EIGHTY-NINTH
ANNIVERSARY
PACIFIC COAST
OBSTETRICAL AND
GYNECOLOGICAL
SOCIETY

Eighty-seventh Annual Meeting
September 5, 2020 and September 12, 2020
Virtual Meeting
OFFICERS

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Fung Lam
San Francisco, California

President-Elect
Dale Reisner
Seattle, WA

Secretary-Treasurer
Thomas G. Gaylord
San Diego, California

Assistant Secretary
Lori Marshall
Seattle, Washington

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HISTORIAN
Martha Goetsch

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Caryl Reinsch       Marc Winter

EDITOR OF SCIENTIFIC PROCEEDINGS
Aaron B. Caughey

SOCIETY ADMINISTRATOR
Daniella Esquivias
ROSTER OF MEETINGS AND PRESIDENTS

November 19-20, 1931 – San Francisco
Organization Meeting
Albert Mathieu, Chairman

December 8-10, 1932 – Los Angeles
Frank W. Lynch

October 19-21, 1933 – Portland
Albert Mathieu

November 21-24, 1934 – Del Monte
Lyle G. McNeile

November 6-9, 1935 – Los Angeles
J. Morris Slemons

November 11-14, 1936 – Seattle
Clarence A. DePuy

November 3-6, 1937 – San Francisco
Ludwig A. Emge

November 30-December 3, 1938 – Los Angeles
Raymond E. Watkins

November 1-4, 1939 – Portland
Edmund M. Lazard

November 6-9, 1940 – San Francisco
Alice F. Maxwell

November 5-8, 1941 – Pasadena
John Vruwink

November 5-7, 1942 – Oakland
T. Floyd Bell

November 3-5, 1943 – San Francisco
C. Frederic Fluhmann

November 6-9, 1946 – San Francisco
Goodrich C. Schauffler

October 1-4, 1947 – Seattle
Henry N. Shaw

November 10-13, 1948 – Los Angeles
Phillip H. Arnot

November 9-12, 1949 – San Francisco
William Benbow Thompson

November 4-19, 1950 – Timberline Lodge
Albert W. Holman

December 5-8, 1951 – Coronado
Roy E. Fallas
October 15-18, 1952 – Del Monte
   Karl L. Schaupp
October 21-24, 1953 – Victoria, B.C.
   Theodore W. Adams
October 27-30, 1954 – Santa Barbara
   Emil J. Krahulik
October 6-9, 1955 – Sun Valley
   Henry A. Stephenson
October 31 – November 3, 1956 – San Francisco
   Donald G. Tollefson
October 30 – November 2, 1957 – Palm Springs
   Bernard J. Hanley
October 15-18, 1958 – Seattle
   Donald J. Thorp
October 21-24, 1959 – San Francisco
   Donald A. Dallas
September 28 – October 1, 1960 – Yosemite
   George E. Judd
September 20-23, 1961 – Yosemite
   Donald W. de Carle
October 3-6, 1962 – Portland
   Daniel G. Morton
September 18-21, 1963 – Yosemite
   Howard C. Stearns
November 4-7, 1964 – Santa Barbara
   Charles T. Hayden
September 29 – October 2, 1965 – Vancouver, B.C.
   Alfred M. McCausland
November 2-5, 1966 – Santa Barbara
   Robert K. Plant
November 29 – December 2, 1967 – Phoenix
   L. Grant Baldwin
October 2-5, 1968 – Shalishan
   Keith P. Russell
October 1-4, 1969 – Yosemite
   Robert D. Dunn
November 9-14, 1970 – Kauai
   Ralph C. Benson
October 5-10, 1971 – La Costa
   Ernest W. Page
October 3-7, 1972 – Harrison Hot Springs
   Purvis L. Martin
October 29 – November 4, 1973 – The Wigwam
   Charles F. McLennan
October 6-10, 1974 – Sun River
   Paul G. Peterson
October 6-11, 1975 – Del Monte
   Ralph H. Walker
November 7-13, 1976 – Kona
   Carl Goetsch
October 4-8, 1977 – Santa Barbara
   Melvin W. Breese
September 26-30, 1978 – Salishan
   William J. Dignam
September 26-30, 1979 – Palm Springs
   Leon J. Shulman
October 6-11, 1980 – Monterey
   Leon P. Fox
September 27 – October 3, 1981 – Kauai
   Colin C. McCorriston
September 26-30, 1982 – Pebble Beach
   Ivan I. Langley
September 6-10, 1983 – Vancouver, B.C. Canada
   George A. Macer
October 21-27, 1984 – Tucson
   Jesse A. Rust, Jr.
September 29 – October 4, 1985 – Napa
   Edward C. Hill
September 21-25, 1986 – Salishan
   Charles D. Kimball
September 27 – October 2, 1987 – Pebble Beach
   Charles F. Langmade
November 12-19, 1988 SS Independence
   Eugene C. Sandberg
September 17-21, 1989 – Coronado
   David C. Figge
September 9-14, 1990 – Sun Valley
   James M. Maharry
September 9-12, 1991 – Ashland
   Richard N. Bolton
October 11-16, 1992 – Ojai
   Walter S. Keifer
September 7-12, 1993 – Bellingham
   Gilbert A. Webb
October 24-29, 1994 – Scottsdale
   David Pent
September 16-21, 1995 – Squaw Valley
   E. Forrest Boyd, Jr.
October 2-6, 1996 – Sunriver
   Theodore W. Loring
September 17-21, 1997 – Coeur d’Alene
   James C. Caillouette
September 16-20, 1998 – Whistler
   E. Paul Kirk
October 20-24, 1999 – Cancun
   Michael R. Smith
November 14-19, 2000 – Hawaii
   S. Gainer Pillsbury, Jr.
October 3-7, 2001 – Ashland
   W. Gordon Peacock
October 22-27, 2002 – Rancho Mirage
   Robert Israel
September 16-21, 2003 – Anchorage
   Emmet J. Lamb
October 19-24, 2004 – Phoenix
   Russell K. Laros, Jr.
September 28-October 2, 2005 – Kauai
   P. Ronald Millard
October 4-8, 2006—Sun Valley, Idaho
   Kenneth A. Burry
October 10-14, 2007—Henderson, Nevada
   Frank R. Gamberdella
October 15-19-2008—Victoria, B. C., Canada
   Jerry M. Shefren
September 30-October 4, 2009—La Jolla, California
   Lyman A. Rust
September 29-October 3, 2010—Kohala Coast, Hawaii
   J. T. (Bill) Parer
September 14-18, 2011—Sunriver, Oregon
   Robert Prins
October 3-7, 2012—Newport Beach, California
   John A. Enbom
October 2-6, 2013—Walla Walla, Washington
   Marilyn K. Laughead
October 22-26, 2014 - Marana, Arizona
Donald Barford

September 2-6, 2015 - Kahuku, Hawaii
Phillip E. Patton

September 28-October 2, 2016, Sun Valley, Idaho
Thomas W. Powers

November 1-5, 2017, Palm Desert, California
Patricia A. Robertson

September 26-30, 2018, Coeur d’Alene, Idaho
David C. Lagrew, Jr.

October 23-27, 2019, San Diego, California
James A. Macer

RECIPIENTS OF
PCOGS FRANK LECOCQ
LIFETIME ACHIEVEMENT AWARD

Frank LeCocq - November 18, 2000

Robert C. Goodlin - October 6, 2001

William Dignam - October 20, 2002

Robert (Bob) Israel - October 3, 2009

Jerry M. Shefren - September 29, 2010

Linda G. Hinrichsen - October 6, 2012

James C. Caillouette - October 23, 2014

John A. Enbom - September 29, 2016
Active Fellows

Acacio
Adams
Adamson
Aghajanian
Ahsan
Asrat
Atamde
Autry
Barkley
Bednarek
Behera
Benoit
Bradley
Branigan
Broberg
Brown
Buchanan
Burlingame
Busse
Cabrera
Card
Caughey
Chandler
Cheng
Cohen
Coleman
Combs
Coonrod
Daskalos
deCastro
Dimer
Druzin
Dunsmoor-Su
Durinzi
Eckert
Ellsworth
El-Sayed
Esakoff
Fassett
Finberg
Fisher
Foley
Francois
Friedman
Fuller
Furukawa
Futoran
Garrett
Gilbert
Goldberg
Gorman
Gosewehr
Grady
Gravett
Greenberg
Gregory, Kathy
Gregory, Kim
Hassan
Hedriana
Hicks
Hoffman
Houmard
Houston
Huerta-Enochian
Incerpi
Israel, J.
Jacobson
Jensen, J.
Johnson
Katz, M.
Keith
Kettel
Khieu
Kilpatrick
Kim, L.
Korman
Kosasa
Lagrew, Jr.
Lam
Lamb, J.
Larsen
Lee, R.
Lenihan
Lentz
Leslie
Lofquist
Luthy
Macaulay
Macdonald
Macer
Manriquez
Maples
Margolin
Marrs
Marshall
McNulty
Melville
Mercer
Mikovsky
Miller
Moran
Morcos
Mukul
Mullin
Munro
Mutch
Nageotte
Nelson, A.
Nelson, H. P.
Nelson, L.
Nichols
Norrell
Norton
Ogasawara
Oliver, John
O’Reilly-Green
Ouzounian
Paek
Paley
Palmer
Pandipati
Partoll
Paulson
Peterson
Phillips
Platt
Press
Prins
Reed
Reinsch, C.
Reiser
Ribbink
Robboy
Robertson
Rogers
Roloff
Romero
Rowles
Schlaerth
Shaffer, B.
Shaffer, L.
Shah
Shahine
Shaw
Shields
Simpson
Smith, W.
Snell
Steinke
Stempel
Tarr
Thomas
Tomlinson
Tomsen
Valenzuela
Vasilev
Veljovich
Walker
Wang
Wentross
<table>
<thead>
<tr>
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<tr>
<td>Wesol</td>
<td>Winter, W.</td>
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<tr>
<td>Wickman</td>
<td>Wittenberg</td>
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<td>Wiggins</td>
<td>Wohlmuth</td>
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<tr>
<td>Williams</td>
<td>Woods</td>
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<tr>
<td>Winch, G. Jr.</td>
<td>Yee</td>
</tr>
<tr>
<td>Winter, M.</td>
<td>Total Fellows - 172</td>
</tr>
</tbody>
</table>
Retired Fellows

Allen
Ambrose
Barbis
Barford
Berek
Boyle
Cain
Clewell
Cole
Collins
Corlett
Corwin
Creasy
Davis
Deasy, K.
Deasy, S.
Der Yuen
Dotters
Enbom
Fearl
Forsythe
Freeman
Gaylord
Giudice
Goetsch
Golditch
Goodno
Goodwin
Graham
Haesslein

Hanson
Hanss
Hartman
Henderson
Hickok, D.
Hickok, L.
Hindle
Hoag
Israel, R.
Katz, V.
Kirk
Lamb, E.
Lamey
Laughead
Lowensohn
Main, D.
Main, E.
Mayo
McCausland
Mouer
Nakayama
Nelson, R.
Neilson
Novy
Oliver, Joseph
Patton
Paul
Peacock
Peters, III
Pillsbury

Pitkin
Plaut
Powers
Quilligan
Reinsch, R.
Resnik
Roberts
Schlesinger
Schrinsky
Schwartz
Segal
Shefren
Shy
Smith, D.
Smith, M.
Smith, R.
Soderstrom
Spanos
Stucky
Tamimi
Unzelman
Veltman
Vontver
Wallace
Watson
Welch
Whitelaw

Total Retired Fellows – 93

Honorary Fellows

Jensen, H.
Smith-Sehdev

Non-Resident Fellows

Ballon
Blanchette
Brewster
Felix
Gabbe

Garite
Hale
Kim
Lanouette
Learman

Martin-Cadieux
Towers

Total Fellowship - 275
A logo is a symbol of identity and, as such, should be filled with symbolism and, in fact, tell a story. With this in mind the Logo Committee, seeking symbols, researched the name of the Society-first the region, Pacific Coast; second our specialty, obstetrics and gynecology; and third our birth, a Society founded in 1931, three elements suggesting a Trinity or three-part logo.

The first effort was to derive symbols from Pacific Coast which would relate to our region and specialty: sun, energy, birth, life. The most common symbol in the Pacific is the sun. Pacific is, of course, from the Latin word Pacificus, meaning "more peaceful"-sunny and more peaceful. It was Magellan who named the Pacific Ocean in 1520 and appropriately so. Since the sun gives life and is symbolic of our region, it was chosen for the outer protective circle of our logo. The middle circle contains essential information providing the initials for Pacific Coast Obstetrical and Gynecological Society and the founding date, 1931.

The third part, and the heart of the logo, required difficult decisions. Once again, symbols began to flow feminine, dynamic, classic, historic, anatomic, scientific, timeless, cyclic, lunar. It seemed appropriate to draw from the work of one of the three great artists of all time, one who was also an anatomist, engineer, inventor-a true Renaissance man, a person to emulate-Leonardo de Vinci. The artist, Dorothy Koll, adapted Leonardo’s work "Canon of Proportions" from his anatomy notebook "Quadrerni di Anatomia," volume VI, folio 8r. This drawing was sketched at approximately the same time that Magellan was naming the Pacific Ocean. What a fitting coincidence for our logo. The central figure is appropriately female rather than Leonardo's male. The anatomy is clear. The figure illustrates structure and movement, depicting the dynamic, cyclic, and ever-changing life of the female.

James C. Caillouette  
Chairman, Logo Committee  
Kauai 1981  
50th Anniversary Meeting
IN

MEMORIAM

David Wolter
1923-2019
HISTORIAN’S CORNER

LEARN ABOUT PCOGS HISTORY!

On our PCOGS web site (www.pcogs.org) under Society Info you can find the drop down called “Historian’s Corner.” Visit it to find many offerings. You’ll find accounts of the founding years, biographies of some members including members honored by memorial funds. Many of the early presidential addresses are there, giving a flavor of the times and perspectives of members on challenging societal and medical issues. These offerings will transport you back in time to earlier years of our profession, as will selected scientific papers presented at meetings over the years. Interviews with members describe important Ob/Gyn history, offer fond recollections, and a few wild stories.

PCOGS MEMBERSHIP PROCESS

The Pacific Coast Ob Gyn Society (PCOGS) was founded in 1931 and has a long tradition of excellent annual scientific meetings that offer presentations from all areas of the specialty. The Society is composed of five regional caucuses representing the geographic organizations of the PCOGS structure. Members (Fellows) reside in seven western states stretching from Arizona to Alaska, including Hawaii. Membership in the society has always been by invitation, and presentation of a scientific paper is the steppingstone to membership. It is hoped that new members will come to value the society, regularly attend meetings, and contribute with subsequent presentations, formal discussions, and/or in the informal discussions from the floor.

In order to evaluate the Society and decide whether guests wish to pursue membership, interested physicians can come to an annual meeting as a member’s personal guest. The formal process to join begins in the applicant’s geographic caucus where a member sponsors a guest physician’s application. Caucus members then vote to invite applicants to be a guest of the Caucus at the following annual scientific meeting. This provides an official introduction to the larger group, allows more exposure to the process, and starts the timeline for presentation of a paper two years later. Guests committed to membership can come in the intervening year as a guest of the Board of Directors if they wish. In years past the candidate always waited out a year before presenting, but prospective members can be welcomed each year. Meeting registration and expenses are the responsibility of invited guests for each meeting.

Two years after becoming a Caucus Guest, and following caucus and board approval, candidates will be invited as a Society Guest to present a scientific paper. Following each annual scientific meeting, the PCOGS members vote on the Society guests, and the board sends its confirmation of membership.

Society guests always present their papers in an oral format for admission to the society. The scientific program also includes presentations by Fellows. Posters are a second presentation format, and every year ObGyn residents and fellows from pacific coast medical centers are invited to exhibit posters as guests of the society. Residents fellows submitting manuscripts compete for an oral presentation, the
Frank Lynch Memorial Essay, which includes an honorarium. The best poster is awarded an honorarium, The Charles Kimball Award, at the meeting. Poster presenters give an oral 5-minute summary from the podium at the meeting so that they can be formally introduced to the membership.

A mentoring process for PCOGS Society guests is in place to facilitate the best project possible with the least distress for the candidate. Each caucus matches the candidate with a suitable mentor. This person will be able to help guests understand the process and find those knowledgeable in their area of research. Some projects require assistance from several mentors to facilitate the planning process, IRB approval, and data analysis. As IRB approval can take time, it is important to factor this in. Your caucus chair should assist in arranging a mentor who suits you. Please ask for more assistance if this does not seem to be working.

The society has always prided itself on the quality of papers presented. Presentations have historically been the culmination of a process of collecting original data, analyzing it, drafting a manuscript suitable for publication, and presenting it orally at the annual meeting. Formal presentation of the manuscript at the meeting is followed by a formal discussion from a member of the society. That member has volunteered to critique the manuscript and therefore needs to have received the completed manuscript before the meeting. They provide several questions to the presenter. After the formal discussion, audience members have the opportunity to ask further questions which the presenter then answers from the podium.

Historically, the various regional ObGyn societies in the country, such as PCOGS, have had a relationship with the American Journal of ObGyn, and papers were first submitted there. As of 2018, there is no longer a prioritized journal to which papers are to be sent. Presenters are expected to submit their paper for publication, but the choice of journal is left to the author and mentor. In order to bolster manuscript quality, the Society offers candidates the expert critique of the society’s editor of scientific proceedings in a non-mandatory pre-submission review, or “pre-review.”

PCOGS is a member-run organization. Many members devote time to making the organization work. There is only one employee, a masterful administrative assistant, who manages correspondence and organizational details. Guests attending a meeting will soon realize that member-volunteers and spouses manage all of the arrangements, the registration and the entire agenda. Attention to provided information and instructions, coupled with timely responses, will help the efforts and efficiency of the hard-working PCOGS Fellows who make these meetings so successful.

The society blends those in community practice and those in academic practice, essentially academic clinicians and clinical academicians, and welcomes their families to meetings. Members take pride in the social aspects of the society, which open opportunities to develop lasting friendships with members geographically distant from their own communities. The addition of enthusiastic new members is vital to the continuation of the Society. We hope our guests will be interested in learning more and pursuing membership.

Martha F. Goetsch & John A. Enbom
2019 PRESENTATIONS

PUBLISHED

Examination of Fetal Growth Trajectories Following Infertility Treatment


2018 PRESENTATIONS

PUBLISHED

Concordance of Adnexal Mass Laterality: from Preoperative Imaging to Surgical Pathologic Findings.


Cumulative Deceleration Area: A Simplified Predictor of Metabolic Acidemia.


Characteristics and Health Care Needs of Gender Dysphoric Pediatric Patients

Trends in Referrals to a Pediatric Transgender Clinic.

### Society Guests

<table>
<thead>
<tr>
<th>Name</th>
<th>Caucus</th>
<th>Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinh Duong</td>
<td>Los Angeles</td>
<td>Rosetta Hassan</td>
</tr>
<tr>
<td>Kristina Eaton</td>
<td>Seattle</td>
<td>Hedric Hanson</td>
</tr>
<tr>
<td>Antonio Garcia</td>
<td>Los Angeles</td>
<td>John Schlaerth</td>
</tr>
<tr>
<td>Tamula Patterson</td>
<td>Los Angeles</td>
<td>Rosetta Hassan</td>
</tr>
<tr>
<td>Kerry Price</td>
<td>Los Angeles</td>
<td>Marc Winter</td>
</tr>
<tr>
<td>Eve Zaritsky</td>
<td>San Francisco</td>
<td>Arzou Ahsan</td>
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<tr>
<td>Name</td>
<td>Caucus</td>
<td>Sponsor</td>
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<tr>
<td>Laila Al-Marayati</td>
<td>Los Angeles</td>
<td>Bob Israel</td>
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<tr>
<td>Sylvanna Bennet</td>
<td>Portland</td>
<td>Laura Greenberg</td>
</tr>
<tr>
<td>Melody Besharati</td>
<td>Los Angeles</td>
<td>Kristy Roloff</td>
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<tr>
<td>Melissa Bush</td>
<td>Los Angeles</td>
<td>David Lagrew</td>
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<tr>
<td>Sigita Cahoon</td>
<td>Los Angeles</td>
<td>Bob Israel</td>
</tr>
<tr>
<td>Taimur Chaudhuri</td>
<td>Los Angeles</td>
<td>Larry Shields</td>
</tr>
<tr>
<td>Ashley Fuller</td>
<td>Seattle</td>
<td>Rebecca Dunsmoor-Su</td>
</tr>
<tr>
<td>Chris Herndon</td>
<td>Seattle</td>
<td>Lori Marshall</td>
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<tr>
<td>Brian Iriye</td>
<td>Los Angeles</td>
<td>David Lagrew</td>
</tr>
<tr>
<td>Emily Rangel</td>
<td>Portland</td>
<td>Duncan Neilson</td>
</tr>
<tr>
<td>Alan Schlaerth</td>
<td>Los Angeles</td>
<td>Thomas Powers</td>
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<tr>
<td>Jodi Steinauer</td>
<td>San Francisco</td>
<td>Jill Foley</td>
</tr>
<tr>
<td>Sara Twogood</td>
<td>Los Angeles</td>
<td>Bob Israel</td>
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</tbody>
</table>
# Personal Guests

<table>
<thead>
<tr>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>Orestas Alvarez- Jacinto</td>
<td>Los Angeles</td>
<td>John Schlaerth</td>
</tr>
<tr>
<td>Shiela Dejbakhsh</td>
<td>Los Angeles</td>
<td>Marc Winter</td>
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<td>Mita Patel</td>
<td>Los Angeles</td>
<td>Marc Winter</td>
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<tr>
<td>Helen Rodriguez</td>
<td>Los Angeles</td>
<td>Kathleen Bradley</td>
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<tr>
<td>Edward Tangchitnob</td>
<td>Los Angeles</td>
<td>Shaun Grady</td>
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<tr>
<td>Christine Walsh</td>
<td>Los Angeles</td>
<td>Mal Margolin</td>
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<tr>
<td>Monique Schoenhage</td>
<td>San Diego/AZ</td>
<td>Larissa Romero</td>
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<tr>
<td>Laurie Greg</td>
<td>San Francisco</td>
<td>Susan Gorman</td>
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<tr>
<td>Tushani Illangesekare</td>
<td>San Francisco</td>
<td>Meg Autry</td>
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<tr>
<td>Gaetan Pettigrew</td>
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<td>Meg Autry</td>
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<tr>
<td>Tina Raine</td>
<td>San Francisco</td>
<td>Angelyn Thomas</td>
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<td>Stephanie Veda</td>
<td>San Francisco</td>
<td>Jeanette Lager</td>
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<tr>
<td>Men-Jean Lee</td>
<td>Seattle</td>
<td>Jane Dimer</td>
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<tr>
<td>Heath Miller</td>
<td>Seattle</td>
<td>Pam Paley</td>
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<tr>
<td>Corina Muller</td>
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<td>Tina Tomsen</td>
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<tr>
<td>Fernanda Musa</td>
<td>Seattle</td>
<td>Chirag Shah</td>
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<tr>
<td>John O’Boyle</td>
<td>Seattle</td>
<td>Pam Paley</td>
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<td>Christi Rodriguez</td>
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<td>Dale Reisner</td>
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<td>Melissa Thrall</td>
<td>Seattle</td>
<td>Pam Paley</td>
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<tr>
<td>Sarah Waller</td>
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<td>Suzanne Peterson</td>
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<tr>
<td>Tom Lee</td>
<td>Portland</td>
<td>Mark Tomlinson</td>
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<tr>
<td>Carolyn Piczcek</td>
<td>Portland</td>
<td>Abby Furukawa</td>
</tr>
<tr>
<td>Weiya Wysham</td>
<td>Portland</td>
<td>Will Winter</td>
</tr>
</tbody>
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Guests of the Board of Directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Caucus</th>
<th>Sponsor</th>
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<tbody>
<tr>
<td>Nyima S. Ali</td>
<td>San Diego/AZ</td>
<td>Dean Coonrod</td>
</tr>
<tr>
<td>Lisa L. Bayer</td>
<td>Portland</td>
<td>Paula Bednarek</td>
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<td>Richard Benoit</td>
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<tr>
<td>John Ozimek D.O.</td>
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<td>John Williams, III</td>
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<td>Emmanuelle Pare</td>
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<td>Brian Shaffer</td>
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<td>Brandi Vasquez</td>
<td>Portland</td>
<td>Barbra Fisher</td>
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<tr>
<td>Neetu K. Sodhi, D.O.</td>
<td>Los Angeles</td>
<td>Anita Nelson</td>
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GENERAL INFORMATION

The 2020 annual meeting will be held virtually via Zoom Webinar.
Registration will be required through Zoom, information to register has been emailed to you.
Business meetings will be held via a Zoom meeting. Invitations have been sent to all PCOGS fellows.

PRESENTATION GUIDELINES

Thirty (30) minute presentations - 15 minutes is for your presentation, 5 minutes for formal discussion and 10 minutes for discussion from the assembly.

Twenty (20) minute presentations - 10 minutes is allowed for your presentation with 10 minutes allowed for questions and discussion from the assembly.

Adherence to the time schedule is important and all are expected to cooperate.

FORMAL DISCUSSION/REVIEW GUIDELINES

FORMAL DISCUSSANT - assigned to 30-minute presentations - Formal discussants will present their discussion orally. Five (5) minutes is allowed for formal discussion.

FORMAL DISCUSSIONS are to be uploaded through the Society web site prior to the annual meeting. References, if any, should be formatted according to the "Information for Authors" in the AMERICAN JOURNAL of OBSTETRICS AND GYNECOLOGY. A revised discussion will be accepted by the Editor if received within 2-weeks of the last day of the Annual Meeting. Submit through the Society web site - www.pcogs.org

FORMAL REVIEWER - assigned to 20-minute presentations. Formal reviewers do not present orally. Review manuscript submitted through the Society’s web site, prepare 1-3 questions for the presenter to respond to during their presentation, submit the questions to the presenter 6 weeks prior to the annual meeting in the form of a PowerPoint slide.
LEARNING OBJECTIVES

1) To learn about specific research projects and their application to clinical practice in obstetrics and gynecology, through oral presentations and poster sessions by different members of the Pacific Coast Obstetrical and Gynecological Society and their invited guests.

2) To review a controversial topic in the field of obstetrics and gynecology, by inviting a national expert to present and review data.

3) To network professionally with leaders in the field of obstetrics and gynecology as regards the future of the specialty, residencies, and medical students.

MISSION STATEMENT

The Pacific Coast Obstetrical and Gynecological Society is composed of individuals dedicated to excellence in the health care of women, dedicated to promoting cooperative efforts and unity between private practice physicians and the academic sector, providing continuing medical education for its membership, and advancing knowledge in the specialty. The Society also deals with concerns in the specialty other than direct patient care, including social issues, health care delivery, and patient education. The Society is dedicated to the continuance of the physician's professional learning from medical school through residency/fellowship training and beyond.
FRANK LYNCH MEMORIAL ESSAYISTS
PCOGS’ 1st President, 1932

2001-2019

Vance McCausland USC 2001
Jennifer Dizon-Israel USC 2002
Arus Zograbyan USC 2003
Iris Colon Stanford 2004
Chad Hamilton Stanford 2005
Katherine Gabriel-Cox Kaiser SF 2006
Anjali Kaimal UCSF 2007
Brian L. Shaffer UCSF 2008
Tania F. Esakoff UCSF 2009
Christine Hiebert USC 2010
Pavithra Venkat UCSF 2011
Not awarded n/a 2012
Jessica Atrio USC 2013
Marc Gualtieri USC 2014
Jonas J. Swartz OHSU 2015
Alexandra Rzepka Univ of AZ 2016
Nicole B. Kurata Univ of HI 2017
Whitney Wellenstein Kaiser Oakland 2018
Meghan Smith USC 2019

CHARLES KIMBALL AWARD
President—1986

2008-2018

Tania Esakoff UCSF 2008
Tevy Tith UCLA 2009
Clara Ward UCSF 2010
Manijeh Torki USC 2011
Uyen Huynh Kaiser-Santa Clara 2012
Melissa Rosenstein UCSF 2013
Sigita Cahoon USC 2014
Kristl Tomlin PIROG 2015
Neetu K. Sodhi UCLA 2016
James A. Sargent OHSU 2017
Martha Tesfalul UCSF 2018
Melody Besharati Santa Clara Med 2019

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ANTI HARASSMENT POLICIES

NON-DISCRIMINATION POLICY

The Pacific Coast Obstetrical and Gynecological Society does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations. These activities include, but are not limited to, hiring and firing of staff, selection of members and vendors, and provision of services. We are committed to providing an inclusive and welcoming environment for all members of our staff, members, candidates, guest speakers, scholarship candidates and recipients. The Society’s nondiscrimination policy also extends to the industry supporters of the Society, whether by education grants or by exhibits.

The Pacific Coast Obstetrical and Gynecological Society is an equal opportunity employer. We will not discriminate and will take affirmative action measures to ensure against discrimination in employment, recruitment, advertisements for employment, compensation, termination, upgrading, promotions, and other conditions of employment against any employee or job applicant on the bases of race, color, gender, national origin, age, religion, creed, disability, veteran’s status, sexual orientation, gender identity or gender expression.

SEXUAL HARASSMENT POLICY

It is the policy of the Pacific Coast Obstetrical and Gynecological Society that the workplace, meetings, and society activities are conducted in an environment free from sexual harassment. This policy applies to all attendees at Society activities, including members, speakers, students, guests, staff, contractors, exhibitors, and volunteers. The Pacific Coast Obstetrical and Gynecological Society strongly disapproves of offensive or inappropriate sexual behavior and participants must avoid any action or conduct which could be viewed as sexual harassment. Sexual harassment is defined by the Equal Employment Opportunity Commission (EEOC) as any unwelcome sexual advance, request for sexual favors, or other verbal or physical conduct of a sexual nature, when: (1) submission to the harassment is made either explicitly or implicitly a term or condition of employment or membership; (2) submission to or rejection of the harassment is used as the basis for employment or membership decisions affecting the individual; or (3) the harassment has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive working environment.

Any employee or Society participant who has a complaint of sexual harassment by anyone, should first clearly inform the harasser that his/her behavior is offensive or unwelcome and request that the behavior stop. The Society strongly urges reporting of all incidents of harassment, regardless of the offender’s identity or position by contacting the Caucus Chair and/or a member of the Board of Directors, who can be reached at (contact members only site at www.pcogs.org). If deemed necessary by those
experiencing harassment, the Board of Directors/Caucus chair will assist in contacting convention center/hotel/venue security or local law enforcement. He or she is not required or expected to discuss the concern with the alleged offender. All complaints will be treated seriously and be investigated promptly. Confidentiality will be honored to the extent permitted as long as the rights of others are not compromised.

If the Caucus Chair and or Board Member knows of an incident of sexual harassment, they shall take appropriate remedial action immediately. If the alleged harassment involves any types of threats of physical harm to the victim, the alleged harasser may be immediately suspended or expelled from the Society. All complaints will be investigated by the Pacific Coast Obstetrical and Gynecological Society Board of Directors. The Board of Directors will name an impartial investigator, usually a Society Officer or Caucus member. Any named investigator who believes they have a conflict of interest should not serve as an investigator. In most cases, the complainant will be interviewed first and the written complaint reviewed. If the complainant has not already filed a formal complaint, he or she should be asked to do so. The details of the complaint should be explained to the alleged offender by the investigator. The alleged offender should be given a reasonable chance to respond to the evidence of the complainant and to bring his or her own evidence. If the facts are in dispute, further investigatory steps may include interviewing those named as witnesses. If, for any reason, the investigator is in doubt about whether or how to continue, he or she will seek appropriate counsel. When the investigation is complete, the investigator should report the findings to the Board of Directors. If the investigation supports charges of sexual harassment by the Board of Directors, disciplinary action against the alleged harasser will take place and may include suspension, expulsion, or other disciplinary actions. If the investigation reveals that the charges were brought falsely and with malicious intent, the charging party may be subject to disciplinary action, including termination or expulsion by the Board of Directors.
PROGRAM SUMMARY

SATURDAY, SEPTEMBER 5, 2020

8:00 am Opening Remarks from President Lam
8:10 am Society Guest Eve Zaritsky “Hysterectomy Variations”
8:40 am PCOGS Fellow Susan Gorman “Physician Reentry”
9:00 am Society Guest Antonio Garcia “Hydatidiform mole”
9:30 am Ted Adams Scholarship Award poster presentations:
   ▪ Jasmine Patel “Withdrawal Contraception”
   ▪ Allyse Ishino “Voiding Protocols Post-Op”
   ▪ Anthonia Ojo “Pediatric Gender Dysphoria”
9:45 am BREAK
10:10 am PCOGS Fellow Laura Mercer “Learning Laparoscopy”
10:30 am Society Guest Jenny Jaque “Advanced Paternal Age”
11:00 am PCOGS Fellow Martha Goetsch “Vestibule in dyspareunia”

11:30 am PCOGS Fellow Annual Business Meeting

SATURDAY, SEPTEMBER 12, 2020

8:00 am Opening Remarks from President Lam
8:10 am Society Guest Kerry Price “Cervical ripening foley”
8:40 am PCOGS Fellow Maria Manriquez “Maternity Care Homes”
9:00 am Special Lecture: PCOGS Fellows Elliott K. Main and Angelyn Thomas “Birth Equity”
9:30 am Ted Adams Scholarship Award Poster Presentations:
   ▪ Christina Buchanan “HIE and Home Birth”
   ▪ Pamela Estrada “Cesarean Reduction Outcome”
   ▪ Adam Brian Crosland “IV Iron for Anemia”
9:45 am BREAK
10:10 am Frank Lynch Memorial Essay Brian Crosland “Accreta Outcomes”
10:40 am Society Guest Kristina Eaton “Neonatal Abstinence”
11:10 Society Guest Tamula Patterson “Cerclage Outcomes”
11:40 Society Guest Thinh Duong “Perineal Trauma”

12:00 pm PCOGS Fellow Annual Business Meeting
HISTORY OF THE MEMORIAL FUNDS

FRANK LYNCH MEMORIAL ESSAY
Frank W. Lynch was the first PCOGS President and was honored after death by initiation of a prize and lecture at each meeting; these now go to the best manuscript submitted by a resident/fellow.

TED ADAM SCHOLARSHIP AWARD
Ted Adams was a charter member from Portland. His wife gifted the society with seed money to start a fund supporting scholarships for resident presenters.

CHARLES KIMBALL MEMORIAL FUND
Charlie Kimball was a member from Seattle who gifted money to the Society. The Board approved utilizing these funds for an award for the “best poster presentation” at each annual meeting.

JAMES C. & JOAN CAILOUETTE GUEST LECTURESHP
James “Jim” and Joan Caillouette funded an annual meeting lecture on the topic of population & family planning.

MEMBERSHIP DEVELOPMENT FUND
The newly formed “Membership Development Fund" honors many of our recently passed members (Bill Parer, Russ Laros and others*). When fully vested, it will help defray the registration costs for Caucus guests and support PCOGS membership.

*gifts designated “In Memory of...” at time of donations
CONTRIBUTIONS TO THE MEMORIAL FUND listing from the Spring Newsletter

Fikret Atamdede
Donald Barford
John Brown
Joel Cohen
Fred Coleman
Andrew Combs
James Fearl
Kurt Finberg
Abby Furukawa
William Gilbert
Ira Golditch
Shaun Grady
Hanns Haesslein
Gary Hoffman
Hanne Jensen
Paul Kaplan
David Lagrew
Fung Lam
Heather Macdonald
James Macer
Lori Marshall
James Moran
Malcom Munro
Anita Nelson
Christopher O’Reilly-Green
Joseph Ouzounian
Patty Robertson
Arthur Segal
Roger Schlesinger
John Williams, III
Heidi Wittenberg
THOSE HONORED BY CONTRIBUTORS

Clifford Fearl
Jan Gorriel
William K. Graves
Russell Laros
George Macer
Lyman Rust
Gilbert Webb
Recently lost Fellows
Factors Associated with Variation in Vaginal Hysterectomy Rates in an Integrated Health Care System

Eve Zaritsky (By invitation)

Objective: Though ACOG endorses vaginal hysterectomy (VH) as the preferred surgical route for benign conditions, clinicians have yet to consistently adopt VH into practice. We aim to assess how variation in VH rates are associated with patient characteristics and modifiable provider factors.

Design: We conducted a retrospective cohort study of minimally invasive hysterectomies (MIH) done for benign conditions excluding uterine prolapse and incontinence surgeries at Kaiser Permanente Northern California from 2008 to 2018. The primary outcome was the proportion performed vaginally over time and surgical outcomes by route. The association between surgical route and patient and provider characteristics was assessed using multivariable logistic regression.

Results: From 2008 to 2018, of the 56,501 hysterectomies performed, 27,518 hysterectomies were performed for benign indications. The MIH rates increased from 29.1% in 2008 to 96.7% in 2018 (P<.001, Table 1). Of the total MIH cases, VH rates varied from year to year but decreased overall from the highest rate in 2008 of 50.6% to 13.2% 2018 (P<.001). The overall rates by hospital ranged from 11.5% to 27.8%. (Table 2). VH rates were significantly lower than laparoscopic hysterectomy (LH) rates in patients who were obese and severely obese (P<.001), were Hispanic, or had uterine weights >500g (P<.001). Differences by hospital persisted after controlling for uterine weight (P<.001). Median (standard deviation [SD]) VH post-operative hospital stay decreased from 33.8 (16.4) hours in 2008 to 6.1 (12.2) in 2018 (Table 1). Median (SD) surgery time was shorter for VH compared to LH (1.7 [0.8] vs 2.5 [1.1] hours, respectively; P<.001); however, operative or perioperative complications were low for all routes and years (Table 3).

Conclusion: VH rates decreased over time as MIH increased with a large variation by medical center even after controlling for patient characteristics. Similar post-op stays, and shorter operative time suggest that greater efforts are needed to preserve VH rates through training and evidence-based guidelines for route selection.

Formal Discussant: Caryl Reinsch
Physician Reentry Program in Obstetrics: A Personal Experience

Susan Gorman

Background: The workforce of the general obstetrician–gynecologist is undergoing demographic changes resulting in an anticipated shortage of obstetricians to meet the needs of a growing population. An increased proportion of female obstetrician-gynecologists are in practice with a higher proportion reducing their work hours or taking extended time off in order to take care of their families and achieve work/life balance. One solution to anticipated workforce needs are programs facilitating physician re-entry into obstetric practice.

Objective: Describes my personal experience of a reentry program into obstetrics after a 9-year absence and the process for successful re-integration into the community.

Methods: Describes barriers to reentry, and how they were overcome. A unique credentialing/preceptorship process was created by the Obstetrics & Gynecology Department at Sutter Medical Center Sacramento to ensure clinical competency and granting of obstetrical privileges.

Results: A Physician Recruitment Agreement with the hospital enabled income guarantee and coverage of expenses while working with a local group practice. I completed 160 hours of observed practice on labor and delivery by members of my group practice and other members of the department, which resulted in successful credentialing. The credentialing process for my reentry into obstetrics resulted in 924 deliveries over a three-year span for the benefit of an underserved community.

Conclusions: Physician recruitment agreements can shift the reentry cost burden to the hospital. Individual programs can be tailored with the collaboration of department supervision. This investment model can facilitate opportunities for physician reentry and ease physician shortage for the benefit of the community.

Reviewer Andrew Combs
9:00 am – 9:30 am O-03
Clinical Management of Hydatidiform Moles, A Ten-Year Experience

Antonio Garcia (By Invitation)

OBJECTIVE: The purpose of this study is to examine the clinical management of women with hydatidiform moles in a non-university setting. Evolving concepts and clinical developments have affected management of trophoblastic diseases. We examined elements of diagnosis, details of clinical management, incidence of pathologic subtypes and outcomes of practice for patient’s recently diagnosed with hydatidiform moles.

STUDY DESIGN: A retrospective review of patients presenting with hydatidiform moles (HM) from January 1, 2010 through December 31, 2019, to a single institution – Kern Medical, Bakersfield, California, were analyzed. Diagnosis was confirmed by histologic examinations as to type, i.e. complete hydatidiform moles (CHM) and partial hydatidiform moles (PHM). Relevant aspects of the clinical aspects of these varieties were analyzed and compared.

RESULTS: During this 10-year period, 50 patients were diagnosed with CHM and 45 patients were diagnosed with PHM. 82% of HM patients were Hispanic. We noted an incidence of 1/294 HM for pregnancies delivered at our institution. (1/558 for CHM and 1/620 for PHM). Ultrasound examinations were usually employed for suspected diagnosis (83%) except where the diagnosis was clinically obvious. Suction curettage was the predominant form of initial management. Re-curettage and hysterectomy were used sporadically. Records were reviewed for complications, i.e. thyrotoxicosis, febrile morbidity and post molar gestational trophoblastic disease.

CONCLUSION: 1. Hispanic patients appear to be at a higher risk for HM than the general population in the United States. 2. The use of ultrasound in early or suspected pregnancy has led to early diagnosis of HM. 3. The complications of HM and its management were less than previously reported. 4. The likelihood of post molar gestational trophoblastic disease may be lessened by Hispanic ethnicity. 5. Life threatening or mortal sequelae to HM management may be things of the past.

Formal Discussant: Anita Nelson
Oral Synopsis of Ted Adams Scholarship Award Poster Presentations

9:30 am – 9:45 am

P-01
From contraceptive providers to users: A thorough evaluation of contraceptive withdrawal

Jasmine Patel (By Invitation)

According to the National Survey of Family Growth (NSFG), the percentage of reproductive age women desiring to avoid pregnancy who reported using withdrawal for contraception rose from 4.8% in 2012 to 8.1% in 2014.¹ As patients increasingly report using withdrawal, healthcare providers need to be able to deliver unbiased, evidence-based counseling to provide truly comprehensive contraceptive counseling. To evaluate current attitudes among family planning providers towards withdrawal for contraception, a 16-item survey was distributed at four national contraceptive conferences. Providers agreed that more education is necessary for patients; yet providers themselves overestimated the risk of pregnancy with withdrawal. Physicians additionally expressed more negative attitudes than advanced practice clinicians. Given the lack of evidence and expert consensus, we conducted a clinical evaluation of sperm concentration in the pre-ejaculate during patient-perceived correct and consistent withdrawal use, with particular interest in the consistency of concentration findings across samples, as well as factors associated with the presence of sperm in the pre-ejaculate. Sperm findings were inconsistent across samples; however, sperm was consistently absent in 77.3% of individuals. All sperm found were motile. Participants reporting a history of sexually transmitted infection were linked to findings of sperm in the pre-ejaculate. These studies contribute to the gap in literature on withdrawal as a contraceptive method and serve as the basis for future research on the topic.
Active Versus Passive Discharge Voiding Protocols: Urinary Dysfunction After Same-Day Minimally Invasive Hysterectomy

Allyse Ishino (By Invitation)

Objective: The primary objective was to assess variations in the proportion of patients who were discharged with a urinary catheter after undergoing a same-day minimally invasive hysterectomy (MIH) for a benign gynecological condition according to active versus passive discharge voiding protocol. Secondary objectives were to determine the length of stay in the post anesthesia care unit (PACU) according to voiding protocol and postoperative urinary retention (PUR) rate, defined as requiring in-person care for urinary retention (either in the Emergency Department or outpatient clinic within 2 weeks of discharge). Design: Retrospective observational data-only cohort study in the setting of a large integrated healthcare system serving approximately 40% of Northern California above 18 years of age. Inclusion: patients aged 18 to 65 who underwent a same-day MIH (laparoscopic, robotic, or vaginal hysterectomy) for a benign gynecological condition between years 2015 and 2018, and were discharged on the same day of their procedure and had at least six months of continuous healthcare system membership to capture potential complications of PUR. Patients undergoing gyn-oncology or urogynecology procedures were excluded. An active voiding trial was defined as patient arriving in PACU with a catheter in place, retrograde filling the bladder in the PACU with 300 ml and allowing the patient to void ≥ 50% within 30 minutes. If unable to void this volume, the patient was sent home with a catheter to be removed at home or in clinic within 24 hours. A passive voiding trial involved filling or not filling the bladder during intraoperative cystoscopy and arriving in PACU without a catheter in place, then allowing patient to void, or performing a straight catheterization in the PACU if unable to void.

Results: 1,977 women were included in the study. Of those, 1,644 (83.2%) underwent a passive voiding trial, while 333 (16.8%) underwent an active voiding trial. (Table 1). In the patients who received a passive voiding trial, 89 (5.4%) were discharged home with a catheter, while of those who received an active voiding trial, 35 (10.5%) were discharged home with a catheter (P<0.0005). The PACU length of stay was shorter in the passive versus active voiding trial cohort, 222 minutes versus 240 minutes, respectively (P<0.0001). There was no statistical difference in the PUR rate between the passive and active voiding protocols, 1.8% and 3.0%, respectively. (P=0.27).

Conclusion: Within a large integrated healthcare system, the passive voiding trial was associated with a smaller proportion of patients discharged home with a urinary catheter, shorter length of stay in the PACU, and a lower rate of postoperative urinary retention. This study suggests that passive voiding trials can be safely utilized after a benign MIH to reduce healthcare resources, hospital duration, and ultimately improve patient experience and satisfaction.
Assessment of Distribution and Time to Treatment for Pediatric Gender Dysphoric Patients Within an Integrated Health Care System.

Anthonia Ojo (By Invitation)

Objective: To assess trends in treatment patterns for pediatric gender dysphoria, time to treatment, and associated patient demographic characteristics.

Design: We performed a retrospective chart review for all patients less than 18 years of age in the Kaiser Permanente Northern California system health records between January 2015 and December 2018 for transgender or gender diverse (TGD) related ICD codes. Diagnoses were verified by manual chart review. Demographics and trends in treatment were reviewed from medical charts and analyzed using descriptive statistics. Time to treatment (TTT) was measured from index diagnosis date to first prescription or surgical date.

Results: 1,021 patients were identified, of whom 805 (79%) were assigned female natal sex. 141 (14%) patients identified as gender nonbinary (GNB), 651 (64%) as male, 182 (18%) as female, and 47 (4%) as not reported or other. In all patients, median age at diagnosis was 15 years (IQR 4 years). 559 (55%) received at least one medical or surgical treatment. There was a significant association between gender identity and first treatment utilization $\chi^2(3, N = 1021) = 58.3, p = <0.0001$. Utilization was most prevalent among patients identifying as male and least common amongst GNB. 385 (38%) patients received hormone blockers, 451 (44%) received hormone therapy (HRT), and 123 (12%) received surgical treatment. Median TTT for the first treatment of any kind was 7 months (IQR 11 months). The median TTT increased by intervention, from 6 months for hormone blockers (IQR 9 months) to 11 months for hormone therapy (IQR 13 months), to 23 months for gender-affirming surgery (IQR 15 months). Of the 123 patients who received surgery, 117 (95%) were natal females. Median age for surgical treatment was 18 years old (IQR 2 years, range 13-21 years). No natal males completed surgery before the age of 18.

Conclusion: In a large integrated health care system, the median TTT was under one year. GNB patients were less likely to receive treatment. This study can inform future interventions to expand delivery of care and identify potential barriers for GNB patients. Further studies are needed to understand the etiology of treatment variation and access.

9:45 am Break

All posters are located on the website at PCOGS.Org
Laura Mercer, MD

**Objective:** To evaluate if individualized preceptor instruction as an introduction to FLS improves a resident’s ability to learn and master these skills compared to self-study.

**Design:** Twenty-four residents (PGY1-PGY3) in an obstetrics/gynecology residency program were randomized by year to either a control group (current self-study introduction) or an intervention group (individualized instruction in addition to self-study as an introduction). In the intervention group, a single faculty instructor presented a consistent explanation and demonstration for the FLS tasks and offered personalized feedback and coaching during the initial session. Sessions were held such that no more than two residents were present in each group, to ensure a student to instructor ratio of either 1:1 or 2:1. All subjects were evaluated at time zero (immediately following their introduction to the curriculum) and at one and six months later. Research study personnel were standardized in their subjective and objective assessments of each subject, using a previously validated assessment tool.

**Results:** In each area scored at time zero, only instrument selection was found to have a statistically significant improvement in the intervention group (p=0.042). All other parameters showed no difference between groups. At both one month and six-month follow-up, the control group was superior in their overall performance (p=0.038 and p=0.004).

**Conclusion:** Though this study is limited by its small sample size, its findings of no improvement performance despite individualized instruction and coaching suggest that there is no role for a dedicated faculty member in a resident’s acquisition of FLS skills.

**Reviewer Paul Fuller**
Fertility concerns and infertility have a large effect on quality of life [1]. In addition, societal deadlines for childbearing age differ between males and females, with the prevalence of advanced paternal age increasing [2, 3, 4]. This study aims to examine patients’ understanding of women’s health topics, their reproductive capabilities and their own bodies, and risks associated with advanced paternal age. For this cross-sectional study, we developed a 15-item assessment, with an additional 5 opinion questions, related to fertility and advanced paternal age. The questionnaire was validated using feedback from anonymous community focus groups, and then distributed to English-speaking and Spanish-speaking female patients at the Women’s Clinic of LAC + USC Medical Center (Los Angeles) and the FMS Clinic at Valley Hospital (Las Vegas). The participant performance as a percentage-correct score on the assessment constituted our primary outcome. Statistical analysis was conducted using two-sample t tests. The majority of our total sample of 107 were Hispanic (52.3%) with a mean age of 43.3 years. We documented deficits in patient knowledge with a mean score of 37.1% correct. Statistically significant lower scores were associated with less education, having children, and Hispanic/Latino origin. The deficits we identified indicate the need to improve fertility and family planning literacy amongst our patients. Understanding what knowledge gaps are present in our patient populations and how that disparity varies amongst different groups allows physicians to properly counsel our patients and provide better future clinical care. Most notably, the majority of patients incorrectly answered questions regarding advanced paternal age risks on fertility and miscarriage, as well as 86.9% who opined it was worse if infertility was due to the woman. The social impact of this is immeasurable, as it highlights the vast majority of women who blame themselves for infertility, negatively impacting their self-esteem and devaluing themselves. By understanding how to provide proper education related to fertility risks, we can help decrease the stigma associated with miscarriage and infertility and help promote self-confidence for these women.

Formal Discussant Herman Hedriana
11:00 am – 11:20 am O-06

Where to Focus for Postmenopausal Dyspareunia – a Randomized Comparative Study of Hormonal Vestibule Therapy.

Martha Goetsch

Objective: to assess the efficacy and safety of nightly doses of estradiol creme applied by postmenopausal women with dyspareunia only to the vulvar vestibule for 3 months, including no vaginal treatments.

Design: An IRB-approved study enrolled woman with moderate or severe dyspareunia. The Brisben Family Foundation and the National Vulvodynia Association funded the study. A power analysis predicted need for 50 subjects. Subjects were randomly assigned estradiol creme 100mcg or 50mcg self-applied nightly to the vestibule for 90 days. Patients scored penetration pain. Serum estradiol levels were measured at baseline, 12 hours, 4 weeks and 12 weeks. Ultrasounds measured stripe widths at outset and 3 months. Analysis was by two-sample t-tests (continuous variables), chi-square tests /Fisher Exact tests (categorical variables) and Wilcoxon rank-sum tests (ordinal variables).

Result: Fifty patients were enrolled and 49 analyzed. The median intercourse pain score was 8/10 (interquartile range, IQR=6,8). 24% never used supplemental estrogen, 73% had previously failed to improve using estrogen, and none had recently used estrogen. 94% completed the 3-month trial. Dyspareunia scores diminished to 5 (2,7) at 4 weeks and 2 (1,4) at 12 weeks. (each p<0.001) The two strengths were equivalent in diminishing pain. Serum estradiol levels did not rise significantly from baseline to 12 weeks. (p=0.06) Uterine stripe widths did not change. (p=0.48)

Conclusion:

Estradiol therapy to the vulvar vestibule rather than the vagina corrected pain in the majority of moderate and severe cases but required many weeks of continuous dosing. Vaginal atrophy as the explanation for coital pain after menopause is problematic. Research addressing postmenopausal dyspareunia should include a vestibule-focused model for pain.

Reviewer: Linda Nelson

11:20 am Break/Sessions done for the day

11:40 am Annual Business Meeting via Zoom for all PCOGS Fellows
Outpatient Transcervical Foley Catheter for Mechanical Cervical Dilation: A Safe, Cost-Effective, and Readily Reproducible way to Initiate Induction of Labor

Kerry C. Price (By Invitation)

OBJECTIVE: The purpose of this study is to demonstrate the safety of outpatient placement of the transcervical foley catheter as a method for initiating induction of labor. In addition, we examined the potential for cost-effectiveness that could be achieved by avoiding admission to the hospital for the cervical ripening phase of induction, shortening hospital stay and reducing use of hospital resources.

DESIGN: A retrospective chart review was performed on a total of 369 charts from a private general Ob-Gyn practice in Laguna Hills, California. Patients were included if a transcervical foley catheter was placed in the outpatient setting to initiate an induction of labor on the day prior to scheduled induction, including 204 nulliparous patients and 130 multiparous patients. Charts were examined for the baseline characteristics, outcomes, and complications for both groups. A subset of 36 charts of patients who had a catheter placed in the office, but then were directly admitted for inpatient induction were also examined for comparison. Statistical analysis comparing each group was performed using two sample t-test, Pearson chi-squared test, and/or two-sample Wilcoxon rank-sum test depending on numerical or categorical data. Statistical significance was set to a p-value of less than 0.05.

RESULTS: There were no maternal deaths in our study. An IUFD in a known Trisomy 18 fetus was the cause of admission and induction in one patient in the inpatient group, and there were no fetal deaths in the outpatient group. In the inclusion group, nulliparous patients were more likely to have a pre-catheter Bishop score of ≥7 than multiparous patients (p <0.001), but both groups achieved an average increase of 2 points with the transcervical foley catheter (p 0.21). Multiparous patients had a statistically significant shorter length of time from admission to delivery (p<0.0001), time of membrane rupture to delivery (p<0.0001), and lower rate of cesarean section (p<0.001). The rate of cesarean section was almost double in nulliparous patients whose admission Bishop score was <7 (64%), compared to those admitted with a Bishop score of ≥7 (33%) (p<0.001). The only statistically significant difference in complications was the administration of non-prophylactic antibiotics, which was higher in the nulliparous group (9.8% v. 1.6%), (p 0.003). There were no significant differences in NICU admission, Apgar score ≤7 at 5 minutes, or emergent delivery.

CONCLUSIONS: Outpatient placement of a transcervical foley catheter for initiating an induction of labor is not associated with a higher degree of serious maternal or neonatal morbidity or mortality, and can achieve adequate cervical ripening without the need for admission, decreasing utilization of hospital resources and personnel.

Formal Discussant Michael Fassett
Are Maternity Care Home Cost effective? An evaluation of a public health systems maternity care and Ob triage visits.

Maria Manriquez, MD

Objective: The Strong Start for Mothers and Newborns initiative, a 2013 effort by the Department of Health and Human Services was aimed to reduce preterm births and improve outcomes for newborns and pregnant women. Maricopa Integrated Health Services (MIHS) the public health system in Arizona was awarded to model a maternity care home. Previous studies have shown that implementation of patient-centered medical home models of care among patients with chronic diseases have led to decreases in frequency of ED visits among these patients. However, research was lacking regarding the effectiveness of implementation of a maternity medical home model of care on reduction of Obstetric (OB) Triage visits.

Methods: Maricopa Integrated Health System IRB committee approval was obtained. A retrospective chart review analyzed high-frequency OB Triage users (n>2 visits) among Strong Start participants (n=87) and non-Strong Start controls (n=48). The initial data set was comprised of Strong Start Maternity Care Home participants (n=958) and non-Strong Start controls (n=1,223) within an urban county hospital network. The Strong Start cohort includes 958 women who were enrolled and delivered at five MIHS clinics. Chief complaints were categorized by those that were medically similar and would require similar hospital resources. These categories were adapted from those published in the meta-analysis by Matteson et al. describing trends in non-emergent complaints at a specialized women’s emergency care facility. Chief complaints were further categorized using the OBCU Obstetrical Triage Acuity Scale (OTAS) with levels of acuity 1-5 representing the range of high acuity (level 1) to low acuity (level 5). The Obstetric Triage Acuity Scale (OTAS) is a 5-category tool (1-Resuscitative, 2-Emergent, 3-Urgent, 4- Less Urgent, 5-Nonurgent) that has been shown to have substantial inter-rater reliability and a high degree of correlation with rates of admission. Odds ratios and 95% Confidence Intervals were calculated using the Generalized Estimating Equation with Logit construct to ascertain the associations between intervention status and chief complaints adjusting for Time. Means and Standard Deviations were calculated using a Linear Mixed Effects Model.

Results: The mean number of OB Triage visits among Strong Start participants (0.78; 95% CI 0.70-0.86) was higher than non-Strong Start controls (0.58; 95% CI 0.52-0.64) (P<0.001) however the acuity of the visits between the cohort was demonstrated to be at a higher level in the Strong Start cohort. Among Strong Start participants, Odds Ratio of >1 OB Triage visits was 2.16 (1.77, 2.62) and Odds Ratio of >2 OB Triage visits was 2.50 (1.94, 3.22) compared to controls (p <0.001). The SS participants were nearly half as likely to present to OB Triage with labor related complaints overall (OR = 0.55 (95% CI 0.36, 0.82)), but were nearly 50% more likely to present with potentially acute complaints of abdominal pain (OR = 1.43 (95% CI 0.87, 2.36)), and more than twice as likely to present with neurological complaints (OR = 2.34 (95% CI 1.03, 5.31)).

Conclusions: Triage care services increased, among participants of a maternity medical home model of care despite increased access to prenatal education and prenatal service. Further research is necessary to determine trends in OB Triage chief complaints, highlight modifiable factors that may allow a reduction in OB Triage visits, and determine the cost effectiveness of patient enrollment in a maternity medical home model of care.

Reviewer Michael Nageotte
Black women have higher rates of severe maternal morbidity (SMM) and mortality than women of other racial groups even after correcting for socioeconomic factors and comorbidities. California Senate Bill 464 signed by Governor Newsom on October 7, 2019 aims to reduce maternal mortality among Black women by requiring all perinatal health care providers to complete implicit bias training and requiring the Department of Public Health to track and publish data on SMM and mortality by race. Additional approaches will also play important roles in reducing racial disparities in SMM, including in and out-patient data-driven Quality Improvement and culture change projects.

The first step begins with an analysis of the causes of morbidity that have the highest impact on disparity. Obstetric hemorrhage is the leading cause of SMM among Black women and has large Black-White disparity. Important secondary drivers for the unequal Black outcomes include: 2-4X higher rates of iron deficiency anemia, 6%-point higher NTSV Cesarean rates, and unequal application of standardized care for acute hemorrhage. Identification of specific care pathways allows for more direct activities to address the effects of structural racism and bias.
Objective: As planned home births increase, emerging evidence on the outcomes of hospital versus planned home births has been inconsistent, and a growing number of states have attempted to legislate out of hospital births. We sought to determine whether an association exists between neonatal hypoxic ischemic encephalopathy (HIE), a complication of ischemic birth injury, and planned location of birth.

Design: A case-control study design was used to compare data from electronic medical records of neonates with HIE to Hawaii state birth certificate data of normal controls.

Methods: For each neonate with HIE diagnosed at Kapiolani Medical Center for Women and Children from 2014-2018, we randomly selected from Hawaii state birth certificate data information on four neonates without HIE matched by gestational age and birth year. To ensure normal controls did not have a diagnosis of HIE, all birth certificates that indicated a neonate had been admitted to the neonatal intensive care unit were excluded. We considered an odds ratio of 4 to be clinically significant and calculated that we would need 143 cases and 572 controls in order to detect an odds ratio of 4 with 80% power and an α of 0.05. Bivariate association between maternal characteristics and presence of HIE was tested using Fisher’s exact test for categorical variables and two-sample t-test for continuous variables. A penalized backward stepwise logistic regression was fitted for the presence of HIE adjusting for the variables with p<0.10 from the bivariate analysis.

Results: We included 164 cases and 656 controls in the study. A home birth was planned in 20 births (2.4%) with 8 (4.9%) among the cases and 12 (1.8%) among the controls. The odds of having been a planned home birth were 2.77 times higher in neonates with HIE compared to controls [95% confidence interval (CI)=1.05-6.87]. After adjusting for insurance, mode of delivery, meconium fluid, maternal hypertension, and chorioamnionitis, infants with HIE were still more likely to have been a planned home birth compared to controls (odds ratio (OR)=11.56; 95% CI=1.37-118.77). Furthermore, compared to infants without HIE, infants with HIE were more likely to have been born to women with hypertension (OR=4.73, 95% CI=2.23-10.00), an operative vaginal delivery (OR=3.56, 95% CI=1.10-10.61), a cesarean delivery (OR=7.04, 95% CI=3.98-12.89), meconium-stained amniotic fluid (OR=11.13, 95% CI=6.14-20.68), and chorioamnionitis (OR=15.27, 95% CI=7.36-33.37). Compared to infants without HIE, infants with HIE were also less likely to have been insured by private/Tricare/military (OR=0.21, 95% CI=0.12-0.36) or self-pay/other (OR=0.01, 95% CI=0.00-0.05) insurance than by Medicaid.

Conclusions: Neonates with hypoxic ischemic encephalopathy were more likely to have been a planned home birth compared to infants without HIE.
P-05
Associations Between the Safe Prevention of Primary Cesarean Delivery Care Consensus and Maternal/Neonatal Outcomes

Pamela Estrada (By Invitation)

Objective: To compare cesarean delivery (CD) rates and maternal/neonatal outcomes before and after the 2014 ACOG/SMFM Obstetric Care Consensus for Safe Prevention of Primary CD

Design: This retrospective cohort study compared unscheduled CD rates and outcomes of singleton, cephalic, term pregnancies at Kapiolani Medical Center for Women and Children. Births 5 years before (March 2009-February 2014) and after (June 2014-May 2019) release of the Consensus were included. Chi-square was used to compare outcomes and logistic regression to adjust for confounders

Results: 44,001 pregnancies were included. CD rates increased after the Consensus (Table 1), however, there was no difference after adjusting for confounders. Vaginal birth after cesarean (VBAC) among multiparas increased, which remained significant after adjustment. Blood transfusion, postpartum hemorrhage, and chorioamnionitis increased, while 3rd degree laceration decreased. Neonatal outcomes were unchanged.

Conclusion: In our institution, the Safe Prevention of Primary CD Care Consensus was not associated with decreased CD rates, though VBAC increased. However, we did not demonstrate improved maternal or neonatal outcomes.

<table>
<thead>
<tr>
<th>Outcome N (%)</th>
<th>Before Guidelines N=20,887</th>
<th>After Guidelines N=23,114</th>
<th>P</th>
<th>aOR [95% CI] * (before consensus as reference)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cesarean delivery</td>
<td>2693 (12.9)</td>
<td>3306 (14.3)</td>
<td>&lt;0.001</td>
<td>0.97 [0.91-1.03]</td>
</tr>
<tr>
<td>Vaginal birth after cesarean (multiparas only)</td>
<td>800 (4.8)</td>
<td>1157 (7.2)</td>
<td>&lt;0.001</td>
<td>1.51 [1.37-1.66]</td>
</tr>
<tr>
<td>Postpartum hemorrhage</td>
<td>1163 (5.6)</td>
<td>1428 (6.2)</td>
<td>0.007</td>
<td>1.09 [1.00-1.19]</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>176 (0.8)</td>
<td>288 (1.2)</td>
<td>&lt;0.001</td>
<td>1.43 [1.17-1.74]</td>
</tr>
<tr>
<td>Uterine rupture</td>
<td>5 (&lt;0.1)</td>
<td>12 (0.1)</td>
<td>0.14</td>
<td>2.20 [0.76-6.39]</td>
</tr>
<tr>
<td>Chorioamnionitis</td>
<td>2370 (11.3)</td>
<td>3227 (14.0)</td>
<td>&lt;0.001</td>
<td>1.27 [1.20-1.34]</td>
</tr>
<tr>
<td>3rd degree laceration</td>
<td>831 (4.6)</td>
<td>714 (3.6)</td>
<td>&lt;0.001</td>
<td>0.65 [0.59-0.73]</td>
</tr>
<tr>
<td>4th degree laceration</td>
<td>102 (0.6)</td>
<td>95 (0.5)</td>
<td>0.27</td>
<td>0.78 [0.58-1.05]</td>
</tr>
<tr>
<td>Neonatal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal intensive care admit</td>
<td>877 (4.2)</td>
<td>1126 (4.9)</td>
<td>0.001</td>
<td>1.05 [0.95-1.15]</td>
</tr>
<tr>
<td>Umbilical artery pH &lt; 7</td>
<td>148 (1.1)</td>
<td>170 (1.1)</td>
<td>0.59</td>
<td>0.89 [0.71-1.13]</td>
</tr>
<tr>
<td>5 minute APGAR &lt; 7</td>
<td>208 (1.0)</td>
<td>301 (1.3)</td>
<td>0.003</td>
<td>1.17 [0.97-1.42]</td>
</tr>
<tr>
<td>Death prior to discharge</td>
<td>15 (0.1)</td>
<td>12 (0.1)</td>
<td>0.40</td>
<td>0.80 [0.35-1.82]</td>
</tr>
</tbody>
</table>

Table 1: Outcomes Before and After the 2014 ACOG/SMFM Safe Prevention of Primary Cesarean Delivery Consensus

* Adjusted for maternal age, body mass index at delivery, race, birthweight, multiparity, and labor induction; except for VBAC, in which multiparity was not included
Treating Anemia with Intravenous Iron Sucrose to Address Severe Maternal Morbidity (SMM) Rates: An Initial Assessment

Brian Crosland (By Invitation)

Objective: Severe maternal morbidity (SMM) rates are driven by several comorbidities that are strongly linked to moderate/severe anemia in the United States(1-3). We aim to determine if the administration of intravenous iron sucrose (IVIS) to pregnant women with iron deficiency anemia (IDA) prior to delivery decreases these known maternal comorbidities. The primary outcome will be the rate of blood transfusion administration and the number of units of packed red blood cells (PRBCs) given. Additional secondary outcomes include but are not limited to: occurrence of postpartum hemorrhage, the number of iron transfusions administered, the total dose of iron administered, and additional obstetric morbidities.

Design: This is a retrospective cohort study comparing perinatal outcomes between patients with IDA who received IVIS and those who did not. Review of the medication administration record (MAR) and IDA ICD-10 diagnoses identified study candidates from electronic medical records (EMR) in patients delivering a liveborn or stillborn at ≥ 28 0/7 weeks gestational age (GA) at Miller Children’s and Women’s Hospital Long Beach Memorial Medical Center (MCH/LBMMC) between January 10th 2011 – December 16th, 2019. For the purposes of this study, anemia was defined as hemoglobin (Hgb) ≤ 10.0 and diagnosed either with third trimester prenatal labs or at time admission for delivery.

Results: 298 patients met inclusion criteria for the study group and received IVIS; 309 were included in the control group. Within the study group, 42.8% of patients received one dose of iron sucrose and 57.2% received at least two doses. 75.1% and 63.5% of patients received 500 mg for their first and second doses respectively. The median gestational age at time of first IVIS dose was 31.7 weeks and median Hgb was 8.5 mg/dl. There were no serious adverse events during 461 doses of iron sucrose administered in our population with 2.5% of doses associated with minor reactions. Compared to controls, women in the IVIS group were more likely to have abnormal placentation (7.7% vs 0.3%, p < .001), were less likely to be Black (16.8% vs 35.9%, p <0.0001) and had higher Hgb levels at admission (10.2 mg/dl vs 9.2 mg/dl, p <0.0001). Median QBL at delivery was similar 541.5 (± 581.7) mL and 573.3 (± 544.0) mL. Although the rate of PRBC transfusion was similar between groups (12.8% and 17.8% respectively, p = 0.8), when excluding those patients with abnormal placentation, transfusion rates were significantly lower in the IVIS group compared to control patients (7.6% and 17.9% respectively, p <0.001). Hospital obstetric transfusion rates during this time period were approximately 2%. The number of PRBC units transfused were not significantly different.

Conclusions: Our results demonstrate that IVIS is well tolerated in pregnancy for the treatment of IDA, even when given in larger individual doses than traditionally recommended. Although the primary outcome was not statistically different, in women without abnormal placentation, antenatal iron sucrose administration was associated with significantly lower transfusion rates at delivery. Further study is needed to determine optimal timing of IVIS administration, as well as identify opportunities to decrease racial/ethnic disparities in the treatment of IDA and potentially transfusion rates as a driver of SMM.

9:45 am Break

Posters are located on the website at PCOGS.Org
10:10 am – 10:40 am Frank Lynch Memorial Essay

'Complicated' Placenta Accreta Spectrum: A High-risk Cohort Warranting Potential Early Intervention
Brian Crosland (by invitation)

Background: Placenta accreta spectrum (PAS) refers to the breadth of diagnoses involving the variable pathologic placental growth into the myometrium and or adjacent maternal tissues.1-2 Early identification of patients with “complicated accretas”, or those with multiple antepartum bleeding episodes, preterm premature rupture of membranes (PPROM), or premature contractions requiring tocolysis, could impact maternal and neonatal outcomes and delivery planning/coordination.3-6 This particular subset of patients may pose more significant risks of catastrophic bleeding and potentially warrant the earlier assembly of a multidisciplinary team and more preterm delivery when compared to those with PAS and no additional antepartum complications.3-5,7,8

Objective(s): This study analyzes prenatal, antepartum, intrapartum, and postpartum diagnosis, management, and overall maternal-neonatal outcomes between patients with complicated accreta cases and those without antenatal risk factors.

Study Design: This is a retrospective chart review of patients who underwent cesarean hysterectomy for suspected PAS between 23 0/7 – 42 0/7 weeks gestational age (GA) from July 1, 2008 – April 11, 2017. The study was conducted at a community-academic hospital, Miller Children’s and Women’s Hospital Long Beach Memorial Medical Center (MCH/LBMMMC). Use of OBStat and UCI Honest Broker Services, two health informatics applications from the aforementioned clinical sites, collected de-identified data utilizing International Classification of Diseases-9 (ICD-9) codes, including but not limited to those involving PAS: placenta previa, placenta accreta, and cesarean hysterectomy. Antepartum, intrapartum and postpartum data for select maternal and neonatal variables was collected and analyzed.

Results: A total of 99 charts were reviewed with 28 meeting inclusion criteria for ‘complicated PAS’ and 30 for “uncomplicated PAS”. Patients with complicated PAS have a statistically significant higher rate of blood product transfusion during their antepartum course: 5 (25%), 2 (33%), and 4 patients (29%) received transfusions compared to 1 patient (3%) with uncomplicated PAS (p = 0.025). The gestational age at time of delivery was significantly earlier with a P < .001 for patients with complicated PAS. The median gestational age was: 30.6 (Q1 = 27.3; Q3 = 31.9), 28.5 (Q1 = 19.1; Q3 = 29.3), and 31.3 (Q1 = 30.4; Q3 = 32.4) for those with multiple bleeding episodes, PPROM, and preterm contractions, respectively. Uncomplicated PAS cases were found to have a median gestational age of 35.0 (Q1 = 32.7; Q3 = 37.0). In addition, the median birthweights (BWT) were found to be significantly lower and the rate of NICU admissions higher for those with complicated PAS; these results met statistical significance with P < .004 and P < .032 respectively. There were no significant differences in most demographic factors including parity, prior cesarean deliveries. There were no statistically significant differences in intraoperative injury, transfusion, ICU admission, or final pathologic diagnosis between the two groups.

Conclusion: We found PAS patients with multiple bleeding episodes, PPROM, and/or preterm contractions requiring tocolysis to have an increased risk for specific maternal and neonatal comorbidities. Future areas of research include evaluating if these complicating factors offer more expedient referrals to centers of higher levels of maternal care and if this subsequently improves maternal and neonatal outcomes for woman affected by PAS. Classifying patients as “complicated” by antenatal obstetric events may assist providers in determining the need for earlier interventions such as maternal resuscitation, earlier iatrogenic preterm delivery, and sooner multidisciplinary delivery planning.
Impact of Third Trimester Daylight Hours on the Severity of Neonatal Abstinence Syndrome in Opioid-Using Women

Kristina Eaton (By Invitation)

OBJECTIVE: Neonatal abstinence syndrome (NAS) is a condition that may affect infants who are exposed to opioids or opioid agonists in utero. Little is known about environmental factors on maternal opioid use and, subsequently, NAS. Daylight hours in Alaska vary substantially by season, with only five to six hours in Anchorage during the shortest months of the year. This study evaluates the impact of daylight hours during the third trimester of pregnancy on the severity of NAS in the infants of opioid-using mothers.

DESIGN: This retrospective chart review included infants of opioid-using women at a single institution in Anchorage, Alaska, admitted between January 2015 and December 2018. Their births were grouped by quartiles of the year, demonstrating daylight hour variation. Infants who delivered prior to 37 0/7 weeks gestational age were excluded from analysis. Severity of NAS was measured by a composite score, which was determined by the length of the infant’s admission and the need for and duration of pharmacologic treatment of symptoms while inpatient. Statistical analysis was done using STATA IC 15.1 (College Park, TX). Distribution of variables was assessed using graphical methods, and summary statistics were done using means and medians, or tabulation if categorical. Comparative statistics were done with parametric and non-parametric analyses as appropriate. Logistic regression was used to look at admission to the NEST unit versus birth quartile and assess for confounding. Linear regression was used to assess composite score by birth quartile and assess for confounding.

RESULTS: 138 term infants with opioid exposure were admitted in the study period, of which 82 were admitted into the Neonatal Abstinence Evaluation Support and Treatment (NEST) unit due to symptomatic withdrawal. Of these, 64 required pharmacologic therapy. The 56 infants that did not exhibit withdrawal symptoms were discharged directly from the postpartum unit. All 138 term infants with opioid exposure were included in this analysis. The mean composite score, representing the severity of NAS by birth month quartile, was 4.44 (Dec-Feb), 4.57 (March-May), 3.63 (June-Aug), and 4.43 (Sept-Nov). The uncontrolled analysis of composite score by birth month quartile showed no statistically significant difference between the cohorts (p=0.78).

Breast feeding decreased the odds of admission to the NEST unit (OR 0.23, 95% CI 0.08-0.68). Maternal use of other illicit substances increased the composite NAS score (β coeff. 1.94, 95% CI 0.32-3.57). Maternal treatment with methadone or buprenorphine also increased the composite NAS score (β coeff. 2.67, 95% CI 1.21-4.13).

CONCLUSIONS: Daylight hours during the third trimester of pregnancy did not impact the severity of NAS in the infants of opioid-using mothers, however, breastfeeding had a positive effect on NAS and maternal polysubstance abuse was associated with higher composite scores.

Formal Discussant: Keith Ogasawara
OBJECTIVE: The objective of the study was to evaluate pregnancy outcomes among women with acute cervical insufficiency (ACI) who underwent cerclage placement.

STUDY DESIGN: Retrospective cohort study of women with a singleton pregnancy that underwent cervical cerclage between January 1, 2009 and July 1, 2019 at a single integrated health care institution. Cervical cerclages were classified as history-indicated, ultrasound-indicated or physical exam-induced. Demographic, maternal and fetal data were reviewed. The primary outcome was to evaluate delivery at or beyond 37 weeks’ gestation. Secondary outcomes include prolongation of pregnancy; delivery outcomes; and neonatal outcomes. Continuous variables were analyzed with Student’s t-test and Mann-Whitney-Wilcoxon; and categorical variable were analyzed with Chi square or Fisher’s exact test. Logistic regression was used for multivariate analysis.

RESULTS: Between 2009 and 2019, 285 cervical cerclage placements at our institution were evaluated. There were 134 (47%) history-indicated cerclage placements while 53% (n=151) comprised the acute cervical insufficiency (ACI) group. There was a significant difference in gestational age at the time of placement between history-indicated and those with ACI (14.4 weeks vs. 18.5 weeks, P<.001). Women with history-indicated cerclage were similar in age to those with ACI; however, tended to have more prior pregnancies and prior preterm births. There were no significant surgical or maternal complications between the groups. Patients with history-indicated cerclage were more likely to deliver ≥34 weeks (88% vs. 72%, P=.001) and ≥37 weeks (76% vs. 57%, P=.001) than those with ACI. Women with ACI delivered at an earlier gestational age (34 weeks vs. 37 weeks, P=0.001) thus more NICU admissions (P=0.03), perinatal deaths (P=0.03), lower birth weights (P<0.001) and increased composite neonatal morbidity (P=0.008) among neonates. Although the 1-minute Apgar score was statistically greater for those with history indicated cerclage (P=.003), the 5-minutes Apgar score was comparable to those with ACI. Those with history-indicated cerclage placement had prolongation of pregnancy of approximately 2.5 days longer after cerclage removal than those with ACI (P=.03).

CONCLUSION: Although patients with history-induced cerclage deliver at a later gestational age than patients with acute cervical insufficiency (ACI), 72% of ACI patients with cervical cerclage deliver at ≥34 weeks’ gestation and almost 60% will deliver at term. Cervical cerclage placement improves the outcomes of women with acute cervical insufficiency (ACI) to deliver at ≥37 weeks.

Formal Discussant: Kirsten Salmeen
Objective: To evaluate the effects of Cesarean delivery reduction efforts (CDRE) on perineal trauma.

Design: This is a retrospective cohort study of all live singleton pregnancies greater than 32 weeks gestation delivering vaginally from 2013-2018 at an urban community tertiary care hospital. Demographic, maternal and fetal data were reviewed. Women delivering the 3 years prior to full implementation of CDRE (2013-2015; pre-CDRE) were compared to women delivering the 3 years following full implementation (2016-2018; post-CDRE). Categorical variables were analyzed with Chi-square or Fisher’s exact test while Student’s t-test was used for continuous variables. Logistic regression analysis was used for multivariate analysis.

Results: During the study period, there were 22,358 total deliveries. Of these, 14,463 women met the inclusion criteria (7,301 prior to 2016, 7,162 after 2016). Prior to full implementation of CDRE, women were more likely to have perineal trauma (63.0% vs. 54.8%, p < .001). The rate of obstetric anal sphincter injuries (OASIS) was higher in the pre-CDRE group (2.9% vs. 2.4%, p = .04). When adjusting for episiotomy use, women in the pre-CDRE group still had higher rates of all-type perineal trauma (49.6% vs. 47.3%, p < .02). However, the post-CDRE group was more likely to have a 2nd degree perineal laceration (OR: 1.15; 95% CI: 1.15 – 1.16) or an OASIS (OR: 1.64; 95% CI: 1.55 – 1.73).

Conclusion: Implementation of Cesarean delivery reduction efforts increases a woman’s risk for higher degree perineal traumas including obstetric anal sphincter injuries.

Formal Discussant: David Lagrew
SOCIETY MEMBERSHIP BY CAUCUS
(GEOGRAPHICAL)

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Bradley - LA-F
Brown - Newport Beach-F
Clewell - Santa Maria-RF
Cohen - Bakersfield-F
Corlett - Santa Barbara-F
Davis - Pacific Palisades-RF
Durinzi - Studio City-F
Ellsworth, Hanford-F
Esakoff - LA-F
Fassett - LA-F
Finberg - Bakersfield-F
Freeman - Long Beach-RF
Friedman – Burbank-F
Fuller - Anaheim-F
Futoran - LA-F
Goodno - LA-RF
Goodwin - LA-RF
Grady - San Gabriel-F
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Hassan - LA-F
Hindle - LA-RF
Incerpi - LA-F
Israel, J. - LA-F
Israel, R. - LA-F
Kilpatrick - LA-F
Lagrew - Orange-F
Lee, R. - LA-F
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Ouzounian – Pasadena-F
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Paulson - LA-F
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Roloff - Redlands-F
Schlaerth - LA-F
Schlesinger - Yorba Linda-RF
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Shaw - LA-F
Shields - LA-F
Spanos - Del Mar-RF
Steinke - Fresno-F
Valenzuela - Colton-F
Vasilev - LA-F
Walker - Pasadena-F
Wallace - LA-RF
Wang– LA-F
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Winter, M - LA-F
Wohlmuthe - LA-F
Yee - Long Beach-F
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Bednarek - P-F
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Garrett - Springfield-F
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Gosewehr - P-F
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Hicks - P-F
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Kaplan - Eugene-RF
Katz, V. - Eugene-RF
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Leslie - P-F
Lowensohn - P-RF
Miksovsky - Hillsboro-F
Morcos - Corvallis-F
Mukul - P-F
Neilson - P-F
Nichols - P-F
Novy - P-RF
Patton - P-RF
Plaut - Vancouver, WA-RF
Ribbink - P-F
Roberts - P-RF
Schrinsky – Tualatin-RF
Schwartz - P-RF
Shaffer, B. - P-F
Shaffer, L. - P-F
Smith, W. – P-F
Stempel - P-F
Tarr – Vancouver-F
Tomlinson – P-F
Veltman - P-RF
Watson - P-RF
Wentross - P-F
Winter, W. - P-F

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Deasy, S - Flagstaff-RF
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Gaylord - Las Vegas-RF
Hanss - Phoenix-RF
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Lamb, E. - Scottsdale-RF
Laughead - Phoenix-RF
Macaulay - SD-F
Manriquez - Phoenix-F
Mayo - SD-RF
Mouer - Phoenix-RF
Reinsch, C. - La Jolla-F
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Romero – Phoenix-F
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Stucky – San Marcos-RF
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SEATTLE: Jane Dimer, Caucus Director (2019-2021) (46)

Branigan - Bellingham-F
Cole - Seattle-RF
Der Yuen - SE-RF
Dimer - SE-F
Dunsmoor-Su - SE-F
Eckert - SE-F
Graham - Bellevue-RF
Gravett - SE-RF
Hanson, H. - Anchorage-RF
Hartman - Spokane-RF
Hickok, D. - SE-RF
Hickok, L. - SE-RF
Houmard - Liberty Lake-F
Lamb, J. - SE-F
Lamey - SE-RF
Lenihan – Tacoma-F
Lentz - SE-F
Luthy - SE-F
Marshall - SE-F
Melville - SE-F
Oliver, John – Alaska -F
Paek - Kirkland-F
Paley - SE-F
Palmer - Seattle-F
Partoll - Spokane-F
Peters, III - SE-F
Peterson - SE-F
Press – SE-F
Prins - Anacortes-F
Reed - SE-F
Reisner - SE-F
Rowles - Yakima-F
Shah - SE-F
Shahine - SE-F
Shy - SE-RF
Simpson - Federal Way-F
Smith, D. - SE-RF
Smith, M. - SE-RF
Soderstrom - SE-RF
Tamimi - SE-RF
Tomsen - Anchorage, AK-F
Veljovich – SE-F
Vontver - SE-RF
Wesol - SE-F
Woods - Coeur d’Alene, ID-F

NON-RESIDENT: (10)
Ballon - Osprey FL
Blanchette - Vahalla, NY
Brewster - North Carolina
Gabbe – Nashville, TN
Garite - Littleton, CO
Hale - Herndon, VA
Kim, M. - Poughkeepsie, NY
Lanouette, Tampa, FL
Learman - Boca Raton, FL
Martin-Cadieux - FL
Towers - Knoxville, TN

HONORARY: (3)
Felix - Milwaukee, WI
Jensen, H - Davis, CA
Smith-Sehdev