ACM program expands in return to Windy City

It’s been eight years since Chicago has hosted ACOG’s Annual Clinical Meeting, and there have been incredible advances in medicine, in ob-gyn, and in the technology available to physicians and their patients since 2001. The 57th Annual Clinical Meeting, which will be held May 2–6 at McCormick Place Lakeside Center in Chicago, will reflect ob-gyn’s newest techniques, cutting-edge technology, and hot-button issues.

ACOG’s Committee on Scientific Program has developed a program that incorporates more audience interaction and hands-on learning. Courses have been specifically designed to include practical, evidence-based information that can be incorporated into practice.

The “scientific sessions”—which have been renamed “plenary sessions”—have been expanded to offer attendees 11 sessions. The 1st Plenary Session, the President’s Program, will lead off the ACM with top patient safety expert Robert M. Wachter, MD, who will offer practical solutions for the prevention of medical errors as this year’s Samuel A. Cosgrove Memorial Lecturer. The President’s Program will also include presentations from women’s cancer advocate Fran Drescher, president of the Cancer Schmancer Movement and star of the television sitcom The Nanny; US Rep. Diana DeGette (D-CO); Dorothy Shaw, MD, president of the International Federation of Gynecology and Obstetrics (FIGO); and Canadian ob-gyn Jean Chamberlain Froese, MD, who will detail her dramatic experiences working to make childbirth safer in the developing world.

Making its debut Tuesday morning is the ACM College Advisory Council Meeting, which has traditionally been a meeting solely for ACOG officers, will be opened up to allow all ACOG members to attend. The CAC Meeting will be held on Sunday, May 3, from 3 to 5 pm at the Hilton Chicago Hotel.

“ACOG’s Council of District Chairs, which organizes the CAC Meeting, wanted the meeting to become an effective venue for multidirectional communication,” said Council Chair Mark S. DeFrancesco, MD, MBA. “Everyone will have the opportunity at this year’s Annual Clinical Meeting to actively participate in discussions about the future of the College and to learn more about the implementation of the new American Congress of Obstetricians and Gynecologists. The ACM College Advisory Council Meeting, which has traditionally been a meeting solely for ACOG officers, will be opened up to allow all ACOG members to attend. The CAC Meeting will be held on Sunday, May 3, from 3 to 5 pm at the Hilton Chicago Hotel.

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New ACM lecture will delve into ACOG’s past

WITH ONE MONTH TO GO, planning for ACOG’s 57th Annual Clinical Meeting has jumped into high gear. This year’s ACM will be held May 2–6 at the McCormick Place Lakeside Center in the friendly, fun, and beautiful Midwestern city of Chicago. If you haven’t already registered for the ACM and made your travel plans, do so now so you don’t miss out on informative and important sessions, fellowship with colleagues, and evenings of entertainment.

Every year the ACM offers attendees the latest information on all aspects of our specialty, while more than 300 exhibitors highlight the most recent women’s health products in the largest exhibition in the US for ob-gyns and other women’s health care professionals.

This year, I will have the pleasure of presenting the inaugural W. Benson and Pamela Harer Lecture, the 8th Plenary Session, “History of the American College of Obstetricians and Gynecologists—How We Arrived at Where We Are Today.” This endowed seminar is to be on a subject related to the history of medicine. Dr. Harer, ACOG’s 51st president, is a recognized world expert in the history of the ob-gyn profession and has spent many years studying early Egyptian medicine as well.

During the session, I will talk about those responsible for the formation of ACOG and the events that led to the creation of the College and its early development, before giving a glimpse of what is happening in the College’s immediate future. Although ACOG was formed in 1951, prior to that time there were many organizations seeking to represent ob-gyns. The earliest of these began in the late 1800s. As the times changed and 20th-century medicine became more scientifically based, physicians began to see a greater need for a single national presence.

Most ob-gyns know little of how the College began and the trials and tribulations that have molded ACOG into the organization it is today. This first Harer session will supply that knowledge.

While in Chicago, be sure to take advantage of what this wonderful city has to offer. Taste a delicious slice or two of deep-dish pizza, see hilarious improv comedy, hear great blues music, get a birds-eye view from the Sears Tower Skydeck or the Hancock Observatory, and visit, with your kids, the Field Museum of Natural History and the Shedd Aquarium.

Ralph W. Hale, MD, FACOG
Executive Vice President
Thank you to ACOG’s individual donors

Personal gifts to the College ensure that ACOG will continue to promote and maintain the highest standards for ob-gyn care. ACOG thanks the following individuals for their financial contribution and personal commitment to the College.

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**Donation List as of Feb 20, 2009**

ACOG recently hosted a meeting of the Physicians’ Electronic Health Record Coalition that included a discussion about the health information technology provisions in the federal stimulus package that President Obama signed in February. Member organizations discussed their health information technology activities and were updated on the activities of national organizations and initiatives.

ACOG helped create the coalition in 2004, and 23 medical societies are now represented. The coalition was formed to assist physicians—particularly those in small- and medium-size practices—in acquiring and using affordable, standards-based electronic medical records and other health information technology to improve quality, enhance patient safety, and increase the efficiency of medical practice. ACOG is represented on PEHRC by District III Chair Owen C. Montgomery, MD, who co-chairs PEHRC, and Mark S. Seigel, MD, a member of the ACOG Committee on Ambulatory Practice Operations.

Other health information activities:
- ACOG will again offer an Electronic Medical Records Challenge at the Annual Clinical Meeting in Chicago on May 3 (see more on page 7).
- ACOG has a white paper specifying the special requirements of electronic medical records in ob-gyn practice, authored by ACOG’s health information technology consultant, Fellow Michael McCoy, MD
- The Certification Commission for Health Information Technology, or CCHIT, has tentatively agreed to develop specialty certification for ob-gyn EMR systems beginning in 2012
- ACOG continues to work with the Integrating the Healthcare Enterprise initiative, or IHE, on interoperability of antepartum and intrapartum workflows, which would allow health care facilities with different EMR systems to share patient records electronically.
ACOG reports on disciplinary actions

A COG PROVIDES THIS REPORT to the Fellowship in accordance with the procedures for handling complaints against Fellows and proposed termination of Fellowship (see article on the right). Using these procedures, a Fellow can be issued a warning, censured, suspended, or expelled from the College for unethical behavior. To determine whether a Fellow has engaged in a violation of the ACOG Bylaws or Code of Professional Ethics, the College reviews complaints submitted by Fellows of the College against other Fellows, severe disciplinary actions taken by state medical boards, and any adverse actions taken against a Fellow’s medical license in any jurisdiction based on sexual misconduct.

2008 Executive Board final actions

One Fellow was expelled from the College. The Executive Board took this action based on the Fellow’s voluntary relinquishment of the Fellow’s medical license while under investigation by a state medical board. As required, the College reported this expulsion to the National Practitioner Data Bank.

The College suspended one Fellow. The Executive Board took this action based on multiple states’ disciplinary actions against this Fellow’s medical license. As required, the College reported the suspension to the National Practitioner Data Bank. The College also issued three censures and two warnings to ACOG Fellows.


info

For further information about the complaint process or ACOG’s Code of Professional Ethics, visit www.acog.org/goto/grievance or contact the Office of the General Counsel: 202-863-2584; grievance@acog.org

Grievance process examines Fellow noncompliance with ACOG ethics code

F OR MORE THAN 10 YEARS ACOG Fellows have been governed by a Code of Professional Ethics. Noncompliance with this code or certain other ethical documents, or behavior inconsistent with College bylaws or policies, can affect a Fellow’s College status.

Fellows who believe that another Fellow has violated the ethics code may file a grievance with ACOG. Complaints cannot be made anonymously, and only Fellows can file complaints. Many members associate the grievance process with unethical expert witness testimony, but the Grievance Committee reviews complaints in other areas also, such as informed consent, sexual misconduct, patient testing, and commercial enterprises in medical practice. Actions that aren’t eligible include business disagreements and matters currently in litigation or those being reviewed by a state medical board.

The committee also pursues and reviews final state medical board actions resulting from professional conduct inconsistent with the ACOG Bylaws, including, but not limited to, severe state medical board actions such as revocation of license and any state medical board disciplinary action based on sexual misconduct.

The grievance process begins once the Grievance Committee decides that the complaint is an appropriate matter for consideration by the College. Then, the Fellow complained about is notified that a complaint was filed by whom. The complaint moves forward to a Hearing Panel, and if a disciplinary action is recommended, the respondent may appeal to the Appeals Panel Committee. Final disciplinary actions and the names of Fellows who resigned or were terminated from Fellowship pending the final outcome of the grievance process will be disclosed in the annual confidential letter to the voting Fellows, on the member side of the College’s website, and in response to written requests from any party asking about the membership status of that Fellow. A disciplinary action becomes final only when ratified by the Executive Board.

The College insists that both parties to the complaint maintain the confidentiality of the complaint.

info

For further information about the Clinical Updates series, visit www.clinicalupdates.org.
ACOG president Douglas H. Kirkpatrick, MD, led a record 270 ACOG members from 48 states, including Alaska and Hawaii, at ACOG’s 27th Annual Congressional Leadership Conference, The President’s Conference. Gathering in Washington, DC, March 1–3, members lobbied Congress about addressing women’s health in health care reform.

The timing for the CLC could not have been better. The week before, President Barack Obama declared, in a de-facto State of the Union Address to a joint session of Congress, that health care reform could wait no longer, and he urged Congress to pass reform this year. The president unveiled a budget proposal that would set aside a 10-year $634 billion reserve fund to help move the nation toward universal coverage and fix Medicare physician payments.

After two days of policy discussions and advocacy training at the CLC, ACOG Fellows and Junior Fellows carried two messages to their legislators on Capitol Hill:

- **Health Care for Women, Health Care for All:** ACOG members promoted ACOG’s policy for women’s health in health care reform and asked their members of Congress to cosponsor the Health Care for Women Resolution, which would commit Congress to passing health care reform legislation that addresses the unique needs of women. The measure was introduced by Rep. Jan Schakowsky (D-IL) and Sen. Debbie Stabenow (D-MI).

- **Pilot test a women’s medical home:** CLC participants urged Congress to make sure medical homes work for women’s health care. Ob-gyns and their allied health partners are uniquely qualified to deliver collaborative and continual care to women of all ages. ACOG Fellows and Junior Fellows asked their members of Congress to support a federal demonstration project of the women’s medical home to determine the potential for improved health outcomes and cost savings to the health care system.
Howard Taylor International Symposium, the 7th Plenary Session, “Patient Safety: Changing Culture, Improving Care.” Howard C. Taylor Jr, MD, was a noted educator and leader at Columbia University. Also new is the W. Benson and Pamela Harer Lecture, the 8th Plenary Session, “History of the American College of Obstetricians and Gynecologists—How We Arrived at Where We Are Today.” (For more about this session, see the Executive Desk on page 2.)

At this year’s ACM, registrants will be able to attend two clinical seminars as part of their general registration. Just a few of the clinical seminar topics are induction of labor, fetal heart rate monitoring, cultural competence, cesarean on demand, urinary incontinence procedures, diabetes in pregnancy, prenatal risk assessment for Down syndrome, depression during pregnancy and postpartum, and cervical cancer prevention.

Hot-button issues will be debated in sessions such as “Cosmetic Medicine in Gynecologic Practice,” the 1st Current Issues Update, presented by Past ACOG President Douglas W. Laube, MD, MEd, on Monday afternoon, and “Direct-to-Consumer Genetic Testing,” the 5th Plenary Session, the Irvin M. Cushner Memorial Lecture, presented Tuesday morning by Kathy Hudson, PhD, director of the Genetics and Public Policy Center at Johns Hopkins University, Washington, DC. In the 2nd Plenary Session, the John I. Brewer Memorial Lecture, Stanley A. Gall, MD, ob-gyn professor at the University of Louisville, will look at “The Road to the Cancer Vaccine” Monday afternoon.

The popular hands-on postgraduate courses will include a new obstetric emergencies simulation course. Participants will work in teams and use computers and mannequins to simulate emergencies, receiving immediate feedback from instructors and the “patients.” Other hands-on courses offer lessons on:

- Laparoscopic techniques in advanced gynecologic surgery, almost exclusively using animate stations, supplemented by inanimate stations and computerized surgical simulators
- Obstetric ultrasound with pregnant models
- Office-based gynecology, including anesthesia techniques and insertion and removal of intrauterine devices and the hormonal implant
- Anatomy related to gynecologic surgery and pelvic floor disorders, in which participants will dissect cadaveric pelvises at Northwestern University
- Operative hysteroscopy, including hysteroscopic myomectomy, endometrial ablation, and hysteroscopic sterilization

ACOG is also going green in 2009. Paid registrants will be able to download syllabi online. Evaluation forms for the postgraduate courses and clinical seminars will be filled out online also, and participants will be able to access and print their certificates of attendance online. Certificates will be available at the end of the first day of the course through Aug 15, 2009.

“Everyone will have the chance to ask questions of ACOG leadership, but we also really want the conversation to flow freely among all members.”
—Mark S. DeFrancesco, MD, MBA

ACOG Executive Vice President Ralph W. Hale, MD, FACOG, will update attendees on the progress of the creation of The American Congress of Obstetricians and Gynecologists, which will be formed as a 501(c)(6) organization. This new “business league” organization will have a different nonprofit Internal Revenue Service status, allowing it to expend more effort on socioeconomic activities and on lobbying. The American College of Obstetricians and Gynecologists will continue to exist, and come 2010, members will pay one set of dues but belong to both organizations.

At the CAC Meeting, ACOG President Douglas H. Kirkpatrick, MD, will report on the strategic planning that the Executive Board undertook during his term. In addition to a question-and-answer period, the meeting will use an audience response system to identify ways ACOG can better serve members.
Welcome Reception

Sunday, May 3  ■  7 to 10 pm
Free to registrants
Kick off the ACM with Chicago-style music, entertainment, and cuisine.

Electronic Medical Records Challenge

May 4–5
This year, meeting-goers will be able to register for two clinical seminars at no extra charge.

Interactive Sessions

May 4–6
Interactive sessions use an audience response system to allow attendees to test their knowledge and respond to clinical scenarios.

Presidential Inauguration and Convocation

Wednesday, May 6  ■  9 to 10:30 am
After the induction of new Fellows, Incoming ACOG President Gerald F. Joseph Jr, MD, will give his inaugural address.

Exhibit Hall

Opens on Monday, May 4, at 10:30 am
More than 300 companies and organizations will gather for the largest exhibition in the US for ob-gyns.

Clinical Seminars

Sunday, May 3  ■  9 am to 4 pm
Free to registrants
Fellows considering purchasing an electronic health record system for their practice won’t want to miss the EMR Challenge.

Interactive Sessions

May 4–6
Interactive sessions use an audience response system to allow attendees to test their knowledge and respond to clinical scenarios.

May 2–6 2009
Robots in the OR? ACM session examines alternatives for minimally invasive surgery

Five years ago, “robotics” was not a word commonly used by physicians or patients discussing gynecologic treatment options. But now, “that term is quite prevalent and physicians actually seek out robotics” to learn if it’s an option for their practice, according to Arnold P. Advincula, MD, associate professor and director of the Minimally Invasive Surgery Program and Fellowship at the University of Michigan.

“Patients are becoming empowered and seeking out these procedures too. Times have really changed,” Dr. Advincula said.

The US Food and Drug Administration approved the use of a robotic system for laparoscopy in 2000 and specifically for hysterectomy in 2005.

Robotic surgery allows a surgeon to sit at a console while three or four robotic arms hanging over the patient move according to the surgeon’s commands. An assistant switches out the instruments. In gynecology, robotics can be used for hysterectomy, myomectomy, adnexectomy, endometriosis, and endometrial and cervical malignancies.

“Robotic surgery is becoming more and more an accepted part of a surgeon’s minimally invasive surgical armamentarium, and it’s not just at the major hospitals anymore,” said Dr. Advincula, who, along with Javier F. Magrina, MD, will present a session at this year’s Annual Clinical Meeting discussing the pros and cons of using a robotic system. Dr. Magrina is the Barbara Woodward Lips Professor and director of gynecologic oncology at the Mayo Clinic in Scottsdale, AZ.

The 3rd Current Issues Update, “Robotic Surgery in Gynecology: Use and Abuse,” will be held on Wednesday, May 6, from 7:30 to 8:30 am. Drs. Advincula and Magrina will describe the differences between conventional and robot-assisted laparoscopic surgery, review the available evidence that supports or refutes the use of robotics in gynecologic surgery, and identify the appropriate gynecologic procedures in which a robotic system may be of added value.

Benefits to using a robotic system
There can be a tremendous learning curve for conventional laparoscopic surgery, which has two-dimensional imaging and counter-intuitive hand movements. Using a robotic system solves some of these challenges because it offers three-dimensional imaging and instruments that move just like the surgeon’s wrist.

“The degree of articulation you get with your instrument is far greater than you get with conventional laparoscopy,” Dr. Advincula said.

The system also eliminates normal hand tremors and allows the surgeon to sit, instead of stand, at the console.

In an informal poll of gynecologic oncologists at a major cancer center, Dr. Magrina found that 24% are regular users of the system, and 66% said they plan to start using the system soon.

Dr. Magrina says that for endometrial and cervical cancer surgery, studies have shown that operating time for robotic surgery has been similar to that of laparotomy and equal to or shorter than the operating time for laparoscopy. When compared with laparotomy, robotic surgery has reduced blood loss, and patient hospital stays and recovery times are shorter.

However, because the technology is so new, there is not yet long-term data.

“What we really need to know is if this holds up long term,” Dr. Advincula said. “In cancer surgery, studies show that you can obtain a better surgical dissection, particularly for lymph nodes, but we don’t know the five-year survival rates. For myomectomies, we need to know what the impact is on fertility long term. For sacrocolpopexy, we need to know if the repair holds up five years later.”

Obstacles to using a robotic system
The biggest drawback to a robotic system is the price, both upfront and ongoing. The system costs about $1.6 million and requires an annual $100,000 maintenance contract, according to Dr. Advincula. In addition, surgeons must undergo a company-sponsored training. Dr. Magrina said surgeons will need a proctor for the first several surgeries and recommends that physicians do several animal surgeries before using the system on patients.

While the system can be an enabling advancement for skilled gynecologic surgeons, Dr. Advincula cautions that it can be disabling to surgeons with little surgical experience or infrequent exposure to the operating arena.

Another drawback to the robotic system is the lack of consensus about training. The FDA-required one- to two-day training certifies that a surgeon can use the system, but that doesn’t mean he or she is ready to operate on patients, Dr. Advincula said. There’s no standardized process for privileging or credentialing on the system.

“The system is not for everyone. For those who don’t know much about it, they may view it as exciting or intimidating,” Dr. Advincula said. “Dr. Magrina and I can share our enthusiasm about the technology but also our trepidation about the pitfalls. It’s clearly something that will impact both the members of the College and the patients who are being taken care of by our members.”
The annual clinical meeting will once again feature the popular “Live Telesurgery Session” in which three procedures will be shown from remote locations. This year, attendees are scheduled to witness a posterior colporrhaphy and possible enterocoele repair, a laparoscopic removal of an adnexal mass, and an operative hysteroscopic myomectomy.

The posterior colporrhaphy and enterocoele repair will be performed at the University of Michigan Women’s Hospital in Ann Arbor by John O.L. DeLancey, MD, Norman F. Miller Professor of Gynecology, director of the pelvic floor research group, and director of the fellowship in female pelvic medicine and reconstructive surgery; and Dee E. Fenner, MD, Harold Furlong Professor of Gynecology, director of gynecology, and director of surgical services. Throughout the surgery, Drs. DeLancey and Fenner will explain the surgery and discuss the surgical objectives.

“Our extensive experience with native tissue repairs has helped us optimize success while minimizing complications,” Dr. DeLancey said. “Providing video and discussion of operative strategies to improve success and decrease complications should help most physicians improve their results.”

John F. Steege, MD, director of the division of advanced laparoscopy and pelvic pain at the University of North Carolina at Chapel Hill, is scheduled to perform the laparoscopic removal of an adnexal mass. Dr. Steege intends to show safe techniques for opening the pelvic sidewall to find the ureter as well as safe ways of dealing with scar tissue and dividing blood vessels.

“Unfortunately, damage to the ureter is one of the most common serious complications seen after laparoscopic surgery,” Dr. Steege said. “I hope to demonstrate techniques for the safe removal of a tube and ovary in ways that minimize the risk of ureteral damage.”

The hysteroscopic myomectomy will be performed by Linda Bradley, MD, vice chair of OB/GYN & Women’s Health Institute and director of the Center for Menstrual Disorders, Fibroids, and Hysteroscopic Services at the Cleveland Clinic. Dr. Bradley plans to show attendees how to assemble the operative hysteroscope, retrieve intrauterine tissue fragments, and manage intrauterine debris.

“I would like audience members to learn clinical pearls to assist them in the removal of a complete leiomyoma,” Dr. Bradley said. “Hysteroscopic surgery is underutilized. Approximately one in three gynecologists feels comfortable in performing this procedure. I hope the audience will leave with more confidence in performing operative hysteroscopy.”

The session, held Tuesday, May 5, from 8 to 11:30 am, will provide opportunities for interaction between the surgeons performing the procedures and the audience. The session is free but limited to professional attendees, and tickets are required.

The ACM preliminary program is now available online: www.acog.org/acm
Research papers to be presented at ACM

Learn about new OB-GYN research when clinical and basic research papers are presented at the Annual Clinical Meeting, May 2–6. Papers will be presented from 2 to 4 pm on Monday and Tuesday, May 4 and 5, in the McCormick Place Lakeside Center. Each researcher will present his or her paper in seven minutes, followed by a three-minute informal question-and-answer session. The three prize-winning papers will be presented from 3:30 to 4 pm on Monday.

The first-place winner is William W. Greenfield, MD, assistant professor of ob-gyn at the University of Arkansas for Medical Sciences, for his paper “Regression of Cervical Lesions Is Associated with CD8 T-Cell Responses to HPV 16 E6 but not E7.”

In Dr. Greenfield’s paper he describes how researchers examined the role of HPV type 16 and CD8 T-cells in women with cervical lesions. They found that T-cell responses to the E6 protein were significantly associated with HPV regression and that such responses appeared to be cross-reactive among other HPV high-risk types.

“The results suggest that HPV 16 E6 protein should be an ideal source of antigen for developing a therapeutic vaccine and that such a vaccine may protect not only against HPV 16 infection but also infections caused by other high-risk HPV types,” Dr. Greenfield said. “Our next step would be to conduct an analogous study examining the CD4 T-cell responses.”

Tuesday’s session will begin with presentations from the two Junior Fellows who won the Donald F. Richardson Memorial Prize Papers (see article on page 11).

Career Connection at ACM

A COG’S CAREER CONNECTION Job Center at the Annual Clinical Meeting allows visitors to post resumes, search the online job database, and respond to job postings, while employers can post job opportunities and search the database for qualified candidates.

The center, which features ACOG’s online career site for women’s health care professionals, will be open Saturday through Tuesday, May 2–5, from 8 am to 4 pm and on Wednesday, May 6, from 8 am to 1 pm. The center will be in the registration area, Lakeside Hall E, in the McCormick Place convention center.

“Conference Connection,” a feature of the Career Connection website, allows both candidates and employers to indicate online that they are attending the ACM and set up face-to-face interviews ahead of time. Employers are encouraged to post all of their available opportunities online prior to the ACM, while those searching for a new position should post their resumes. Both employers and candidates can then indicate online whether they will be an ACM attendee or exhibitor and provide their local contact information.

ACOG Career Connection is a part of HEALTHCareERS Network.
Junior Fellow prize paper winners announced

The winners of the 2008–09 Donald F. Richardson Memorial Prize Papers are Junior Fellows Anthony N. Imudia, MD, of District V, and Sharai C. Amaya, MD, of District IV. Their papers were selected from Junior Fellow papers nominated by each district and will be presented on Tuesday, May 5, at the Annual Clinical Meeting in Chicago.

**USE OF FETAL CELLS IN THE CERVICAL CANAL TO IDENTIFY ABNORMAL PREGNANCY**

In Dr. Imudia’s paper, “Retrieval of Trophoblast Cells from the Cervical Canal for Prediction of Abnormal Pregnancy,” he shows that the number of fetal trophoblastic cells in the cervical canal can be identified, quantified, and used to predict ectopic pregnancy or blighted ovum early in the pregnancy. The findings could lead to a simple noninvasive screening test to distinguish normal pregnancy from abnormal pregnancy.

Using a method similar to that of a Pap test, fetal cells were collected from 37 women presenting with a normal intrauterine pregnancy, 10 women with symptoms of ectopic pregnancy, and five women with blighted ovum. Immunohistochemical staining identified those cells with HLA-G, which is expressed in fetal cells. The average frequency of HLA-G positive cells in the samples from the women with a normal intrauterine pregnancy was approximately 1 in 2,000, four to five times higher than those from patients with ectopic pregnancy or blighted ovum.

Dr. Imudia is a third-year ob-gyn resident at Wayne State University/Detroit Medical Center. He received his MD from Universidad Latina de Panama in the Republic of Panama.

**BENEFITS OF RED WINE AND SOY ON ENDOMETRIOSIS**

Dr. Amaya’s paper, “Dietary Impact on Endometriosis: A Closer Look at the Active Ingredients of Red Wine and Soy,” shows that dietary compounds found in red wine and soy may have a role in the treatment of endometriosis. The study looked at the effect that resveratrol, a red wine component, and genistein, a soy protein, had on endometrial cells, both in mice and with alkaline phosphatase assays. Both components have been demonstrated to have estrogenic activity. Soy is a source of phytoestrogens and is thought to provide cardiovascular benefits, enhance bone strength, and alleviate vasomotor symptoms of menopause. Resveratrol in red wine is also thought to have cardiovascular benefits.

By examining the estrogenic and antiestrogenic characteristics of both resveratrol and genistein, researchers showed that these compounds act as anti-estrogens. Resveratrol, in particular, significantly reduced the growth of endometriosis in mice.

Dr. Amaya is a fourth-year ob-gyn resident at Greenville Hospital System in Greenville, SC. She received her MD from the Medical University of South Carolina in Charleston.

**ACM Junior Fellow lecture covers medical practice basics**

For the past three years, ACOG has offered an Annual Clinical Meeting symposium specifically designed for Junior Fellows called the “Business of Medicine,” which aims to educate residents on a variety of business skills needed in medical practice.

This year, the symposium, now called the “Junior Fellow College Advisory Council Lecture,” will feature two sessions focused on aiding residents in specific areas of their transition into practice: office-based ultrasound and career planning. Advance registration is required, and the cost of the course covers both days.

Session I, “Basics of Coding, Office-Based Ultrasound,” will be held on Monday, May 4, from 11 am to 1:30 pm. The session will be led by ultrasound expert Joshua A. Copel, MD, professor and vice chair of the department of obstetrics, gynecology, and reproductive science and pediatrics at Yale University School of Medicine, New Haven, CT.

Dr. Copel’s session will cover how to select an ultrasound machine for purchase, how to set up the flow of patients, appropriate patient selection, basics of ultrasound coding and billing, and how to avoid common problems with office-based ultrasound.

Session II, “Practice, Contracts, and Financial Planning,” will be held on Tuesday, May 5, from 11 am to 1:30 pm. Patrick Molloy, president of Molloy & Co and a member of the Medical Group Management Association, will take Junior Fellows through the process of entering medical practice.
Challenges to routine rapid HIV testing in L&D

All pregnant women are tested for syphilis as a routine part of prenatal care. They are also tested routinely for hepatitis B, and if their status is unknown at delivery, they are tested then. Clinicians don’t question these practices; there’s no stigma to being tested, and few barriers stand in the way of obtaining the test results. The time has come for perinatal HIV testing to be treated the same way.

ACOG and the Centers for Disease Control and Prevention both recommend the “opt-out” approach for perinatal HIV testing, which calls for HIV testing as a routine part of prenatal care unless a patient declines testing. (Physicians should be aware of and follow their states’ prenatal HIV screening requirements.) Antiretroviral medications given to women with HIV during pregnancy and labor, and to their newborns in the first hours after birth, can reduce the mother-to-child transmission rate from 25% to 2% or less.

If a woman presents to labor and delivery with unknown HIV status, she should be given a rapid HIV test, unless she declines, because instituting maternal therapy during labor and delivery can still substantially decrease the rate of infection in infants.

Rapid HIV testing is a tremendous breakthrough for women arriving in labor with no record of their HIV status. But the reality is that many barriers exist to implementing an effective and seamless rapid HIV testing process in the labor and delivery unit.

“The major challenges are really related to practice philosophy and a unit’s ability to develop a protocol to do testing,” said Robert T. Maupin, MD, ob-gyn professor at Louisiana State University and a principal investigator for the landmark Mother-Infant Rapid Intervention at Delivery (MIRIAD) study (see “Info” below). “Not having a commitment to testing is the first hurdle. Then, you need a structure and protocol in place.”

Hospitals should not be “profiling” pregnant patients to determine who should and shouldn’t be tested for HIV, said Mary Jo O’Sullivan, MD, ob-gyn professor at the University of Miami in Florida and an investigator for the MIRIAD study.

“You shouldn’t just be testing the drug user who comes in,” Dr. O’Sullivan said. “The hospital has to mandate the procedure for the labor and delivery unit and hold people accountable. You should know a pregnant patient’s HIV status, just as you would want to know her syphilis status. This benefits both the mother and baby for treatment and/or prophylaxis.”

To ensure all pregnant patients with an unknown HIV status are tested, the CDC recommends including a standing order for testing as part of the admissions orders for women in labor. It’s also important for ob-gyns to indicate patients’ HIV status in their prenatal records as appropriate so patients who already received an HIV test as part of routine prenatal care won’t have to undergo an unnecessary second test.

Lab tests vs. point-of-care tests

Once a labor and delivery unit plans to implement rapid testing, there are still several practical issues that must be sorted out.

“You have a series of logistical challenges,” said Howard L. Minkoff, MD, chair of ACOG’s HIV Expert Work Group and chair of ob-gyn at Maimonides Medical Center, Brooklyn, NY. “Most of the tests are not point-of-care tests, and they take some expertise. Some are point-of-care tests, but you have to train physicians, and they may only do these tests once a month.”

Using a laboratory-based rapid test requires a lab that is available 24 hours a day and that will convey results quickly. Alternatively, point-of-care testing requires clinicians to be trained to perform that test. With either test, clinicians must be prepared to counsel patients confidentially about their results and their need for antiretroviral prophylaxis.

“If they’re doing this all the time, clinicians will know how to explain the test, but if you have only one HIV-infected patient a year—and there are lots of places like that—how do you make sure that every person (in the ward) knows how to counsel properly?” Dr. Minkoff asked.

According to ACOG, the obstetric provider should explain to the patient that she may have HIV infection but that false-positives are possible and that a second test is being done to confirm the results. Women should be told that antiretroviral prophylaxis should be initiated immediately to reduce the risk of transmission to the infant.

Tackling these challenges requires someone, whether it’s an ob-gyn, nurse, or an infectious disease physician, to take the lead to implement procedures and get buy-in from staff, experts say. Without a champion to encourage and oversee the implementation of a standardized rapid testing protocol, testing won’t become routine in that facility, Dr. O’Sullivan said.

“The rollout of rapid testing in labor and delivery settings has been increasingly successful in metropolitan communities the last several years, especially with the CDC’s position on routine testing for HIV,” Dr. Maupin said. “It’s likely to be more of a challenge for small community hospitals, but it’s an incredibly important safety net. We screen for syphilis, and we screen for hepatitis; we should have the capacity to do HIV testing. Once a facility commits to doing this, it becomes workable and we see fewer barriers.”

Info

- www.cdc.gov/hiv/rapid_testing

ACOG Today | April 2009
Evaluating a patient’s risk of hereditary breast and ovarian cancer syndrome should be a routine part of ob-gyn practice, ACOG says in the new Practice Bulletin Hereditary Breast and Ovarian Cancer Syndrome, which was developed jointly by ACOG and the Society of Gynecologic Oncologists. The document was published in the April issue of Obstetrics & Gynecology.

Screening should begin by asking patients about their personal and family history of breast and ovarian cancer. The results will help determine whether the patient may benefit from a more in-depth hereditary cancer risk assessment. The Practice Bulletin includes a list of those women who may have a greater than 20% to 25% chance of an inherited predisposition to breast or ovarian cancer and for whom genetic risk assessment is recommended. These women include those with a personal history of breast and ovarian cancer. It also includes those with ovarian cancer and a close relative with ovarian cancer or premenopausal breast cancer. The Practice Bulletin also outlines those women who may have a greater than 5% to 10% chance of inherited predisposition to breast or ovarian cancer and for whom genetic risk assessment may be helpful. See the Practice Bulletin for the entire list.

The new document provides information on how to counsel patients with a BRCA mutation on reducing their risk of cancer and how to perform a salpingo-oophorectomy in this population.

“The document provides recommendations on how to identify and manage these women when they come into your office,” said Karen H. Lu, MD, professor of gynecologic oncology at the University of Texas MD Anderson Cancer Center, who helped develop the Practice Bulletin. “These guidelines can be helpful when a patient with the BRCA gene mutation starts asking her ob-gyn questions like ‘When should I have my ovaries removed?,’ ‘What should I do for screening?’”

Offering risk-reducing salpingo-oophorectomy

Women who have BRCA1 or BRCA2 mutations should be offered risk-reducing salpingo-oophorectomy by age 40 or when childbearing is complete, the Practice Bulletin says.

Fewer than 2% to 3% of women with BRCA mutations will be diagnosed with ovarian cancer before age 40, but the risk for BRCA1 carriers markedly increases during the 40s, according to the document.

Ovarian cancer screening approaches are currently limited, and risk-reducing salpingo-oophorectomy can reduce the risk of ovarian cancer and fallopian tube cancer by about 85% to 90% in BRCA1 and BRCA2 carriers, according to the Practice Bulletin. Risk-reducing salpingo-oophorectomy can also reduce the risk of breast cancer by 40% to 70%, but the protection likely occurs only in premenopausal patients and may not be as effective in BRCA1 carriers.

In a risk-reducing salpingo-oophorectomy, all tissue from the ovaries and fallopian tubes should be removed, and a complete, serial sectioning that includes microscopic examination for occult cancer should be conducted, according to the Practice Bulletin. A thorough visualization of the peritoneal surfaces with pelvic washings should be performed. Any abnormal areas should undergo biopsy.

“In this population, it’s extremely important that a thorough pathology review is conducted of the ovaries and fallopian tubes,” Dr. Lu said.

National Day to Prevent Teen Pregnancy on May 6

Promotional materials and ideas on how to promote the National Day to Prevent Teen Pregnancy on May 6 are now available. ACOG is a partner in the annual event, organized by the National Campaign to Prevent Teen and Unplanned Pregnancy.

The message of the day is straightforward: Sex has consequences. In January, the Centers for Disease Control and Prevention confirmed that the teen birth rate had increased 3% between 2005 and 2006—the first increase after 14 years of steady decline.

On May 6, teens will be asked to visit the website www.stayteen.org to take a short, scenario-based quiz that asks them what they would do in a number of risky sexual situations. In 2008, more than 300,000 individuals took the quiz, and 54% said the quiz made the risks of sex and teen pregnancy seem more real to them.

On its website, the campaign offers National Day promotional materials (pens, wristbands, and buttons), web banners, sample press releases and articles for online discussion groups, and a list of local community events.

info

www.thenationalcampaign.org/national
Many older Americans struggle with COPD

While many Americans have heard of chronic obstructive pulmonary disease, or COPD, few know what causes it or that treatment is available. A National Heart, Lung, and Blood Institute survey showed that 64% of Americans had heard of COPD, but only 44% knew it was treatable and 66% did not know smoking was a risk factor. Even worse, just 22% of current smokers knew their smoking put them at greater risk for COPD.

COPD is the fourth leading cause of death in the US, typically striking people older than 45. More than 12 million people in the US are currently diagnosed, and another 12 million may have COPD but remain undiagnosed despite recognizable symptoms, according to NHLBI.

Smoking is the leading risk factor, but it’s not the only one. Those who have had long-term exposure to fumes or dust in the environment, secondhand smoke, or other air pollution are also at risk. Heredity and a history of childhood respiratory infections are additional risk factors.

Patients may think that their “out of breath” feeling, wheezing, or coughing are just signs that they’re getting older and may not mention these symptoms to their physician. Both diagnosed and undiagnosed patients with COPD may suffer from depression, as they struggle to maintain their normal activities. The American Lung Association cites data that show that 80% of people with chronic breathing disorders suffered from depression, anxiety, or both, but only 31% of COPD patients were being treated for these conditions.

The lung association says that treatment can improve and prevent COPD symptoms, reduce the frequency and severity of exacerbations, and improve a person’s health status and ability to exercise. Treatment may include bronchodilators, pulmonary rehabilitation, oxygen therapy, and surgery.

Grant applications due April 27

New NIH research grants available

Millions of dollars for biomedical and biobehavioral research are now available from the National Institutes of Health, thanks to the federal stimulus package.

NIH announced in March that $200 million has been designated to support two-year, $1 million grants as part of a new initiative called the NIH Challenge Grants in Health and Science Research. Challenge grants are intended to support research on topic areas that address specific scientific and health research challenges in biomedical and behavioral research that would benefit from significant two-year jumpstart funds. Grant applications are due April 27 (see “info” below). In addition, economic stimulus money allocated to NIH specifically for comparative effectiveness research may be available for additional grants.

NIH has selected specific topics within each of several overall areas. Some of the areas are behavior, behavioral change, and prevention; bioethics; biomarker discovery and validation; clinical research; genomics; health disparities; stem cells; and translational science. Each area lists several topics that have been accorded the highest priority by NIH (see box at right).
### April

- **2–5**
  - Society for Sex Therapy and Research Annual Meeting
  - Arlington, VA
  - www.ststarnet.org/annualmeeting.cfm

- **3–5**
  - ACOG District XI Joint Meeting with the Texas Association of Obstetrics and Gynecology
  - Austin, TX
  - www.txobgyn.org

### May

- **2–6**
  - ACOG 57th Annual Clinical Meeting
  - Chicago
  - www.acog.org/acm

- **8–9**
  - Council of Medical Specialty Societies Spring Meeting
  - Chicago
  - www.cmss.org

### June

- **12**
  - ACOG WEBCAST: Coding with Colposcopies
  - 1–2:30 pm ET
  - 800-673-8444, ext 2498

### July

- **14**
  - 1–2:30 pm ET
  - 800-673-8444, ext 2498

### August

- **11**
  - ACOG WEBCAST: Coding for Multiple Services on the Same Day
  - 1–2:30 pm ET
  - 800-673-8444, ext 2498

### September

- **4**
  - ACOG WEBCAST: Intrapartum Fetal Heart Rate Monitoring—The Evolution of Consensus
  - 1–2:30 pm ET
  - 800-673-8444, ext 2498

- **12**
  - American Medical Association Annual Meeting
  - Chicago
  - www.ama-assn.org

- **17–21**
  - American College of Nurse-Midwives 54th Annual Meeting & Exposition
  - Seattle
  - www.midwife.org/am

### October

- **16–18**
  - North American Menopause Society Annual Meeting
  - San Diego
  - www.menopause.org
  - 440-442-7550

### November

- **12–14**
  - Practical Obstetrics and Gynecology
  - Las Vegas

### December

- **3–5**
  - Update on Cervical Diseases
  - New York City

- **4–6**
  - Coding Workshop
  - Tampa, FL
Breastfeeding women needed for breast cancer study

Breast cancer researchers are asking for ob-gyns’ help in recruiting 250 lactating women who are scheduled for a breast biopsy or who have had a breast biopsy in the past year. The study at the University of Massachusetts Amherst will examine the relationship between hypermethylation in breast cells and breast cancer or breast cancer risk. Hypermethylation interferes with the proper functioning of DNA and can lead to the unrestricted multiplication of cells seen in cancer.

Women in the study will be asked to donate a fresh breast milk sample and ship it to researchers, at no cost or travel time to the women. Participants will also fill out a questionnaire assessing their family history and lifestyle and provide a copy of their biopsy report.

Recruitment will continue for the next year and a half. Ob-gyns are asked to provide this information to potentially eligible patients. Ob-gyns can also request brochures for their office (see “info” at left).

Preeclampsia research grants available

The Preeclampsia Foundation is accepting applications for its Vision Grants, which provide up to $25,000 for medical research pertaining to the pathophysiology, diagnosis, and treatment of hypertensive disorders of pregnancy. Submissions are due by May 15.

Vision Grants are small awards intended to provide initial funding for innovative ideas that might otherwise not be pursued due to lack of funding. While preliminary data are not required, careful development of hypothesis based on existing information is expected. These awards are ideal for, but not limited to, young investigators. They should, however, be directed toward novel, rather than well-established, lines of research.

Research applications are at www.preeclampsia.org/vgrants.asp