Women lack knowledge about gynecologic cancers

A majority of women in the US, 54%, believe they are at risk for developing a gynecologic cancer, but most cannot name any symptoms or ways to reduce their risk, according to a poll conducted by the Gynecologic Cancer Foundation and Research!America.

Of 800 women surveyed by telephone, 46% were unaware of any risk factors for developing gynecologic cancer and 19% could not name any test for gynecologic cancer. Of those who could name risk factors, 20% cited genetics or family history and 11% mentioned exposure to viruses/STDs and having multiple sex partners. Of those who could name ways to lower risk, 13% said regular check-ups/Pap tests and 12% said a healthy lifestyle and diet.

“The poll findings show that women face a lack of knowledge about gynecologic cancers,” said Karl C. Podratz, MD, PhD, chair of GCF. “Particularly alarming—since early detection is critical to successful treatment—is that half of the women polled could not name a single symptom. In this case, lack of awareness leads to unnecessary deaths, so we must work even harder to educate women and help save lives.”

Complete ACOG survey and win

ACOG needs your help in gathering crucial professional liability data. Preparations are under way for the College’s 2006 Survey of Professional Liability and, for the first time, Fellows will be able to complete the survey online.

All Fellows who complete the survey by March 20 will be eligible to win free registration to the 2006 ACOG Annual Clinical Meeting, to be held May 6—10, in Washington, DC. Three winners will be randomly selected.

“ACOG’s Survey of Professional Liability plays a critical role in educating our lawmakers and the public about the liability crisis and its negative effect on access to care for women across the country,” said ACOG President Michael T. Mennuti, MD. “Participation by all Fellows is essential for the accuracy and credibility of the survey results.”

Look for an email and/or postcard in January that provides instructions on how to complete the survey.
The use of ACOG guidelines not mandatory

ACOG HAS A NUMBER of committees, made up of active practitioners, that respond to current clinical situations with contemporary guidelines and recommendations. However, the use of these ACOG guidelines by physicians and/ or hospitals is not mandatory.

Instituting a rigid body of rules is not in the best interest of the patient or the physician. Therefore, all ACOG documents carry a qualifying statement to explain the use of guidelines. The statement for ACOG Practice Bulletins states: “The information is designed to aid practitioners in making decisions about appropriate obstetric and gynecologic care. These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.”

Recently, as pay-for-performance and related issues have arisen, ACOG has been asked about the qualifying statements in its documents. Why does ACOG use such statements? The answer is both simple and complex. First, anyone who has treated patients understands that some patients do not fit into a classic pattern and that management requires the physician, in the best interest of the patient, to go outside of usual guidelines.

There is a more complex reason as well. When writing a guideline, the authors have to consider the usual patient with the usual findings who will respond in the usual way. In any bell-shaped curve of two standard deviations, 95% will be inside the curve, and 5% will be outside the curve. It’s the management of these 5% that can be confusing and difficult. After four years of medical school and four years of specialty training, the physician can and should be able to make a decision for the best care of the patient that may not follow a guideline.

Some medical organizations insist upon strict adherence to guidelines, making it mandatory to follow them. However, ACOG believes this is not in the best interest of the patient or you, as her physician.

Ralph W. Hale, MD, FACOG
Executive Vice President

New ACOG officers chosen

THE ACOG COMMITTEE on Nominations met on November 19 and selected the following slate of national officers for 2006-07:

- **President Elect**
  Kenneth L. Noller, MD (District I)

- **Vice President**
  Sandra A. Carson, MD (District VII)

- **Treasurer**
  James T. Breeden, MD (District VIII)

- **Assistant Secretary**
  Peter A. Schwartz, MD (District III)

- **Fellow-at-Large**
  Steven J. Fleischman, MD (District I)

Photos and brief bios of the nominees are on the ACOG website. ACOG Today will publish a profile of each nominee in the March issue, along with the official notice of ACOG’s May 8 Annual Business Meeting in Washington, DC, which is when the slate will be voted upon. New officers will begin their terms on May 11, at the post-Annual Clinical Meeting Executive Board meeting.
Obesity researcher wins Issue of the Year award

**Junior Fellow D. Yvette LaCoursiere, MD, MPH**, who has been researching obesity and pregnancy the past two years, was selected to receive the 2005 ACOG Issue of the Year award, which addresses “Successful Interventions for Achieving and Maintaining Weight Loss: The Role of the Obstetrician-Gynecologist.” Dr. LaCoursiere is an assistant professor at the University of Utah.

Dr. LaCoursiere’s past research shows that the number of prepregnancy women who were overweight or obese in Utah increased by 40% from 1991 to 2001 and that the number of pregnant women who were obese at delivery increased by 36%. In addition, among cesarean deliveries in 2001 in Utah, 1 in 7 was attributable to overweight and obesity, according to Dr. LaCoursiere.

“It’s interesting that we spend so much money researching topics that occur in a few number of people, yet obesity happens in such a large population of people and it’s not been getting due respect,” Dr. LaCoursiere said. “Physicians are expected to be qualified both to address the problem of obesity and to offer appropriate treatment options. However, our research at the University of Utah suggests that there is insufficient training in obesity and weight management during residency.”

As recipient of the Issue of the Year award, Dr. LaCoursiere is required to develop a thoroughly researched and referenced background paper of 50–100 pages. She said she wants to encourage ob-gyns to address obesity in their practice and that her paper will provide them with information to understand the problem, identify and assess the obese patient, and offer successful interventions for achieving and maintaining weight loss.

**Researching effective techniques**

As part of her research, Dr. LaCoursiere plans to:

- Review literature to determine effective techniques for identification, assessment, and communication with patients
- Conduct a comprehensive review of weight loss and maintenance interventions, outlining both successful and unsuccessful interventions
- Provide information on special populations, such as teens, pregnant women, and minorities, and on special issues, such as breastfeeding, smoking cessation, herbal remedies, and hormone therapies
- Use a survey of residency programs and an ob-gyn record review to provide information on the need for comprehensive training on obesity and weight management in residency and the need for improved surveillance, documentation, and treatment of obese patients

“Research shows that ob-gyns are not bringing up the issue of weight with their patients. Some say it’s hard to talk about such a sensitive issue, but we, as ob-gyns, deal with lots of health issues that are sensitive. That’s part of our job. We need to make weight management a part of a routine visit,” Dr. LaCoursiere said.

“I hope to provide a document that outlines tools ob-gyns can use to effectively communicate overweight and obesity issues with their patients.”

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**IN MEMORIAM**

- **Richard L. Hermes, MD**
  Lawrence, KS • 2/05
- **Joe S. Hester, MD**
  Muskogee, OK
- **Hugh M. Hill, MD**
  Gainesville, FL
- **Edward T. R. Holt, MD**
  Groton, CT • 1/05
- **Robert R. Hughes, MD**
  Memphis, TN • 3/05
- **Charles F. Kramer, MD**
  Glenwood, IL
- **James W. Kuykendall, MD**
  Alto, NM • 2/05
- **Joseph Laurora, MD**
  Hackettstown, NJ • 3/05
- **George C. Lawrence, MD**
  Atlanta
- **Harold E. Merkley, MD**
  Salt Lake City
- **John L. Monahan, MD**
  Milton, MA
- **Jack R. Nolen, MD**
  Muskogee, OK • 1/05
- **John W. Patrick, MD**
  Montreal, QC
- **Rochelle Kuhr Peskin, MD**
  Akron, OH • 5/05
- **John S. Rienzo, MD**
  Bayside, NY • 6/05
- **Florence S. Ristine, MD**
  Medford, NJ
- **Edward A. Rogers, MD**
  Moultrie, GA • 7/05
- **Philip R. Sanfilippo, MD**
  San Jose, CA
- **Lloyd V. Shields, MD**
  Greenwood Village, CO
- **Robert Leland Smith, MD**
  Altamonte Springs, FL • 1/05
- **S. Allen Truex, MD**
  Jackson, TN • 8/05
- **C. Lee VanNamen, MD**
  Grand Rapids, MI • 5/05
- **Joseph B. Watrous Jr, MD**
  Hallstead, PA • 3/05
- **Paul S. Woodall, MD**
  Birmingham, AL

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2006 ACM: Exploring Washington, DC

Not only is Washington, DC the nation’s capital, it is a city that celebrates diverse cultures, historical landmarks, posh restaurants, and thrilling entertainment. Take time to explore all the city offers during the 2006 Annual Clinical Meeting, to be held May 6–10 in DC.

Beginning January 6, the ACM Preliminary Program will be available online and those planning on attending will be able to register for educational sessions.

One of the newest additions to DC is the Smithsonian’s National Museum of the American Indian, which opened on the National Mall in 2004. The museum’s permanent exhibit, “Our Universes, Our Peoples, and Our Lives,” depicts the important ideas and experiences in native life and history.

In the neighborhoods of Georgetown, Adams Morgan, and DuPont Circle, visitors can enjoy restaurants offering Mexican, Asian, Italian, and regional cuisines. In the evening, experience the famous John F. Kennedy Center for the Performing Arts, presenting the best dancers, actors, and musicians, world-renowned for their expertise in ballet, opera, classical music, and theater.

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www.acog.org/acm

Order spring/summer copies of pause™

Copies of the new fall/winter 2005 issue of pause™ were shipped to Fellows in November. If you haven’t ordered this free resource to give to your perimenopausal and menopausal patients, be sure to request your copies for the spring/summer 2006 issue. Fellows who received the fall/winter 2005 issue will automatically receive the spring/summer 2006 issue. (The magazine is published twice a year and is available in bulk quantities.)

In May 2005, ACOG Fellows received the newly redesigned pause™ magazine, formerly called Managing Menopause™ and the Years Beyond. Pause™ covers a wide range of health issues pertinent to your perimenopausal and menopausal patients.

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pause™ subscription forms are available on ACOG’s member-access website at www.acog.org/member_access/misc/mm2form.pdf
ACOG’s Office of Communications: 800-673-8444, ext 2560; communications@acog.org

Canadian Fellow to become FIGO’s first female president

An ACOG fellow will become the first female president of the International Federation of Gynecology and Obstetrics in the organization’s 51-year history. Dorothy Shaw, MBChB, Vancouver, BC, is now serving as FIGO president-elect and will assume the presidency in November 2006 during the closing ceremony of the FIGO World Congress of Gynecology and Obstetrics in Kuala Lumpur, Malaysia.

“I feel deeply honored and privileged to be in this very significant leadership role,” Dr. Shaw told ACOG Today. “I am well aware of the positive effect that women leaders can bring to professional organizations, especially those involved in women’s health care. The support I have received to date from women and men around the world has been truly humbling and will be critical in our team approach to saving women’s lives.”

Dr. Shaw has been a member of ACOG since 1979. She served as president of the Society of Obstetricians and Gynecologists of Canada in 1991–92 and became active in FIGO during plans for the FIGO Congress in Montreal, QC, in 1994. She has represented Canada on the FIGO Executive Board since 2000 and has chaired the FIGO Committee for Women’s Sexual and Reproductive Rights.

During her presidency, Dr. Shaw plans to focus on collaboration as a key component of the international efforts to improve women’s health, especially maternal mortality. The relevance of sexual and reproductive rights to the practicing ob-gyn will be a part of this approach, she said.

Dr. Shaw received her medical degree from the University of Edinburgh, Scotland, and trained in the UK. She immigrated to Canada to pursue perinatology, an emerging subspecialty at the time. She joined the faculty of the University of British Columbia in Vancouver in 1979, where she remains today. She is a clinical professor of ob-gyn and medical genetics and serves as senior associate dean, faculty affairs. She is also on staff at British Columbia Women’s Hospital.

Dr. Shaw will replace current FIGO President Arnaldo Acosta, MD, of Paraguay, who is also a Fellow of ACOG.
Roundtable highlights value of having a lobbyist at state capital

L O N G T I M E M I N N E S O T A advocate Janette H. Strathy, MD, attended this year’s ACOG State Lobbyist Roundtable as a member of the College’s Committee on Government Relations, joining more than 30 section chairs and lobbyists at the October meeting.

“Overall, I thought it was a very valuable interchange of experiences,” Dr. Strathy said. “It is very clear that the states that have lobbyists who are devoted to ob-gyn are more effective in educating legislatures because they are there consistently when things are happening.”

The annual roundtable—an invitational meeting for active sections, who send their legislative chairs and lobbyists—provides an opportunity for sections to share legislative success stories and setbacks. Participants have a chance to gather ideas and effective strategies to use in their own section’s advocacy efforts. Discussion this year focused on erosion of women’s health care coverage; medical liability reform and Medicare cuts. “An equally important part of my job is to keep the ob-gyns informed about legislative activities, develop issue papers and strategies on bills we are supporting or opposing, and facilitate meetings and communications between ACOG physicians and their legislators.”

Effective lobbying crucial
According to Dr. Strathy, without effective lobbying, the medical community can miss out on opportunities to inform legislatures about issues relating to women’s health and, thus, miss out on influencing votes on legislation related to those issues.

“It is a positive thing to have a full-time lobbyist representing a section, even though it can be expensive,” Dr. Strathy said. “For Minnesota, our section has hired lobbyists for certain issues that come about in the state Legislature,” she said.

Florida Section Chair Paul A. Gluck, MD, said the roundtable provides a good networking opportunity for active ob-gyns and professional lobbyists. Dr. Gluck and Florida Section lobbyist Amy Young, who has lobbied on behalf of the Florida Section and the Florida State Ob-Gyn Society since the 1980s, shared with the group their experience hosting an annual forum for women legislators in Florida.

“ACOG and Fellows are the most credible resource to state and federal legislators,” Dr. Gluck said. “There is no question that the government influences so much of what we do in our practice, and you cannot ignore [legislators], but, instead, work with them to continue to provide quality care for women.”

Ohio Fellow Jason V. Melillo, MD, attended the roundtable for the first time.

“I am starting to realize that unless physicians start to get involved in policy issues, decisions will be made without any of our input,” Dr. Melillo said. “Forums like the roundtable are a way to get our opinions addressed so that other sections can learn from each other and lobbyists can continue to inform our legislatures.”

Accompanying Dr. Melillo at the roundtable was Carole Rogers, a full-time lobbyist for the Ohio Section.

“As a lobbyist, my job is to maintain a persistent presence for ACOG’s Ohio Section in the General Assembly,” Ms. Rogers said. “I meet with all legislators to educate them on our issues, monitor committee hearings, and testify when needed.

“An equally important part of my job is to keep the ob-gyns informed about legislative activities, develop issue papers and strategies on bills we are supporting or opposing, and facilitate meetings and communications between ACOG physicians and their legislators.”

Registration deadline: February 10
Develop advocacy skills at ACOG’s Congressional Leadership Conference

L E A R N H O W T O C O M M U N I C A T E with state and federal legislators and advocate for women’s health issues on Capitol Hill during the 2006 ACOG Congressional Leadership Conference. Registration is open until February 10 for this year’s conference, which will be held March 12–14, in Washington, DC.

Most Fellows and Junior Fellows who attend the conference are sponsored by their districts or sections. Nonsponsored Fellows or Junior Fellows can attend for a $300 registration fee plus travel and accommodations.

Conference participants gain valuable knowledge from Washington insiders and congressional representatives about legislation affecting the ob-gyn specialty and their patients. The conference also provides effective lobbying and communication techniques and prepares ob-gyns to become active in state and federal advocacy efforts. The conference culminates in a visit to Capitol Hill, where participants meet with their state delegations to discuss key legislative issues such as medical liability reform and Medicare cuts.

Contact your district or section chair or Stephanie Cherkezian in ACOG’s Government Relations Department: 800-673-8444, ext 2566; scherkezian@acog.org
District VII residency initiative energizes Junior Fellows

Before Geraldine Alba, MD, was asked to serve as her residency program's representative to District VII, she had little knowledge of ACOG. But that all changed when she began attending district meetings and interacting with district leaders.

“ACOG was something I didn’t really know much about. Basically, I thought it was an entity that puts out the Compendium and administers the CREOG exam,” said Dr. Alba, a third-year resident at the University of Tennessee in Memphis. “But now I know that ACOG is the working engine of our careers as obstetricians-gynecologists. It is where all ob-gyns should look with any questions of practice.”

District VII’s Residency Program Representative Initiative was created two years ago to encourage ob-gyn residents to become more active in ACOG. In turn, ACOG learns more about residency issues and concerns. The initiative selects one resident from each of the 39 US residency programs in District VII to serve as his or her program’s representative to the district. The district funds each representative to attend the Annual District Meeting.

Involvement increasing

During the 2004 District VII ADM, seven program representatives attended. One year later, 27 representatives showed up, and even more were expected but were stymied by the aftermath of Hurricane Katrina and the threat of Hurricane Rita. At the 2005 ADM, nearly 70 Junior Fellows attended the Junior Fellow business meeting, compared with just a handful in 2001.

“The program has energized residents to get involved with ACOG,” said Patrick S. Ramsey, MD, MSPH, vice chair of the Junior Fellow College Advisory Council and immediate past chair of District VII. “Before this program, many Junior Fellows attended our ADM only if it happened to be in their state or nearby. Now, more residents are becoming engaged with ACOG.”

Increased involvement of the youngest physicians will have a positive effect on women’s health, according to District VII Junior Fellow Chair Rajiv B. Gala, MD.

“The earlier we get resident physicians involved with organized medicine, the more likely we are to create individuals who will later continue to advocate for their patients and for issues related to women’s health,” Dr. Gala said. “Our goal has been to help make ACOG tangible to those physicians in training. This is how grassroots activism will continue to emerge.”

Representatives seek office

Dr. Alba is a shining example of the program’s effect. After serving as a program representative, she decided to run for a district office and is now the District VII Junior Fellow secretary-treasurer. And she’s not the only one to increase her involvement. Three other former program representatives now hold an ACOG office: Christina L. Greig, MD, is the new Junior Fellow chair of the Texas Section, Mistie R. Peil Mills, MD, is now the Junior Fellow vice chair of the Missouri Section, and Stacey L. Holman, MD, is the Junior Fellow vice chair of the Louisiana Section.

“I knew I wanted to get more involved in the College, and I thought it would be interesting to be on the business side of things as well,” Dr. Alba said. “I’m also much more aware of the medical students and what we need to do to get them interested in our incredible specialty. I have since been active in student recruiting activities, setting up ‘meet and greets’ for the med students and answering any questions they have about our program. Now, I feel a sense of responsibility being involved in ACOG.”

Find ideal position through ACOG’s Career Connection

Start your search for a rewarding career in women’s health through ACOG’s Career Connection. Post your resume online and search for jobs at no cost. The search function allows candidates to search by job positions, locations, and keywords. Employers can search through online responses to postings and can quickly search a candidate’s profile, review his or her CV, and contact the candidate online. Career Connection is a part of the HEALTHeCAREERS Network. info

- Click on the ACOG Career Connection logo on the ACOG home page, www.acog.org
- 888-884-8242; info@healthecareers.com
B-GYN RESIDENT AND ACOG Junior Fellow N. Summer Khan, MD, was recognized recently for her commitment to some of the poorest residents of New Orleans. The Association of American Medical Colleges’ Organization of Resident Representatives selected Dr. Khan to receive the 2005 ORR Community Service Recognition Award. The annual award recognizes residents who demonstrate a commitment to community service above and beyond the rigors of their residency training.

As a resident at Louisiana State University, Dr. Khan oversaw staffing of the LSU homeless clinics and initiated the LSU Prenatal Education Class.

“LSU was a great experience. Working at Charity and University hospitals, I dealt with uninsured patients in southern Louisiana,” Dr. Khan said. “I staffed our homeless clinic all four years of residency, offering counseling, Pap tests, STD screening. The idea was to show compassionate care without judgment.”

While caring for pregnant patients at the two hospitals, Dr. Khan recognized that many patients had little knowledge of pregnancy issues. Therefore, she created a free prenatal class, which included tours of the labor and delivery department and free ultrasounds. Staff also threw a baby shower for class participants.

Beyond helping New Orleans moms-to-be, the class increased interest in the ob-gyn specialty among medical students. Dr. Khan recruited med students to help with the prenatal classes, and several of the students became energized by the experience and expressed interest in selecting ob-gyn as their specialty.

Hurricane halts resident’s efforts

Unfortunately, the community service efforts Dr. Khan was recognized for at University and Charity hospitals came to an abrupt halt as Hurricane Katrina devastated the city in August and left the two hospitals unsalvageable. Now, Dr. Khan finds herself among those who lost everything.

“That’s what I went to medical school for, to help people. I never thought in a million years I would be needy,” Dr. Khan said. “But [because of the hurricane] I lost everything.”

Dr. Khan completed her ob-gyn residency at LSU last year. She recently entered private practice in Pensacola, FL.

“What I found since the aftermath of Hurricane Katrina is the amazing kindness and generosity of people,” she said. “Neighboring communities came forward to help those affected. LSU faculty, residents, and students volunteered at the many American Red Cross medical shelters. There is now a strong spirit to rebuild LSU School of Medicine in New Orleans and to make it even better.

“I’m very proud to be a graduate of such a place, where so many doctors tried so hard to help the people of New Orleans. I feel very lucky to be recognized and will continue to make helping the less fortunate a part of my life.”

Becoming knowledgeable about PL coverage in residency

What are the limits of my coverage?

Is tail coverage paid by my residency program? If so, what are the limits and how are they applied? If not, will I be able to purchase tail coverage when I complete residency?

Does the policy include any limitations on my practice?

Will claims filed during residency affect my ability to obtain insurance after residency?

Obtaining documentation crucial

Be sure to get copies of your residency program’s medical liability insurance policies for each year you are in the program. Keep documentation of coverage indefinitely. Also, be sure you have proof of coverage. You could be sued for an incident that occurred during residency long after you completed the program and long after the residency program discarded its records.

If your residency program is self-insured and assumes all risk for medical liability claims, obtain and keep a written statement or certificate of the coverage provided. If your residency program is self-insured and has reinsurance from an outside insurer for claims above a specified level, obtain documentation of both policies.

The best tool for protecting your interests now and in the future is information. Learn as much as you can about the options for obtaining coverage, the benefits and disadvantages of different types of coverage, and the provisions of the policy you select.
During National Folic Acid Awareness Week, January 9–15, organizers will focus on health disparities, especially among Hispanic women. Hispanic women have a higher risk than non-Hispanic white women for having a baby born with neural tube defects, according to the Centers for Disease Control and Prevention.

National Folic Acid Awareness Week is sponsored by the National Council on Folic Acid. ACOG is a cosponsor of the week and a founding member of the national council.

The week's events, which will focus on the theme “Folic acid: You don't know what you're missing!” aim to raise awareness among women and practitioners about the importance of folic acid in the prevention of birth defects.

While raising awareness, organizers of National Folic Acid Awareness Week are also contacting manufacturers of corn flour and tortillas in the US to encourage them to begin fortifying their corn flour with folic acid.

**Women need to take folic acid before they become pregnant**

While fortification is important in the prevention of birth defects, most women still do not consume enough folic acid in their daily diet. In 2005, only 33% of women ages 18–45 took a daily vitamin with folic acid, according to a Gallup survey conducted for the March of Dimes Birth Defects Foundation. ACOG endorses the US Public Health Service recommendation that all women capable of becoming pregnant take 400 micrograms of folic acid daily. Women who have previously had a child with a spine or skull defect should take 4 milligrams daily.

“National Folic Acid Awareness Week will educate both patients and physicians about the importance of taking folic acid supplements every day—before women become pregnant. It's important to recognize that more than half of all pregnancies are unplanned, and the neural tube is nearly formed in the first few weeks of pregnancy, often before a woman even realizes she's pregnant,” said Ann L. Honebrink, MD, ACOG’s physician representative on the National Council on Folic Acid. “Educating all women of reproductive age about the benefits of folic acid supplementation before pregnancy is a wonderful opportunity for prevention of neural tube defects.”

On the website for National Folic Acid Awareness Week, physicians can order free consumer materials, including a brochure, bookmark, and poster available in both English and Spanish.

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For those interested in participating in the Spina Bifida trial, the Arnold Chiari II malformation of the brain starts between T1 and S1 (it can extend below S1), and the Myelomeningocele defect that starts between T1 and S1 (it can extend below S1).

**To be eligible, a patient must:**
- Be at least 18 years old
- Be a resident of the US
- Be screened and enrolled by her 25th week of pregnancy
- Have a BMI of 35 or less

**In addition, the fetus must have:**
- A Myelomeningocele defect that starts between T1 and S1 (it can extend below S1)
- The Arnold Chiari II malformation of the brain
- Normal chromosomes

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**Spina bifida trial seeks enrollees**

T he management of Myelomeningocele Study (MOMS), a randomized, controlled clinical trial comparing the safety and efficacy of prenatal and postnatal repair of spina bifida, continues to enroll pregnant women. The study is funded by the National Institute of Child Health and Human Development.

During Phase I of the two-phased screening process, potential patients’ medical records are evaluated for inclusion and exclusion criteria, and all patients have the opportunity to discuss both the fetal condition and the trial at length with MOMS Program Manager Catherine Shaer, MD.

Interested participants who qualify are offered the opportunity to travel to one of three MOMS Centers for Phase II screening: Children's Hospital of Philadelphia, the University of California at San Francisco, or Vanderbilt University Medical Center in Nashville. During Phase II, patients are further evaluated for participation and are able to decide if they wish to enroll. If so, they are randomly assigned to either the prenatal or postnatal arm of the trial.

The prenatal surgery will be done between the 19th and 25th weeks of pregnancy. Patients in both groups will deliver their baby by cesarean section in the 37th week of their pregnancy. Follow-up evaluations will be done on all infants born in the trial through age 2 1/2. The study covers expenses for the patient, infant, and one support person.
Ortho Evra labeling updated
Blood clot risk unclear with contraceptive patch

A

n updated label for the Ortho Evra contraceptive patch has physicians and patients asking questions about the patch’s safety and use. In November, the Food and Drug Administration approved an updated label to warn that the patch, which is produced by Ortho McNeil Pharmaceuticals, exposes women to higher levels of estrogen than most birth control pills. The patch has not been recalled, nor has the FDA warned women to stop using the patch.

The updated label states that women who use Ortho Evra are exposed to about 60% greater average concentration of ethinyl estradiol at steady state compared with a birth control pill containing 35 micrograms of estrogen. However, the peak concentrations are about 25% lower with Ortho Evra than with typical birth control pills. The label states, “In general, increased estrogen exposure may increase the risk of adverse events. However, it is not known whether there are changes in the risk of serious adverse events based on the differences in pharmacokinetic profiles of EE [ethinyl estradiol] in women using Ortho Evra compared with women using oral contraceptives containing 35 µg of EE.”

No published studies on blood clot risk
The new labeling comes on the heels of several lawsuits filed on behalf of women who suffered blood clots or died while using the patch. The Associated Press reported last summer that there have been 23 deaths associated with the patch and that about 17 of them may have been related to blood clots. AP based its conclusions on a review of FDA drug safety reports obtained through the Freedom of Information Act.

ACOG has reviewed the updated label for Ortho Evra. Neither the new label nor accompanying information from the FDA describes the total number of patch users among whom the reported thrombotic events have occurred, and there has been no published evidence that details these adverse events. Thus, the absolute risk of a thrombotic event for women using the contraceptive patch is unclear. ACOG will continue to monitor this issue and will review any new data as they become available.

Currently, the FDA and the updated label both recommend that physicians and women balance the increased exposure to estrogen against the chance of pregnancy if a birth control pill is not taken daily.

The FDA is continuing to monitor safety reports for Ortho Evra, and Ortho McNeil Pharmaceuticals is conducting additional studies to compare the risk of developing serious blood clots while using Ortho Evra with the risk in women using typical birth control pills that contain 35 micrograms of estrogen. ©

Page highlights include:

 ➤ An update on the progress of the HPV vaccine, which has been highly effective against targeted HPV types in clinical trials. A study released at the 2005 Society of Gynecologic Oncologists Annual Meeting on Women’s Cancer found that 69% of women with a daughter would consent to having her vaccinated against HPV if a vaccine were available, according to the report.

 ➤ Progress report on detecting invasive cervical cancer. Results have not yet been released on a study that compares the ability of a CT scan with that of an MRI scan performed before surgery to correctly measure the size, extent, and location of a cervical cancer. The report notes that a summary report of 15 prior studies of PET scans showed there was good evidence that PET is useful in detecting lymph node metastases in women with cervical cancer. Such detection would allow women to avoid unnecessary surgery.

 ➤ Discussion of important recent findings on endometrial cancer, including the value of lymphadenectomy for most patients with endometrial cancer. ACOG joined with the Society of Gynecologic Oncologists in August to publish the Management of Endometrial Cancer Practice Bulletin (#68), which addresses the critical component of lymph node assessment in surgical staging. “The importance of this recommendation cannot be overstated because it may change the location of treatment for women with endometrial cancer,” according to the State of the State report. ©

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 ➤ www.fda.gov/cder/drug/infopage/orthoevra/default.htm

 ➤ www.thegcf.org

 ➤ ACOG Patient Education Pamphlets on specific gynecologic cancers: www.acog.org, under “Publications,” click on “Patient Education Pamphlets”
ACOG Fellow at the frontline of African HIV/AIDS epidemic

The Neverending Day Began in Juneau, AK, with a flight to Seattle.

Next, another flight across the US and the Atlantic to Amsterdam, the Netherlands, followed by an eight-hour flight to Nairobi, Kenya. But the trip wasn’t over yet. Next came a one-hour flight to Kisumu, the third largest city in Kenya, where a four-wheel drive vehicle was waiting for a five-hour ride to Matoso, a remote village in western Kenya on the shores of Lake Victoria.

That’s the long and exhausting route that ACOG Fellow Carolyn V. Brown, MD, MPH, took to arrive at her volunteer position at Lalmba Clinic in Matoso, Kenya. Dr. Brown is more than halfway through a two-year commitment as the clinic’s medical director, volunteering through a program with the Lalmba Association, a nonprofit created by an American couple 40 years ago that has dubbed itself the “smallest relief agency” in Africa. Previously, Dr. Brown has been in private practice in the US and was the deputy director of public health for the Alaska Division of Public Health.

Dr. Brown arrived in Matoso in September 2004 and is committed to stay through September 2006. As medical director, she is responsible for addressing the medical, public health, and health education issues at the general Matoso Clinic (100–150 patients per day), Ongoro Children’s Home (33 orphans), and the foster care feeding program (1,100 orphans who have lost one or both parents). Dr. Brown and her pediatrician husband, George, work side-by-side, addressing the needs of women, children, and families engulfed in the HIV/AIDS epidemic and the multiple health issues of tropical Africa.

During her stay, Dr. Brown has found the time to write description-filled “tomes,” as she calls them, that she mails to friends and family back in the US. The eloquent and moving journal details heartwarming, exhilarating, frustrating, and funny moments as she describes everything from clinical encounters to the outhouse.

“I have written the tomes out of a lifelong history of journaling,” she told ACOG Today. “Writing enables me to maintain a focus and clarity about who I am, where I am, and what I think I am about.”

Developing an ART program

In Kenya, Dr. Brown has encountered cases she’d never seen in the US, including patients suffering from rabies, malaria, and leprosy. But one of her primary directives is to set up an HIV/AIDS antiretroviral therapy program in Matoso. The village is located in the Nyanza Province, which has the highest prevalence rate of HIV/AIDS in Kenya.

Dr. Brown and her staff refurbished an unused building to set up a waiting room, counseling room, and exam room for the HIV/AIDS program. The staff received education and training about HIV/AIDS medications, toxicities, opportunistic infections, and the plethora of other factors in a patient’s life. Now in place are counselors, clinicians, and support systems for pre-ART (Septra and multivitamins), ART, home-based care, nutrition, relief transport, laboratory and X-ray services, and community assistance.

“Our HIV/AIDS program here is fascinating,” she writes in one of her tomes. “We do enormous numbers of voluntary counseling and testing, diagnostic testing and counseling, and prenatal mother-to-child testing. … We have not had to advertise. What we have had to do is build trust and [build] hope that HIV/AIDS is not a death sentence and that there is help to be had. The people are now beginning to believe this, and they are coming [to us]. Our challenge will be to get and maintain sustainable systems in place; otherwise, I believe the work will overwhelm us.”

She continues, “Among the saddest parts of my work has been watching some of the people live in denial of their HIV status while they quietly and very painfully waste away and...
It has been equally incredible to watch people who agree to treatment gain weight, get strength back enough to work and care for their children, and become productive members of their communities again.”

**Testing and training TBAs**

Because traditional birth attendants, or TBAs, perform the majority of deliveries in Matoso, they play an important role in women’s health, Dr. Brown said. She surveyed about 80 TBAs in December 2004 to ask them if they would agree to be tested for HIV.

“I wondered if they would agree to such testing and was pleasantly surprised that 100% of these women wanted to be tested,” she writes. “What an incredible opportunity to provide these women their own HIV status and then to use that as a springboard for teaching.”

In March 2005, the clinic was ready to test the women in an all-day workshop. “The day-long seminar was used entirely for HIV/AIDS—to teach the TBAs about their own personal information … and the importance of their work in delivering women and in dealing with the babies. It was an incredible day. There were 66 TBAs in attendance. … We had videos, speeches, group teaching, and then split the women into groups of five each for pretest counseling about AIDS.”

Each woman was tested, told her results confidentially, and provided in-depth post-counseling. The five counselors in attendance told Dr. Brown that they had never seen so many people tested in one day. It turns out that 15% of all the TBAs tested were HIV+.

“Now the real teaching begins to enlist these TBAs (HIV+ or not) to work with pregnant women,” Dr. Brown writes. “Our program of providing pregnant women who are HIV+ nevirapine when they go into labor and then providing nevirapine syrup to the newborn within 72 hours cuts the vertical transmission rate by 40% if done correctly. TBAs can be very helpful with this program because they do the bulk of deliveries in our area. It was an incredible day of clinical medicine, health education, and good public health. We are not through with this.”

**The highs and the lows**

Dr. Brown’s experience has had its ups and downs, frustrations and celebrations. “Some days I think this is really working,” she told ACOG Today. “Other days I am so overwhelmed and too tired to get out of my own way. There are days I cry and other days when I feel as though I have been a caring physician. So, why do I do this? I think it comes from my life experiences that have challenged me to continually ask the question ‘What is it I can do to make a difference in the human condition that will enable people to get and maintain control of their own destinies?’”

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**Passages from Dr. Brown’s tomes**

I was fascinated to find four to five Kenyan women outside the clinic in a heated talk this week about what can be done about the men? Yet another man went to the hospital this week with sickness and died. Of course he has AIDS. People are in denial about this, and it is extremely rare that it is admitted. Yet, this young man left a wife (who probably now has AIDS) and three children. … Women [here] have no say in whether to have sex or not. If they do not acquiesce, they will be beaten, or the man will cast that woman off and take another wife. That woman is then without any resources, education, or way to exist and the kids go with her. I know it’s like that all over the world, but it’s very real here.”

“I have spent a good bit of my time when I can in what I call the ‘medicine barn.’ This is a challenge not to be undertaken by the light-of-heart. Things are sort of alphabetical, but that could be in generic, trade name, or any one of eight different languages. If only that were it. The rat and bat deposits drive me crazy, and I would welcome any remote modicum of cleanliness. … [One day] I’m sitting in the medicine barn … when I look up to the door and see a four-foot monitor lizard looking at me and wandering in. A little startled? Yes. I had no way out of the building except over the lizard, and I just sat there [until he left]. I heard later that he caught a chicken on the way to wherever. That’s a no-no for the Luo people because chickens are dear. I expect the lizard’s days are numbered.”

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Dr. Brown, sitting with staff members, allows a young boy living with AIDS to listen to his own heartbeat.
**DISTRICT I • QUEBEC CITY**

Vermont Fellow
Stephen J. Woodruff, MD, and his wife, Micki

▲ ADM Program Chair Jacques E. Rioux, MD, with two Quebec tour guides in historical costume

**DISTRICT II • NEW YORK CITY**

▲ District II Vice Chair Scott D. Hayworth, MD; Secretary Howard L. Minkoff, MD; and Past Chair William P. Dillon, MD

▲ John Boyce, MD, and ACOG Past President Vicki L. Seltzer, MD

**DISTRICT III • LOS CABOS**

▲ Pennsylvania Section Chair Ann L. Honebrink, MD; ACOG President Michael T. Mennuti, MD; and Dr. Mennuti’s wife, Nancy

▲ At the Tri-District III, IV, and IX ADM, JFCAC Immediate Past Chair Leah A. Kaufman, MD; JFCAC Chair May Hsieh Blanchard, MD; Pennsylvania Section Treasurer Mitchell I. Edelson, MD; and New Jersey Fellow Archana Pradhan, MD

Welcome Reception of the Tri-District III, IV, and IX ADM in Los Cabos, Mexico
**District IV • Los Cabos**

District of Columbia Section Chair Stephen I. Proctor, MD, receives a certificate from District IV Chair Ramon A. Suarez, MD, for serving as the DC Section vice chair.

Georgia Life Fellow John S. Inman Jr and his wife, Willa

**District V • Toronto**

Kentucky Section Secretary-Treasurer Connie G. White, MD, with Ohio Fellow Dr. Victor H. Bazzoli and his wife, Ruth

Medical student Okeoma Mmeje, Junior Fellow Shavonne T.D. Ramsey Coleman, MD, and medical student Meredith Dixon

Ontario Fellow Dalip K. Bhangu, MD, on the right, speaks with an exhibitor.

**District VI • St. Thomas**

District VI Chair James D. Miller, MD, and Junior Fellow Vice Chair Christine S. Goudge, MD

Joel B. Henry, MD, Wisconsin Section vice chair, and Paul G. Tomich, MD, ACOG assistant secretary and District VI Junior Fellow advisor

**District VII • San Antonio**

Missouri Section Chair Gordon M. Goldman, MD, and Missouri Section Vice Chair Roger P. Smith, MD

JFCAC Vice Chair Patrick S. Ramsey, MD, MSPH; ACOG President Elect Douglas W. Laube, MD; and District VII Junior Fellow Chair Rajiv B. Gala, MD

Weesie Hollis; ADM Program Chair Lisa M. Holler, MD; and ACOG Past President Richard S. “Pete” Hollis, MD
**District VIII • San Antonio**

- Central America Section Vice Chair Paulino E. Vigil de Gracia, MD, and District VIII Vice Chair J. Joshua Kopelman, MD
- District VIII Fellow Jennifer Gunter, MD, with her poster presentation at the District VII and VIII ADM
- District VIII Chair Luis “Ben” Curet, MD, and Immediate Past Chair James T. Breeden, MD, make friends with a beluga whale at Sea World of Texas.

**District IX • Los Cabos**

- Local Arrangements Chair and District IX Vice Chair Jeanne A. Conry, MD, of District IX, and her husband, Bruce Webb
- ACOG President Elect Douglas W. Laube, MD, and Dr. Cindy Macer, with her husband, District IX Immediate Past Chair James A. Macer, MD
- Life Fellow Roger W. Hoag, MD, and his wife, Silvii

**Armed Forces District • Seattle**

- Fellow Richard T. Welham, MD; Junior Fellow Kedric E. Webster, MD; and Fellow Michael J. Sexton, MD
- Michael C. Gordon, MD, receives the Professor of the Year Award.
- Drs. Linda Chan and Nanette L. Rollene

**Keep Updated On** district and section news, including information on upcoming Annual District Meetings: Visit the ACOG website, www.acog.org, and search under “Membership.”
### January

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<tr>
<td>14</td>
<td><strong>ACOG WEBCAST:</strong> Global Surgical Package&lt;br&gt;1-2:30 pm ET&lt;br&gt;800-673-8444, ext 2498</td>
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### February

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<tr>
<td>9-11</td>
<td>33rd Annual Meeting of the North American Society for Psychosocial Obstetrics and Gynecology&lt;br&gt;Kohala Coast, HI&lt;br&gt;www.naspsog.org&lt;br&gt;202-863-2570</td>
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<tr>
<td>14</td>
<td><strong>ACOG WEBCAST:</strong> Misadventures and Complications of Care Coding&lt;br&gt;1-2:30 pm ET&lt;br&gt;800-673-8444, ext 2498</td>
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### March

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<tr>
<td>2-5</td>
<td>CREOG and APGO Annual Meeting&lt;br&gt;Orlando, FL&lt;br&gt;CREOG: 800-673-8444, ext 2558&lt;br&gt;APGO: 410-451-9560</td>
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<td>13-17</td>
<td>American Society for Colposcopy and Cervical Pathology Biennial Meeting&lt;br&gt;Las Vegas&lt;br&gt;www.asccp.org/biennial.shtml&lt;br&gt;800-787-7227</td>
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### April

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<td>1-5</td>
<td>Society of Gynecologic Surgeons 32nd Annual Scientific Meeting&lt;br&gt;Tucson, AZ&lt;br&gt;www.sgsonline.org&lt;br&gt;901-682-2079</td>
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<tr>
<td>8-10</td>
<td>18th European Congress of Obstetrics and Gynaecology&lt;br&gt;Torino, Italy&lt;br&gt;www.ebcog2006.it</td>
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### May

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<tr>
<td>12-14</td>
<td>The Mature Woman: From Perimenopause to the Elderly Years&lt;br&gt;Vail, CO</td>
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### June

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<tr>
<td>2-4</td>
<td>CPT and ICD-9-CM Coding Workshop&lt;br&gt;Portland, OR</td>
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<td>22-24</td>
<td>The Art of Clinical Obstetrics&lt;br&gt;Kohala Coast, HI</td>
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### August

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<tr>
<td>4-6</td>
<td>CPT and ICD-9-CM Coding Workshop&lt;br&gt;Secaucus, NJ</td>
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<tr>
<td>10-12</td>
<td>Screening in Obstetrics and Gynecology&lt;br&gt;Vancouver, BC</td>
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### September

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<tr>
<td>8-10</td>
<td>CPT and ICD-9-CM Coding Workshop&lt;br&gt;San Diego</td>
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<tr>
<td>14-16</td>
<td>Quality Improvement and Management Skills for Leaders in Women’s Health Care&lt;br&gt;San Francisco</td>
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### October

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<tr>
<td>13-15</td>
<td>CPT and ICD-9-CM Coding Workshop&lt;br&gt;Chicago</td>
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Newly revised Patient Education Pamphlets available

Our Pregnancy and Birth

Patient Education Pamphlets have been revised and are now available through ACOG.

The pamphlets are:
- Morning Sickness (AP126)
- Repeated Miscarriage (AP100)
- The Rh Factor: How It Can Affect your Pregnancy (AP027)
- Vaginal Birth after Cesarean Delivery (AP070)

Get answers to your coding questions

Do you have a coding question? Facing a coding conundrum? Help is available. Fellows or their staff can submit specific questions to ACOG’s coding staff.

Submit questions by email to Terry Tropin at ttropin@acog.org or Savonne Alford at salford@acog.org or by fax to 202-484-7480. Please do not include any identifiable Protected Health Information in your email or fax. Questions are answered in approximately three to four weeks.

Clinical Updates focuses on hypertension

Ob-gyns can play a pivotal role in the management of hypertension, according to Clinical Updates in Women’s Health Care, Hypertension, the latest in the Clinical Updates series. The monograph enables ob-gyns to:
- Understand the pathophysiologic mechanisms that contribute to hypertension and cardiovascular disease
- Monitor risk factors for hypertension and determine the need for intervention
- Counsel patients about lifestyle factors that lower the risk of hypertension and cardiovascular disease
- Define the new classification that includes a prehypertension category as recommended by the National High Blood Pressure Education Program
- Screen patients for hypertension
- Evaluate patients who have hypertension and initiate management
- Treat the early stages of hypertension
- Identify indications for referral of patients with hypertension

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PO Box 96920
Washington, DC 20090-6920

Mental health screening tools available

The non-profit organization Screening for Mental Health offers free mental health diagnostic and treatment aids online. The materials are designed to help clinicians easily and effectively provide screening, diagnosis, treatment, and referral for some of the most common and treatable mental health problems, including depression, bipolar disorder, generalized anxiety disorder, and posttraumatic stress disorder.

Materials include pocket reference cards, a clinician’s guide, patient screening forms, and educational brochures. The pocket cards and clinician guide are also provided in text format to download onto personal digital assistants, or PDAs.

Enter “pc” as the user name and “primary” as the password.