

ACOG does not support 'vaginal rejuvenation'

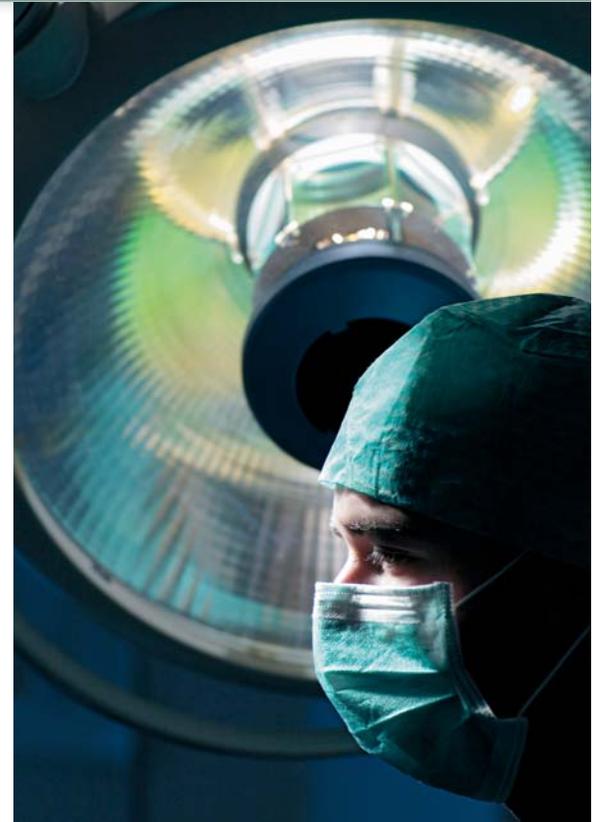
ACOG'S COMMITTEE ON GYNECOLOGIC PRACTICE IS speaking out against so-called "vaginal rejuvenation" and other cosmetic vaginal procedures. With names such as "designer vaginoplasty," "revirgination," and "G-spot amplification," these procedures are not medically indicated, and the safety and effectiveness have not been documented. In fact, it's often unclear what type of procedure is being performed, as medical nomenclature is not used.

"It is deceptive to give the impression that [these procedures] are accepted and routine surgical practices," states the Committee Opinion, which was published in the September issue of *Obstetrics & Gynecology*. "Absence of data supporting the safety and efficacy of

these procedures makes their recommendation untenable."

Over the past several years, an increasing number of physicians have been offering various types of vaginal surgeries that are marketed to women as ways to enhance genital

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States enact perinatal HIV legislation

IN 2007, STATE LEGISLATURES ALL across the US began recognizing the importance of perinatal HIV testing. A record number of legislatures debated the issue, and approximately 10 states ultimately passed some type of legislation.

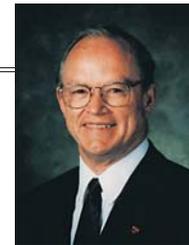
Why the increased attention? The turning point came last fall when the Centers for Disease Control and Prevention released recommendations that called for universal HIV testing for all patients in the US ages 13 to 64. The ensuing media spotlight on HIV testing allowed ACOG to call attention to a specific issue: pregnant women and the need for rou-

tine perinatal HIV testing.

ACOG, the CDC, the Institute of Medicine, and the American Academy of Pediatrics all recommend the "opt-out" approach for perinatal HIV testing, which calls for HIV testing as a routine part of prenatal care. Clinicians notify a pregnant patient that she will receive an HIV test. The patient can choose to decline, but she does not have to give written or verbal consent to have the test.

Until this year, only six states had implemented laws allowing variations of the opt-out approach. Most other states required the "opt-in" approach, which requires specific in-

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EXECUTIVE DESK

Aloha to new and departing staff

ON JULY 1, DR. HAL C. LAWRENCE III, of Asheville, NC, joined ACOG's staff. Dr. Lawrence is a generalist ob-gyn who will become ACOG's vice president of the Practice Activities Division on Oct 1, 2007.

We are extremely fortunate that Dr. Lawrence has accepted this responsibility. His long-term association with ACOG began as a Junior Fellow chair. He has served on numerous committees, including as chair of the Committee on Scientific Program, and as ACOG's representative to the Residency Review Committee. Dr. Lawrence has been very active in District IV and is the district's most recent past chair.

Outstanding service to the College

While we welcome Dr. Lawrence, it is also time to recognize that Dr. Stanley Zinberg will be leaving. Stan has been an outstanding College vice president. Many of the College activities we now take for granted were the product of his undertaking. As just one example, Stan conceived and developed the use of Practice Bulletins as our evidence-based publications.

Stan has served not only as vice president of practice activities but also as deputy executive vice president. In this role, he has been my strong right arm and represented the College when I was unavailable or when duties required me to be away from the office.

"Stan has been an outstanding College vice president. Many of the College activities we now take for granted were the product of his undertaking."

Stan has spent 13 years at ACOG, and the College thanks him for his time, effort, and dedication. However, he will "not go slowly into the sunset" because he is the College representative to several key organizations—positions that he achieved as opposed to receiving through College appointment. Stan has agreed to continue in those roles until their terms end so that the College won't lose a key position.

Thanks, Stan, for all you have done for ACOG. You have served the College and our specialty well. Women's health care in the US has benefited from your presence at ACOG. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

IN MEMORIAM

- | | |
|-------------------------------------------------------------|-----------------------------------------------------------|
| James F. Connaughton, MD
Phoenixville, PA • 12/06 | Kermit E. Krantz, MD
Kansas City, KS |
| Eleanor C. Crim, MD
Kailua, HI • 6/07 | James V. McNulty, MD
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Washington, DC • 7/07 |
| Howard Lund Judd, MD
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Obstetrics & Gynecology HIGHLIGHTS



The September issue of the Green Journal includes the following ACOG documents:

Research Involving Women
(Ethics Committee Opinion #377, new)

Vaginal 'Rejuvenation' and Cosmetic Vaginal Procedures

(Gynecology Committee Opinion #378, new)
For more information, see page 1.

Management of Delivery of a Newborn with Meconium-Stained Amniotic Fluid
(Obstetrics Committee Opinion #379, new)

Pelvic Organ Prolapse
(Gynecology Practice Bulletin #85, revised)

ACOG announces 2008 postgraduate courses

ACOG HAS DEVELOPED several new and exciting courses for the 2008 postgraduate course calendar.

21st century ob-gyn

In February, the course “Twenty-first Century Obstetrics and Gynecology” will include experts in genetics, oncology, patient safety, and imaging to discuss new developments that will transform ob-gyn. Whether it’s reinventing the operating room or redesigning office processes, innovative concepts have the promise to improve outcomes, increase efficiency, reduce risks, and increase both patient and provider satisfaction.

The course, which will be held February 14–16 in Jamaica, will cover topics such as:

- ▶ The changing methods for genetic risk assessment
- ▶ The evolving methods for prenatal diagnosis
- ▶ Current and future issues for breast cancer chemoprevention
- ▶ Current therapy and future treatment options for uterine fibroids
- ▶ Advances and future directions for minimally invasive gynecologic surgery
- ▶ Current and future applications for robotic and computer-enhanced surgery
- ▶ New concepts for prevention, diagnosis, and treatment of cervical cancer
- ▶ Application of team concepts to improve patient safety and office and hospital efficiency

Complex gyn surgery

Another course offered in February is “Complex Gynecologic Surgery: Prevention and Management of Complications,” which will be held February 7–9 in Phoenix.

Sexuality, body image, and psychological well-being

A “no frills” course in Chicago, June 7–8, will focus on an emerging issue in office practice: sexuality, body image, and psychological well-being. The course will address sexual dysfunc-



tion, weight loss, hair removal, liposuction, depression, and fear of cancer. Interactive sessions will allow participants and their spouses or guests to examine their own definitions of beauty, body image, and ideal sexual health.

Update on cervical diseases

Later in the year, a course will serve as an update on cervical diseases. The course recognizes that in the last five to 10 years, there has been a dramatic change in the understanding of cervical precancer, what causes it, and how to screen, prevent, identify, and manage it. The course will be held September 18–20 in Charleston, SC.

The course will cover topics such as:

- ▶ New standards for cervical cancer screening, including HPV testing
- ▶ Prevention of cervical neoplasia and genital warts using HPV vaccines
- ▶ The challenges of colposcopy and management of cervical neoplasia for select populations
- ▶ Diagnostic characteristics of cervical abnormalities on cytologic, colposcopic, and histologic exam
- ▶ Diagnosis and management of vulvar and vaginal neoplasia ♀

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- More information on the 2008 courses will be available online later this year. Stay tuned to the ACOG website, www.acog.org. Under “Meetings,” click on “Postgraduate Courses and CPT Coding Workshops”



Call for participation for 2008 ACM

THE ACOG COMMITTEE ON Scientific Program is inviting submissions of abstracts of paper or poster presentations on any topic related to ob-gyn for the 2008 Annual Clinical Meeting, to be held May 3–7 in New Orleans. All abstracts must be submitted online.

The committee also welcomes online submission of abstracts of films for the 2008 Film Festival on topics of interest to practicing ob-gyns. For submission details and the online application, visit www.acog.org/acm.

Deadlines for online submission

- ▶ Paper/poster abstracts: September 14
- ▶ Film Festival abstracts: November 2 ♀

ACOG offers links to teratology resources

ACOG HAS UPDATED ITS teratology and toxicology “web-treat,” a list of online resources about toxic sources, food safety, birth defects, and more. The site also includes a link to a list of pregnancy exposure registries from the US Food and Drug Administration’s Office of Women’s Health. The registries, which can be used for prospective observational studies, collect information on women who take medicines and receive vaccines during pregnancy. ♀

info

- On the ACOG website, www.acog.org, under “Information,” click on “Resource Center” and “Webtreats” and then “Teratology/Toxicology”

AMA to study genetics advertising

Erin E. Tracy, MD, MPH, ACOG delegate to the AMA House of Delegates

AT ITS ANNUAL MEETING in Chicago, the American Medical Association adopted a number of resolutions that were brought forth by the ACOG delegation, addressing domestic violence, evidence-based policy development, and direct-to-consumer advertising of genetics tests.

The latter policy directs that “the AMA study the issue of direct-to-consumer advertising of genetics tests and the provision of genetics testing to patients on the Internet or other vehicles not directly involving the patient’s physician, taking into consideration appropriate mechanisms to regulate this practice.”

ACOG’s Committee on Genetics is also looking into the issue of direct-to-consumer advertising of genetics testing. The AMA’s policy recognizes the increasing prevalence of this



PHOTO COURTESY OF AMA

type of advertising. In a 2003 study (Gollust et al, *Genetics in Medicine*, July/August 2003), multiple Internet searches identified 105 websites in which consumers could purchase genetics testing services without directly involving their physicians. Most were sites pertaining to paternity tests, identity tests, or DNA banking. Fourteen sites allowed consumers to

purchase health-related genetics tests, including those for hemochromatosis and cystic fibrosis, as well as unconventional tests for nutrition, behavior, and aging. Only six of the 14 sites offered genetics counseling.

The AMA already has extensive policy regarding direct-to-consumer advertising of pharmaceuticals. Previous policy states that the medical profession needs to take an active role in ensuring that the care patients receive is not compromised as a result of such

advertising.

As always, the ACOG AMA delegation is eager to bring forth your ideas for resolutions, so please feel free to contact us regarding new or current issues. ♀

info

→ EETracy@partners.org; 617-726-3564

Former ACOG national officer dies



FORMER ACOG VICE PRESIDENT Charles A. White Jr, of Kenner, LA, died April 27 at age 84.

Dr. White, a Life Fellow, served as College vice president in 1991–92 and was a West Virginia Section chair and vice chair in the late 1970s and early 1980s.

He was also active on several ACOG committees, including those related to the Annual Clinical Meeting. He was always very helpful whenever ACOG held its ACM in New Orleans, and he was looking forward to ACOG’s return to New Orleans for the 2008 ACM.

Dr. White began his medical career as a veterinarian, and through a friendship with an ob-gyn while living in Mesa, AZ, he became interested in the specialty and enrolled in medical school at the University of Utah, according to *The Times-Picayune* newspaper in New Orleans.

He completed his residency at the University of Iowa, where he became a full professor, and later headed the ob-gyn departments at West Virginia University and Louisiana State University, *The Times-Picayune* stated. ♀

AMA, ACOG conducting physician practice survey

THE AMERICAN MEDICAL ASSOCIATION, WITH THE support of ACOG and more than 60 other medical specialty societies, is conducting a multi-specialty survey of America’s physician practices.

The purpose is to collect up-to-date information on physician practice characteristics to develop and redefine AMA and ACOG policy. Data related to professional practice expenses will also be collected. The AMA and ACOG will survey thousands of physicians over the year from virtually all physician specialties to ensure accurate and fair representation for all physicians and their patients.

During 2007, you may be contacted by the Gallup Organization to participate in this study. We encourage your participation in this survey, as the data obtained will be a critical source of information for the AMA and ACOG. Should you be called upon to contribute, your participation ensures that the information collected will represent you and your patients’ concerns to national policy-makers.

Please watch for this survey in 2007 and do your part in completing it in a thorough and accurate manner. ♀

Webcasts provide crucial tips to ob-gyns and their staff

DEVELOP STRATEGIES TO review and negotiate managed care contracts with ACOG's October webcast, "Negotiations with Payers." The webcast will be held October 9, from 1 to 2:30 pm Eastern Time.

The webcast will help participants identify and assemble the data they need before they negotiate and renegotiate their contracts with insurance payers. Participants will be able to identify the leverage they have with plans; identify data-based approaches for developing and analyzing managed care rate proposals; and understand how managed care plans set rates and how a practice can use that information to its advantage.

The webcast will be presented by Cara Farrell, MPH, vice president for managed care contracting at Women's Health Connecticut.

Preparing for cross-examination

Learn techniques for preparing and giving a discovery deposition during the November 13 webcast, "Preparing for Cross-Examination." Although a deposition is not a trial, the testimony carries the same weight as trial testimony. The webcast will present various strategies that highlight the importance of communica-



tion skills and behavior during a deposition and trial cross-examination. The program director is Victoria L. Green, MD, JD.

New webcast every month

ACOG webcasts are offered on the second Tuesday of each month, helping physicians and their staff to stay updated on important issues without leaving the office. Presentations are given in real time over the Internet. All webcasts are held from 1 to 2:30 pm Eastern Time. Archived webcasts are also available. ♀

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→ To register for a webcast or access the webcast archives: On the ACOG website, www.acog.org, under "Meetings," click on "Postgraduate Courses and CPT Coding Workshops"



District and section treasurers invited to ACOG Treasurers Conference

CURRENT AND INCOMING district and section treasurers are invited to the 10th Annual Treasurers Conference, to be held Jan 19–20, 2008, in Scottsdale, AZ. Other district and section officers and administrators responsible for the financial management of their district or section are also invited. There is no registration fee for attending.

The conference is a two-day educational meeting designed to train officers and administrators in the financial management of their district or section and update them on new ACOG policies and changes in tax laws. Sessions cover areas such as:

- ▶ An overview of the investment management of district and section funds
- ▶ Budgeting for general operations and meetings
- ▶ Processing of funds received by districts and sections
- ▶ Processing of disbursements from district and section funds
- ▶ How to read and understand monthly financial statements
- ▶ Duties of district and section treasurers
- ▶ Discussion of IRS tax laws that affect activities of districts and sections

Presenters will include ACOG finance staff, national and district officers, and outside investment managers. ♀

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→ Conference registration is free, but participants must register by December 21. Contact Steve Cathcart: 800-281-1551; scathcart@acog.org

FIMR PROGRAMS SHARE BEST PRACTICES



AT ITS SIXTH NATIONAL CONFERENCE in August, the National Fetal and Infant Mortality Review program allowed local and state FIMR programs to share successful strategies and discuss new ideas and directions for the FIMR program. NFIMR is a collaborative effort between ACOG and the federal Maternal and Child Health Bureau.



MRI of an ovarian cancer (in red)

Latest ovarian cancer research

With no reliable screening method for ovarian cancer, a group of researchers is studying the effectiveness of an ovarian cancer symptom index.

Led by Fellow Barbara A. Goff, MD, professor and director of the division of gynecologic oncology at the University of Washington, the group found that duration and frequency of symptoms were the most predictive for ovarian cancer.

The greatest sensitivity included the presence of six symptoms—pelvic pain, abdominal pain, increased abdominal size, bloating, feeling full, or difficulty eating—for less than 12 months and for more than 12 times per month.

“Having bloating 12 times a month seems to be predictive. Occasional bloating, only a few days a month, is not. Symptoms should be almost daily or every other day,” Dr. Goff said. “Also, it needs to be a relatively new symptom. It shouldn’t be a problem you’ve had all your life. It should be present for under a year, preferably under six months.”

ACOG’s Committee on Gynecologic Practice is keeping abreast of the latest ovarian cancer research and will evaluate new data as part of its regular review process.

Ovarian cancer focus of Gynecologic Cancer Awareness Month

SEPTEMBER IS GYNECOLOGIC Cancer Awareness Month, and this year’s focus is on the deadliest gynecologic cancer: ovarian cancer. While it’s not common, ovarian cancer can be deadly because it isn’t usually diagnosed until the late stage. According to the National Cancer Institute, an estimated 22,430 women will be diagnosed with ovarian cancer this year, and 15,280 will die.

Despite being labeled a “silent killer,” ovarian cancer does produce symptoms in women at an early stage, but the symptoms often appear to be innocuous gastrointestinal and abdominal problems.

Currently, the best way to detect early ovarian cancer is for both the patient and the clinician to be suspicious when certain symptoms appear, according to ACOG’s Committee Opinion *The Role of the Generalist Obstetrician-Gynecologist in the Early Detection of Ovarian Cancer* (#280, December 2002).

According to the document, certain persistent symptoms should be evaluated with ovarian cancer included in the differential diagnosis. These symptoms include pelvic pain, abdominal pain, increased abdominal size, bloating, difficulty eating, indigestion, urinary frequency, recent urinary incontinence, unexplained weight loss, back pain, constipation,

and fatigue. These symptoms should not be ignored in postmenopausal women because ovarian cancer occurs most often in this group.

In evaluating symptoms, physicians should perform a physical exam, including a pelvic exam; a vaginal ultrasound may be helpful. A CA 125 measurement may be useful in postmenopausal women, but a normal measurement does not rule out ovarian cancer, and the test is not useful in premenopausal women.

“Unfortunately, it can be difficult to detect ovarian cancer,” said Denise J. Jamieson, MD, MPH, chair of ACOG’s Committee on Gynecologic Practice. “The symptoms of ovarian cancer are common symptoms that many women experience—bloating, abdominal cramping—and are similar to symptoms for many other ailments.” ♀

info

- ACOG Committee Opinion *The Role of the Generalist Obstetrician-Gynecologist in the Early Detection of Ovarian Cancer* (#280, December 2002, reaffirmed in 2005): www.acog.org/publications/committee_opinions/co280.cfm
- *Cancer of the Ovary Patient Education Pamphlet* (AP096): www.acog.org/publications/patient_education
- “Development of an Ovarian Cancer Symptom Index”; Goff et al; *Cancer*; Jan 15, 2007



Breast cancer CME modules

A NEW ONLINE CME program aims to educate clinicians about providing appropriate and timely management of women with breast symptoms or abnormal results on examination. The program was developed by the Centers for Disease Control and Prevention, in consultation with ACOG and the US Food and Drug Administration, and issued through Medscape from WebMD.

“Follow Up of Abnormal Clinical and Imaging Findings of the Breast: Five Self-Study Modules for Primary Care Clinicians” trains physicians on the latest evidence, protocols, and guidelines for evaluating breast symptoms and abnormalities that appear on exam. The focus is on detecting early signs of breast cancer, but other conditions of the breast are addressed as well. The activity consists of five modules:

OCTOBER IS BREAST CANCER AWARENESS MONTH

Materials are available at www.nbcam.com

- 1 Breast Anatomy, Physiology, and Pathology
- 2 Health History and Clinical Breast Examination
- 3 Work-up of Abnormal Clinical Findings
- 4 Follow-up of Abnormal Imaging Findings: Biopsy Methods
- 5 Risk Management ♀

info

- www.medscape.com/editorial/public/breastcancer-cdc

Studies question WHI results

WHEN THE WOMEN'S Health Initiative was halted a few years ago, many menopausal women, fearing an increased risk of heart attacks and breast cancer, stopped taking the estrogen that had helped alleviate their hot flashes and night sweats. Since then, new studies analyzing WHI appear to show that the risks may not be as high for some groups of women as previously feared.

"WHI included much older women, some many years removed from menopause and symptom free," said Isaac Schiff, MD, chair of the medical advisory board for ACOG's *pause*® magazine. "Since then, we're learning that while WHI may be relevant to women in their 60s and 70s, the results are not so clear cut for younger, symptomatic women. For these women, estrogen is still the best medicine we have for relieving their vasomotor symptoms."

In a new analysis of WHI, researchers found that women who took hormone therapy closer to the beginning of menopause—the group of patients ob-gyns are more likely to see—had a reduced risk of coronary heart disease than did women who were taking hormone therapy further away from the start of their menopause. However, the increased risk of stroke remained, regardless of the number of years since menopause, according to the study published in the Apr 4, 2007, issue of the *Journal of the American Medical Association*.

In another analysis, released last year, researchers learned that conjugated equine estrogens used alone did not increase breast cancer incidence in postmenopausal women who had had their uterus removed (Apr 12, 2006, *JAMA*). This was in sharp contrast to results of the combined hormone therapy arm of WHI, which was halted in 2002 after showing a significant increase in breast cancer, as well as



heart attack, stroke, and blood clots.

"As we learn more and more about WHI, the pendulum is swinging back to an appropriate balance between the risks and the benefits," Dr. Schiff said. "Physicians should present the information to their patients and, in a partnership, decide what is appropriate for each individual patient."

ACOG continues to recommend that women take the lowest effective dose of hormone therapy for symptom relief and that they continue to reevaluate their need for hormone therapy each year with their doctor. ♀

ACOG does not support 'vaginal rejuvenation'

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appearance and sexual gratification. Some of these procedures, such as "vaginal rejuvenation," appear to be modifications of traditional vaginal surgical procedures for genuine medical conditions. However, very few cosmetic vaginal procedures are medically indicated, and there are no published studies that assess the safety, complication rates, and long-term satisfaction for any of these procedures.

"Many women don't realize that the appearance of external genitals varies significantly from woman to woman. As ob-gyns, we know this to be the case from years of experience," said Abbey B. Berenson, MD, a member of ACOG's Committee on Gynecologic Practice.

An honest discussion about the wide variation in the appearance of normal genitalia could reassure women who are insecure about their genitalia's appearance, Dr. Berenson said.

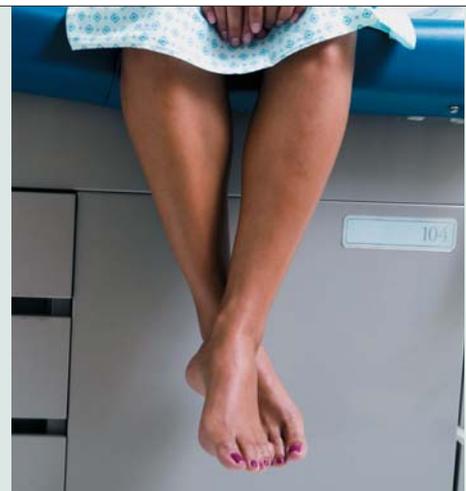
Handling patient requests

Ob-gyns whose patients ask about these procedures should discuss the reason for the request and also perform an evaluation for any signs or symptoms that may indicate a need for surgical intervention. Women who want to improve their sexual response should be evaluated for sexual dysfunction; nonsurgical interventions, including counseling, should be discussed.

"There are always risks associated with a surgical procedure," Dr. Berenson said. "It's important that women understand the potential risks of these procedures and that there is no scientific evidence regarding their benefits."

Concerns with ethical issues

ACOG also expressed concern with the ethical issues associated with the marketing and



national franchising of cosmetic vaginal procedures. A business model that controls the dissemination of scientific knowledge is troubling, according to the Committee Opinion.

"When a new surgical procedure or a variation of an established surgical procedure is developed, physicians typically do not attempt to keep it proprietary or restrict who can perform the procedure," Dr. Berenson said. ♀

Mt. Sinai program teaches medical students about obesity and pregnancy

STUDENTS AT MT. SINAI Medical School in New York City are given a unique opportunity to closely develop relationships with obese pregnant patients and see the complications of obesity firsthand. Students are an important part of Mt. Sinai's Lifestyle Modification Program, or LMP, which educates pregnant patients who are obese about healthy lifestyles.

The program, which began this year, identifies and enrolls pregnant patients with a BMI of 30 or higher. Approximately 20–25 women are enrolled. Most are urban, low-income women who have not routinely seen a doctor in the past.

"The main goal is to encourage an appropriate weight gain of 15 pounds through educating patients about physical activity, nutrition, lifestyle changes, and overall healthy living," said District II Junior Fellow Vice Chair Taraneh Shirazian, MD, who developed the program during her residency. Dr. Shirazian is now a clinical instructor at Mt. Sinai.



"I have been able to identify perceived barriers to health and nutrition and have learned much about the team that works with a patient throughout pregnancy."

—Sreekala Raghavan, medical student

Each student is paired with a patient as a "buddy." The patients are given food diaries and pedometers, and the students motivate them to keep up with their diaries and to exercise and strive for a healthy diet. The students accompany the patients to their clinical visits and LMP seminars, which cover educational topics such as food label reading, exercise, and barriers to maintaining a healthy weight.

"For the students, it's a unique service-learning opportunity in which they are an integral part of a community outreach program. They follow women longitudinally and learn the risks of obesity in pregnancy and the barriers women face in attempting to lose weight," Dr. Shirazian said. "Students also learn about the complications that obstetricians face daily, as obesity represents one of the most difficult management issues on the labor floor."

LMP student liaison Sreekala Raghavan, a third-year medical student, said the program has taught her much about the community, about obesity as an epidemic, and about complications of pregnancy and delivery associated with obesity.

"I have been able to identify perceived barriers to health and nutrition and have learned much about the team that works with a patient throughout pregnancy and how this multidisciplinary care fits together," said Ms. Raghavan, an ACOG medical student member.

Keeping the patients motivated

LMP works with the patients to overcome cultural, economic, and social barriers to a healthier lifestyle.

"The biggest challenge is retaining the patient in the program. That's another way the student buddy comes in—the buddies are a motivating force. They're seen as allies to our patients, who often confide in them," Dr. Shirazian said.

The program tracks each patient's fasting glucose level, blood pressure, weight gain, delivery specifics, and any complications that develop.

Dr. Shirazian wants to continue to work



Junior Fellow Taraneh Shirazian, MD, standing, and medical student Sreekala Raghavan discuss goals of appropriate weight gain during pregnancy with a patient enrolled in the Lifestyle Modification Program at Mt. Sinai.

with the patients after they deliver. She hopes to include them as part of a new postpartum clinic that will follow diabetic patients, so that the patients can continue to work toward a healthier lifestyle and decrease their risk of heart disease, diabetes, and other diseases.

Exposing students to ob-gyn

"What's appealing to students is the patient care aspect, the public health implications, and playing an important and needed role with our patients. We're able to give them a glimpse of what we do as ob-gyns and really give them a great hands-on experience. The patients are very grateful for their involvement," Dr. Shirazian said.

Ms. Raghavan agrees: "Being able to work with the patients as part of a team caring for them, rather than just being an observer, has allowed me to see that it is a patient population that benefits greatly from health care advocates. Although I must admit I am only three weeks into my clinical rotations, I'm very interested in choosing ob-gyn as my specialty." ♀

States enact perinatal HIV legislation

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formed consent. Physicians should be aware of and follow their states' prenatal HIV screening requirements. Specific prenatal HIV screening requirements can be verified with state or local public health departments.



New Jersey makes issue a priority

A perinatal HIV testing bill was a priority of legislative leaders in New Jersey, a state with a high prevalence of HIV and AIDS. Among all states, New Jersey has the fifth highest number of women with AIDS and the fifth highest number of children younger than 13 with AIDS, and the state ranks fifth in the number of new AIDS cases among children.

The state Senate and Assembly each passed a bill that would require HIV opt-out testing as part of routine prenatal testing. The bill was a priority for Sen. Richard J. Codey (D-Essex), Senate president and former acting governor. A final vote is expected this fall, and Governor Jon Corzine is expected to sign the bill into law.

Some state laws that are intended to allow the opt-out strategy include contradictory and confusing language. Rhode Island lawmakers

appear to support the goal of universal testing, but a new law passed this summer does not remove or simplify burdensome informed consent requirements. Also, Rhode Island and Nevada both require mandatory testing of the newborn, which ACOG does not support. In Illinois, in addition to a new perinatal testing law, a companion bill was passed that doubles the penalties for violating informed consent rules under the state's AIDS Confidentiality Act.



Georgia ob-gyns advocate strongly

Unlike in Rhode Island and Nevada, a new law in Georgia is more promising, allowing for a straightforward opt-out approach. Ob-gyns in Georgia were involved from the beginning, testifying before the Legislature several times, and the bill incorporated language from ACOG's perinatal HIV legislative toolkit (see "ACOG Resources" at right).

"Involvement by Fellows was invaluable in bringing this serious public health threat to lawmakers' attention and passing a strong and straightforward bill," said Sandra B. Reed, MD, Georgia Section chair. ♀

ACOG needs your help

THE FACT REMAINS THAT only a handful of states allow the opt-out approach for perinatal HIV testing. Fellow involvement is critical to enacting these important laws; Fellows can explain clinical care and terms to legislators to ensure a sound law is passed.

Grabbing lawmakers' attention on perinatal HIV was half the battle, as with any legislative issue. Now, Fellows need to take advantage of this attention on perinatal HIV testing—which may last only one or two legislative sessions—to inform legislators about the issue to ensure that the laws that are passed accurately reflect current scientific recommendations and are consistent with shared goals of universal screening.

Get involved by contacting your section or district leaders and ACOG staff:

- Kathryn Moore, director of ACOG's Department of State Legislative and Regulatory Affairs: 800-673-8444, ext 2506; kmoores@acog.org
- Rebecca Carlson, manager, perinatal HIV grant projects, 800-673-8444, ext 2356; rcarlson@acog.org

CDC campaign offers perinatal HIV education tools

A NEW CAMPAIGN FROM THE Centers for Disease Control and Prevention is designed to overcome barriers to prenatal HIV testing. "One Test. Two Lives." offers free tools to help clinicians recommend HIV testing as a routine part of prenatal care to all their pregnant patients. Knowledge of a pregnant woman's HIV status allows the provider to introduce treatment interventions that can greatly reduce the risk of transmission to the newborn and improve the health of the mother.

Campaign materials include CDC's practical guide on rapid HIV testing during labor and delivery, a poster for reception areas, a pa-



tient brochure, a fact sheet on recommended prenatal tests, and ACOG's HIV testing recommendations for pregnant women. ♀

info

- Campaign materials are available online, www.cdc.gov/1test2lives, or by request at info@cdcnpin.org; 800-458-5231

ACOG RESOURCES

- www.acog.org. Under "Women's Issues," click on "Perinatal HIV." The site includes links to College Committee Opinions, policy statements, Patient Education Pamphlets, and other resources. Newly added is an HIV fact sheet from ACOG's Department of State Legislative and Regulatory Affairs.
- Email rcarlson@acog.org for copies of **ACOG's perinatal HIV legislative toolkit**, which assists state lawmakers and advocates in understanding the benefits of the opt-out approach and the issues surrounding mother-to-child transmission and includes suggested legislative language to implement the opt-out approach.

Begin using new codes October 1

FOLLOWING ARE THE NEW, EXPANDED, AND REVISED ICD-9-CM codes that are of interest to ob-gyns and that take effect October 1. HIPAA requires providers to use the medical code set that is valid at the time the service is provided. Therefore, physicians must cease using discontinued codes for services after the new codes become effective October 1. ♀

info

- On the ACOG website, www.acog.org, click on "CPT Coding" in the "Quick Links" box on the left side of the page
- Questions and comments: coding@acog.org or fax to 202-484-7480

ICD-M	DESCRIPTION	#
GYNECOLOGIC		
789.00	Abdominal Pain	
789.37	Abdominal Mass	
795.0	Abnormal Pap Smear	
626.8	Abnormal Uterine Bleed.	
626.0	Amenorrhea	
616.3	Bartholin Abscess	
616.2	Bartholin Cyst	
610.1	Breast-Fibrocystic Dis.	
611.72	-Mass	
611.71	-Mastodynia	
112.1	Candidiasis - Vulva/Vaginal	
622.1	Cervical Dysplasia	
616.0	Cervicitis	
678.10	Condyloma - Cervix	
620.76	DES Exposure	

Vulvar and vaginal intraepithelial neoplasia III

Codes in the "carcinoma in situ of other and unspecified female genital organs" subcategory (233.3) will be expanded to include separate codes for vaginal intraepithelial neoplasia III (VAIN III) and vulvar intraepithelial neoplasia III (VIN III):

- ▶ Carcinoma in situ, unspecified female genital organ (233.30)
- ▶ Carcinoma in situ, vagina (VAIN III) (233.31)
- ▶ Carcinoma in situ, vulva (VIN III) (233.32)
- ▶ Carcinoma in situ, other female genital organ (233.39)

Vulvar intraepithelial neoplasia I and II

The code "dystrophy of vulva" (624.0) will be expanded to include vulvar intraepithelial neoplasia I (VIN I) and vulvar intraepithelial neoplasia II (VIN II):

- ▶ Vulvar intraepithelial neoplasia I (VIN I) (624.01)
- ▶ Vulvar intraepithelial neoplasia II (VIN II) (624.02)
- ▶ Other dystrophy of vulva (624.09)

Anal sphincter tear

Code category "other specified disorders of rectum and anus" (569.4) will be expanded to include a code for anal sphincter tear in nonpregnant patients:

- ▶ Anal sphincter tear [healed] [old] (569.43)

A new subcategory will be created within the "trauma to perineum and vulva during delivery" category (664) for anal sphincter tears in pregnant patients:

- ▶ Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration (664.6)

Malignant ascites

The subcategory "ascites" (789.5) will be expanded to include codes for malignant and other ascites:

- ▶ Malignant ascites (789.51)
- ▶ Other ascites (789.59)

Personal history of cervical dysplasia

A new code for personal history of cervical dysplasia will be established within the subcategory "personal history of other genital system and obstetric disorders" (V13.2):

- ▶ Personal history of cervical dysplasia (V13.22)

Family history of bladder cancer

A new code will be created in the "family history of malignant neoplasm, urinary organs" subcategory (V16.5) for family history of malignant neoplasm of bladder:

- ▶ Family history of malignant neoplasm, bladder (V16.52)

Family history of multiple endocrine neoplasia

The "family history of other endocrine and metabolic diseases" subcategory (V18.1) will be expanded to include family history of multiple endocrine neoplasia:

- ▶ Family history of multiple endocrine neoplasia (MEN) syndrome (V18.11)
- ▶ Family history of other endocrine and metabolic diseases (V18.19)

Natural family planning for contraceptive and procreative management

A new code will be created within the "general counseling and advice" subcategory (V25.0) for natural family planning to avoid pregnancy:

- ▶ Counseling and instruction in natural family planning to avoid pregnancy (V25.04)

The subcategory for "general counseling and advice" (V26.4) will be expanded to include codes for procreative counseling using natural family planning:

- ▶ Procreative counseling and advice using natural family planning (V26.41)
- ▶ Other procreative management, counseling, and advice (V26.49)

Patient undergoing assisted reproductive technology

Codes will be developed within the "other specified procreative management" subcategory (V26.8) to report for patients receiving treatment using assisted reproductive fertility procedures:

- ▶ Encounter for assisted reproductive fertility procedure cycle (V26.81)
- ▶ Other specified procreative management (V26.89)

HPV screening

The subcategory for "other specified viral and chlamydial diseases" (V73.8) will be expanded to report screening for human papillomavirus (HPV):

- ▶ Special screening examination, human papillomavirus (V73.81)

Genetic susceptibility to multiple endocrine neoplasia

To include codes for genetic susceptibility to multiple endocrine neoplasia, the subcategory "genetic susceptibility to other disease" (V84.8) will be expanded:

- ▶ Genetic susceptibility to multiple endocrine neoplasia (MEN) (V84.81)
- ▶ Genetic susceptibility to other disease (V84.89)

Experiencing problems with Medicare pessary payments?

ACOG FELLOWS HAVE REPORTED that Medicare reimbursement for pessaries is less than the cost of the pessary provided. After some investigation, two problems have been identified:

- 1 The service and the supply are being reported incorrectly
- 2 Even when reported correctly, reimbursement for the pessary is sometimes less than the cost

How to bill correctly

Two codes should be submitted on the 1500 claims form—one for the actual fitting and insertion of the pessary and one for the pessary itself. CPT code 57160 (“fitting and insertion of pessary or other intravaginal support device”) is used to report the physician’s service of fitting and inserting the pessary. Either HCPCS code A4561 (“pessary, rubber, any type”) or A4562 (“pessary, nonrubber, any type”) should be reported for the supply of the pessary. In most cases, physicians are using nonrubber (silicone) pessaries, meaning code A4562 should be reported. Check with the vendor and/or package description with questions about whether the pessary is rubber or nonrubber (silicone).

Pessary supplies should not be reported to durable medical equipment regional carriers. Therefore, a “durable medical equipment, prosthetics, orthotics, and supplies” number is not required. As of Jan 1, 2002, jurisdiction for processing claims for pessaries changed from the DMERCs to local Medicare carriers.

It should be noted that an office visit code (99201–99215) may be reported with the fitting and insertion of a pessary, provided that the physician documents the required elements of a separate evaluation and management (E/M) service. The modifier 25 (“significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service”) should be appended to the applicable E/M service code.

What to do if you are underpaid

Pessary supplies are priced by Medicare carriers, so reimbursement may vary slightly from carrier to carrier. The Centers for Medicare and Medicaid Services does expect carriers to reimburse physicians adequately for the cost of pessaries. If you are being reimbursed less than the cost of supplying the pessary, please let ACOG know so that we can inform CMS. ♀

Help ACOG collect pessary data

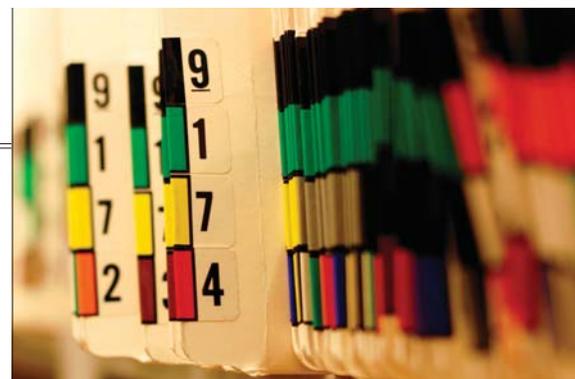
TO HELP US COLLECT DATA REGARDING inadequate reimbursement associated with supplying pessaries, ACOG Fellows are asked to send the following to ACOG:

- ▶ Doctor’s name and contact information
- ▶ Contact name (if different from the doctor)
- ▶ Location of practice
- ▶ Medicare carrier
- ▶ A receipt showing the cost of the pessary
- ▶ The 1500 claims form on which the pessary was submitted for reimbursement
- ▶ An EOB from the Medicare carrier that shows how the supply was coded and paid

Be sure to delete all patient information before forwarding the claims form and EOB to ACOG.

Send information to:

Kim Chisolm, manager,
physician payment policy
Fax: 202-484-7480
Mail: ACOG
ATTN: Kim Chisolm
Health Economics Department
PO Box 96920
Washington, DC 20090-6920 ♀



CMS initiates physician quality reporting program

THE CENTERS FOR MEDICARE and Medicaid Services began a quality reporting program in July, allowing physicians to earn a bonus payment for services covered by Medicare.

Dubbed the Physician Quality Reporting Initiative, the program rewards physicians who successfully report a designated set of quality measures on claims for dates of service from Jul 1 to Dec 31, 2007. Physicians can earn a bonus payment, subject to a cap, of 1.5% of their total allowed charges for services covered by the Medicare physician fee schedule.

No registration required

Physicians do not need to register to participate in PQRI; they can participate by reporting the appropriate quality measure data on submitted Medicare claims. To meet the program requirements and receive the bonus payment, certain reporting thresholds must be met. When no more than three quality measures are applicable to services provided by an eligible professional, each such measure must be reported in at least 80% of the cases in which the measure is reportable. When four or more measures are applicable to the services provided by an eligible professional, the 80% threshold must be met in at least three of the measures reported. ♀

info

- More information and ob-gyn-specific measures are on the ACOG website, www.acog.org. Under “Practice Management,” click on “Practice Management and Managed Care” and then “CMS Initiates Physician Quality Reporting Program”
- PQRI information, including specifications for the 74 measures: www.cms.hhs.gov/PQRI

YOU ASKED, WE ANSWERED

Develop risk management tools while you're in residency

Q I WILL BE COMPLETING MY residency this year. What measures can I take to avoid a liability claim?

A IF YOU BEGIN NOW TO SEE your daily routines—as well as emergency situations—through a risk management lens, you may reduce the chances that you will be named in a professional liability case during residency and you will also be prepared for practice in the years ahead.

Communication skills

Good communication with patients and the health care team is a powerful risk management tool and essential to good patient care. Communication skills are seldom taught during medical training, but they can make a huge difference in patient satisfaction and other patient outcomes, such as compliance with treatment, participation in important treatment decisions, and even psychological adjustment.

Good communication includes listening skills. If physicians are not good listeners, it

is unlikely that they will be good communicators.

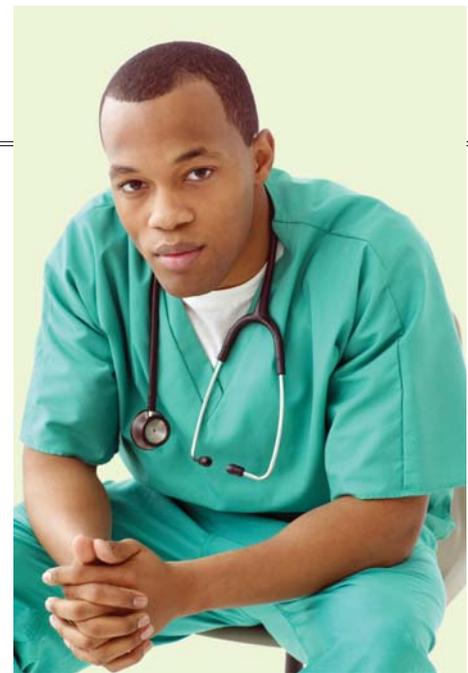
Informed consent

A thorough informed consent process and strong documentation practices are cornerstones of risk management. Effective informed consent is not just a form—it's a process to ensure that a patient makes the health care decision that is right for her. When documenting informed consent or other patient care information, keep in mind that the major principles of medical record documentation are accuracy, comprehensiveness, legibility, objectivity, and timeliness.

Contacting your attending

One of the many difficult situations you face as a resident is when to contact the attending physician about a change in your patient's status. These conflicting thoughts are probably familiar:

- ▶ "I want to learn to rely on my own judgment, and I know my attending physician wants



me to learn this too"

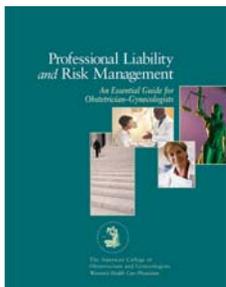
- ▶ "I am reluctant to interrupt my attending at home or in the office"

Take a risk management approach to these situations. If you are in doubt about whether you should notify the attending physician, make the call. If he or she thinks you called unnecessarily, you may be embarrassed for awhile, and your attending may even be angry. But, if you do not call and your skills and knowledge are not adequate to help the patient, she could suffer serious and unnecessary harm. ♀

The information in this article should not be construed as legal advice. As always, physicians should consult their personal attorneys about legal requirements in their jurisdiction and for legal advice on a particular matter.

professional liability lessons

Common terms and definitions



Risk management resource

ACOG's *Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists*

The elements of professional liability

IF A PATIENT SUES YOU FOR professional liability, she must prove the following:

- ▶ You owed her a duty of care
- ▶ You breached that duty
- ▶ Your breach of duty (your negligence) caused her injury
- ▶ She suffered damages as a result of that injury

Duty of care: It begins once the physician-patient relationship has been established. It usually begins with the first face-to-face contact, but there are exceptions—it may begin with advice given via telephone or email or when the patient makes an appointment and is a member of a managed care plan or a capitated patient list.

Breach of duty: The patient must prove your breach of duty either by an "act of commission" (you did something you should not have done) or by an "act of omission" (you failed to do something you should have done).

Causation: The patient must also prove that your negligence directly caused her injury. Causation is the most difficult element to prove; patients usually rely on expert witness testimony. Evidence of causation must prove that your negligence caused the injury to a "reasonable degree of medical probability." The patient does not need to demonstrate absolute proof or proof beyond a reasonable doubt.

Damages: If a patient proves that she suffered physical, financial, or emotional injury as a result of your negligence, the jury or court can award her damages. ♀

2007 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

SEPTEMBER

5-8

Society of Laparoendoscopic Surgeons 16th Annual Meeting and Endo Expo

San Francisco
www.sls.org
305-665-9959

11

ACOG WEBCAST: Coding for the Non-Medicare Preventive Care Visit

1-2:30 pm ET
800-673-8444, ext 2498

11-12

ACOG District V Junior Fellows Annual Meeting

Indianapolis
800-673-8444, ext 2532

14-16

ACOG District IV Annual Meeting

Chicago
800-673-8444, ext 2488

16-19

ACOG District V Fellows Annual Meeting

Napa, CA
800-673-8444, ext 2574

26-29

American Gynecological and Obstetrical Society Annual Meeting

Chicago
www.agosonline.org
800-673-8444, ext 2648

26-29

Association of Reproductive Health Professionals 44th Annual Meeting

Minneapolis
www.arhp.org
202-466-3825

27-29

American Urogynecologic Society 28th Annual Scientific Meeting

Hollywood, FL
www.augs.org
202-367-1167

28-30

ACOG District I Annual Meeting

Newport, RI
800-673-8444, ext 2531

OCTOBER

3-6

American Academy of Family Physicians Scientific Assembly

Chicago
www.aafp.org
800-926-6890

3-6

North American Menopause Society 18th Annual Meeting

Dallas
www.menopause.org
440-442-7657

5-7

ACOG District VI Junior Fellows Annual Meeting

Lake Geneva, WI
800-673-8444, ext 2588

6

Sixth New York University School of Medicine Reproductive Psychiatry Conference

New York City
212-263-5295

7-11

American College of Surgeons 93rd Annual Clinical Congress

New Orleans
www.facs.org
312-202-5240

9

ACOG WEBCAST: Negotiations with Payers

1-2:30 pm ET
800-673-8444, ext 2498

10-14

Pacific Coast Obstetrical and Gynecological Society Las Vegas Meeting

Henderson, NV
www.pcogs.org

11-14

Academy of Breastfeeding Medicine 12th Annual International Meeting

Fort Worth, TX
www.bfmed.org

13-17

American Society for Reproductive Medicine 63rd Annual Meeting

Washington, DC
www.asrm.org
205-978-5000

17-20

Central Association of Obstetricians and Gynecologists 74th Annual Meeting

Chicago
www.caog.org
701-838-8323

25-28

ACOG District VII Annual Meeting

Las Vegas
800-673-8444, ext 2542

26-28

ACOG District II Annual Meeting

New York City
518-436-3461

27-30

American Academy of Pediatrics National Conference and Exhibition

San Francisco
www.aap.org/nce
866-843-2271

28-31

ACOG Armed Forces District Annual Meeting

Louisville, KY
800-673-8444, ext 2571

NOVEMBER

2-7

Association of American Medical Colleges Annual Meeting

Washington, DC
www.aamc.org
800-798-8432

9-11

ACOG District III Annual Meeting

Santo Domingo, Dominican Republic
800-673-8444, ext 2574

10-13

American Medical Association Interim Meeting

Honolulu
www.ama-assn.org
800-673-8444, ext 2516

13

ACOG WEBCAST: Preparing for Cross-Examination

1-2:30 pm ET
800-673-8444, ext 2498

13-17

The 36th Global Congress of Minimally Invasive Gynecology—American Association of Gynecologic Laparoscopists Annual Meeting

Washington, DC
www.aagl.org
800-554-2245

15-17

Council of Medical Specialty Societies Annual Meeting

Chicago
www.cmss.org
847-295-3456

DECEMBER

11

ACOG WEBCAST: Preview of New Codes for 2008

1-2:30 pm ET
800-673-8444, ext 2498

ACOG COURSES

- For Postgraduate Courses, call 800-673-8444, ext 2540/2541, weekdays 9 am-4:45 pm ET or visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings"
- For Coding Workshops, visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings." Telephone registration is not accepted for Coding Workshops.

Registration must be received one week before the course. On-site registration subject to availability.

SEPTEMBER

7-9

ICD-9-CM and CPT Coding Workshop

Houston

8-9

"No Frills" New Surgical Approaches to Incontinence and Prolapse

Atlanta

28-30

ICD-9-CM and CPT Coding Workshop

St. Louis

NOVEMBER

15-17

Ob-Gyn Pearls

Las Vegas

16-17

ICD-9-CM and CPT Coding Workshop

Los Angeles

29-Dec 1

Practical Obstetrics and Gynecology

New York City

30-Dec 2

ICD-9-CM and CPT Coding Workshop

Atlanta

DECEMBER

6-8

The Mature Woman: From Perimenopause to the Elderly Years

Chicago

2008

FEBRUARY

7-9

Complex Gynecologic Surgery: Prevention and Management of Complications

Phoenix

14-16

Twenty-first Century Obstetrics and Gynecology

Jamaica, West Indies

9-Mar 2

ICD-9-CM and CPT Coding Workshop

Orlando, FL

Depression screening tools available



info

- For materials and to register:
www.mentalhealthscreening.org/careprov/depression.aspx
- ACOG Patient Education Pamphlets *Depression* (AP106) and *Postpartum Depression* (AP091): Order at <http://sales.acog.org>; 800-762-2264

OB-GYNS ARE ENCOURAGED TO screen patients for mental health disorders next month as part of National Depression Screening Day. The event will be held on October 11, but ob-gyns are asked to select any day to conduct mental health screening as part of their office-based appointments. ACOG is a cosponsor of the day.

This year's theme for National Depression Screening Day is "Stop a Suicide Today!," a new program to educate the public about the warning signs of suicide and how to effectively respond to someone who may be at risk.

Physicians can register for the day on the NDSD website to receive screening kits that include a suicide risk questionnaire, screening tools, educational brochures, a video, posters, promotional templates, and an implementation and promotion guide. Other materials include a resource guide for implementing the Joint Commission's 2007 patient safety goals on suicide. ♀

Review of breastfeeding

AN EVIDENCE-BASED REVIEW ON breastfeeding and maternal and infant outcomes is available from the US Agency for Healthcare Research and Quality. The review showed that breastfeeding reduced an infant's risk of ear infections by up to 50% and serious lower respiratory tract infections by 72%. There was also a reduced risk of leukemia, SIDS, asthma, type 1 and type 2 diabetes, and skin rash. ♀

info

- www.ahrq.gov/clinic/tp/brfouttp.htm

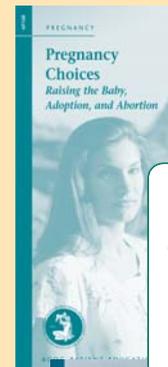


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ACOG PATIENT EDUCATION

Information you and your patients can trust



Save 20% for a limited time. Take advantage of this special offer on ACOG's revised pamphlets.

Pregnancy Choices *Raising the Baby, Adoption, and Abortion (AP168)*

- ▶ Options during pregnancy
- ▶ The effects of each choice
- ▶ What happens if a woman changes her mind



Hormonal Birth Control *Injections, Implants, Rings, and Patches (AP159)*

- ▶ How these methods work
- ▶ Benefits
- ▶ Side effects and risks

info

- To preview these pamphlets:
www.acog.org/goto/patients
- To order pamphlets: <http://sales.acog.org>;
800-762-2264 (use source code DM68 1006)
- To request a free sample: resources@acog.org

NHLBI develops COPD campaign

A NEW CAMPAIGN IS AIMED AT improving awareness of chronic obstructive pulmonary disease, or COPD, and encouraging those at risk to talk to their health care provider about a simple breathing test.

The National Heart, Lung, and Blood Institute developed "COPD: Learn More, Breathe Better," which targets women and men older than 45 with a history of smoking, shortness of breath, or other respiratory symptoms. ♀

info

- www.learnaboutcopd.org