS</td>
</tr>
<tr>
<td>Stephanie Cunningham, DO</td>
</tr>
<tr>
<td>Stephen A. D’Abreo, DO</td>
</tr>
<tr>
<td>Raymond W. Deiter, DO</td>
</tr>
<tr>
<td>Andrew Demasi, DO</td>
</tr>
<tr>
<td>Gary L. Doublestein, DO</td>
</tr>
<tr>
<td>Rebecca Dresser, J.D.</td>
</tr>
<tr>
<td>Sherman Dunn, DO</td>
</tr>
<tr>
<td>Stephen F. Dyke, DO</td>
</tr>
<tr>
<td>Fernando M. Fernandez, DO *</td>
</tr>
<tr>
<td>Salvatore Finazzo, DO</td>
</tr>
<tr>
<td>William J. Gall, DO</td>
</tr>
<tr>
<td>Norman Gan, MD</td>
</tr>
<tr>
<td>Lisa Gilbert, DO</td>
</tr>
<tr>
<td>Craig Glines, DO</td>
</tr>
<tr>
<td>Kenneth P. Glinter, DO</td>
</tr>
<tr>
<td>Becky Graham, DO *</td>
</tr>
<tr>
<td>Robert Gray</td>
</tr>
<tr>
<td>John R. Guerra, DO</td>
</tr>
<tr>
<td>Kurt D. Harrison, DO</td>
</tr>
<tr>
<td>Kathleen Heer, DO</td>
</tr>
<tr>
<td>William Ashley Hood, DO</td>
</tr>
<tr>
<td>Teresa Ann Hubka, DO</td>
</tr>
<tr>
<td>Rachael Humphrey, MD</td>
</tr>
<tr>
<td>Jeanie Huynh, DO</td>
</tr>
<tr>
<td>Brad Irving, DO *</td>
</tr>
<tr>
<td>Mohammed Kabir, DO</td>
</tr>
<tr>
<td>Howard K. Kaufman, DO</td>
</tr>
<tr>
<td>Karen Kemp-Glock, DO</td>
</tr>
<tr>
<td>Nasreen M. Khan, DO</td>
</tr>
<tr>
<td>Marilyn J. Kindig, DO</td>
</tr>
<tr>
<td>Joseph Kingsbury, DO</td>
</tr>
<tr>
<td>Peter Konchak, DO</td>
</tr>
<tr>
<td>Jeffrey C. Kosczucz, DO</td>
</tr>
<tr>
<td>Sue Leasure, RN</td>
</tr>
<tr>
<td>Robert S. Lee, DO</td>
</tr>
<tr>
<td>Marty Levine, DO</td>
</tr>
<tr>
<td>Steven Lown, DO</td>
</tr>
<tr>
<td>Cynthia A. Mace-Motta, DO</td>
</tr>
<tr>
<td>John J. Maceluch, DO</td>
</tr>
<tr>
<td>Douglas Neal MacGregor, DO</td>
</tr>
<tr>
<td>Scott MacGregor, DO</td>
</tr>
<tr>
<td>Jewell E. Malick, DO</td>
</tr>
<tr>
<td>Carol Markiewicz, DO</td>
</tr>
<tr>
<td>Steve McCaray, MD</td>
</tr>
<tr>
<td>Thomas E. McCurdy, MD</td>
</tr>
<tr>
<td>Michael McKenna, MD</td>
</tr>
<tr>
<td>Jeannine M. McMahon, DO</td>
</tr>
<tr>
<td>Melissa McNett</td>
</tr>
<tr>
<td>Craig L. Meechelke, DO</td>
</tr>
<tr>
<td>Mark E. Melton, DO</td>
</tr>
<tr>
<td>Joseph L. Milio, DO</td>
</tr>
<tr>
<td>Todd A. Moyerbraillean, DO *</td>
</tr>
<tr>
<td>Moses T. Mukai, Jr., DO *</td>
</tr>
<tr>
<td>Corrina Muller, DO</td>
</tr>
<tr>
<td>Beth H. Mulvihill, DO</td>
</tr>
<tr>
<td>Arax Nazarian, DO *</td>
</tr>
<tr>
<td>Fred Nichols, DO</td>
</tr>
<tr>
<td>Jennifer Nichols, DO</td>
</tr>
<tr>
<td>Mary O’Connor, J.D.</td>
</tr>
<tr>
<td>Kaaren Olesen, DO</td>
</tr>
<tr>
<td>Betty Orange, DO</td>
</tr>
<tr>
<td>John J. Orris, DO *</td>
</tr>
<tr>
<td>Tracy Papa, DO</td>
</tr>
<tr>
<td>Jennifer L. Papp, DO *</td>
</tr>
<tr>
<td>Trisha Parks, DO</td>
</tr>
<tr>
<td>Kimberly Perkins, DO *</td>
</tr>
<tr>
<td>Jerry Polsinelli, DO</td>
</tr>
<tr>
<td>Douglas E. Pugmire, DO</td>
</tr>
<tr>
<td>Marydonna Ravasio, DO</td>
</tr>
<tr>
<td>Frank Raymond, DO</td>
</tr>
<tr>
<td>Edward O. Reece II, DO</td>
</tr>
<tr>
<td>Joel B. Rose, DO</td>
</tr>
<tr>
<td>George W. Russian, DO</td>
</tr>
<tr>
<td>Mary Beth Sandin</td>
</tr>
<tr>
<td>Larry E. Seals, DO</td>
</tr>
<tr>
<td>Stacy L. Sensor, DO</td>
</tr>
<tr>
<td>Erik J. Smith, DO</td>
</tr>
<tr>
<td>William Stanley, Jr., DO</td>
</tr>
<tr>
<td>John S. Stevens Jr., DO</td>
</tr>
<tr>
<td>Hovik Taymoorian, DO</td>
</tr>
<tr>
<td>Mary Testa, DO</td>
</tr>
<tr>
<td>Melicen Tettambel, DO</td>
</tr>
<tr>
<td>Lisa Thiel, DO</td>
</tr>
<tr>
<td>Lorie A. Thomas, DO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BRONZE LEVEL $500-999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa M. Allen, DO</td>
</tr>
<tr>
<td>William Anderson II, DO</td>
</tr>
<tr>
<td>Mark Barbee</td>
</tr>
<tr>
<td>Lori Barker, Esq</td>
</tr>
<tr>
<td>Terrance J. Barrett, DO</td>
</tr>
<tr>
<td>Corinne Bell, DO</td>
</tr>
<tr>
<td>David R. Boesier, DO</td>
</tr>
<tr>
<td>Robert Bonaminio, DO</td>
</tr>
<tr>
<td>Nancy J. Bucy, DO</td>
</tr>
<tr>
<td>Lisa A. Bukovac, DO</td>
</tr>
<tr>
<td>Debra Carson, DO</td>
</tr>
<tr>
<td>Kenneth H. Chen, DO</td>
</tr>
<tr>
<td>Christoff Coutifardous, DO</td>
</tr>
<tr>
<td>Sylvia S. Cruz, DO</td>
</tr>
<tr>
<td>George Davis, DO</td>
</tr>
<tr>
<td>Dipak Delvadia, DO</td>
</tr>
<tr>
<td>Mark DeMasi, DO</td>
</tr>
<tr>
<td>Marianne DiGiovanni, DO</td>
</tr>
<tr>
<td>Walter Dodard, DO</td>
</tr>
<tr>
<td>Todd Dreuxel, DO</td>
</tr>
<tr>
<td>William Driscoll, DO</td>
</tr>
<tr>
<td>John J. Eberhart</td>
</tr>
<tr>
<td>Stephanie Fitzgerald, DO *</td>
</tr>
<tr>
<td>Judith Florido, DO</td>
</tr>
<tr>
<td>Kevin L. Foster, DO</td>
</tr>
<tr>
<td>Ferio J. Francois, DO</td>
</tr>
<tr>
<td>Lisa A. Fritz, DO</td>
</tr>
<tr>
<td>Regen Gallagher, DO</td>
</tr>
<tr>
<td>Joseph Gambone, DO</td>
</tr>
<tr>
<td>Regen Gallagher, DO</td>
</tr>
<tr>
<td>Carol Markiewicz, DO</td>
</tr>
<tr>
<td>Jewell E. Malick, DO</td>
</tr>
<tr>
<td>Scott MacGregor, DO</td>
</tr>
<tr>
<td>Edward O. Reece II, DO</td>
</tr>
<tr>
<td>Joel B. Rose, DO</td>
</tr>
<tr>
<td>George W. Russian, DO</td>
</tr>
<tr>
<td>Mary Beth Sandin</td>
</tr>
<tr>
<td>Larry E. Seals, DO</td>
</tr>
<tr>
<td>Stacy L. Sensor, DO</td>
</tr>
<tr>
<td>Erik J. Smith, DO</td>
</tr>
<tr>
<td>William Stanley, Jr., DO</td>
</tr>
<tr>
<td>John S. Stevens Jr., DO</td>
</tr>
<tr>
<td>Hovik Taymoorian, DO</td>
</tr>
<tr>
<td>Mary Testa, DO</td>
</tr>
<tr>
<td>Melicen Tettambel, DO</td>
</tr>
<tr>
<td>Lisa Thiel, DO</td>
</tr>
<tr>
<td>Lorie A. Thomas, DO</td>
</tr>
</tbody>
</table>

*Thank you for moving up a level

**BOLD** reflects first tim donor in 2018

(Continued on Page 29)
Membership Donations

(Continued from Page 29)

Joseph Johnson, DO
Kenneth Johnson, DO
Gloria Jue, DO *
Peter E. Kaczkosky, DO
Andre Kasko, DO
Denise Kazmierzak, DO
Talaksoon Khademi, DO
Rhonda Kobold, DO
La Quinta Resort & Club
Michele J. Lapayowker, DO
Thomas Lee, DO
David Lenzisky, DO
Eav Lim, DO
James Lindeinulder, DO
Tracey S. Linden, DO
Simon Lubin, DO
Louis Manara, DO *
Richard Markwood, DO
Ranette Marshall, DO
Karen Matus
Eric Connor Mayfield, DO
Timothy McGuinness, DO
Dennis William McNally, DO
Stephen P. Meese, DO
Cynthia Morris, DO
Samer Mossallam, DO
Mark Neerhof, DO
Samer Mossallem, DO
Michael Sobel, DO
Jerrold M. Snyder, DO
Guy W. Sneed, DO
James Smith, DO
Steven Sheppard, DO
Cynthia Smith, DO
Howard Spence, DO
* Thank you for moving up a level

BOLD reflects first timer donor in 2018

* Thank you for moving up a level

Scott Springer, DO
Suzanne Steinbaum, DO
Michael Stokes, J.D.
Emmie Strassberg, DO
David Stroh, DO
Berm Studios
Michelle Style, DO
Patricia C. Summers, DO
Scott C. Syndergaard, DO
Takeko Takeshige, DO
Robert Thiele, DO *
Robert L. Tripp, DO *
Rick A. Visci, DO
Robert G. Walsh, DO
Laurel A. Walton, DO
Bonita Wang, DO
Kimberly Warren, DO
Michael Weiss, DO
Benjamin White, DO
Patricia Wilhelm, DO

CENTURY LEVEL $100-499

Darren Adams, DO
Diane A. Adams, D.O.
Ahmad I. Al-Jerdi, DO
Lauren Allen, DO *
Mark A. Almalifano, DO
Shahin Arnett, DO
Amy Articolo, DO
Gyasi Askia, DO
Diane Aslanis, DO
Terry King Badzinski, DO
Manuel Ballas, DO
Tabatha Barber, DO
Daniel R Barkus, DO
Bill Barnes, DO
Katherine Barrett-Avendano, DO
Melissa Bayne, DO
Michelle L. Beecher, DO
Shawneece Beeson, DO
Karen Benz, DO
Armando Bernal, DO
William Beuchat, DO
Peter Bianco, DO
David E. Biats, DO
Janelle Blickensderfer, DO
Maria A. Bohi-Witchey, DO
Carrie Bolander, DO
Teresa Borchers, DO
Sylvia Botros-Brey, DO
Alisa Bowersock, DO
Carolyn A. Brainwaite
Jessica Brannham, DO
Deanna Brasile, DO
Maryanne Freeman Brndjar, DO
Douglas L. Brown, DO
Israel K. Brown, DO
Catherine Browne, DO
Lorna A. Brudie, DO
Christopher Buckley, DO
Deanna Bullaro-Anderer, DO
Gerald V. Burr

Peter J. Cabala, DO
Daniel J. Cain, DO
Joni S. Canby, DO
Sheila Carnett, DO
Bruce Carnivale, DO
Lony Castro, MD
Nicole Cataldi, DO
Carrie Champine, DO
Wallace Chaplain Jr., DO
Craig W. Chandler, DO
Dudley J. Chapman, DO
Lisa Chobanian
Max A. Clark, DO
Kenneth R. Clayton, Jr., DO
Gerard Cleary, D.O
Richard J. Colman, DO
Thomas Connolly, DO
Fred Couts, DO
Rebecca Crockett, DO
Michelle M. D’Almeida, DO
Jonette D’Amato, DO
Steven Daube, DO
Lee W. Davis, DO
Mark Day, DO
Melissa L. Delaney, DO
Michael DeNardis, DO
Melinda DeSanti, DO
Terry J. Dierdorff, DO
Gina Dietrich, DO
Benjamin D. DiJoseph, DO
James T. Dodge, DO
Robert Donley, DO
Stephen Downey
Liam Duggan, DO
Cristina Dupree, DO
Stephanie Parsons Eckert, DO
Brian J. Egan, DO
Rinda P. Ellis, DO
Arlene England, DO
Gerald Englund, DO
Thomas P. Enyart, DO
Leo H. Eschbach, Jr., DO
Diane L. Evans, DO
Jacqueline Evans, DO
Kathleen Fabian, DO
Ellen D. Fauccet, DO
Kristen Fernandez, DO
Sheldon H. Fisher, DO
Ronald Fitch, DO
Kimberly J. Fletcher, DO
Megan J. Forshee, DO
Katelyn G. Foss, DO
Macy Fox, DO
John P. Franchina, DO
Ralph G. Frank, DO
Roseann J. Freundel, DO
Jennifer Frink, DO
Lisa M. Galbraith, DO
Lisa Gardner, DO
John J. Garvey, DO
John Gelasas, DO
Justine Gelasas, DO
Cathy L. Geria, DNP, APN,C
Shannon Gillham, DO
Brent W. Gillum, DO
William J. Goldsmith Jr.
Christina Goldstein-Charbonniau, DO
Cari Graber, DO
Sheri L. Graf, DO
Stephen B. Graham, DO
Grapevine Wine Tours
Ray S. Greco, II, DO
Mitchell G. Greenbaum, DO
Mary P. Greiss-Coutl, DO
Jan C. Gromada, DO
Tracey Grossenger, DO
Dominick M. Guiffrida, DO
Reproductive Gynecologists
Travis K. Haldeman, DO
William V. Hamilton, DO
Katherine Hanson, DO
Katharine K. Hansul, DO
Craig Hartman, DO
Lynne A. Haspedis, DO
Jennifer S. Hayes, DO
Jodanne W. Hedrick, DO
Kendi Hensel, DO
Daira Hertel
Tara Heyliger, DO
James Hole, DO
William Hole, DO
Stephan B. Hosmer, DO
Jennifer Howell-Welle, DO
Joseph Hudgens, M.D.
Janette R. Huffman, DO
Juanita K. Huggins, DO
Mary Joy Hyde, DO
David W. Jackson, DO
Carol L. Jane
Margaret Jaskowski-Lutsic, DO
Kim Johnson, DO
Rosanna Johnson, DO
Thomas C. Johnson, DO
David Jones, DO
Sarah Jones, DO
Kenneth S. Kacenga, DO
Katheryn Kaldor, DO
Sarah R. Kanalitzky, DO
Deborah G. Kauffman, DO
Susan Kaufman, DO
Michael F. Kenner, DO
David M. Keuchel, DO
Joseph Keuchel, Jr., DO
Nazafarine Keyvani, DO
Hyuk Kim, DO
Robert S. Kinsella, DO
James Koerner, DO
Daniel T. Kopiskey, DO
Maria Kossak, DO
Donna Koszczuk
Susan Kroener, DO
Mary C. Kruzwzewski, DO
Alan Kuester, DO
Rosanna Kulisz, DO
Laura A. L’Heureux, DO
David B. Land, DO

(Continued on Page 28)
Membership Donations

(Continued from Page 30)

Bruce Lastra, DO
Casey E. Laws, DO
Stavros G. Lazarou, DO
Troy R. Lehman, DO
Juliet E. Leman, DO
Geoffrey Levitt
Paul Loeb, DO
Azieb Lofton, DO
Bradley J. Logston, DO
Karla F. Loken, DO
William M. Long, DO
William P. Long, DO
Thomas A. Losure, DO
Jack Ludmir, DO
Harry A. Ludwig, DO
Kurt A. Ludvig, DO
Rosie Lynch
Jerald M. Lynn, DO
Cecil Lyttle
Lou E. MacManus, DO
Robert A. Mairs, DO
Edward M. Marici, DO
Gregory Mann, DO
Robert A. Mairs, DO
Lou E. MacManus, DO
Cecil Lyttle
Gerard W. Szczygiel, DO
Joseph P. Sypniewski, DO
Donna Sweets, DO
Renee Sundstrom, DO
Mary H. Strizzi, DO
Gary W. Stephens, DO
Carrie L. Speier-Schafer, DO
Kimberly A. Sorensen, DO
Shanna Snow, DO
Jennifer Smith, DO
Edward A. Slotnick, DO
Jerome Siudara, DO
Michael Sinapi
Queen Shiva
Phyllis Sheriff-White, DO
Rosanna Shayeghi
Clayton Shaw, DO
Michael Shaheen, DO
Sonali Shah, DO
Robert Saretsky, DO
John & Julie Saunders
Deborah Schlief
Paul Schneider, DO
Robert Seiler, DO
Sonali Shah, DO
Michael Shaheen, DO
Stuart Shalit, DO
Clayton Shaw, DO
Rosanna Shayeghi
Phyllis Sheriff-White, DO
Queen Shiva
Michael Sinapi
Jerome Siudara, DO
Edward A. Slotnick, DO
Jennifer Smith, DO
Shanna Snow, DO
Kimberly A. Sorensen, DO
Carrie L. Speier-Schafer, DO
Candace Steele
Joyce Stein, DO
Gary W. Stephens, DO
Pamela A. Stetzer, DO
Elizabeth Stevenson, DO
Mary H. Strizzi, DO
Renee Sundstrom, DO
Donna Sweets, DO
Joseph P. Szyniewski, DO
Gerard W. Szczygiel, DO
Tanya Taival, DO
Joseph P. Talcott, DO
Joe Talvacchia, DO
Donald R. Taylor, DO
Karin M. Taylor, DO
Joseph H. Tedesco, DO
Jill Terry, DO
Kenneth A. Thompson, DO
Mark C. Torres, DO
Yardie Toussaint, DO
Terry Tressler, DO
Stephens Tripplett, DO
Nan Traiano, DO
LaKeeya Tucker, DO
Linda R. Tucker, DO
Krista Turner, MD
Joanna Twombly, DO
Christopher Tykokki, DO
Richard Underwood, DO
Mary Jo Urso, DO
Guillermo Valenzuela, DO
Melinda Velez, DO
Peter Vienne, Jr., DO
Stella Volpe, DO
Lisa R. Waterman, DO
Michelle E. Webster, DO
Arnold Wechsler, DO
Lori W. Weinstein, DO
Herbert G. Wendelken, DO
Erik Westerholm, DO
Gehred D. Wetzel, DO
Barbara R. White, DO
Elaine Wilson
Monica L. Wirrig, DO
Chris Wirsing, DO
Amita Wolf
Richard Wolf, DO
Women’s Health For Life, Inc
Jeffrey C. Wong, DO
Ellen G. Wood, DO
Mark Woodland, MD
Carolyn Yost, DO
David Young, DO
Andrew Zink, DO
Mary J. Zygmunt, DO

SUPPORTER LEVEL $1-99

Edwin W. Abbott, DO
Ixcel Alvarez, DO
Amazon Smile
Ralph Armstrong, DO
Carol Arnett, DO
Dennis U. Atienza, DO
Sharon Baer, DO
Cecilia W. Banga, DO
Jeffrey Barrows, DO
J. Martin Beal, DO
Lev Belder, DO
Kimberly Besky
Jodi A. Benett, DO
James S. Betoni, DO
Angela Breckenridge, DO
Joseph Camardo
Mary Cameron
Jeffrey Carver
Wesley Chodos, DO
Annemarie Clark, DO
D. J. Clow, DO
Catherine A. Coats, DO
Marcia J. Coleman, MD
Maureen B. Conroy, DO
Andrew B. Crim, CHCP
Natalia D’Souza
Katherine Dadisman, DO
Stephen Dalm, DO
Davis Dalton, DO
Darlene Daly, DO
Elisa D. Depani-Sparkes, DO
Bernardita Druhan, DO
Peter Edinburg
Rosemary Fadool, DO
Joseph Flynn, DO
Jeffrey V. Fowler, DO
John Fuller
Patricia Gabig
Daniel Gabrielson, DO
Linda Gallen
Edna M. Garcia, DO
Grace Gibbs, DO
Barbara Melican Gleason, DO
Anne Grieves, DO
Gary S. Grubb, M.D.
Tom Gayton
Sherry M. Halm
Cheryl A. Hammes, DO.
Deirdre Harde-Perry, DO
Heather Harris
Ron Hayden
Brent Hurd, DO
Amy Hurburt, DO
Connie Januzelli, DO
Holly Jaskierny, DO
Corrine Jeppson, DO
Brian K. Jolitz, DO
Derek T. Jurus, DO
Eileen Kampf
Linda Karadshes, DO
Linda M. Karbonit, DO
Mark T. Karnes, DO
Thomas M. Kazmierczak, Jr., DO
Elizabeth Kerschen, DO
Amy Keurentjes, DO
Alysha Kirkwood, DO
John V. Knaus, DO
John Knoll, DO
Michael Krause, DO
Sara E. Krueger, DO
Stacy Lahti, DO
Christopher Lane, DO
Sheri Liliefield
Debra Littlejohn
Margaret C. Mader

BOLD reflects first time donor in 2018
* Thank you for moving up a level

(Continued on Page 29)
Membership Donations

(Continued from Page 30)

Marissa Magid, DO
Latriece E. Manning, DO
Angela Mannino, DO
Ena A. Marsan, DO
Pamela Martin-Hershner, DO
Kristen McDaniel, DO
Grace and Joe McEnaney
Denise McSherry, DO
Michael J. Messina, DO
Joseph Meunier, DO
Lauren Michelson, DO
Mark Molnar
Aubrey Narke
Stephen A. Naymick, DO
Gary J. Newman, DO
Mary Ellen O’Donnell
Linda Oberholzer
Charlene Okomski, DO
Peachy Clean Housekeeping

Neil M. Ponder, DO
Vanna M. Powell, DO
Sara Ramquist
Shawn Ramsey, DO
Janice Russell, NP
Janet L. Salvina
Howard Saul, DO
Pamela R. Seaman, DO
William K. Seifert, DO
Thomas A. Sipprell, DO
Becky Jo Smith, DO
Kathline Smith
Leonard J. Staszak, DO
George Stefennelli, DO
Karen Stellabotte
Angelo Stoyanovich, DO
Stephanie Swan, DO
Brian Thomas
William C. Tindall, DO
Douglas N. Toussaint, DO
William E. Trent, DO
Lisa Lynn Vendeland, DO
Richard Vitali
Doug Wells, DO
Rose White, OB/GYN
Rosanna Winchester, DO
B. Edward Yanke, DO
Debra Zwerlein

IN MEMORY OF

Anita H. Atkins, DO, FACOOG (Dist.)
Richard Foster Waters, DO, FACOOG
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

2018-2019 Corporate Partnership Council (CPC) Members are:

**Platinum $15,000+**

- AbbVie
- BTL

**Gold $10,000-15,000**
MEFACOOG Donation Form

I would like to donate $_________ to help support the following program:

- MEFACOOG General Support Donation
- Barbara Hawkes Honorary Fellows Lecture
- MEFACOOG Distinguished Lecture
- Past President’s Honorary Lecture
- Distinguished Fellows Endowed Lecture
- Resident Reporter Scholarship

**Donor Information (please print or type)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Billing Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Telephone (Home)</td>
<td></td>
</tr>
<tr>
<td>Telephone (Business)</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>E-Mail</td>
<td></td>
</tr>
</tbody>
</table>

**Payment Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credit Card Type</td>
<td></td>
</tr>
<tr>
<td>Credit Card Number</td>
<td></td>
</tr>
<tr>
<td>Expiration Date and CCV#</td>
<td></td>
</tr>
<tr>
<td>Authorized Signature</td>
<td></td>
</tr>
</tbody>
</table>

**Acknowledgement Information**

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

___ I wish to have our donation remain anonymous.

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

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

MEFACOOG DONATION FORM 2018

<table>
<thead>
<tr>
<th>Level</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman's Circle:</td>
<td>$50,000 and up</td>
</tr>
<tr>
<td>Diamond Level:</td>
<td>$40,000 – 49,999</td>
</tr>
<tr>
<td>Sapphire Level:</td>
<td>$30,000 – 39,999</td>
</tr>
<tr>
<td>Emerald Level:</td>
<td>$20,000 – 29,999</td>
</tr>
<tr>
<td>Platinum Level:</td>
<td>$10,000 – 19,999</td>
</tr>
<tr>
<td>Gold Level:</td>
<td>$5,000 – 9,999</td>
</tr>
<tr>
<td>Silver Level:</td>
<td>$1,000 – 4,999</td>
</tr>
<tr>
<td>Bronze Level:</td>
<td>$500 – 999</td>
</tr>
<tr>
<td>Century Level:</td>
<td>$100 – 499</td>
</tr>
<tr>
<td>Supporter Level:</td>
<td>$1 – 99</td>
</tr>
</tbody>
</table>

MEDICAL EDUCATION FOUNDATION OF ACOOG
201 MAIN STREET, 6TH FLOOR
FORT WORTH, TEXAS 76102
You shop. Amazon gives.
Amazon donates 0.5% of the price of your eligible AmazonSmile purchases to the charitable organization of your choice.

Search for charity:
*Medical Education Foundation of the Amer Coll of Osteopathic Ob-Gyn*
*Location: Fort Worth, TX*

to start shopping at smile.amazon.com
The mission of the MEFACOOG is to foster continuing improvements in women's healthcare.

The goals of the MEFACOOG are to support

- Continuing Medical Education
  - Undergraduate
  - Graduate
  - Postgraduate Research Programs
- Faculty Development
- Development of Educational Networks in women's healthcare