



THE CENTRAL ASSOCIATION OF OBSTETRICIANS & GYNECOLOGISTS



93rd
ANNUAL
MEETING
October 21-24, 2026

MELIÁ CARIBE
BEACH RESORT
PUNTA CANA
DOMINICAN REPUBLIC

MELIÁ
HOTELS & RESORTS

**CENTRAL ASSOCIATION OF
OBSTETRICIANS AND
GYNECOLOGISTS
(FOUNDED 1929)**

2026 ANNUAL MEETING

OCTOBER 21 – 24, 2026

**MELIÁ CARIBE BEACH RESORT
PUNTA CANA
DOMINICAN REPUBLIC**

**+1 809-221-1290
AV. ALEMANIA S/N
PUNTA CANA 23301
DOMINICAN REPUBLIC**

www.melia.com

Since 1929, the Central Association of Obstetricians & Gynecologists (CAOG) has been promoting the optimal health care of women. Optimal healthcare assumes equitable opportunities at every encounter, every day.

As a women's health organization, we are cognizant of the many racial disparities in the delivery of quality health care, both in the United States and abroad. This is a time to reach out, to listen, and to strive to make changes as advocates for all women.

CAOG wishes to join other healthcare organizations to effect social changes that affects everyone, every day.

The CAOG extends its
appreciation and gratitude to:

Natera

Natera has been a valued friend
from industry for nearly a decade.
Their generous support of the
educational and scientific
objectives of the
93rd CAOG Annual Meeting
is greatly appreciated.

2026 CENTRAL ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS

OFFICERS

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Thomas F. Arnold, M.D.
UND School of Medicine & Health Sciences
Dickinson, North Dakota

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Louisiana State University
Shreveport, Louisiana

Immediate Past President

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Univ. of Missouri School of Medicine
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Children's Mercy Kansas City
Kansas City, Missouri

Angelina K. Gangestad, M.D. (2025 – 2028)
University Hospitals Case Medical Center
Cleveland, Ohio

Michael R. Handler, M.D. (2024 – 2027)
SSM Health St. Joseph Hospital
Lake Saint Louis, Missouri

Luissa V. Kiprono, D.O. (2025 – 2026)
World Gateway Perinatal Consultants, PLLC
San Antonio, Texas

Theresa L. Robinson, M.D. (2024 – 2027)
Donna Sana Ob-Gyn
HCA Woman's Hospital of Texas
Houston, Texas

Teresa Tam, M.D. (2025 – 2028)
All for Women's Healthcare, SC
Chicago, Illinois

CAOG Management/Headquarters

Dennis J. Lutz, M.D., Managing Director
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Minot, ND 58702-0190
701-852-1555 (office)
dlutz@caog.org

Rochelle Hickel, Executive Director
P.O. Box 3010
Minot, ND 58702-3010
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rhickel@caog.org

PROGRAM COMMITTEE* - 2026

Dani G. Zoorob, M.D., MHA, MBA, MHI, Chair
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Shreveport, Louisiana

Robert A. Wild, M.D., MPH, Ph.D., Vice Chair
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Aurora Fertility Clinic
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University of Missouri School of Medicine
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Tiffany R. Tonismae, M.D.
University of Louisville
Louisville, Kentucky

*Ex officio members not listed

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Emily A. DeFranco, D.O., M.S.
University of Kentucky College of Medicine
Lexington, Kentucky

Catherine L. Van Hook, M.D.
University of Toledo Medical Center
Toledo, Ohio

Dani G. Zoorob M.D., M.H.A., M.B.A., M.H.I.
Louisiana State University Health Sciences Center
Shreveport, Louisiana

* Ex officio members not listed

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CommonSpirit Health
Morehouse School of Medicine
Nashville, Tennessee

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Central Obstetrics & Gynecology
Denver, Colorado

* Ex officio members not listed

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Maywood, Illinois

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Houston, Texas

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Indianapolis, Indiana

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Springfield, Illinois

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University of Alabama
Birmingham, Alabama

* Ex officio members not listed

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Thomas F. Arnold, M.D.

UND School of Medicine & Health Sciences
Dickinson, North Dakota

Vice Chair

President Elect I

Emily A. DeFranco, D.O., M.S.

University of Kentucky College of Medicine
Lexington, Kentucky

Immediate Past President

Jean R. Goodman, M.D., M.B.A.

University of Missouri School of Medicine
Columbia, Missouri

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Toledo, Ohio

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Thomas F. Arnold, M.D.
Shilpa Babbar, M.D., M.S.
David A. Billings, M.D.
Emily A. DeFranco, D.O., M.S.
Angelina K. Gangestad, M.D.
Jean R. Goodman, M.D., M.B.A.
David M. Haas, M.D., M.S.
Michael R. Handler, M.D.
Rochelle Hickel, CAOG Exec. Director
Emmet Hirsch, M.D.
Albert L. Hsu, M.D.
Mary L. Johnson, CME Program Admin.
Luissa V. Kiprono, D.O.
Elliot M. Levine, M.D.
J. Ricardo Loret de Mola, M.D.
Dennis J. Lutz, M.D.
Sarah R. Novotny, M.D.
Rebecca C. Pierson, M.D.
Theresa L. Robinson, M.D.
Teresa Tam, M.D.
Karen M. Thies, D.O., Ph.D.
Tiffany R. Tonismae, M.D.
Catherine L. Van Hook, M.D.
Robert A. Wild, M.D., M.P.H., Ph.D.
Dani G. Zoorob, M.D., M.H.A, M.B.A.

MEETING OBJECTIVES

The Central Association of Obstetricians and Gynecologists is one of the oldest and most prestigious specialty organizations in the United States. Since its founding in 1929, the CAOG has actively encouraged and promoted the study of obstetrics and gynecology and women's health care. In support of its mission, the national program this year is designed to address important advances in clinical care and practice management, as well as fundamental research. The program is integrated to promote open discussion between attendees, who are leaders in obstetrics, gynecology, genetics, reproductive endocrinology, gynecologic oncology and women's health care. The program format of hot topics, a keynote speaker and scientific research presentations will promote a better understanding of each subject by filling gaps in knowledge.

Specific learning objectives for each presentation are listed on the speaker evaluation forms.

DISCLOSURE OF FACULTY AND INDUSTRY RELATIONSHIPS

In accordance with ACCME policy, all faculty members have signed a conflict of interest statement in which they have disclosed any relevant financial interests or other relationships with industry relative to topics they will discuss at this program. At the beginning of the program, faculty members are expected to disclose any such information to participants. Such disclosure allows you to evaluate better the objectivity of the information presented in lectures. Please report on your evaluation form any undisclosed conflict of interest you perceive.

MEETING EVALUATION FORMS

Speaker evaluation forms for each lecture will be available electronically for all attendees. A signed, completed evaluation is required by our CME provider in order to receive credit. This also assists with CAOG's future needs assessment.

ACCME ACCREDITATION STATEMENT

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the University of North Dakota School of Medicine and Health Sciences and the Central Association of Obstetricians and Gynecologists. The University of North Dakota School of Medicine and Health Sciences is accredited by the ACCME to provide continuing medical education for physicians.

AMA/PRA CREDIT

DESIGNATION STATEMENT

The University of North Dakota School of Medicine and Health Sciences designates this Live activity for a maximum of 15.00 *AMA PRA Category 1 Credit(s)*TM. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CATEGORY 1 CREDIT CERTIFICATES

Award Certificates will be e-mailed to each attendee after the meeting and will include only those credits for presentations which you have attended and for which a completed and signed evaluation form has been returned.

ACOG COGNATES

The American College of Obstetricians and Gynecologists has assigned up to 15 cognate credits to this program.

Daily signature sheets are also required for credit documentation. Your attention to this is appreciated.

GENERAL INFORMATION

REGISTRATION (Isabela Foyer)

Registration for all attendees will take place during the following hours:

Wednesday, October 21	1:00 p.m. – 6:00 p.m.
Thursday, October 22	8:00 a.m. – 1:00 p.m.
Friday, October 23	8:00 a.m. – 1:00 p.m.
Saturday, October 24	8:00 a.m. – 1:00 p.m.

NAME BADGES (two different colors)

Please wear your name badge to all CAOG events. This is your identification for admission to CAOG activities. Attendees registered for educational credits will receive a white badge. Partners and guests will receive a tan badge. All badges will be in CAOG “green” holders. Ribbons denote state and other information (officers, speakers, award winners, new members).

WELCOME RECEPTION (Wednesday, October 21)

The traditional CAOG Welcome Reception will be held by the Cape Nao Pool Wednesday, October 21 from 6:00 p.m. – 7:00 p.m. **Admission is by name badge** so please register on arrival.

BREAKFAST (Thur., Fri., Sat., October 22-24)

The restaurants for breakfast open at 7 a.m. each morning. Breakfast will be on your own prior to the presentations starting each day at 8:00 a.m.

PARTNERS/GUESTS PROGRAM (Thursday, October 22)

From 8:30-10:00 a.m. the traditional spouse/guest program will be an immersive chocolate experience where guests will discover the rich history and exceptional quality of cacao from the Dominican Republic. After a short presentation guests will participate in a hands-on chocolate truffle workshop guided by Pastry Chef Manuela Rossi from Chocolate World. This experience is designed to be interactive, educational and enjoyable for both chocolate lovers and beginners.

SCIENTIFIC SESSIONS

All general scientific sessions will be held in the Isabela Ballroom. The sessions will begin at 8:00 a.m. on Thursday, Friday and Saturday. Hot topic lectures will be part of each general session.

HOT TOPIC LECTURES AND KEYNOTE ADDRESS

Six “hot topic” lectures will be presented, with three on Thursday, one Friday and two on Saturday. These will complement the 22 original research oral presentations by emphasizing the most up-to-date information on (1) viral infections (2) medical legal issues in ob-gyn, (3) ob-gyn education for students and residents, (4) national medical school administrative issues, (5) periviable birth counseling & management, and (6) minimally invasive gyn surgery.

The Keynote Address will be delivered on Friday, October 23rd by Dr. Thomas M. Gellhaus from Iowa City, Iowa. The title of his talk is “What is Your Legacy?”.

PRESIDENTIAL ADDRESS (Friday, October 23)

CAOG President Thomas F. Arnold from Dickinson, North Dakota will be escorted to the podium by the Past Presidents of CAOG who are in attendance. He will deliver his Presidential Address at 12:30 p.m. on Friday in the Isabela Ballroom. All registrants are invited to attend his thought-provoking presentation, “Ob-Gyn Care in Rural America.”

The 93rd incoming CAOG President, Emily A. DeFranco, D.O. will be installed in a brief ceremony immediately following the Presidential Address.

ANNUAL BUSINESS MEETING (Friday, October 23)

The CAOG Annual Business Meeting will be held following the Presidential Address at 1:30 p.m. on Friday, October 23, in the Isabela Ballroom. New members elected in 2025 will be introduced at this time and membership certificates will be presented.

RECEPTION/DINNER/AWARDS (Friday, Oct. 23)

The traditional Friday Evening CAOG Gala Banquet is the highlight of the Annual Meeting. This year is no exception. The reception will begin at 6:00 p.m. on the beach with a buffet dinner to follow. Awards for the best papers and posters will be presented along with other special acknowledgements by Dr. Tom Arnold.

DRESS/ATTIRE Business casual attire is acceptable for this evening as well as for the meeting events throughout the week. Otherwise, tasteful resort and beach wear is suggested. Saturday support your preferred sports team by wearing your favorite team apparel to the meeting for the “**Team CAOG**” group photo to be taken during the break.

CHILD CARE

The CAOG will not provide childcare at this meeting. The Meliá Caribe Beach can provide recommendations for this. Please contact the hotel if interested in assistance arranging childcare.

INDUSTRY EXHIBITS

The Industry Exhibits will be located in the **Isabela Ballroom**. The electronic Scientific Posters will also be displayed in the same area. Hours are:

Exhibit Set-Up

Wednesday, October 21 1:00 p.m. – 5:00 p.m.

Exhibit Hall Hours

Thursday, October 22 8:00 a.m. – 1:00 p.m.

Friday, October 23 8:00 a.m. – 12:00 noon

Exhibit Dismantle

Friday, October 23 12:00 noon

SCIENTIFIC POSTER DISPLAYS

The Scientific Poster Sessions will also be located in the Isabela Ballroom in the Exhibit Hall. Poster judging will be:

Poster Hours

Thursday, October 22 8:00 a.m. – 1:00 p.m.

Friday, October 23 8:00 a.m. – 12 noon

Digital Posters will be on display while the Exhibit Hall is open. Short oral presentations of each poster (non case reports only) will be held during the scheduled break times on Thursday and Friday.

Thursday, October 22 10:30 – 11:15 a.m.

Friday, October 23 10:45 – 11:30 a.m.

CAOG ANNUAL MEETING POLICY

Absolutely no refunds after

5:00 pm (CDT) Friday, September 11, 2026

PROGRAM SCHEDULE
93rd Annual Meeting Central Association
of Obstetricians and Gynecologists
Meliá Caribe Beach Resort
Punta Cana, Dominican Republic
October 21 – 24, 2026

WEDNESDAY, OCTOBER 21, 2026

- 9 a.m. - 12 noon CAOG Officers and Trustees
Annual Meeting
Senate Boardroom
- 1:00 - 6:00 p.m. General Registration (Isabela Foyer)
- 6:00 - 7:00 p.m. Welcome Reception (Cape Nao Pool area)

THURSDAY, OCTOBER 22, 2026

- 8:00 a.m. General Registration (Isabela Ballroom)
- 8 a.m. - 1:00 p.m. **INDUSTRY EXHIBITS OPEN**
- 8 a.m. - 1:00 p.m. **SCIENTIFIC POSTER SESSION OPEN**

FIRST SCIENTIFIC SESSION
(Isabela Ballroom)

Moderators:

Thomas F. Arnold, M.D. – CAOG President
Catherine L. Van Hook, M.D. – CAOG President Elect II

- 8:00 a.m. Opening Remarks
- 8:00 - 9:00 a.m. **Hot Topic #1**
“Viral Infections: They Can Really
Affect Your Life and Pregnancy –
An Update on Zika, COVID, etc.”
David F. Lewis, M.D.
Louisiana State Univ. Health Sciences Ctr
Shreveport, Louisiana

9:00 - 9:30 a.m. **Paper #1 Dr. Kermit E. Krantz
Memorial Paper Award**

“A Study of Phthalates in Association
With Cardiovascular Biomarkers
and Reproductive Hormones in
a Hispanic Community”
Heba Ahmed, B.S.
Texas Tech Univ. Health Sciences Center
El Paso, Texas

Discussant: David M. Haas, M.D., M.S.
Indianapolis, Indiana

9:30 - 10:00 a.m. **Paper #2 Young Investigator’s
Award**

“Evaluation of Fertility Counseling
at the Initial Oncologic Visit”
Nikita R. Peramsetty, M.D.
University of Kansas Medical Center
Kansas City, Missouri

Discussant: Sarah Morgan Carpenter, M.D.
Carmel, Indiana

10:00 - 10:30 a.m. **Paper #3 Dr. Jack A. Pritchard
Memorial Paper Award**

“Evaluation of Saposin C-
Dioleoylphosphatidylserine Nanovesicles
for Drug Delivery to the Placenta”
Ameya Gourisetty
University of Cincinnati
Cincinnati, Ohio

Discussant: Jean R. Goodman, M.D., MBA
Columbia, Missouri

10:30 - 11:15 a.m. **Break/Refreshments/Exhibits/Posters
(Isabela Ballroom)**

SECOND SCIENTIFIC SESSION (Isabela Ballroom)

Moderators:

Shilpa Babbar, M.D. – CAOG Trustee

Michael R. Handler, M.D. – CAOG Trustee

11:15 - 12:15

Hot Topic #2

“The Quagmire of
Medico-Legal Exposure”

Mark I. Evans, M.D.

Comprehensive Genetics
New York, New York

and

Ralph F. Valitutti, J.D.

Kitch Attorneys & Counselors
Mount Clemons, Michigan

12:15 - 12:45 p.m. Paper #4

**Central Prize
Award**

“Irritable Bowel Syndrome–Like
Presentation of Ovarian Cancer and
Associated Secondary Health Outcomes
in a National Propensity-Matched Study”

Varsha K. Vedapudi, B.S.

University of Toledo
Toledo, Ohio

Discussant: Angelina K. Gangestad, M.D.
Cleveland, Ohio

12:45 - 1:15 p.m. Paper #5

**President's Certificate of
Merit Award**

“Cervical Screening Inequities in
AI/AN Women: Comparing IHS
and Private Insurance Coverage”

David A. Billings, M.D.

UND School Medicine & Health Sciences
Minot, North Dakota

Discussant: Elliot M. Levine, M.D.
Chicago, Illinois

1:15 - 2:00 p.m.

Hot Topic #3

“Medical Education Challenges in 2026”

Catherine L. Van Hook, M.D.

University of Toledo
College of Medicine & Life Sciences
Toledo, Ohio

FRIDAY, OCTOBER 23, 2026

8:00 a.m. General Registration (Isabela Ballroom)

8 a.m. - 12 noon **INDUSTRY EXHIBITS OPEN**

8 a.m. - 12 noon **SCIENTIFIC POSTER SESSION OPEN**

THIRD SCIENTIFIC SESSION
(Isabela Ballroom)

Moderators:

Jean R. Goodman, M.D., - CAOG Past President

Luissa V. Kiprono, D.O. – CAOG Trustee

8:00 a.m. Announcements

8:00 - 8:45 a.m. **Hot Topic #4**
“The New Era of Academic Medicine:
Technology, Transformation, and Trust”
Marjorie R. Jenkins, M.D.
UND School Medicine & Health Sciences
Grand Forks, North Dakota

8:45 - 9:15 a.m. Paper #6 **Community Hospital
Award**
“Evaluation of the Adherence to
Established Guidelines for Labor
Arrest Disorders and Category II Fetal
Heart Tones in Nulliparous, Term,
Singleton, Vertex Cesarean Births”
Laurel L. Pietrzak, D.O.
Aurora Sinai Medical Center
Advocate Health
Milwaukee, Wisconsin

Discussant: Luissa V. Kiprono, D.O.
San Antonio, Texas

9:15 - 9:45 a.m. Paper #7
“Speech Communication Interference
in the C-Section Operating Room”
Gary Sutkin, M.D.
University of Missouri
Kansas City, Missouri

Discussant: Martin J. Caliendo, M.D.
Buffalo, New York

9:45 - 10:15 a.m. Paper #8
“Impact of Structured Trial of Labor After
Cesarean Training on Rates of Uterine
Rupture at an Academic Institution”
Rachel L. Hartman, M.D.
University of Texas Medical Branch
Galveston, Texas

Discussant: Emmet Hirsch, M.D.
Evanston, Illinois

10:15 - 10:45 a.m. Paper #9
“The Association of Water Source and
Consumption Type with Urine Pesticides
in a Midwest Pregnancy Cohort”
Lucy Salter, B.S.
Indiana University School of Medicine
Indianapolis, Indiana

Discussant: Lisa E. Moore, M.D.
Santa Teresa, New Mexico

10:45 - 11:30 a.m. **Break/Refreshments/Exhibits/Posters**
(Isabela Ballroom)

FOURTH SCIENTIFIC SESSION (Isabela Ballroom)

Moderators:

Emily A. DeFranco, D.O.–CAOG President Elect I
Teresa Tam, M.D. – CAOG Trustee

11:30 - 12:30 **Keynote Address**
“What is Your Legacy?”
Thomas M. Gellhaus, M.D.
Univ. of Iowa Carver College of Medicine
Iowa City, Iowa

12:30 - 1:30 p.m. **Presidential Address**
“Ob-Gyn Care in Rural America”
Thomas F. Arnold, M.D.
UND School Medicine & Health Sciences
Dickinson, North Dakota

1:30 p.m. **Installation of New President**

1:30 - 2:00 p.m. **Annual Business Meeting CAOG**

6:00 - 8:00 p.m. **Annual Gala**
Reception/Bufferet Dinner/Awards
(Beach Area)

SATURDAY, OCTOBER 24, 2026

8:00 a.m. General Registration (Isabela Ballroom)

FIFTH SCIENTIFIC SESSION
(Isabela Ballroom)

Moderators:

Thomas F. Arnold, M.D. – CAOG President

David A. Billings, M.D. – CAOG Vice President

8:00 - 9:00 a.m. **Hot Topic #5** (Isabela Ballroom)
“Periviable Birth:
Counseling and Management”
Emily A. DeFranco, D.O., M.S.
Univ. of Kentucky College of Medicine
Lexington, Kentucky

9:00 - 9:15 a.m. Paper #10
“Cultural Competency and
Communication with VR:
A Training Intervention to
Address Bias in Medical Education”
Julia S. LaForce, B.A.
Creighton University School of Medicine
Omaha, Nebraska

9:15 - 9:30 a.m. Paper #11
“The WHO Therapeutic Definition
of Postpartum Hemorrhage and First-
Line Drug Treatment, Real-World
Implications for an Urban Practice”
Elise A. Patrick, M.D.
Indiana University School of Medicine
Indianapolis, Indiana

9:30 - 9:45 a.m. Paper #12
“Maternal RSV Vaccines Knowledge,
Attitudes, Mistrust, and Decision-Making:
A National Survey”
Camille F. Bratton, M.D.
University of Toledo
Toledo, Ohio

9:45 - 10:00 a.m. Paper #13
“Bridging the Gap in Prenatal Education:
Patient Preferences, Disparities, and
Opportunities for Intervention”
Rebecca L. Anderson, M.D.
University of Nebraska Medical Center
Omaha, Nebraska

10:00 - 10:15 a.m. Paper #14
“Post-Legalization Cannabis Use
During Pregnancy and Its Effects
on Neonatal Outcomes”
Gabrielle F. Thro, M.D.
Southern Illinois Univ. School of Medicine
Springfield, Illinois

10:15 - 10:30 a.m. Paper #15
“Respiratory Syncytial Virus (RSV)
Vaccine Acceptability Following
Recent FDA Approval of Abrysvo®”
Summer Lawrence, M.D.
Southern Illinois Univ. School of Medicine
Springfield, Illinois

10:30 – 11:00 a.m. **Break/Refreshments**
(Isabela Ballroom)

SIXTH SCIENTIFIC SESSION (Isabela Ballroom)

Moderators:

Angelina Gangestad, M.D. – CAOG Trustee
Theresa L. Robinson, M.D. – CAOG Trustee

11:00 – 12 noon **Hot Topic #5**
“When Love Hurts: Endometriosis
and Female Sexual Dysfunction”
Teresa Tam, M.D.
Director, Minimally Invasive Gyn. Surgery
Prime Healthcare/Saint Francis Hospital
Chicago, Illinois

12:00 - 12:15 p.m. Paper #16
“Social Drivers of Health Associated with
Smoking Cessation During Pregnancy”
Sara C. Ueland, B.A.
Univ. of Kentucky College of Medicine
Lexington, Kentucky

- 12:15 - 12:30 p.m. Paper #17
 “Latency after Preterm Prelabor Rupture of Membranes (PPROM) and Outcomes at Single Community Hospital”
Ciera M. Danen, M.D.
 Aurora Sinai Med. Center, Advocate Health Milwaukee, Wisconsin
- 12:30 - 12:45 p.m. Paper #18 **Dr. George W. Morley Memorial Paper Award**
 “Is There a Need for Vaginitis Screening in the Era of Preoperative Antibiotics?”
Aaron D. Adams, M.D.
 Univ. of Louisville School of Medicine Louisville, Kentucky
- 12:45 - 1:00 p.m. Paper #19
 “Establishing a Multidisciplinary Placenta Accreta Spectrum Taskforce to Improve Care: A Quality Improvement Initiative”
Elizabeth L. Mirsky, M.D.
 Univ. of Kentucky College of Medicine Lexington, Kentucky
- 1:00 - 1:15 p.m. Paper #20
 “Persistent Gaps in Addiction Care for Pregnant Patients with Opioid Use Disorder in Appalachia”
Idhaya S. Vasu, M.P.H. & Elizabeth Lepovsky, M.P.H.
 Univ. of Louisville School of Medicine Louisville, Kentucky
- 1:15 - 1:30 p.m. Paper #21 **Dr. Bryan D. Cowan FAR Research Network Award**
 “The Association of Urine Glyphosate Concentrations with Pregnancy Loss in Nulliparas”
Leah Bode Langford, M.D.
 Indiana University Indianapolis, Indiana

ADJOURN

**A Qualtrics link will be sent
by e-mail for the pre-test,
post-tests and evaluations.**

**The pre-test will be sent
prior to the conference.**

**The post-tests will be sent
with the evaluation each day.**

**Please complete all to track
attendance and receive
educational credits.**

**We try to RECYCLE name
badges so please turn them
in to the CAOG Registration
Desk before departing.**

**Thank You
For Attending!**

SCIENTIFIC PRESENTATIONS

THURSDAY, OCTOBER 22, 2026

8:00 a.m. General Registration (Isabela Ballroom)

8 a.m. - 1:00 p.m. **INDUSTRY EXHIBITS OPEN**

8 a.m. - 1:00 p.m. **SCIENTIFIC POSTER SESSION OPEN**

FIRST SCIENTIFIC SESSION (Isabela Ballroom)

Moderators:

Thomas F. Arnold, M.D. – CAOG President

Catherine L. Van Hook, M.D. – CAOG President Elect II

8:00 - a.m. Opening Remarks

8:00 - 9:00 a.m. **Hot Topic #1**

“Viral Infections: They Can Really
Affect Your Life and Pregnancy –
An Update on Zika, COVID, etc.”

David F. Lewis, M.D.

Louisiana State Univ. Hlth. Sciences Center
Shreveport, Louisiana

Learning Objectives:

- Review the history of Zika virus in pregnancy.
- Describe the current approach to Zika virus in pregnancy.

9:00 - 9:30 a.m.

Paper #1

**Dr. Kermit E. Krantz
Memorial Paper Award**

A Study of Phthalates in Association with Cardiovascular Biomarkers and Reproductive Hormones in a Hispanic Community

Heba Ahmed, BS¹, Pallavi Dubey, PhD², Nathalie Moreno, BS¹, Chinthana Thangavel, MD², Madison Bencomo, MPH², Sireesha Reddy, MD²

Paul L. Foster School of Medicine, Texas Tech University Health Sciences Center El Paso, El Paso, TX¹, Department of Obstetrics and Gynecology, Texas Tech University Health Sciences Center El Paso, El Paso, TX²

Phthalates are established endocrine disruptors that are commonly found in plastics and household items. Prior research has linked phthalate exposure to hormonal dysregulation, obesity, and increased cardiovascular risk. Women with irregular menses, often a phenotype of polycystic ovarian syndrome (PCOS), are at higher risk for metabolic and cardiovascular disease. However, the relationship between phthalates, reproductive hormones, and early cardiovascular biomarkers in pre-menopausal women is unclear. The purpose of our study was to evaluate the association between phthalates and sex hormones and to assess the relationship between phthalate metabolites and cardiovascular biomarkers, specifically high-sensitivity troponins. We conducted a cross-sectional case-control study of 38 Hispanic women aged 18-42. The cases were women aged 18-42 with irregular menses, not on hormonal birth control or hormonal supplements in the past two months, and not pregnant. Controls included age-matched women with regular menses. We collected clinical data, including BMI, waist circumference, and waist-to-hip ratio as markers of abdominal obesity, and urine and blood samples for hormonal profiling. We found that total testosterone and hs-troponin levels differed significantly between cases and controls. Our cases had significantly increased levels of total testosterone and hs-troponin compared to our controls. The SHBG levels approached significance, with a p-value of 0.059. Increasing our sample size may contribute to a significant difference in SHBG levels in future studies. There was no significant difference in BMI between our cases and controls. Two urinary phthalate metabolites, DEHP (r -0.343, p 0.035) and di-2-ethylhexylisophthalate (r -0.491, p 0.011), were significantly negatively associated with SHBG levels. Only di-2-ethylhexylisophthalate out of the eight urinary metabolites studied was significantly associated with total

testosterone levels (r 0.512, p 0.005) and hs-troponin levels (r 0.467, p 0.016). DEHP in association with hs-troponin levels was also approaching significance (r 0.289, p 0.078). DEHP was significantly associated with waist circumference (r 0.430, p 0.009). Dibutyl phthalate (r -0.429, p 0.018) and butyl isobutyl phthalate (r -0.482, p 0.017) were significantly negatively associated with waist: hip ratio. Our proposed mechanism for these findings is that phthalate exposure suppresses SHBG, increasing androgen activity and leading to irregular menses and inflammation (Figure 1). Inflammation leads to subclinical cardiometabolic stress, resulting in elevated hs-troponin levels. Interestingly, DEHP is significantly associated with waist circumference, but Di-2-ethylhexyl isophthalate is not. This implies that DEHP has obesogenic properties that di-2-ethylhexylphthalate lacks, suggesting that obesity does not play a significant role in the pathogenic mechanism linking phthalates to increased hs-troponin levels.

Discussant: David M. Haas, M.D., M.S.
Indianapolis, Indiana

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Phthalate	Outcome	N	R-value	P-value
Di-2-ethylhexyl isophthalate	SHBG	25	-0.527	0.007
DEHP	SHBG	37	-0.341	0.039
Di-2-ethylhexyl isophthalate	Total Testosterone	26	0.492	0.011
Di-2-ethylhexyl isophthalate	hs-Troponin	26	0.467	0.016
DEHP	hs-Troponin	38	0.289	0.078
DEHP	Waist circumference	36	0.430	0.009
Dibutyl phthalate	Waist: hip ratio	30	-0.429	0.018
Butyl isobutyl phthalate	Waist: hip ratio	24	-0.482	0.017

Table 1 Phthalates vs. metabolic parameters and sex hormones: strongest signals

9:30 - 10:00 a.m.

Paper #2

Young Investigator's Award

Evaluation of Fertility Counseling at the Initial Oncologic Visit

Nikita R Peramsetty, MD¹, Sharon Fitzgerald, PhD, MPH², Elizabeth Riley, MD¹, Courtney Marsh, MD¹

The University of Kansas Medical Center, Kansas City, KS¹,
The University of Kansas Department of Population Health,
Kansas City, KS²

Objective: The American Society of Clinical Oncology recommends fertility preservation for those undergoing cancer-directed therapy. The objective of this retrospective chart review was to evaluate whether fertility preservation was discussed during oncology consultations for patients with a new oncologic diagnosis.

Materials and Methods: We conducted a retrospective chart review on 525 reproductive-aged patients with a new cancer diagnosis in 2024 using convenience sampling. The primary outcome was documentation of fertility counseling at the initial oncology consultation. Differences in documentation of counseling by demographic characteristics were evaluated using Chi-square and independent samples t-tests. Secondary outcomes included barriers to fertility preservation and percentage of patients who underwent fertility preservation.

Results: Fertility counseling was discussed in 38.1% (200/525) of initial oncology consultations. There was no association between counseling and BMI ($p=0.71$), age ($p=0.41$), or race ($p=0.24$). Among patients who received fertility counseling, 37.5% were offered referral to fertility services. 66.7% of those who were offered a referral had one placed. Of patients referred, 64% were evaluated by a fertility specialist. 43.8% of patients seen in clinic ($N=32$) ultimately underwent fertility preservation treatment. The treatments that people chose to undergo include oocyte or embryo cryopreservation, gonadal suppression, and ovarian or testicular tissue cryopreservation. The most common reason for declining referral or treatment was lack of interest followed by completed childbearing. Cost and time were infrequently reported.

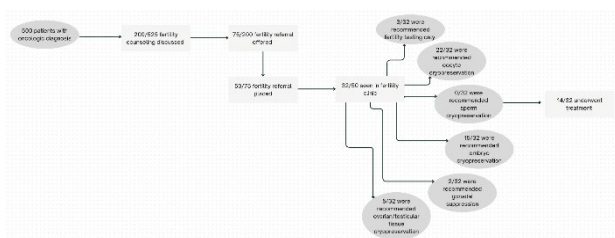
Conclusions: Fewer than 40% of reproductive-age patients with newly diagnosed cancer received fertility counseling at their initial consultation, highlighting a significant gap in evidenced-based care. Although 64% of those referred were seen by a fertility specialist, less than half the patient

proceeded with fertility preservation with the most common reason being that they are not interested. Therefore, improving access to fertility care requires standardized counseling and ensuring referrals to fertility care better align with patient interest.

Discussant: Sarah Morgan Carpenter, M.D.
Carmel, Indiana

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10:00 - 10:30 a.m.

Paper #3

**Dr. Jack A. Pritchard
Memorial Paper Award**

**Evaluation of Saposin C-Dioleoylphosphatidylserine
Nanovesicles for Drug Delivery to the Placenta**

Ameya Gourisetty¹, Kylan Hill, DO¹, Josephine Kemp, BS²,
Ahmet Kaynak, PhD¹, Xiaoyang Qi, PhD¹, Braxton Forde,
MD¹

University of Cincinnati, Cincinnati, OH¹, Cincinnati
Children's Hospital Medical Center, Cincinnati, OH²

Objective: Saposin C-Dioleoylphosphatidylserine Nanovesicles (sapC-DOPS) have been used to target serine expressing cells; expressed at the placenta's maternal-fetal interface due to cellular merging, and in states of hypoxia or stress found in fetal growth restriction (FGR). We evaluated sapC-DOPS localization following intra-amniotic injection in a murine model to determine if it could serve as a carrier for FGR therapeutics while minimizing maternal off-target uptake.

Methods: Wild-type mice underwent mini-laparotomy for intra-amniotic injection of 50 uL of sapC-DOPS nanovesicles at gestational age E17.5. SapC-DOPS nanovesicles were tagged with Cellvue Maroon dye (CVM), which fluoresces in far-red. Intra-amniotic injection was selected to maximize fetal-placental exposure while minimizing maternal uptake and off-target distribution. After 24 hours, fetuses and placental tissue were harvested for analysis. Uninjected pregnant mice were used as negative controls for baseline fluorescence comparisons. All maternal and fetal organs underwent fluorescent In Vivo Imaging (IVIS) to identify any organ uptake of tagged sapC-DOPS. Injected and control placentas were also examined via immunofluorescent staining (IF) and Hematoxylin and Eosin (H&E) staining to confirm that the intra-amniotic administration of the sapC-DOPS nanovesicles did not negatively affect the placental architecture between the treatment and control tissue.

Results: No maternal organs had increased fluorescence when compared with controls. IVIS imaging, analyzed with ImageJ and GraphPad software, depicted significantly higher fluorescence in sapC-DOPS treated placentas compared to the uninjected controls (Figure 1, $p < 0.01$). This primary indication of selective localization is supportive of the hypothesis that sapC-DOPS preferentially associates with serine-expressing regions of placental tissue. Placental size and weight were equivalent between treatment and controls (p

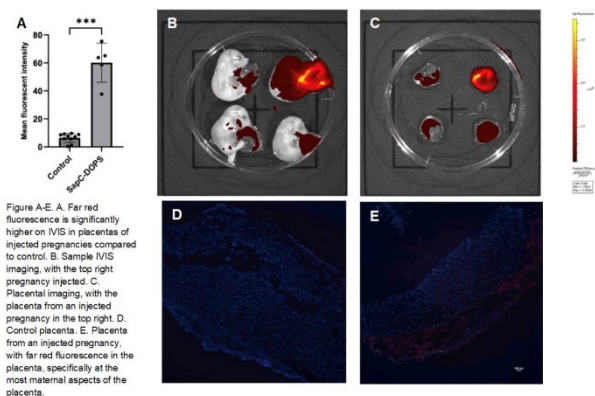
= 0.79, $p = 0.65$, respectively) and consistent with these findings, no difference was noted in placental structure on H&E staining, overall, depicting no signs of altered placenta morphology thus far following intra-amniotic injection of CVM tagged sapC-DOPS nanovesicles. IF staining revealed CVM fluorescing at the most maternal aspects of the placenta only, consistent with the expectation of sapC-DOPS localization. The only other organ noted to have sapC-DOPS nanovesicle uptake on IVIS imaging was the fetal lung, however, follow up with IF and flow cytometry confirmed that the sapC-DOPS fluorescence signal was not observed intra-cellularly, but rather sitting in the bronchi, indicating no true tissue uptake.

Conclusion: SapC-DOPS nanovesicles seem to safely and effectively target the placenta when injected intra-amniotically in a murine model and may be a suitable candidate as a carrier for potential FGR treatments.

Discussant: Jean R. Goodman, M.D., MBA
Columbia, Missouri

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10:30 – 11:15 a.m. **Break/Refreshments/Exhibits/Posters**
(Isabela Ballroom)

SECOND SCIENTIFIC SESSION (Isabela Ballroom)
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Moderators:

Shilpa Babbar, M.D. – CAOG Trustee

Michael R. Handler, M.D. – CAOG Trustee

11:15 - 12:15

Hot Topic #2

“The Quagmire of
Medico-Legal Exposures”

Mark I. Evans, M.D.

Comprehensive Genetics

New York, New York

and

Ralph F. Valitutti, J.D.

Kitch Attorneys & Counselors

Mount Clemons, Michigan

Learning Objectives:

- Review the most pressing medical-legal issues facing practicing ob-gyn’s today.
- Implement a plan to help physicians reduce the chance of medical liability when treating patients.

12:15 - 12:45 p.m.

Paper #4

Central Prize Award

Irritable Bowel Syndrome–Like Presentation of Ovarian Cancer and Associated Secondary Health Outcomes in a National Propensity-Matched Study

Varsha K Vedapudi, BS, Andrew Edgington, BS, Syed Shehryar Azeem, MBBS, MPH, James W Van Hook, MD

University of Toledo, Toledo, OH

Background: Symptoms of irritable bowel syndrome (IBS), including bloating, early satiety, and constipation, overlap with early manifestations of ovarian cancer and may contribute to diagnostic uncertainty and worse clinical outcomes. The impact of a pre-existing IBS diagnosis on ovarian cancer outcomes remains unexplored. Although IBS is common and affects 4%-12% of women in North America, ovarian cancer remains a leading cause of gynecologic cancer-related mortality, particularly when diagnosed at an advanced stage.

Objective: To determine whether pre-existing IBS is associated with worse clinical outcomes in women with ovarian cancer, including secondary malignant neoplasms, ascites, intestinal obstruction, and emergency department or inpatient visits, in women diagnosed with ovarian cancer.

Methods: We conducted a retrospective cohort study using TriNetX, a multi-center EHR network, and identified females over the age of 18 years with ovarian cancer (C56). Patients were stratified based on the presence or absence of IBS diagnosed within 3 months prior to ovarian cancer diagnosis. The control cohort included women with ovarian cancer and no documented history of IBS. One-to-one propensity score matching was performed to balance baseline demographic characteristics. Outcomes were assessed from 1 day to 180 days (about 6 months) after the index of ovarian cancer diagnosis and included secondary malignant neoplasms, ascites, intestinal obstruction, emergency department or inpatient visits, and all-cause mortality. Risk ratios (RRs) and Kaplan-Meier analyses were used to compare outcomes between cohorts.

Results: At 6 months of follow-up, patients with IBS (n=780) had a significantly higher risk of secondary malignant neoplasms compared with those without IBS (14.2% vs 9.4%; risk ratio [RR], 1.51; $p = 0.011$), along with lower survival probability (85.27% vs 89.97%; log-rank $p = 0.025$). Patients with IBS also had significantly greater healthcare utilization,

with higher rates of emergency department or inpatient visits (49.1% vs 33.2%; RR, 1.48; $p < 0.001$) and lower event-free survival probability (49.15% vs 63.84%; log-rank $p < 0.001$). There were no statistically significant differences in ascites (9.7% vs 8.4%; $p = 0.42$), intestinal obstruction (2.8% vs 1.7%; $p = 0.169$), or all-cause mortality (6.3% vs 6.2%; $p = 0.901$) between cohorts.

Conclusion: Although IBS was not associated with increased all-cause mortality at 6 months, it was associated with worse secondary health outcomes, including higher rates of secondary malignant neoplasms and greater healthcare utilization. One explanation is that an IBS-like symptom profile at presentation may reflect greater symptom burden at onset. Alternatively, underlying IBS-related visceral hypersensitivity may contribute to symptoms that are more difficult to control with standard treatment regimens. These findings suggest that overlapping clinical features between IBS and ovarian cancer may contribute to delayed recognition and more advanced disease at diagnosis, underscoring the need for heightened suspicion for ovarian cancer in older women presenting with IBS-like symptoms.

Discussant: Angelina K. Gangestad, M.D.
Cleveland, Ohio

12:45 - 1:15 p.m.

Paper #5

**President's Certificate of
Merit Award**

**Cervical Screening Inequities in AI/AN Women:
Comparing IHS and Private Insurance Coverage**

Karrah Peterson, BS¹, Mia Wilkinson, BS¹, Charles C Hosford, PhD¹, James R Beal, PhD¹, Abe E Sahmoun, PhD¹, Dennis J Lutz, MD²

University of North Dakota School of Medicine and Health Sciences, Northeast Campus, Grand Forks, ND¹, University of North Dakota School of Medicine and Health Sciences, Northwest Campus, Minot, ND²

Introduction: Cervical cancer occurs when dysplastic cervical cells invade beyond the basement membrane. Screening with Pap and HPV testing enables early detection and prevention and remains essential despite HPV vaccination. USPSTF recommends screening ages 21–65. However, only 57.1–65% of American Indian and Alaska Native (AI/AN) women are up to date compared with 73.5% nationally. The Indian Health Service (IHS) provides care for many AI/AN individuals, though some use private insurance, and differences in screening by insurance type are not well defined. This study evaluates whether insurance type (IHS vs private) is associated with cervical cancer screening among AI/AN women.

Methods: Retrospective cross-sectional study using 2020–2024 BRFSS, a nationally representative multistage probability survey. Included AI/AN women aged 21–65; excluded non-AI/AN, out of age range, or missing screening/insurance data. Outcome: up-to-date cervical screening (Pap ≤ 3 years or HPV ≤ 5 years). Exposure: insurance type (IHS vs private). Covariates included age, marital status, education, rural/urban status, smoking, and access to care (personal doctor, routine exam, usual source of care). Analyses used SAS 9.4 with BRFSS weighting; chi-square tests assessed associations ($p < 0.05$).

Results: A total of 1,323 AI/AN women (weighted $N=589,982$) were included; 11.0% (SE 1.6) reported IHS coverage and 89.0% (SE 1.6) other insurance. No significant differences were seen by insurance type in age, education, marital status, access to a personal doctor, smoking, or screening. Screening rates were similar (IHS 67.6%, SE 5.99 vs private 70.1%, SE 2.28; $p=0.71$). IHS users were more likely to report a recent routine checkup (87.4% vs 76.9%; $p=0.015$) and rural residence (24.0% vs 14.6%; $p=0.027$).

Conclusion: Cervical cancer screening rates did not differ by insurance type among AI/AN women. Similar rates may reflect effective preventive care within IHS and greater routine care engagement. Despite higher rural residence among IHS users, parity suggests IHS may mitigate geographic barriers. Overall, access and routine utilization may matter more than insurance type alone. Future work should examine longitudinal screening, service quality and frequency, regional IHS differences, and patient-level barriers (transportation, cultural factors, trust) to explain persistent disparities.

Discussant: Elliot M. Levine, M.D.
Chicago, Illinois

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Table 1: Participant characteristics by Indian Health Service (IHS) insurance status, BRFSS 2024

Variables	IHS % (s.e.)	Other % (s.e.)	P-value
Total Unweighted (n=1,323) Weighted (n=589,982)	11.0 (1.6)	89.0 (1.6)	
Age groups (years)			0.259
18-49	72.5 (4.6)	66.2 (2.5)	
50-69	27.5 (4.6)	33.8 (2.5)	
Education level			0.137
High school graduate	47.7 (7.37)	39.6 (3.60)	
Attended College or Technical School	37.8 (7.23)	34.2 (2.53)	
Graduated from College or Technical School	14.8 (2.99)	26.2 (2.12)	
Marital Status			0.24
Married	29.3 (5.02)	36.8 (2.41)	
Not Married	70.7 (5.02)	63.2 (2.41)	
Personal Doctor			0.733
Yes	87.2 (4.87)	85.3 (1.45)	
No	12.8 (4.87)	14.7 (1.45)	
Recent checkup (≤1 year)			0.015
Yes	87.4 (2.95)	76.9 (2.04)	
No	12.6 (2.95)	23.1 (2.04)	
Cervical cancer screening			0.71
Up to date	67.6 (5.99)	70.1 (2.28)	
Not up to date	32.4 (5.99)	29.9 (2.28)	
Residence			0.027
Urban	76.0 (4.19)	85.4 (1.65)	
Rural	24.0 (4.19)	14.6 (1.65)	
Smoking status			0.613
Non-smoker	72.4 (6.30)	75.5 (2.39)	
Smoker	27.6 (6.30)	24.5 (2.39)	

1:15 - 2:00 p.m.

Hot Topic #3

“Medical Education Challenges in 2026”

Catherine L. Van Hook, M.D.

University of Toledo

College of Medicine & Life Sciences

Toledo, Ohio

Learning Objectives:

- Review the current standard for ob-gyn educators of students and residents.
- Present an improved strategy for educating students and residents in ob-gyn.

SCIENTIFIC PRESENTATIONS

FRIDAY, OCTOBER 23, 2026

8:00 a.m. General Registration (Isabela Ballroom)

8 a.m. - 12 noon **INDUSTRY EXHIBITS OPEN**

8 a.m. - 12 noon **SCIENTIFIC POSTER SESSION OPEN**

THIRD SCIENTIFIC SESSION (Isabela Ballroom)

Moderators:

Jean R. Goodman, M.D. – CAOG Past President

Luissa V. Kiprono, D.O. – CAOG Trustee

8:00 a.m. Announcements

8:00 - 8:45 a.m. **Hot Topic #4**

“The New Era of Academic Medicine:
Technology, Transformation, and Trust”

Marjorie R. Jenkins, M.D.

UND School Medicine & Health Sciences
Grand Forks, North Dakota

Learning Objectives:

- Describe the current nature of medical school administrative issues in the United States.
- Explain why periodic refreshing of medical school curriculum is necessary.

8:45 - 9:15 a.m.

Paper #6

Community Hospital Award

Evaluation of the Adherence to Established Guidelines for Labor Arrest Disorders and Category II Fetal Heart Tones in Nulliparous, Term, Singleton, Vertex Cesarean Births

Laurel Pietrzak, DO¹, Sarai Trenhs, DO¹, Manuel R. Lamptey, MS², Jessica Kram, MPH³, Callie Cox Bauer, DO⁴

Aurora Sinai Medical Center, Advocate Health, Milwaukee, WI¹, Aurora UW Medical Group, Aurora Sinai Medical Center, Advocate Health, Milwaukee, WI², Aurora UW Medical Group, Center for Urban Population Health, Aurora Sinai Medical Group, Advocate Health³, Aurora Sinai Medical Center, Advocate Health, Aurora UW Medical Group, Milwaukee, WI⁴

Nulliparous, Term, Singleton, Vertex (NTSV) cesareans account for ~25.6% of births (national benchmark 23.6%). Labor arrest disorders account for ~18-35% of primary deliveries, making them a common indication for NTSV cesarean, with limited studies evaluating adherence to diagnostic criteria. Similarly, non-reassuring fetal status (Category II or III) is also a frequent indication for NTSV cesareans. We aimed to determine the rate of NTSV cesarean births at our institution compared to national benchmark, evaluate adherence to American College of Obstetricians and Gynecologists (ACOG) Safe Prevention of the Primary Cesarean Delivery diagnostic criteria for labor arrest disorders, and evaluate adherence to fetal heart rate (FHR) monitoring guidelines (Clark guidelines) among NTSV cesareans within a high-risk obstetric population.

This QI project was conducted within one urban, teaching hospital among patients who had a NTSV delivery at ≥ 37 weeks' gestation between June 1, 2021 – June 1, 2022. Patients were included if they had singleton gestation, vertex presentation, and was their first term live birth. Data was obtained from the electronic medical record, and maternal/neonatal characteristics and outcomes were further reviewed and collected. A subpopulation of patients who were identified as having NTSV cesarean and documented labor arrest disorder (arrest of dilation, arrest of descent, failed induction of labor) were evaluated to determine adherence to ACOG diagnostic criteria for labor arrest disorders. A subpopulation of patients who were identified as having NTSV cesarean and non-reassuring FHR was also identified. FHR tracings and labor progression data were separately reviewed by two OB/GYN physicians to assess adherence to Clark guidelines, with discrepancies between interpretations

reviewed by a third OB/GYN physician for final decision on adherence. Descriptive statistics were computed.

Of those with NTSV birth (N=528), 127 (24.05%) had a cesarean delivery. Among NTSV cesarean deliveries, 20.5% (N=26) documentation of labor arrest disorder. This subpopulation had a median age of 22.0 years, were predominately Black, non-Hispanic (48.8%) and had a median gestational age of 39w3d; gestational hypertension was present in 30.0% of patients. Only 61.5% (N=16) met criteria for labor arrest: 50.0% (N=8) criteria for arrest of dilation, 43.8% (N=7) arrest of descent, or 6.3% (N=1) failed induction of labor. Neonates born within this population had a median 5-min APGAR of 9.0; 19.2% were admitted to the NICU. Of NTSV cesareans citing non-reassuring FHR (66.1%, N=84), 61.9% did not meet Clark guidelines; those not meeting criteria had 11.5% and 88.5% decreased and increased time, respectively. Neonates born within this population had a median 5-min APGAR of 9.0; 14.3% were admitted to the NICU.

More than one-third of NTSV cesarean deliveries performed for a labor arrest disorder and over half for category II fetal heart tones did not meet established guidelines. These findings reveal an opportunity for targeted QI efforts, including provider education, real-time clinical support tools, and structured FHR review protocols aimed at strengthening adherence to evidence-based guidelines.

Discussant: Luissa V. Kiprono, D.O.
San Antonio, Texas

9:15 - 9:45 a.m.

Paper #7

Speech Communication Interference in the C-Section Operating Room

Carsen Steele, BS¹, Gary Sutkin, MD, MBA², Alleana Corpin, BA², Richard J Simonson, PhD³, Yui-Yee Raymond Chan, MD³, Amber Davies, DNP², Ken Catchpole, PhD⁴

Wichita State University, Wichita, KS¹, University of Missouri - Kansas City, Kansas City, MO², Children's Mercy Kansas City, Kansas City, MO³, Medical University of South Carolina, Charleston, SC⁴

Miscommunication is a common cause of surgical error. Our objective was to characterize miscommunication events among teams in the C-section (C-S) operating room (OR) and determine how these events threaten patient safety. We directly observed 135 C-sections over 260.1 hours. Speech Communication Interference (SCI) was defined as "surgery-related discourse obstructed according to the goals of the communication, or the physical and situational context of the exchange," and measured using a SCI tool with an inter-rater reliability ranging from 0.87 to 0.98. Team members included attending surgeons, OBGyn residents and MFM fellows, anesthesiologists, circulating nurses, scrub techs, and pediatric providers. Each SCI event was categorized by surgical phase, individuals involved, contextual details, and evidence of the event. Roles were recorded identifying the sender, receiver, and "messengers" who repeated the sender's message. Evidence of miscommunication included the receiver asking for clarification, a sender repeating themselves, or no response meaning the message was entirely lost. Near misses and case delays were recorded. End-of-surgery interviews were conducted with 175 staff to explore causes and threats to patient safety. We observed 955 SCI events, mean 7.2 (SD=3.8) SCI events per case, 8.3 (SD=1.9) per hour. One case had 21 miscommunication events and two had zero. Evidence included the receiver asking for clarification or repetition: 723 (75.7%); the sender repeating themselves: 196 (20.5%); the message was entirely lost: 62 (6.5%). Of the 955 events, 255 (26.7%) occurred between uterine incision and hysterotomy closure, 201 (21.0%) during setup, 52 (5.4%) during the epidural, 11 (1.2%) during the surgical safety checklist, and 428 (44.8%) during other portions of surgery. The surgical team was involved in 46.1% of the events, the nursing team in 31.1%, the anesthesia team in 10.3%, and the pediatric team in 5.0%. The most common causes were loud noises (88.4%), overlapping conversations (70.4%), and the receiver focused on another task (55.4%). Loud noises

included suction, cautery, instrument sounds, the heart rate monitor and baby warmer, and the baby crying. Overlapping conversations emanated from surgeons discussing the operation, the pediatric team discussing the baby, nurses and scrub tech discussing the instrument count, anesthesia staff discussing pain management, and the patient's support person conversing with the patient. Concurrent tasks related to miscommunication included the circulating nurse charting or the surgeons making a bladder flap. In 770 events (80.6%), more than one contributing context was present. 439 (46.0%) miscommunication events resulted in a case delay, with a median of three seconds. Miscommunication resulted in 29 near misses. Participants reported in post-surgery interviews that they felt preventable miscommunication events compromised patient safety. Miscommunication is common in the C-S OR and threatens patient safety. Potential interventions include limiting staff in the room, implementing supply storage within the OR, ensuring nurse charting can be done close to the scrub tech, and improving line of sight for anesthesia team members.

Discussant: Martin J. Caliendo, M.D.
Buffalo, New York

9:45 - 10:15 a.m.

Paper #8

Impact of Structured Trial of Labor After Cesarean Training on Rates of Uterine Rupture at an Academic Institution

Rachel L Hartman, MD, Lindsay Wilken, MD, Shannon Clark, MD

UTMB, Galveston, TX

Objective: The rate of trial of labor after cesarean section (TOLAC) has decreased in the last two decades due to increased concern over poor outcomes, despite knowing that a successful vaginal birth after cesarean section (VBAC) has lower morbidity. For an institution to safely offer TOLAC, they must have adequate NICU, anesthesia, and obstetric capabilities. Each of these parties must be well trained in the management of TOLAC complications, especially uterine rupture. However, due to the relatively low frequency of uterine rupture, hands-on training is often limited. Simulation provides an alternative training method that allows for increased exposure to these cases without added risk to patients. While simulation has proven effective for high risk events such as shoulder dystocia, postpartum hemorrhage, and eclampsia, uterine rupture simulation is less studied. As an institution that performs a high volume of TOLACs, our quality control committee reviews cases monthly. They identified an increase in the rate of uterine ruptures in 2023. After reviewing several of these cases, simulation drills were initiated in June 2024. The objective was to develop a simulation curriculum for uterine rupture in the setting of TOLAC, using real clinical scenarios. We believed these simulations would both decrease the rate of uterine rupture and improve management of suspected uterine rupture.

Methods: A multifaceted approach involving targeted, case-based learning and multidisciplinary in situ simulation drills were initiated in June 2024. These drills used scenarios created from cases of uterine rupture that happened at the institution. The first simulation was developed and was trialed in March 2024. After updating the TOLAC guidelines and revising the simulation, standardized multidisciplinary simulations became scheduled multiple times throughout the year in June 2024. The number of uterine ruptures prior to initiation of these drills in June 2024 was compared to the number after. Statistical analysis was performed using Fisher's exact test using R statistical software (R Foundation for Statistical Computing, Vienna, Austria), and a two-sided p-value < 0.05 was considered statistically significant.

Results: Prior to initiation of these simulations, there were 116 scheduled TOLACs between February and June 2024. Of these, 4 resulted in uterine ruptures (3.45%). From July 2024 until March 2026, there were 589 scheduled TOLACs with 11 uterine ruptures (1.87%). Overall, the rate decreased by 1.58%, which is a 46% relative reduction in uterine rupture cases after implementation of the simulations. This is not statistically significant ($p= 0.29$) due to the low incidence of uterine ruptures. However, considering the morbidity and mortality associated with uterine rupture, this decrease is clinically significant.

Conclusions: The initiation of a standardized simulation curriculum for uterine rupture in the setting of TOLAC, using real clinical scenarios from case review, decreased the uterine rupture rate in our institution. While our data prior to the intervention was limited to 4 months, this still highlights the benefits of simulation training.

Discussant: Emmet Hirsch, M.D.
Evanston, Illinois

10:15 - 10:45 a.m.

Paper #9

The Association of Water Source and Consumption Type with Urine Pesticides in a Midwest Pregnancy Cohort

Lucy Salter, BS, Kevin J. Moss, BS, Emily Starnes, BS, Kathleen Flannery, BS, Joanne K. Daggy, PhD, David M. Haas, MD

Indiana University School of Medicine, Indianapolis, IN

Background and Objective: Environmental chemicals, such as herbicides and other pesticides, have been found in the urine of the majority of pregnant individuals in many US cohorts, even from those who do not live or work near farmland. Exposure to these chemicals may come from food residue, airborne exposure, or from water consumption. The objective of this study was to catalogue self-reported sources of water consumption and test for associations with higher concentrations of urine pesticides during pregnancy.

Methods: This was an exploratory analysis using a subset of the Heartland Study, an ongoing pregnancy cohort in the Midwest United States (currently in Indiana, Iowa, and Wisconsin). At study visits, participants complete questionnaires and have urine collected. Questionnaires asked about residential water source (municipal or well water) and drinking water consumption type. A subgroup of participants (n=528) had early pregnancy visit urine specimens analyzed for 17 pesticides, with the 4 most prevalent herbicides (glyphosate, its degradation product AMPA, 2,4-D, and dicamba) and the most prevalent insecticide metabolite (3-PBA) analyzed for association with water source and consumption type. Specific-gravity adjusted concentration values were compared using parametric survival to account for values below the limit of detection (LOD), assuming lognormal. A false discovery rate (FDR) adjustment was implemented to account for multiple comparisons. The geometric mean and associated 95% CI of specific gravity-adjusted values are reported using substitution with $\text{LOD}/\sqrt{2}$ for values below the LOD.

Results: Of 528 current HS participants with urine measures, 350 (66.3%) had complete survey data on residential water source, with 320 (91.4%) reporting metropolitan water and 30 (8.6%) reporting well water. The mean maternal age was slightly lower among well water users (28.7 years, SD 4.6) compared with metropolitan water users (30.3 years, SD 4.9). For self-reported drinking water type consumed, most participants were missing/mixed (37.7%), followed by filtered

or unfiltered tap (35.1%) and bottled only (27.2%). Detection frequencies of urinary chemicals were: 100% (2,4-D), 98.9% (3-PBA), 77.4% (AMPA), 72.0% (glyphosate), and 57.6% (Dicamba). Concentrations (ug/L) of 2,4-D and dicamba were significantly higher among metropolitan water users compared to well water users (0.517 vs. 0.346, adjusted $p=0.036$ for 2,4-D and 0.284 vs 0.154, adjusted $p=0.036$ for dicamba). After FDR adjustment, no differences were observed for 3-PBA, AMPA, or glyphosate by residential water source. When examining drinking water consumption type no statistically significant differences were found after FDR adjustment, though geometric mean concentrations of 3-PBA, AMPA and glyphosate were lower among unfiltered or filtered tap water users compared to bottled water only, while 2,4-D and dicamba concentrations were higher in consumers of unfiltered or filtered tap water (all FDR adjusted p values 0.061-0.066).

Conclusions: In this Midwest pregnancy cohort, concentrations of 2,4-D and dicamba were higher for participants reporting home metropolitan water source. About one-quarter of the participants used only bottle.

Discussant: Lisa E. Moore, M.D.
Santa Teresa, New Mexico

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Table: Geometric Means (95% Confidence Intervals) of pesticide concentrations by residential water source.

Chemical	N	Percent Above LOD	Metropolitan Water N=320	Well Water N=30	p-value	FDR Adjusted p-value
2,4-D	349	100.0	0.517 (0.478,0.559)	0.346 (0.280,0.426)	0.009	0.036
3-PBA	348	98.9	0.577 (0.511,0.652)	0.885 (0.585,1.338)	0.063	0.106
AMPA	344	77.4	0.207 (0.187,0.229)	0.180 (0.129,0.251)	0.517	0.646
Glyphosate	344	72.0	0.188 (0.167,0.210)	0.171 (0.116,0.253)	0.725	0.725
Dicamba	338	57.6	0.284 (0.244,0.330)	0.154 (0.103,0.229)	0.014	0.036

LOD= limitation of detection. FDR= false discovery rate adjustment for multiple comparisons.
2,4-D= 2,4-dichlorophenoxyacetic acid, 3-PBA= 3-phenoxybenzoic acid, AMPA= aminomethylphosphonic acid. Concentrations are adjusted for specific gravity and expressed in micrograms/liter.

10:45 - 11:30 a.m. **Break/Refreshments/Exhibits/Posters**
(Isabela Ballroom)

FOURTH SCIENTIFIC SESSION (Isabela Ballroom)
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Moderators:

Emily A. DeFranco, D.O. – CAOG President Elect I
Teresa Tam, M.D. – CAOG Trustee

11:30 - 12:30 **Keynote Address**
“What is Your Legacy?”
Thomas M. Gellhaus, M.D.
Univ. of Iowa Carver College of Medicine
Iowa City, Iowa

Learning Objectives:

- Develop advocacy as component of residency and practice.
- Develop mentoring as a mechanism of supporting and advancing the careers of medical students, residents, fellows, early career ob/gyns, and established ob-gyns.

12:30 - 1:30 p.m. **Presidential Address**
“Ob-Gyn Care in Rural America”
Thomas F. Arnold, M.D.
UND School Medicine & Health Sciences
Dickinson, North Dakota

Learning Objectives:

- Describe the challenges of ob-gyn care in rural America today.
- Develop a plan to reduce the challenges of ob-gyn care in rural America.

1:30 p.m. **Installation of New President**

1:30 - 2:00 p.m. **Annual Business Meeting CAOG**

6:00 - 8:00 p.m. **Annual Gala**
Reception/Buffer Dinner/Awards
(Beach Area)

SCIENTIFIC PRESENTATIONS

SATURDAY, OCTOBER 24, 2026

8:00 a.m. General Registration (Isabela Ballroom)

FIFTH SCIENTIFIC SESSION (Isabela Ballroom)

Moderators:

Thomas F. Arnold, M.D. – CAOG President

David A. Billings, M.D. – CAOG Vice President

8:00 - 9:00 a.m. **Hot Topic #5** (Isabela Ballroom)
“Periviable Birth:
Counseling and Management”
Emily A. DeFranco, D.O., M.S.
Univ. of Kentucky College of Medicine
Lexington, Kentucky

Learning Objectives:

- Define periviable birth.
- Outline the optimal components of counseling and management of periviable birth.

9:00 - 9:15 a.m.

Paper #10

Cultural Competency and Communication with Virtual Reality (VR): A Training Intervention to Address Bias in Medical Education

Julia S LaForce, BA¹, Charee M. Thompson, PhD², Joseph M Maurice, MD, MS³

Creighton University School of Medicine, Omaha, NE¹,
University of Illinois Urbana-Champaign, Urbana, IL²,
University of Illinois at Chicago College of Medicine,
Chicago, IL³

Objective: Current cultural competency training programs in healthcare demonstrate mixed effectiveness in preparing providers to care for diverse populations and address implicit bias. The objective of this study is to close content and delivery gaps by testing the efficacy of a communication-based virtual reality (VR) training program for healthcare providers that was developed by an interdisciplinary team of communication researchers, obstetrician-gynecologists, and computer engineers and addresses Black maternal health outcomes, where mortality and morbidity remain ongoing public health crises.

Methods: In this study, ninety-five medical students were recruited and completed a pre-training survey, then they watched five scenes using a head-mounted VR display, which shows a postpartum visit between a Black woman and her white male obstetrician displaying implicit bias and culturally insensitive communication, and are asked to recognize microaggressions, non-verbal communication, and consider the impact of the provider's delivery. After completion of the VR module, participants took a post-test to document their changes in attitudes and provide any feedback they had. The pre-survey collected demographic information and included questions about participants' prior medical education on racial implicit bias training, caring for Black women, and caring for postpartum Black women. In the post-survey, participants re-evaluated their attitudes with the same questions from the pre-survey, and additionally answered questions related to the module's strengths, areas for improvement, and user engagement to evaluate efficacy. They were given space to note their key takeaways from the training and provide feedback for improvement of future modules. Five academically vetted surveys were used to assess changes in the subjects from pre- to post-test, and collected data was analyzed with a series of paired sample, one-tailed t-tests.

Results: The results indicated that participants demonstrated significant improvements in attitudes toward implicit bias instruction ($p < .001$), recognition of cultural competency's importance in patient care ($p < .001$), and communication efficacy when interacting with Black pregnant patients ($p < .001$). In the qualitative responses, participants consistently emphasized the importance of active listening during patient interactions, asking open-ended questions to employ shared-decision making, and bias awareness. They also rated the training highly for both engagement and effectiveness, stating it was immersive and clearly depicted a realistic patient-provider interaction.

Conclusion: Findings from this study supports the training's short-term efficacy, and ongoing research will evaluate sustained impact over time and the effectiveness of the complete program under development. As expectations for culturally responsive care grow, this training program's framework offers a scalable, adaptive, and evidence-informed model of care for improving communication between patients and providers in healthcare and building capacity to address health inequity.

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Table 1
Paired Samples t-Test

	Mean	Std. Deviation	Std. Error	95% Confidence Interval		<i>t</i>	<i>df</i>	<i>p</i>	Cohen's <i>d</i>
				Lower	Upper				
Attitudes Implicit Bias Instruction, Pre-Post	.09	.23	.02	.04	.13	3.68	94	<.001	.23
Elicit Opinions, Pre-Post	.07	.36	.04	-.002	.14	1.91	94	.03	.20
Determine Beliefs, Pre-Post	.29	.56	.06	.18	.41	5.07	94	<.001	.52
Psychosocial Impacts Pre-Post	.08	.42	.04	-.01	.16	1.79	93	.04	.19
Healthcare Quality, Pre-Post	.43	.62	.06	.30	.55	6.62	93	<.001	.68
Comm. Efficacy, Pre-Post	.76	.75	.08	.60	.91	9.87	94	<.001	1.01

9:15 - 9:30 a.m.

Paper #11

The WHO Therapeutic Definition of Postpartum Hemorrhage and First-Line Drug Treatment, Real-World Implications for an Urban Practice

Elise A Patrick, MD¹, Jennifer A Spaulding, BS², Randall Grout, MD², David M Haas, MD, MS¹

Indiana University School of Medicine, Department of Obstetrics & Gynecology, Indianapolis, IN¹, Indiana University - Regenstrief Institute, Indianapolis, IN²

Objectives: With the World Health Organization's (WHO) new therapeutic definition of postpartum hemorrhage (PPH) and recommendation of implementation of a first-line treatment bundle, our objective was to use a real-world assessment of current PPH medication use and how many more patients would potentially have treatment initiation after implementation of the new thresholds.

Methods: A retrospective cohort of all deliveries at an urban, US hospital from January 2024 through June 2025 was constructed to assess rates of defined PPH based on previous guidelines ($\geq 1,000$ ml, still listed by both British and American Colleges of Obstetricians and Gynecologists) and the new WHO therapeutic definition (≥ 500 ml or ≥ 300 ml with clinical signs). A calculated shock index was used for clinical signs of hypovolemia. Data were pulled from the electronic health record that included maternal demographics, delivery information, quantitative blood loss (QBL), any medications or procedures performed for PPH, hemoglobin concentrations, and need for transfusion. Rates of PPH by both definitions were assessed and the number who received PPH medications (tranexamic acid, misoprostol, methylergonovine or carboprost) was compared by PPH definition. Using factors other than definition criteria, predictors of receiving medication were assessed using a backwards stepwise logistic regression using all significant variables in the univariate comparison.

Results: 5005 delivered patients comprised the cohort. Using PPH defined as $\geq 1,000$ ml, 640 (13.0%) would be diagnosed with PPH, compared to 1,881 (37.6%) would meet the definition of PPH using WHO criteria. A total of 607 patients (12.1%) received a PPH treatment drug, with 168 (26.3%) of patients meeting AGOC PPH definition and 375 (19.9%) of patients qualifying as PPH by the WHO definition receiving drug. In this population, misoprostol was the most common first PPH drug given (58.3%). A total of 472 patients meeting

ACOG PPH definition did not get PPH drugs, compared to 1,506 meeting the WHO definition. Logistic regression demonstrated that receiving PPH medications was independently associated with Black race compared to White (OR 0.62, 95%CI 0.48-0.80), gestational age (OR 0.94, 95%CI 0.91-0.98), the number of prior births (OR 0.91, 95%CI 0.84-0.98), QBL (OR 1.002, 95%CI 1.002-1.002, and having a cesarean delivery (OR 0.05, 95%CI 0.04-0.08).

Conclusions: The new therapeutic definition of PPH may lead to almost three times as many women being diagnosed with PPH. Further, with this lower threshold, more patients would be recommended to receive the PPH bundle, which could include additional uterotonic drugs. This has the potential to impact utilization of medications and interventions, as 80% of our patients who would meet WHO PPH definition did not need additional PPH drugs in this real-world analysis. Therefore, organization and hospital leadership will need to assess implications for this updated definition and acceptance, with the likelihood of increased resource needs and ensuring resources are distributed justly.

9:30 - 9:45 a.m.

Paper #12

Maternal RSV Vaccines Knowledge, Attitudes, Mistrust, and Decision-Making: A National Survey

Camille F Bratton, MD, Mounika Polavarapu, MBBS, MPH, PhD, Shipra Singh, MBBS, MPH, Syed Shehryar Azeem, MBBS, MPH, Camelia Arsene, MD, PhD, MHS, Sarah Bon, MPH, MD, James W Van Hook, MD, Deepa Mukundan, MD, DNB, FAAP, FPIDS

University of Toledo, Toledo, OH

Background: Respiratory Syncytial Virus (RSV) is a major cause of severe respiratory illness and hospitalization among infants in the U.S. In 2023, the first maternal vaccine, Abrysvo, was FDA approved during pregnancy and is recommended during seasonal administration between 32-36 weeks gestation. Despite this major public health development, the vaccine uptake is low, and the factors driving hesitancy are not understood.

Objective: Examine knowledge, attitudes, and beliefs regarding the maternal RSV vaccine among women of reproductive age. Participants were recruited from a nationwide sample in the US via online survey distribution.

Materials and Methods: A cross-sectional online survey was conducted using QuestionPro online research panel. Eligible participants included women aged 18-50 years who were currently or recently pregnant or planning a future pregnancy. Using the Integrated Behavioral Model, the survey assessed sociodemographic characteristics, vaccination decision-making and related factors such as health information sources, knowledge and attitudes, vaccine skepticism, institutional mistrust, environmental access barriers, and social influence. Statistical analyses were performed using STATA Version 17. Results: There was a total of 201 responses; 13 were excluded due to medical contraindications, resulting in 188 participants. Results were organized into these sections: (A) Description of Participants, (B) Vaccination Decision, (C) Knowledge and Attitudes, (D) Perceptions of RSV Risk, (E) Environmental Constraints, (F) Skepticism and (G) Influence of Others. Detailed sociodemographic characteristics are in Table 1. The most common belief was that getting vaccinated is a personal choice (43%) while 34% felt it is everyone's responsibility to protect children and 11% agreed with both views. Vaccine decision stages were categorized as unaware/unengaged (56%), hesitant (17%), and receptive (27%). Knowledge of RSV transmission was high, with 85% respondents correctly

identifying RSV modes of transmission. Awareness of vaccine safety and side effects was lower (71%). Attitudes toward the maternal RSV vaccine were mixed. Overall responses were positive, 33% had positive responses and 32% selected neutral responses. Approximately, 45% rated the vaccine as comforting, not painful, easy to obtain, effective, safe, and beneficial. Preventing serious RSV outcomes was highly valued, 50% rated prevention such as death very important. Perceived infant susceptibility was high (60%). Environmental barriers to vaccine access were rated low. There was moderate vaccine skepticism regarding safety (40%). Institutional mistrust increased hesitancy (35%). Vaccine skepticism was moderate, 29% had agreement of skeptical statements, and 39% had neutral responses. Healthcare providers were the most influential source of vaccine information (60%).

Conclusion: Knowledge of RSV was strong, but understanding of vaccine safety is limited. Safety concerns and institutional mistrust are key contributors to hesitancy, whereas healthcare providers remain the most trusted information source. These findings suggest targeted, provider led counseling to address vaccine safety may improve overall uptake.

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Table 1: Sociodemographic Characteristics |

Characteristic	N=201	
	N	(%) [*]
Age		
18-25	29	(14.43)
26-35	71	(35.32)
36-45	79	(39.30)
>45	22	(10.95)
Race**		
White	140	(69.65)
Black/African American	45	(22.39)
American Indian/Alaska Native	9	(4.48)
Asian	7	(3.48)
Native Hawaiian/Pacific Islander	0	(0.00)
Middle Eastern/ or North African	2	(1.00)
Other	6	(2.99)
Highest level of education		
Less than high school	2	(1.00)
High school graduate	73	(36.32)
Less than 4 years of college / Associate degree	85	(42.49)
College graduate	41	(20.40)
Employment		
Employed (full time/self-employed)	110	(54.73)
Employed (part time)	32	(15.92)
Not currently employed	49	(24.38)
Student	9	(4.48)
Retired	1	(0.50)
Health insurance coverage		
No coverage at all	26	(12.94)
Employer sponsored	68	(33.83)
Private insurance	24	(11.94)
Government sponsored (Medicaid, Medicare, Tricare)	83	(41.29)
[*] Due to rounding, numbers and percentages may not sum to 100%		
^{**} Participants could select more than one response; therefore, percentages may exceed 100%		

9:45 - 10:00 a.m.

Paper #13

Bridging the Gap in Prenatal Education: Patient Preferences, Disparities, and Opportunities for Intervention

Rebecca L Anderson, MD, Zoe Keese, BS, Rachel Weber, BS, Santiago Ortiz Barragan, MD, MPH, Mridula Ghotane, MPH, Rebecca R Rimsza, MD

University of Nebraska Medical Center, Omaha, NE

Objective: To evaluate patient preferences for prenatal and childbirth education, identify gaps between desired and received education, and assess how sociodemographic factors influence access, preferences, and barriers to care. The impact of parity and digital resource use on educational needs was also examined.

Methods: A prospective cross-sectional survey was conducted among pregnant patients (≥ 32 weeks of gestation) receiving care at a Midwestern tertiary care center between October 2024 and December 2025. Eligible participants were ≥ 19 years old and proficient in English or Spanish. Following informed consent, participants completed an author-derived 24-item survey assessing preferred educational modalities, topics of interest, timing of education, perceived gaps in prenatal counseling, and prior childbirth experience (if applicable). Demographics, obstetric history, and delivery outcomes were collected from electronic health records. Descriptive and comparative analyses were performed, with significance set at $p < 0.05$.

Results: Of 214 patients approached, 200 consented (93.5%) and were included. Mean gestational age at survey completion was 35.2 weeks. Sixty-eight patients (34.5%) were nulliparous, and 43 patients (21.5%) had prior cesarean delivery. Common prior education modalities included discussion with a provider (61.5%), printed materials (36.5%), and educational videos (27.5%). Provider-based education was also the most preferred (69.0%). Nearly half of patients (48.5%) expressed interest in additional prenatal education.

Patients preferred education early, at the initial prenatal visit (46.0%), followed by the second (37.8%) and third trimesters (31.3%). Most (81.3%) desired their support person to be involved in education, and 90.0% planned partner presence at delivery. Although digital resource use was high (apps 75.2%, social media 63.6%), users had 3.82 times the odds of preferring provider-led discussion (95% CI 1.60–9.14,

p=0.003).

Among multiparous patients, 90.7% previously received counseling, yet 46.9% reported insufficient postpartum recovery education ($p<0.0001$). Across the cohort, patients also demonstrated strong interest in breastfeeding (34.0%) and postpartum recovery (38.0%). Compared to multiparous patients, nulliparous patients had significantly higher odds of fearing pain (OR 2.81, 95% CI 1.49 – 5.38, $p=0.002$) and greater interest in the labor process (33.8% vs 9.2%, $p<0.001$).

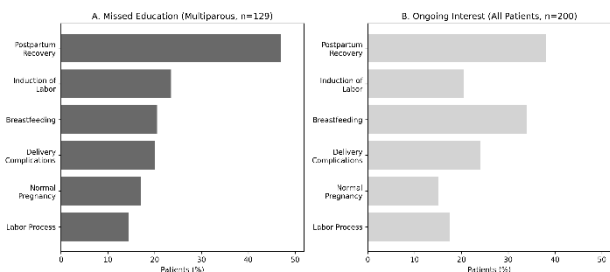
Sociodemographic disparities were observed. Medicaid patients were more likely to miss prenatal visits due to transportation barriers (9.7% vs 2.7%, $p=0.049$) and demonstrated differences in delivery support, including a trend toward lower partner involvement (OR 0.48, 95% CI 0.22–1.01, $p=0.078$).

Conclusion: While digital health utilization is prevalent, it functions as a supplement to, rather than a replacement for, provider-based prenatal education. Persistent gaps, particularly in postpartum recovery and sociodemographic barriers, support the implementation of early, provider-led, and family-inclusive prenatal education models. Structural support for provider time and reimbursement may improve alignment between patient expectations and clinical practice.

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Educational Gaps and Ongoing Needs in Prenatal Education



10:00 - 10:15 a.m.

Paper #14

Post-Legalization Cannabis Use During Pregnancy and its Effects on Neonatal Outcomes

Gabrielle F Thro, MD, Emily Eschenbaum, BS, Caitlyn McCracken, BS, Justine Crowell, BS, Kristin Delfino, PhD, Elizabeth Ramsey Unal, MD, Kathleen Groesch, MS, Paula L Diaz-Sylvester, PhD, Erica E Nelson, MD

Southern Illinois University School of Medicine, Springfield, IL

Background: Cannabis use during pregnancy has been associated with adverse neonatal outcomes. In 2019, we reported that the patient-reported cannabis use in our obstetrical population before legalization was 11.5%, which was higher than the national average (2-7%) reported at that time. Despite ACOG recommendations against cannabis use in pregnancy, legalization and greater availability/acceptability have increased national rates of prenatal cannabis use (3.9%-16%).

Objectives: We aimed to identify patient-reported cannabis use during pregnancy in our obstetrical population after its legalization in Illinois, and examine its effects on neonatal outcomes. We hypothesized the rate of cannabis use has increased after legalization and that cannabis use is associated with poorer neonatal outcomes.

Methods: A retrospective chart review (IRB #21-823) included pregnant women and their neonates who delivered in 2021 at HSHS St. John's Hospital in Springfield, Illinois. Demographic characteristics, the mother's medical and obstetrical history, intrapartum and postpartum events and all substance use during pregnancy including tobacco, cannabis and illicit drugs were extracted. Fisher's exact, Chi Square, and Mann-Whitney tests were used for comparisons. A logistic regression assessed cannabis use as a predictor of adverse outcomes in infants.

Results: 328 charts were reviewed for this study. Of these, 72 subjects (22%) reported cannabis use during pregnancy. Given the well-known correlation between cannabis use and tobacco, alcohol and illicit drug use and their association with adverse neonatal outcomes, we removed these confounders by excluding patients who reported using substances other than cannabis (or had a positive toxicology screen). 82 subjects were removed, of which 40 were using other substance(s) in addition to cannabis, 39 were using other substance(s) without

cannabis and 3 had incomplete documentation. This resulted in a subset of 246 with 32 patients (13%) reporting cannabis use. Race and ethnicity distribution in this subset was 74% White, 16% Black, 3% Asian, 1% Multi-racial, and 6% other, with 2% of Hispanic ethnicity. No differences in race/ethnic distributions were found between cannabis users vs. non-users. Cannabis users were younger than non-users (25.9 ± 0.92 vs. 28.9 ± 0.37 years; $p=0.004$) and more likely to be insured via Medicaid, Medicare or being uninsured ($p=0.037$). No associations were detected between cannabis use and neonatal outcomes such as fetal growth restriction, gestational age at delivery, birth weight, NICU admission and need for ventilation.

Conclusions: Cannabis use in our obstetrical population has almost doubled after legalization (22%) and it continues to be significantly higher than the current national average (ranging from 4-16%). Differences in maternal age and insurance status between users and non-users suggest socioeconomic status and/or social determinants of health as potential targets for intervention. Although we did not detect differences in neonatal outcomes, emerging evidence of long-term effects of maternal cannabis use to newborns and infants continues to increase. Further research on a larger sample is imperative.

10:15 - 10:30 a.m.

Paper #15

Respiratory Syncytial Virus (RSV) Vaccine Acceptability Following Recent FDA Approval of Abrysvo®

Summer Lawrence, MD, Jill Beckham, BS, Emily Eschenbaum, BS, Kathleen Groesch, MS, Kristin Delfino, PhD, Paula L Diaz-Sylvester, PhD, Allison M Sweeney, MD, Elizabeth Santana, BS, Jongjin (Anne) Martin, MD

Southern Illinois University School of Medicine, Springfield, IL

Objective: Respiratory syncytial virus (RSV) is the leading cause of infant hospitalization in the US. In August 2023, Pfizer's Abrysvo® RSV vaccine was approved for pregnant patients to prevent RSV-related infant morbidity. ACOG recommended Abrysvo® vaccination for all pregnant patients seasonally and suggested counseling techniques and personalized considerations to ensure every patient has access to Abrysvo®. During the 2024-2025 season, we assessed RSV awareness, Abrysvo® acceptability and vaccination rates in our obstetrical patients. While acceptability was 58.3%, only 16.6% of the surveyed patients received Abrysvo®. The main barrier was accessibility, as the vaccine was not available in clinic, patients had to be referred elsewhere. We aimed to reassess acceptability and vaccination rates after vaccine became available in our clinic during the 2025-2026 season. We hypothesized increase in accessibility would have a positive impact in vaccination rates.

Methods: This study was approved by the local IRB (#24-612). To assess our patient's perception of Abrysvo®, a pre-education survey was administered prenatally between 28w0d-31w6d GA. At subsequent prenatal visits, providers counseled patients regarding Abrysvo®. All Abrysvo® patient discussions and vaccination status were documented in the electronic medical record.

Results: 61 patients completed the survey. Their racial distribution was 64% White, 28% Black and 8% mixed race/other/declined. 9% reported Hispanic ethnicity. Most patients had a low socioeconomic status, indicated by the majority (62%) being Medicaid-insured. Specific to RSV, 80% of surveyed patients indicated they were previously aware of RSV and 65% knew of the RSV vaccine for pregnant women. The majority reported hearing about Abrysvo® from healthcare providers (82.1%), with some reporting they learned about it through social media and/or the news (28.2%). When asked if they would receive

Abrysvo® upon provider recommendation, 64% indicated ‘yes’, with only 12% not willing to get Abrysvo® and 25% were unsure. The most important factors to consider in their decision to receive Abrysvo® were potential RSV-related health consequences to the infant (75%) and/or themselves (40%). Those not planning to receive Abrysvo® were primarily concerned about possible side effects/safety (54.5%). Patient's preferred educational method to learn more about Abrysvo® was direct provider discussion (55.7%), with a lower number preferring other approaches such as self-education (9.8%), brochures (9.8%) or links to reputable websites (8.2%). Additionally, 14.8% declined further education. At the end of the 2025-2026 season, vaccination rates increased from 16.6% of all surveyed patients in 2024-2025 to 70.5% in 2025-2026 ($p<0.001$). Of surveyed patients expressing willingness to get the vaccine, 29% got vaccinated in 2024-2025 vs. 94.9% in 2025-2026 ($p<0.001$).

Conclusions: Accessibility to Abrysvo® after implementation in prenatal clinics improved vaccination rates independent of patient perception/acceptability. While 63.9% of surveyed patients were willing to receive Abrysvo® and 24.6% were unsure, overall, 70.5% received Abrysvo® by the end of the 2025-2026 season.

10:30 – 11:00 a.m. **Break/Refreshments**
(Isabela Ballroom)

SIXTH SCIENTIFIC SESSION (Isabela Ballroom)

Moderators:

Angelina Gangestad, M.D. – CAOG Trustee

Theresa L. Robinson, M.D. – CAOG Trustee

11:00 - 12:00

Hot Topic #5

“When Love Hurts: Endometriosis
and Female Sexual Dysfunction”

Teresa Tam, M.D.

Director, Minimally Invasive Gyn. Surgery
Prime Healthcare/Saint Francis Hospital
Chicago, Illinois

Learning Objectives:

- List at least 5 types of minimally invasive gynecologic surgery.
- Compare minimally invasive gynecologic surgical procedures with their more invasive counterpart.

12:00 - 12:15 p.m.

Paper #16

Social Drivers of Health Associated with Smoking Cessation During Pregnancy

Sara C Ueland, BA¹, Jamie Levine, BA², Elizabeth Kelly, MD, MS³, Emily A DeFranco, DO, MS²

Claremont McKenna College, Claremont, CA¹, University of Kentucky, Lexington, KY², University of Cincinnati College of Medicine, Cincinnati, OH³

Purpose: Cigarette smoking during pregnancy is a leading modifiable cause of adverse perinatal outcomes, yet cessation rates remain low. Though nicotine dependence is well characterized, less is known about how Social Drivers of Health (SDOH) affect a pregnant person's ability to quit smoking. This study examines which SDOH domains are associated with smoking cessation in comparison to continued smoking throughout pregnancy.

Methods: A prospective cohort study was conducted with 629 postpartum patients enrolled at two urban medical centers in the Midwest between 2011–2025. Standardized surveys were administered during delivery hospitalization and self-reported data were collected on cigarette use across pregnancy trimesters and SDOH exposures. Smoking status was categorized as: non-smoker, quit smoking during pregnancy, or smoked throughout pregnancy. SDOH exposures were organized into five domains: Unstable Neighborhood & Built Environment, Economic Instability, Poor Health Care Access & Quality, Poor Social & Community Context, and Limited Joy/Resilience. Generalized linear models were used to estimate relative risks (RRs) and 95% confidence intervals (CIs) for each smoking category: quit smoking vs. non-smokers, smoked throughout vs. non-smokers, and quit smoking vs. smoked throughout.

Results: The cohort included 629 patients: non-smokers N=429 (68.2%), quit smoking N=81 (12.9%), smoked throughout N=119 (18.9%). Among patients who smoked cigarettes during pregnancy, those who quit were more likely to smoke ≤ 10 cigarettes/day preconception compared to those who smoked throughout (86.8% vs. 38.2%, $p < 0.001$). Patients who smoked throughout pregnancy were significantly more likely to have no prenatal care (10.7% vs. 0.0%, $p = 0.002$) and later timing (> 20 w gestation) of first prenatal visit (16.5% vs. 7.6%, $p = 0.010$). For patients who smoked, Economic Instability was the strongest SDOH predictor of smoking behavior and was associated with a 47% lower likelihood of

cessation (RR 0.53, 95% CI 0.35–0.80). In addition, Economic Instability was strongly associated with continued smoking compared to non-smokers (RR 8.86, 95% CI 2.88–27.32). Unstable Neighborhood & Built Environment was associated with a significantly increased risk of smoking throughout (RR 1.59, 95% CI 1.09–2.32) when compared to non-smokers. Inadequate prenatal care utilization (limited or no visits vs. ≥ 6 visits) was associated with a 58% reduction in the likelihood of quitting (RR 0.42, 95% CI 0.23–0.78). Delayed initiation of prenatal care (>12 weeks or no care) was similarly associated with reduced cessation (RR 0.63, 95% CI 0.43–0.92). Notably, 56.9% of those who smoked throughout planned to resume postpartum, compared to only 10.3% of those who quit ($p<0.001$).

Conclusion: Economic Instability and Unstable Neighborhood & Built Environment were the SDOH domains most strongly associated with failure to achieve smoking cessation during pregnancy. These findings suggest that smoking cessation interventions should address economic and housing vulnerabilities, encourage early and sustained prenatal care engagement, and extend from preconception through postpartum.

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	Non-smokers with exposure (Total N = 429)	RR of Quit Smoking (N=81) (ref = Non-smoker) (95% CI)	RR of Smoked Throughout (N=119) (ref = Non-smoker) (95% CI)	RR of Quit Smoking vs. Smoked Throughout
Unstable Neighborhood & Built Environment	N = 268 (62.5%)	1.54 (0.97-2.45)	1.59 (1.09-2.32)	0.97 (0.66-1.40)
Economic Instability	N = 329 (76.7%)	2.43 (1.21-4.88)	8.86 (2.88-27.32)	0.53 (0.35-0.80)
Poor Health Care Access & Quality	N = 193 (45.0%)	1.28 (0.85-1.90)	1.19 (0.86-1.65)	1.04 (0.75-1.45)
Limited Joy/Resilience	N = 313 (73.0%)	1.18 (0.73-1.89)	1.36 (0.91-2.04)	0.89 (0.61-1.32)
Poor Social & Community Context	N = 397 (92.5%)	0.88 (0.43-1.77)	1.40 (0.66-2.98)	0.73 (0.43-1.30)

12:15 - 12:30 p.m.

Paper #17

Latency after Preterm Prelabor Rupture of Membranes (PPROM) and Outcomes at Single Community Hospital

Ciera M Danen, MD¹, James O Adefisoye, PhD², Jessica J F Kram, MPH³, Marie M Forgie, DO⁴

Aurora Sinai Medical Center, Advocate Health, Milwaukee, WI¹, Aurora UW Medical Group, Aurora Sinai Medical Center, Advocate Health / Department of Biostatistics and Data Science, Division of Public Health Sciences, Wake Forest University School of Medicine, Milwaukee, WI², Aurora UW Medical Group, Center for Urban Population Health, Aurora Sinai Medical Center, Advocate Health, Milwaukee, WI³, Aurora UW Medical Group, Aurora Sinai Medical Center, Advocate Health, Milwaukee, WI⁴

Objective: The American College of Obstetrics and Gynecology currently cites that most people with preterm prelabor rupture of membranes (PPROM, membrane rupture <37 weeks gestation) deliver within 7.0 days. This guidance is based on an older study out of Israel that may not be generalizable in the US. Our study aimed to identify updated information on latency with inpatient PPRM management, and secondarily the relationship between latency and gestational age or other maternal/fetal factors.

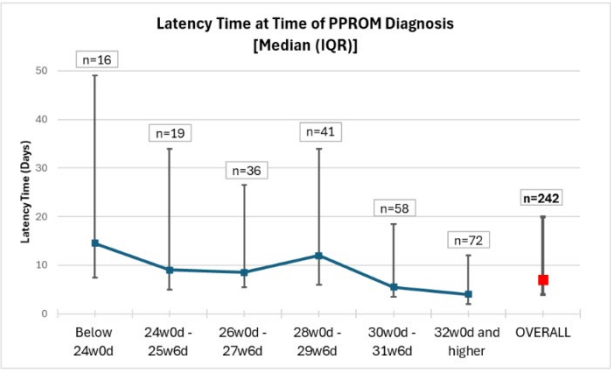
Methods: We conducted a retrospective cohort study of patients admitted to a single, urban teaching hospital with singleton pregnancies diagnosed with PPRM between 23w0d–34w0d from October 2012 – October 2024. Cohort and basic characteristics were identified from the electronic medical record via ICD-9 and ICD-10 codes for PPRM. Further manual chart review was performed to collect all variables of interest. Encounters were excluded if patients did not receive standard management (7-day course of antibiotics, corticosteroids, and magnesium sulfate use if <32w0d). Frequencies with proportions and medians with interquartile ranges (IQR) were calculated to describe the characteristics and outcomes of the study cohort. For the primary objective, we estimated the median latency period. For the secondary objective, we implemented crude and adjusted generalized linear models (GLMs) with a Tweedie distribution and a log link to accommodate the mixed discrete–continuous nature of latency and its right-skewed dispersion structure. Results are reported as mean ratios with corresponding 95% confidence intervals (CIs). Two-sided p-values < 0.05 were considered statistically significant

Results: A total of 343 pregnancy encounters were identified. Following exclusions, 242 unique encounters were included. Primary reasons for delivery were spontaneous delivery (59.1%), induction at 34w0d (19.8%), and placental abruption (9.1%). Median latency from inpatient management to delivery was 7.0 (IQR 3.0, 13.0) days. Patients diagnosed before 24w0d had the longest latency (14.5 days; IQR 7.0, 34.5), and patients diagnosed after 32w0d had the shortest latency (4.0 days; IQR 2.0, 8.0). Gestational age at time of PPRM diagnosis (adjusted Mean Ratio (aMR) 0.98, 95% Confidence Interval [CI] 0.97-0.99; $p < 0.01$) and spontaneous delivery (aMR 0.65, 95%CI 0.44-0.96; $p < 0.03$) were associated with latency time in adjusted models. There were no other statistically significant factors associated with latency when evaluating maternal age, race, or medical comorbidities including body mass index, diabetes, hypertension, tobacco use, history of spontaneous preterm birth/PPROM, and sexually transmitted infections during pregnancy.

Conclusion: Our study reinforces previously available evidence in establishing the median latency time of 7.0 days following PPRM diagnosis. It further supports the finding of shorter latency periods with later PPRM diagnosis. Having accurate information on timing of delivery helps to inform the gestational age at birth, which is correlated to neonatal outcomes. Moreover, it can also help patients anticipate length of hospitalization, which is time away from their family and day-to-day living. Anticipatory guidance is crucial for the mental well-being of patients who may have a prolonged hospital stay.

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12:30 - 12:45 p.m.

Paper #18

Dr. George W. Morley

Memorial Paper Award

Is There a Need for Vaginitis Screening in the Era of Preoperative Antibiotics?

Aaron D Adams, MD, Shivani Parikh, MD, Rebecca Barbaresso, DO, Tiffany R Tonismae, MD

University of Louisville, Louisville, KY

Background: Bacterial vaginosis (BV) is associated with an increased risk of postoperative infectious complications following gynecologic surgery. Although perioperative antibiotic prophylaxis is routinely administered for hysterectomy, the clinical utility of preoperative vaginitis testing in the modern antibiotic era remains unclear. This study aimed to evaluate the association between preoperative vaginitis testing and postoperative outcomes following total laparoscopic hysterectomy (TLH) for benign indications.

Methods: A retrospective cohort study was conducted evaluating patients ≥ 18 years old who underwent TLH for benign indications at a tertiary hospital between 2020 and 2025. Patients undergoing hysterectomy for malignancy, pregnancy-related conditions, or supracervical hysterectomy were excluded. Subjects were stratified by whether preoperative vaginitis testing was performed. Demographic, perioperative, and postoperative data were collected and reviewed through electronic medical. The primary outcome was a composite postoperative complication rate, including urinary tract infection, vaginal cuff cellulitis or dehiscence, hematoma, surgical site infection, readmission, reoperation, visceral injury, and conversion to laparotomy. Continuous variables were analyzed using Mann–Whitney U testing and categorical variables using Fisher exact testing.

Results: A total of 270 patients met inclusion criteria, including 64 (23.7%) who underwent preoperative vaginitis testing and 206 (76.3%) who did not. Among screened patients, 68.8% tested positive for infection and 56.2% were positive for BV. Patients who underwent testing had higher rates of diabetes (23.4% vs 7.8%, $p=0.001$) and hypertension (40.6% vs 22.3%, $p=0.006$). Median uterine weight was significantly greater in the screened group (138.0 g vs 112.0 g, $p=0.014$). There was no significant difference in the overall postoperative complication rate between screened and non-screened groups (15.6% vs 17.0%, $p=1.000$). Additionally, no significant differences were identified in rates of urinary tract

infection, vaginal cuff cellulitis, vaginal cuff dehiscence, readmission, reoperation, or visceral injury.

Conclusion: Preoperative vaginitis testing prior to TLH for benign indications was not associated with a reduction in postoperative complications in patients receiving standard perioperative antibiotic prophylaxis. These findings suggest that routine vaginitis screening may have limited clinical utility in the setting of contemporary prophylactic antibiotic protocols. Further prospective studies are needed to evaluate whether specific high-risk populations may benefit from targeted screening strategies/protocols.

12:45 - 1:00 p.m.

Paper #19

Establishing a Multidisciplinary Placenta Accreta Spectrum Taskforce to Improve Care: A Quality Improvement Initiative

Elizabeth L Mirsky, MD, Andrew Greene, DO, James Damron, MD, Emily A DeFranco, DO

University of Kentucky, Lexington, KY

Problem Statement: Placenta Accreta Spectrum (PAS) is associated with significant maternal morbidity and benefits from coordinated multidisciplinary care. Standardized, multidisciplinary approaches have been shown to improve outcomes. Variation in coordination of care for PAS existed at our institution.

Aim: We aimed to optimize maternal and neonatal outcomes through development of a multidisciplinary PAS taskforce and implementation of a standardized protocol and checklist.

Interventions: We conducted a pre-post quality improvement study following implementation of a multidisciplinary PAS care initiative in July 2024. Interventions included monthly multidisciplinary taskforce meetings, a standardized antepartum and intrapartum checklist, and a standardized PAS management protocol.

Measures: Process, outcome, and balancing metrics were evaluated pre- and post-implementation. Metrics included rate of delivery at planned gestational age, preoperative gynecologic oncology and anesthesia consultation rates, maternal blood loss, blood transfusion, intraoperative injury, and neonatal length of stay, among others (Table). Descriptive statistics, including t-test and chi square, were used to compare means, and rate differences with 95% confidence intervals (CI) were reported.

Results: 21 patients were included in the pre-implementation group (January 2023- June 2024) and 17 patients post-implementation (July 2024- December 2025). Baseline demographics, including maternal age, parity, number of prior cesareans, and PAS severity were similar between groups. Post-implementation, patients were more likely to deliver at the planned gestational age (rate increase 19.8% [95% CI -16.9 to 56.7%]), and to be transferred to Maternal-Fetal Medicine prior to delivery (rate increase 25.4% [95% CI -23.2 to 40.8%]). Improvements were also observed in clinical outcomes, including lower estimated blood loss (EBL) (-574

mL [CI -1816 to 668 mL], reduced blood transfusion rates (-21.8% [CI -55.0 to 11.3%]), fewer intraoperative injuries (-16.8% [CI -43.9 to 10.3%]), and a shorter neonatal length of stay (LOS) (-9.4 days [CI -23.4 to 4.6 days]) (Table).

Sustainability/Lessons Learned: In this quality improvement study, implementation of a multidisciplinary care model for patients with PAS was associated with clinically meaningful improvements across multiple outcomes. While these differences did not reach statistical significance, this is expected given the rarity of the condition and the limited sample size, as this project was not designed to be powered for hypothesis testing. The consistent direction and magnitude of effect across outcomes suggest a meaningful, positive impact on patient safety and care. Multidisciplinary care for PAS has widely been considered best practice, and our findings align with this expected benefit. These findings support the multidisciplinary model as a promising approach for PAS management and warrant continued implementation and further study.

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Table: Implementation of PAS Multidisciplinary Taskforce and Outcome Measures

	Pre-Implementation (n=21)	Post-Implementation (n=17)	Rate Difference, % (95% CI)
Process Metrics			
PAS cases delivered at planned GA*	8 (44.4%)	9 (64.3%)	19.8 (-16.9 to 56.7)
PAS cases with pre-delivery admission GYO consult*	13 (72.2%)	12 (78.6%)	6.3 (-26.1 to 38.8)
PAS cases with outpatient anesthesia consult*	3 (16.7%)	2 (14.3%)	-2.4 (-30.0 to 24.9)
PAS cases transferred to MFM*	7 (38.9%)	9 (64.3%)	25.4 (-11.0 to 61.8)
Average time from US to MFM transfer (in days)	20.4 (± 31.3)	29.2 (± 28.3)	8.8 (-23.2 to 40.8)
Outcome Metrics			
Average EBL (in mL)	1856 (± 2357)	1282 (± 990)	-574 (-1816 to 668)
Average Operative Time (in minutes)	206 (± 93.4)	201 (± 51.6)	-5 (-56.6 to 46.2)
Transfusion Rate	12 (57.1%)	6 (35.3%)	-21.8 (-55.0 to 11.3)
Massive Transfusion Rate	3 (14.3%)	1 (5.9%)	-8.4 (-29.1 to 12.3)
Intraoperative injury	6 (28.6%)	2 (11.8%)	-16.8 (-43.9 to 10.3)
ICU admission	1 (4.8%)	2 (11.8%)	7.0 (-11.2 to 25.2)
Planned treatment completed			
Hysterectomy	14 (of 17, 82.4%)	13 (of 13, 100%)	17.6 (-0.4 to 35.7)
Conservative	1 (of 1, 100%)	1 (of 1, 100%)	--
Repeat cesarean	2 (of 3, 66.7%)	1 (of 3, 33.3%)	-33.4 (-108.8 to 42.1)
Average total LOS (in days)	7.9 (± 5.9)	10.9 (± 12.1)	3.1 (-3.0 to 9.2)
Average postpartum LOS (in days)	4.0 (± 1.2)	3.9 (± 1.8)	-0.1 (-1.1 to 0.8)
Average GA at delivery (in weeks and days)	32w6d (± 4d)	33w4d (± 4d)	8d (-18 to 34d)
Average neonatal LOS (in days)	26.5 (± 25.4)	17.1 (± 11.8)	-9.4 (-23.4 to 4.6)
Balancing Metrics			
Rate of unnecessary preterm delivery	2 (9.5%)	0	-9.5 (-24.4 to 5.3)
Rate of unexpected PAS	3 (14.3%)	3 (17.6%)	3.4 (-21.4 to 28.1)
Main OR utilization in known PAS*	17 (94.4%)	14 (100%)	5.6 (-7.4 to 18.5)

PAS, Placenta Accreta Spectrum. GA, gestational age. GYO, Gynecologic Oncology. MFM, Maternal-Fetal Medicine. US, ultrasound. EBL, estimated blood loss. ICU, intensive care unit. LOS, length of stay. OR, operating room.

* Of anticipated PAS cases, n = 18 pre-implementation and n = 14 post-implementation

1:00 - 1:15 p.m.

Paper #20

Persistent Gaps in Addiction Care for Pregnant Patients with Opioid Use Disorder in Appalachia

Elizabeth Lepovsky, MPH¹, Idhaya S Vasu, MPH¹, Anne Claire Clemmons, MD², Emily Major, MD³, Edward Miller, MD⁴, Tiffany R Tonismac, MD⁴

University of Louisville School of Medicine, Louisville, KY¹, University of Louisville, Department of Obstetrics, Gynecology, & Women's Health, Louisville, KY², Eastern Virginia Medical School, Department of Obstetrics, Gynecology, & Women's Health, Norfolk Virginia³, University of Louisville, Division of Maternal-Fetal Medicine, Department of Obstetrics, Gynecology, & Women's Health, Louisville, KY⁴

Objective: Opioid Use Disorder (OUD) is a leading cause of maternal mortality. The Appalachian region has been disproportionately impacted, with mortality rates 64% higher than the national average. Although national initiatives have emphasized the importance of medication for opioid use disorder (MOUD) during pregnancy, concerns persist regarding access to integrated prenatal and addiction care in Appalachian communities. This study assessed the accessibility to obstetric care and MOUD services for pregnant patients with OUD in Appalachia during two time periods to assess whether access to care has improved over time.

Methods: This cross-sectional telephone survey study evaluated access to prenatal care and MOUD services among obstetric clinics in Appalachia during two collection periods in 2022 and 2025. OBGYN clinics in Kentucky (KY), Tennessee (TN), and West Virginia (WV) were identified using Healthgrades.com in order to stimulate a commonly used patient-centered approach to locating obstetric providers and seeking prenatal care services. Clinics listed as providing prenatal or obstetric care services were included, while duplicate listings and clinics no longer providing obstetric care were excluded. A standardized survey script was used to assess clinic willingness to care for pregnant patients receiving MOUD, direct MOUD prescribing practices, and referral patterns for addiction treatment. Average call duration and survey completion rates were recorded. Geographic mapping was used to identify healthcare deserts and regional distribution of services throughout Appalachia.

Results: In 2022, 297 clinics were identified and contacted (156 in KY, 89 in TN, and 52 in WV). 58% completed the survey. Among responding clinics, 56% reported caring for pregnant patients receiving MOUD, while only 15% prescribed MOUD directly. KY had the highest number of MOUD prescribing clinics (n=14), compared to TN (n=6), and WV (n=6). Average call duration was 3.3 minutes. In 2025, 313 clinics were identified and contacted (96 in KY, 95 in TN, and 13 in WV). 24% completed the survey. Among responding clinics, 93% reported caring for pregnant patients receiving MOUD, while only 19% prescribed MOUD directly. KY had the highest number of MOUD prescribing clinics (n=7), compared to TN (n=6), and WV (n=2). Average call duration was 4.2 minutes. Geographic mapping demonstrated persistent clustering of MOUD prescribing services near urban and academic centers, with rural areas lacking access to these services. Among counties containing clinics that prescribed MOUD, the majority had only a single identified prescribing clinic.

Conclusion: Despite years of national guidance supporting MOUD as standard of care, access to integrated obstetric and addiction care in Appalachia remains limited. Across both time periods, only a minority of clinics directly prescribed MOUD, suggesting persistent gaps between national recommendations and real world accessibility. These findings suggest that increased awareness alone has not substantially improved access in Appalachia. Efforts to improve maternal outcomes in Appalachia should focus on expanding addiction care and increasing provider support for MOUD prescribing.

1:15 - 1:30 p.m.

Paper #21

**Dr. Bryan D. Cowan FAR
Research Network Award**

**The Association of Urine Glyphosate Concentrations With
Pregnancy Loss in Nulliparas**

David M Haas, MD¹, Yunpen Yu, MS¹, Kevin J Moss, BS¹,
Kathleen M Flannery, MS¹, Lynn M Yee, MD², Bhavana
Janga, MD³, Eric Gaudreau, PhD⁴, Leah Bode Langford,
MD¹, Joanne K Daggy, PhD¹

Indiana University School of Medicine, Indianapolis, IN¹,
Northwestern University, Chicago, IL², Case Western
Reserve University, Cleveland, OH³, Centre de Toxicologie
de Quebec, Quebec City, Quebec⁴

Background and Objective: Exposure to environmental chemicals, such as herbicides, before or during pregnancy has been associated with some adverse reproductive outcomes. Data on glyphosate exposure and pregnancy loss have been mixed, but exposure was not measured with urine concentrations in prior studies. The objective of this study was to test for an association of herbicide concentration with the outcome of pregnancy loss, defined as either stillbirth or miscarriage, in a cohort of nulliparas.

Methods: A case-control study was performed with participants of the nuMoM2b nulliparous pregnancy cohort who were recruited from sites in Illinois, Indiana, and Ohio. Participants who had an outcome of stillbirth or miscarriage after the first study visit (<14 weeks gestation) were identified as cases of pregnancy loss. Control participants without this outcome were selected using propensity score matching with age at the study visit, study site, and tobacco smoking, with 4 controls matched for each case. First trimester urine specimens obtained from the study visit were analyzed for the specific gravity-adjusted concentrations of glyphosate, its degradation product AMPA, and 3-MPPA. An indicator for 3-MPPA if $\geq$ Limitation Of Detection (LOD) was used for this analyte. Multiple-imputation using a truncated lognormal distribution was used to handle values below the limit of detection for other analytes. Conditional logistic regression was used to assess the association of each analyte with risk of pregnancy loss.

Results: 46 cases (10 stillbirths, 36 miscarriages <20 weeks) of pregnancy loss and 180 controls had valid samples with measurements. Glyphosate was detected in 87.0% and 72.9%, AMPA in 84.8% and 90.5%, and 3-MPPA in 8.9% and 14.2% of cases and controls, respectively. Conditional logistic

regression demonstrated that neither glyphosate nor 3-MPPA (indicator $\geq$ LOD) were associated with risk of stillbirth or miscarriage (OR for one interquartile ratio (IQR) increase 1.16, 95% CI 0.83-1.61; OR 1.71, 95% CI 0.56-5.23, respectively), but that a higher concentration of AMPA was associated with pregnancy loss (OR for one IQR increase 1.26, 95% CI 1.02-1.55).

Conclusions: Higher first trimester concentrations of the glyphosate degradation product AMPA may be associated with an increased risk of pregnancy loss in nulliparous pregnant individuals.

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Table: Conditional Logistic Regression for Risk of Pregnancy Loss

Exposure	N	Cases/Controls	N Imputations	OR (95% CI)	p-value
Glyphosate (1 IQR)	223	46/177	25	1.16 (0.83, 1.61)	0.382
AMPA (1 IQR)	225	46/179	25	1.26 (1.02, 1.55)	0.032
3-MPPA (= LOD)	221	45/176	--	1.71 (0.56, 5.23)	0.348

*Glyphosate IQR = 0.331 and AMPA IQR = 0.347 from full nuNoM2b cohort. IQR= Interquartile Ratio

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SCIENTIFIC POSTERS

POSTER SESSIONS

THURSDAY

OCTOBER 22, 2026

8:00 A.M. – 1:00 P.M.

FRIDAY

OCTOBER 23, 2026

8:00 A.M. – 12 NOON

Poster #1

“Rates and Predictors of Oophorectomy at the Time of Cystectomy: A Retrospective Institutional Review”

Camille F. Bratton, M.D.
University of Toledo
Toledo, OH

Poster #2

“Factors Associated with Timely Follow-Up after Index Colposcopy”

Sarah Morgan Carpenter, M.D.
Indiana University
Indianapolis, Indiana

Poster #3

“Marijuana Use in Pregnancy Amid Evolving Cannabis Policies”

Jamie N. Levine, B.A.
University of Kentucky College of Medicine
Lexington, Kentucky

Poster #4

“Intraoperative Fluid Restriction Effect on Hysterectomy Outcomes: A Modality-Specific Analysis”

Carlie Cryer, B.S.
University of Kentucky
Lexington, Kentucky

Poster #5

“Assessing Blood Loss in Robotic Versus Abdominal Myomectomy: The Impact of Tranexamic Acid, Vasopressin, and Misoprostol”

Yissa D. Fonticiella, M.D.
Florida Fertility Institute
Clearwater, Florida

Poster #6

“Does Experience Build Resilience? Associations Between Career Longevity and Resilience in Academic Medicine”

Milah D. Shah-Bruce, M.D., Ph.D.
Louisiana State University Health Sciences Center
Shreveport, Louisiana

Poster #7

“Outcomes of Multifetal Reduction by Indication at a Tertiary Care Institution”

Nkechinyelum Q. Ogu, M.D.

Northwestern University Feinberg School of Medicine
Chicago, Illinois

Poster #8

“Food Insecurity and Weight Gain Among Individuals Using Contraception”

Amanda Doerr, M.S.

Louisiana State University Health Sciences Center
Shreveport, Louisiana

Poster #9

“Association of Proximity to Public Transportation and Prenatal Care Utilization and Obstetric Outcomes”

Layne A. Landry, M.D.

Louisiana State University Health Sciences Center
Shreveport, Louisiana

Poster #10

“Maternal Outcomes of Elective Inductions in Nulliparous Adolescents”

Margaret Specht, M.D.

University of Kentucky
Lexington, Kentucky

Poster #11

“Patient Preferences for Management of Abnormal Pap Smears”

Meredith Kelley, M.D.

Indiana University
Indianapolis, Indiana

Poster #12

“Obstetrical Risk Factors for Newborns Based on 10-Minute Apgar Scores”

Gabrielle J. Maire, MHA

Loyola University Chicago Stritch School of Medicine
Maywood, Illinois

Poster #13

“Sonographic Features of Fetal Brain Biometry in Pregnancies in PCOS Women”

Brandon K. Ta, B.S.
Paul L. Foster School of Medicine
Texas Tech Health Sciences Center
El Paso, Texas

Poster #14

“Understanding Decision Making in Contraceptive Use and Reproductive Health for Individuals with Chronic Kidney Disease”

Vidhisha S. Chahande
University of Cincinnati
Cincinnati, Ohio

Poster #15

“Perinatal Asphyxia in Obese vs Non-Obese Mothers Based on Cord Blood Gas Levels”

Leila S. Jordan, B.A.
Loyola University Chicago Stritch School of Medicine
Maywood, Illinois

Poster #16

“Prenatal Care Utilization and Preterm Birth: A Dose Response Relationship in an Urban Cohort”

Jonathan K. Muraskas, M.D.
Loyola University Medical Center
Maywood, Illinois

Poster #17

Withdrawn

Poster #18

“Identifying Attitudes and Knowledge Gaps Regarding Fertility and Oocyte Cryopreservation Among Professional Students at Ohio University”

Jillian M. Kirby, B.S.
Ohio University Heritage College of Osteopathic Medicine
Athens, Ohio

Poster #19

“Feasibility of a Remote Blood Pressure Monitoring in Pregnant Women of Color at Increased Risk of Preeclampsia”

Reem Esseghir, B.A.

Rutgers Robert Wood Johnson Medical School

East Brunswick, New Jersey

Poster #20

“Effect of Fluid Restriction on Outcomes Following Hysterectomy”

Carlie Cryer, B.S.

University of Kentucky

Lexington, Kentucky

Poster #21

“Mobile-Integrated Health for Postpartum Hypertension: A Pilot Study in an At-Risk Population”

Nia Byrd, M.D.

Henry Ford Health

Detroit, Michigan

Poster #22

“Timing Matters: Comparing Doula Care Starting Prenatally vs During Labor Among Publicly Insured Patients”

Nia Byrd, M.D.

Henry Ford Health

Detroit, Michigan

Poster #23

“Improving Resident Satisfaction and Efficiency in the Labor and Delivery Unit”

Michael R. Boldt, M.D., MEd

University of Cincinnati Medical Center

Cincinnati, Ohio

Poster #24

“Incidental Finding of Malignant Peritoneal Mesothelioma During a Routine Gynecologic Procedure”

David A. Billings, M.D.

Univ. of North Dakota School of Medicine & Health Sciences

Minot, ND

Poster #25

“Disseminated Herpes Simplex Virus (HSV) Infection in Pregnancy Presenting with Hypothermia: A Case Series”

Katlyn Sullivan, M.D., MPH, MSc
MetroHealth Medical Center
Case Western Reserve University
Cleveland, Ohio

Poster #26

“Navigating Obstetrical Trauma in the Setting of Uterine Rupture and Spinal Fracture: A Case Report”

Lilly P. Deljoo, B.S.
University of Louisville School of Medicine
Louisville, Kentucky

Poster #27

“Prolonged Expectant Management of Severe Mitral Stenosis and Pulmonary Hypertension in Pregnancy: A Multidisciplinary Case Report”

Ashley S. Boerrigter, M.D.
University of Kentucky
Lexington, Kentucky

Poster #28

“Neuraxial Anesthesia in a Pregnant Patient with Type III von Willebrand Disease: A Multidisciplinary Case Report”

Ashley S. Boerrigter, M.D.
University of Kentucky
Lexington, Kentucky

Poster #29

“Gravid Intrauterine Pregnancy with Complete Ventral Wall Hernia Emplacement”

Thomas F. Arnold, M.D.
Univ. of North Dakota School of Medicine & Health Sciences
Dickinson, North Dakota

Poster #30

“Fertility-Sparing Management of Ectopic Pregnancy in Resource-Limited Rural Areas: A Case Report”

Reese H. Siegle, B.S.
Univ. of North Dakota School of Medicine & Health Sciences
Minot, North Dakota

Poster #31

“Ectopic Abdominal Hidradenitis Suppurativa During Pregnancy Managed with Combined Panniculectomy and Cesarean Delivery”

Christian H. Siegle, B.S.

Oklahoma State University College of Osteopathic Medicine
Tulsa, Oklahoma

Poster #32

“An Uncommon Cause of Fetal Hydrops”

Ashley O. Ikwuezunma, M.D.

Texas Tech Permian Basin
Odessa, Texas

Poster #33

“Application of Direct and Indirect Nondisclosure PGT-M in Families at Risk for BRCA1”

Brandon B Wagner, B.S.

Midwestern University
Chicago College of Osteopathic Medicine
Downers Grove, Illinois

Poster #1

Rates and Predictors of Oophorectomy at the Time of Cystectomy: A Retrospective Institutional Review

Camille F Bratton, MD, James W Van Hook, MD, Shea Sharma, BS, Dana Rector, MD

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Objective: To determine the incidence of oophorectomy at the time of surgery for benign ovarian cysts in patients treated at ProMedica Toledo Hospital and to identify potential predictors of oophorectomy in this population.

Design: A retrospective chart review was comprised of patients undergoing surgical management for benign ovarian cysts at ProMedica Toledo Hospital between January 1, 2016, and January 13, 2025. Inclusion criteria encompassed patients with low-malignancy-risk ovarian cysts scheduled for cystectomy. Exclusion criteria included confirmed or suspected malignant cysts, ovarian torsions, patients consented for an oophorectomy. Data collected included total number of cystectomies and oophorectomies, surgical approach (diagnostic laparoscopy, robotic laparoscopy, or laparotomy), cyst size and location, pathology, and patient age.

Materials and Methods: Statistical analysis included chi-square testing for categorical variables and t-tests for independent samples. Logistic regression analysis was performed to identify independent predictors of oophorectomy.

Results: A total of 119 patients met inclusion criteria. Of these, 27 (22.7%) underwent cystectomy alone, while 92 (77.3%) underwent oophorectomy. The difference between the two procedures was statistically significant ($p=0.018$). Patient ages ranged from 14 to 78 years old. The mean age for oophorectomy was 39, compared to 32 years old for cystectomy ($p=0.018$). Larger cyst size and increasing age were associated with a higher chance of oophorectomy ($p=0.31$). Robotic approach was significantly associated with ovarian preservation ($p=0.0001$). Dermoid cysts had the highest likelihood of oophorectomy.

Conclusions: This study reveals a strikingly high rate of oophorectomy (77.3%) at the time of surgery for benign ovarian cysts at ProMedica Toledo Hospital. Factors that influence the rate of oophorectomy include age, pathology, and surgical approach. Understanding these associations can

improve preoperative counseling, guide surgical planning, and help optimize ovarian preservation, particularly in reproductive-age women.

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Table 1: Pathology Results

Pathology	Total Cases	Oophorectomy (n)	Oophorectomy (%)
Dermoid / Teratoma	31	27	87.1%
Endometrioma	18	12	66.7%
Serous cystadenoma / cystadenofibroma	17	13	76.5%
Hemorrhagic / corpus luteum cyst	15	11	73.3%
Simple cyst	12	8	66.7%
Mucinous cystadenoma	5	4	80.0%
Benign unspecified cyst	13	11	84.6%
Other benign tumors (fibroma, adenofibroma, seromucinous)	8	6	75.0%

Poster #2

Factors Associated with Timely Follow-Up after Index Colposcopy

Arielle Moss, DO, MPH, Sarah Carpenter, MD, Sarah Schaller, MD, Karina Reynoso, Vitoria Simas,

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Preventing cervical cancer requires appropriate management and timely follow up after an abnormal colposcopy result. The purpose of this study is to examine the demographics and clinical characteristics of patients who received timely follow-up after index colposcopy at a safety-net hospital in Indiana that serves predominantly immigrant and under- or uninsured patients, which is a population that bears the brunt of cervical cancer incidence, morbidity, and mortality but is underrepresented in cervical cancer data. Timely follow-up was considered receiving either pap smear with co-testing, repeat colposcopy, or excisional procedure within 18 months of index colposcopy, per 2019 ASCCP guidelines. The cohort included patients ages 21-65 who received their index colposcopy from 2022-2023. Patient demographics (age, race/ethnicity, spoken language, insurance status, desiring fertility), HPV risk factors (BMI, smoking status, and HPV vaccination status), pap smear cytology, and colposcopy biopsy results were obtained from electronic health records (EHR). Of the 183 patients who underwent colposcopy and met inclusion criteria, 57.4% received follow-up within 18 months of index colposcopy. Patients with a high-grade index pap result had significantly higher odds of completing follow-up compared to those with low-grade results (OR 4.62, $p < 0.001$). Similarly, patients with CIN2 or high-grade (HSIL, AGC, ASC-H, suspicious for cancer, AIS, CIS) pathology on index colposcopy had significantly higher odds of follow-up completion compared to those with low-grade (LSIL or ASCUS) pathology (OR 15.3, OR 52.6, respectively, $p < 0.001$). Of the 77 patients with high-grade or CIN2 colposcopy results, 90% of these patients underwent excisional procedure within 6 months of index colposcopy. Although a substantial proportion (42.6%) of patients did not have any timely follow-up after index colposcopy, it is reassuring that the highest risk individuals were more likely to have timely treatment with an excisional procedure. This data suggests opportunities for patient-level and systems-level interventions to identify the underlying causes for incomplete or inadequate follow-up after colposcopy, create more robust tracking systems to improve the delivery of timely interventions, and ultimately reduce cervical cancer burden amongst underserved populations.

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Factors Associated with Timely Follow Up After Index Colposcopy – Tables
Arielle Moss, DO MPH

	Total	Received Recommended Follow-Up in <18 Months		p-value ¹
	N = 183 (100%)	No N = 78 (42.6%)	Yes N = 105 (57.4%)	
Age, n (%)				0.8
21-24 y/o	13 (7.1%)	4 (5.1%)	9 (8.6%)	
25-39 y/o	118 (64.5%)	51 (65.4%)	67 (63.8%)	
40-49 y/o	29 (15.8%)	12 (15.4%)	17 (16.2%)	
50 y/o and older	23 (12.6%)	11 (14.1%)	12 (11.4%)	
Race/Ethnicity², n (%)				0.2
White, Non-Hispanic	21 (11.5%)	12 (15.6%)	9 (8.6%)	
Black or African American, Non-Hispanic	65 (35.7%)	24 (31.2%)	41 (39.0%)	
Hispanic	87 (47.8%)	39 (50.6%)	48 (45.7%)	
Other	9 (4.9%)	2 (2.6%)	7 (6.7%)	
Missing	1	1	0	
Spoken language, n (%)				0.3
English	81 (44.3%)	31 (39.7%)	50 (47.6%)	
Spanish	79 (43.2%)	35 (44.9%)	44 (41.9%)	
Haitian Creole	18 (9.8%)	8 (10.3%)	10 (9.5%)	
Other	5 (2.7%)	4 (5.1%)	1 (1.0%)	
Insurance status³, n (%)				0.5
Commercial	42 (23.0%)	19 (24.4%)	23 (21.9%)	
Eskenazi Advantage	53 (29.0%)	25 (32.1%)	28 (26.7%)	
Medicaid	35 (19.1%)	11 (14.1%)	24 (22.9%)	
Other	53 (29.0%)	23 (29.5%)	30 (28.6%)	
BMI², n (%)				0.5
< 18.5	3 (1.7%)	1 (1.4%)	2 (1.9%)	
18.5-24.9	27 (15.3%)	11 (15.1%)	16 (15.4%)	
25-29.9	64 (36.2%)	31 (42.5%)	33 (31.7%)	
>30	83 (46.9%)	30 (41.1%)	53 (51.0%)	
Missing	6	5	1	
Smoking status, n (%)				0.9

Marijuana Use in Pregnancy Amid Evolving Cannabis Policies

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Purpose: Despite recommendations to abstain from marijuana (MJ) use during pregnancy due to potential risks for adverse perinatal outcomes, many pregnant individuals use MJ. This behavior may be influenced by changing societal attitudes and ongoing legislative shifts surrounding marijuana in the US. We aim to assess whether frequency in use of marijuana in pregnancy has increased in recent years reflective of evolving public perspectives.

Methods: Prospective cohort of 646 postpartum patients enrolled from 2 urban academic medical centers in the Midwest from 2011-2025. Structured surveys were administered to consented patients during their delivery hospitalization to collect data on social determinants of health and birth outcomes. The primary outcome was self-reported MJ use during pregnancy; the primary exposure was year of study enrollment. Their association was analyzed with time modeled as a continuous variable by linear regression and categorical with chi-square. Logistic regression estimated odds of factors associated with MJ use.

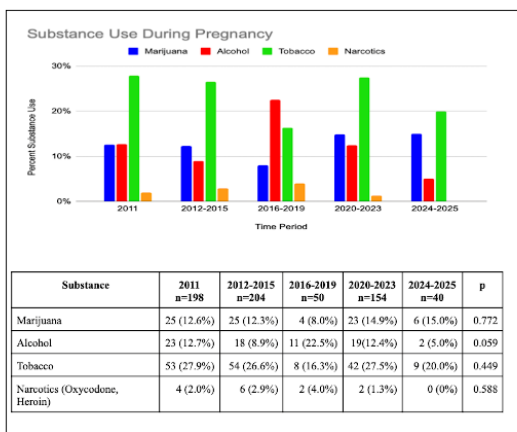
Results: The frequency of MJ use during pregnancy among the study population was high, 12.9% (10.3-15.4%). Self-reported MJ use peaked at 15% in recent years (2024-2025), compared to a low of 8.0% during 2016-2019. However, the rate of MJ use did not change significantly over the study period, R-squared=0.0009, p=0.454. When comparing the rate of maternal MJ use prior to legalization of MJ in Ohio (Nov 2023, 12.7%) the odds increased 72% (OR 1.72, 95%CI 0.36-8.34) after legalization (20.0%), although not statistically significant, perhaps due to small sample size in the post-legalization period (n=10). MJ use in pregnancy was most strongly associated with maternal age <35, non-Hispanic Black race, unmarried, lower education level (<high school diploma), enrollment in Medicaid.

Conclusion: Prenatal marijuana use showed no significant overall increase but peaked after legalization, indicating there

may be shifting social and legal influences. MJ use was associated with sociodemographic variables that may assist with both public health messaging and social support efforts.

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Poster #4

Intraoperative Fluid Restriction Effect on Hysterectomy Outcomes: A Modality-Specific Analysis

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Objective: This study evaluated the impact of an intraoperative fluid restriction protocol on postoperative outcomes after hysterectomy across surgical modalities.

Methods: This retrospective cohort study included 468 hysterectomy patients at an academic center before, during, and after implementation of an institutional fluid restriction protocol in September 2024. Patients with a history of chronic kidney disease were excluded. Postoperative outcomes, including length of stay (LOS), 30-day hospital readmission and ED admission, acute kidney injury (AKI), postoperative nausea or vomiting (PONV), ileus or small bowel obstruction (SBO), and vasopressor use, were stratified by hysterectomy modality and compared between fluid-restricted (September-December 2024) and unrestricted (May-September and December 2024) periods. The modalities investigated were abdominal, laparoscopic, robotic assisted, and vaginal hysterectomies. Associations for continuous variables were estimated using negative binomial regression to obtain incidence rate ratios (IRRs), and categorical variables were analyzed using logistic regression, with exact logistic regression for sparse outcomes, to estimate odds ratios (ORs).

Results: Among 83 abdominal, 84 laparoscopic, 261 robotic assisted, and 40 vaginal hysterectomy patients, fluid restriction was consistently associated with a non-significant decrease in LOS across all modalities. Similarly, there were non-significant reductions in odds of 30-day hospital readmission and ED admission, except for increased odds of ED admission in the vaginal group. PONV was generally more common with fluid restriction, while postoperative ileus was generally less common across all modalities. Vasopressor use was more frequent in most modalities, reaching statistical significance in the abdominal group (aOR 2.87; 95% CI, 1.01–8.17), while remaining non-significant in the other approaches.

Conclusion: Postoperative outcomes did not differ significantly between fluid restriction groups, suggesting that reduced intraoperative fluid volume is not associated with worse outcomes. Although directional trends were generally

consistent across hysterectomy modalities, variation in effect estimates suggests potential differences in effect magnitude, illustrating the importance of modality-stratified analyses in future, larger studies.

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Outcome	Abdominal (n=83)	P	Laparoscopic (n=84)	P	Robotic (n=261)	P	Vaginal (n=40)	P
LOS, days (IRR)	0.784 (0.586-1.050)	0.103	0.620 (0.300-1.263)	0.198	0.966 (0.736-1.269)	0.805	0.582 (0.323-1.049)	0.072
30-day hospital readmission (OR)	0.943 (0.121-6.538)	1.000	0.406 (0.063-1.941)	0.343	0.906 (0.211-3.704)	1.000	0.564 (0.006-49.885)	1.000
30-day ED admission (OR)	0.591 (0.130-2.452)	0.606	0.617 (0.180-1.993)	0.523	0.553 (0.162-1.687)	0.369	1.399 (0.173-16.749)	1.000
AKI (OR)	0.750 (0.019-m)	1.000	1.190 (0.46-4.29)	1.000	3.162 (0.248-169.111)	0.596	—	—
N/V (OR)	1.802 (0.563-6.068)	0.394	0.964 (0.066-14.011)	1.000	1.993 (0.687-6.276)	0.242	1.606 (0.124-m)	0.722
Ileus/SBO (OR)	0.234 (0.004-3.111)	0.413	0.426 (0-5.503)	0.515	0.914 (0-35.657)	0.955	—	—
Vasopressor use (OR)	2.874 (1.011-8.173)	0.048	0.886 (0.348-2.256)	0.800	1.077 (0.643-1.801)	0.779	2.506 (0.828-10.007)	0.193

LOS, length of stay; IRR, incidence rate ratio; OR, odds ratio; AKI, acute kidney injury; N/V, nausea/vomiting; SBO, small bowel obstruction.

Values are adjusted odds ratios (aOR) or incidence rate ratios (aIRR) with 95% confidence intervals, comparing fluid-restricted to unrestricted (reference) groups.

Outcomes not modeled had zero events.

Poster #5

Assessing Blood Loss in Robotic versus Abdominal Myomectomy: The Impact of Tranexamic Acid, Vasopressin, and Misoprostol

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Objective: Uterine fibroids are the most common symptomatic neoplasm in women and occur in 70% of women. Myomectomy is performed for women with symptomatic uterine fibroids who desire to retain future fertility. There are medications that can help reduce blood loss during a myomectomy. Our goal is to evaluate the effectiveness of combining pitressin, tranexamic acid (TXA), and/or misoprostol in reducing estimated blood loss (EBL) during abdominal and robotic myomectomies.

Methods: A multi-site retrospective chart review was conducted on 171 patients who underwent myomectomy (Mean = 36.9; 17.4% White, 48.3% Black, 24.4% Hispanic, 9.9% Other Races). Patients were stratified based on type of procedure (robotic or abdominal). Use of pharmacologic adjunct medications to reduce blood loss (Pitressin, Cytotec, and TXA) were dichotomized to assess the effects of 3-Medication Combination compared to all other medication combinations (Pitressin only, Pitressin and Cytotec, or Pitressin and TXA). Univariate comparisons (Independent t-tests and Chi-Square tests of Independence) were conducted on demographics, comorbidities, hemoglobin levels, EBL, number, type, and size of fibroids.

Results: Patients in the Robotic group (n = 80) who received the 3-Medication Combination (n = 60) had a significantly higher number of fibroids (6.6 vs 3.1, p = .005) and larger proportion of intramural fibroids (86.4% vs 61.1%, p = .036) compared to the patients who received other medication combinations (n = 20). There was no significant difference in EBL between the two medication groups undergoing Robotic myomectomy. Patients in the Abdominal myomectomy group (n = 91) in the 3-Medication Combination group (n = 28) had a significantly larger number of fibroids (11.2 vs 5.7, p = .037), higher proportion of intramural fibroids (96.3% vs 76.7%), and lower pre-operative hemoglobin levels (11.0 vs 12.2) compared to the other medication combination group (n = 63). Further, the patients undergoing Abdominal myomectomy with the 3-Medication Combination

experienced significantly higher levels of EBL (387.9ml vs 183.3ml; $p = .016$) as compared to the other medication combination group.

Conclusion: We reviewed 171 patients who underwent Robotic or Abdominal myomectomies to compare whether a 3 medication combination versus other medication combinations can help reduce blood loss. In robotic cases there was no significant difference in EBL between the two groups undergoing robotic myomectomy. In the abdominal myomectomy group, the 3 drug combination group had larger number of fibroids, more intramural fibroids, and a significantly higher EBL compared to the other drug combination.

Overall the 3 drug combination had similar blood loss in robotic cases but appears to be less effective in abdominal myomectomy cases. We cannot say if the 3 drug combination used in abdominal myomectomies were in response to hemorrhage.

We can suggest further randomized studies for the administration of prophylactic 3 drug combination in abdominal myomectomies in the case of higher disease burden, complexity of case, and risk of potential hemorrhage.

Poster #6

Does Experience Build Resilience? Associations Between Career Longevity and Resilience in Academic Medicine

Mila D Shah-Bruce, MD/PhD¹, Peggy Gesing, PhD²

Louisiana State University Health Sciences Center, Shreveport, LA¹, Macon & Joan Brock Virginia Health Sciences at Old Dominion University, Norfolk, VA²

Background: Resilience is an important protective factor against occupational stress and burnout among academic medical faculty. Understanding how resilience varies across career stages may help identify vulnerable groups and inform targeted faculty development and wellness interventions. This study evaluated the association between career longevity and resilience among clinicians, clinician educators (CEs), and nonclinician undergraduate medical educators (UMEs).

Methods: A cross-sectional survey study was conducted among faculty affiliated with academic medical centers and associated educational institutions. Resilience was measured using the validated 14-item Resilience Scale (RS-14) and analyzed as a continuous outcome variable. Participants were categorized into three faculty groups: clinicians, CEs, and UMEs.

Independent variables included age, years educating, and years as a practicing clinician, each categorized into discrete groups. Age was grouped by decade, and experience variables were categorized into ordinal ranges to reflect increasing career duration. Generalized linear modeling (GLM) with least squares estimation was performed to evaluate associations between independent variables and LS mean resilience scores while accounting for multiple predictors.

Interaction terms between faculty group and key variables (age and years as a clinician) were included to assess effect modification and explore whether the relationship between experience and resilience differed across faculty roles.

Results: Faculty group alone was not a significant predictor of resilience scores ($p = .953$). However, several career-related variables were significantly associated with resilience, including age ($p < .001$), years educating ($p = .032$), and years as a practicing clinician ($p < .001$).

Resilience varied significantly across age groups, with faculty aged 55–64 years demonstrating the highest LS mean resilience scores, while those aged 18–24 years had the lowest. Increasing clinical experience was strongly associated with higher resilience, with clinicians reporting more than 25 years of practice demonstrating the highest resilience scores

overall (LS mean = 66.59). In contrast, individuals with 21–25 years of educational experience demonstrated comparatively lower resilience (LS mean = 59.16), suggesting potential variability across different forms of professional experience.

Significant interaction effects were observed between faculty group and age ($p = .034$) and between faculty group and years as a clinician ($p = .005$). Clinician educators aged 45–54 years and those with more than 25 years of clinical experience demonstrated particularly elevated resilience scores, indicating that the relationship between experience and resilience may differ by faculty role.

Conclusions: Career longevity is strongly associated with resilience among academic medical faculty, with higher resilience observed in later career stages. Early-career faculty demonstrated lower resilience, suggesting they may represent a vulnerable population for occupational stress. These findings support targeted mentorship and faculty development initiatives aimed at strengthening resilience across the academic career trajectory.

Poster #7

Outcomes of Multifetal Reduction by Indication at a Tertiary Care Institution

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Objectives: Compared to singleton gestations, multifetal gestations are associated with higher rates of adverse pregnancy outcomes, including spontaneous preterm delivery, hypertensive disorders of pregnancy, gestational diabetes, cesarean delivery, abnormal fetal growth, and postpartum hemorrhage. These risks increase with higher order gestations. Multifetal reduction (MFR), typically performed before 14 weeks, may improve outcomes. MFR procedure is not without risk. We aimed to evaluate procedure-related complications and perinatal outcomes among patients undergoing FMR at our institution.

Methods: We conducted a retrospective cohort study of all patients undergoing MFR at a tertiary academic center from January 2020 to March 2026. Outcomes were compared by gestational age at MFR, fetal number after reduction, and reduction of the presenting fetus. Wilcoxon rank sum, Fisher exact, and chi squared tests were used, with $p < 0.05$ considered significant.

Results: Among 107 patients, 22 (20.6%) underwent MFR due to a genetic anomaly, 24 (22.4%) for a structural anomaly, and 4 (3.7%) for both, while 57 (53.3%) underwent MFR for other indications, including psychosocial reasons. Demographics, including race, ethnicity, and body mass index, were similar between groups. However, groups differed by mode of conception, with 27% of patients with structural anomalies conceiving via IVF, while 40% of the other cohort conceived via intrauterine insemination ($p=0.04$). There were no significant differences in procedure-related complications (13.6% vs. 8.3%, $p=0.39$) or live birth rates (100% vs. 95%, $p=1.00$). Overall, the complication rate was 12.7%, with a 1.3% procedure-related loss rate.

Although differences did not reach statistical significance, reductions performed for structural anomalies demonstrated a trend toward higher maternal and neonatal morbidity compared with reductions for genetic anomalies. Reduction in the setting of structural anomalies was associated with higher

rates of adverse outcomes compared with reduction for genetic anomalies (57.9% vs. 26.3%, $p=0.14$). Structural anomaly reductions were associated with numerically higher rates of hypertensive disorders, NICU admission, and preterm delivery compared to genetic anomalies (26.3% vs. 10.5%, $p=0.28$), (22.2% vs. 5.3%, $p=0.14$), (31.6% vs. 11.5%, $p=0.76$) respectfully.

Conclusion: MFR demonstrated high live birth rates and low procedure-related loss overall. While complication rates were similar across indications, reductions for structural anomalies showed trends toward worse obstetric and neonatal outcomes compared with genetic indications.

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Perinatal outcomes by gestational age at the time of the fetal reduction

	Genetic (n=22)	Structural (n=24)	Both (n=4)	Other (n=57)	p-value
Procedure complications*	3 (13.6)	2 (8.3%)	2 (25.0%)	3 (6.8%)	0.39
VB	0	1 (5.3%)	1 (12.5%)	2 (6.7%)	0.42
PPROM	3 (16.7%)	0	1 (12.5%)	2 (6.7%)	0.22
Miscarriage	0	1 (4.2%)	0	0	0.23
SCH	0	0	0	1	1.00
Adverse pregnancy outcome composite	5 (26.3%)	11 (57.9%)	2 (28.6)	17 (53.1%)	0.14
HDP	2 (10.5%)	5 (26.3%)	2 (28.6%)	5 (26.3%)	0.28
GDM	0	1 (5.3%)	0	1 (3.1%)	1.00
PPH	2 (10.5%)	2 (10.5%)	0	4 (12.5%)	1.00
Hysterectomy	0	1 (5.3%)	0	1 (3.1%)	1.00
NICU	1 (5.3%)	4 (22.2%)	0	8 (27.6%)	0.14
Route of delivery					0.77
Vaginal	11 (57.9%)	9 (43.4%)	4 (57.1%)	20 (62.5%)	
Operative	0	0			
Cesarean section	8 (42.1%)	10 (52.6%)	3 (42.9%)	12 (37.5%)	
At least one live born	19 (100%)	19 (95%)	7 (100%)	32 (96.9%)	1.00
Preterm delivery	2 (10.5%)	6 (31.6%)	0	9 (28.1%)	0.2
Delivery GA					0.76
<28wk	0	2 (10.5%)	0	2 (6.3%)	
28-34wk	0	1 (5.3%)	0	3 (9.4%)	
34-37wk	2 (10.5%)	3 (15.8%)	0	5 (15.6%)	
>37wk	17 (89.5)	13 (68.4%)	7 (100%)	22 (68.8)	

Poster #8

Food Insecurity and Weight Gain Among Individuals Using Contraception

Kaysie A Winston, MD, Mila D Shah-Bruce, MD, PhD,
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Food insecurity remains a significant public health concern in the US, affecting approximately 13.5% of households in 2023, with even higher prevalence reported in Louisiana (16.2%). Social determinants of health, including food insecurity, have been increasingly recognized as important contributors to overall health outcomes. Certain contraceptive methods, particularly depot medroxyprogesterone acetate, have been associated with weight gain; however, the extent to which food insecurity modifies this relationship remains unclear. Individuals experiencing food insecurity may have altered dietary patterns and inconsistent access to nutritious foods, which could influence weight trajectories independent of contraceptive use. This retrospective study aimed to evaluate the relationship between food insecurity and weight change among women using different contraceptive methods. We hypothesized that there would be no significant difference in weight gain between individuals in food-insecure and food-secure settings, regardless of contraceptive type. The primary research question examined the extent to which food insecurity influences weight change among users of Depo-Provera, short-acting contraceptives (e.g., oral contraceptive pills, patch, and vaginal ring), long-acting reversible contraceptives (IUDs and nexplanon), and individuals not using contraception. Data was collected from 01/01/2020-12/31/2023. This retrospective cohort study included 245 individuals aged 15–42 years receiving care in North Louisiana. Food insecurity was approximated using high-risk ZIP codes based on regional socioeconomic indicators. Contraceptive methods were categorized as Depo-Provera, combined oral contraceptives (COCs), progestin-only pills (POPs), implantable devices (Nexplanon), intrauterine devices (IUDs), and transdermal patch. Weight change was calculated as the difference between follow-up and baseline weight. A multivariable linear regression model was used to assess the association between food insecurity and weight change, adjusting for age, race, and contraceptive type. An interaction term between food insecurity and contraceptive type was included to evaluate effect modification. Descriptive and graphical analyses, including boxplots and geographic heat mapping, were performed. Results: The mean age of

participants was 25.9 ± 6.0 years. The majority of participants were classified as experiencing food insecurity (73%), with 25% residing in high-risk ZIP codes. Nexplanon was the most commonly used contraceptive method (48%), followed by COCs (21%) and Depo-Provera (15%). The mean weight change was 1.9 ± 12.6 kg, with substantial variability (range: -27.5 to 127.9 kg). In multivariable analysis, food insecurity was not significantly associated with weight change ($p = 0.664$), nor was contraceptive type ($p = 0.441$). There was no significant interaction between food insecurity and contraceptive method ($p = 0.997$). Age ($p = 0.188$) and race ($p = 0.347$) were also not significantly associated with weight change. The model explained a small proportion of the variance in weight change ($R^2 = 0.043$). Geographic analysis demonstrated clustering of participants within northwest LA, specifically Caddo parish.

Poster #9

Association of Proximity to Public Transportation and Prenatal Care Utilization and Obstetric Outcomes

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Background: Transportation access has been identified as a potential barrier to prenatal care utilization and may contribute to adverse maternal and neonatal outcomes. Limited access to public transportation may disproportionately affect socially vulnerable populations and reduce healthcare accessibility during pregnancy. This study aimed to evaluate whether proximity to public transportation, measured by distance to the nearest bus stop, was associated with prenatal care utilization and obstetric outcomes in an underserved obstetric population.

Methods: A retrospective cohort study was conducted of 272 obstetric patients receiving care within a single healthcare system. Distance from patient residence to the nearest bus stop was categorized into three groups: <1 mile, 1.1–5 miles, and >5 miles. Primary outcomes included adequacy of prenatal care, late prenatal care (>20 weeks gestation), and number of prenatal visits. Secondary outcomes included tobacco use, alcohol use, illicit drug use, chronic hypertension, severe preeclampsia/eclampsia, preterm birth, neonatal intensive care unit admission, low birth weight, small for gestational age, and respiratory distress syndrome. Continuous variables were assessed for normality using Shapiro-Wilk testing and visual histogram inspection. Normally distributed variables were analyzed using one-way ANOVA, while non-normally distributed variables were analyzed using Kruskal-Wallis testing. Categorical variables were analyzed using chi-square testing. Statistical significance was defined as $p < 0.05$.

Results: A total of 269 patients had complete data available for analysis. Most patients resided within 1 mile of a bus stop (74.7%), while 16.0% lived 1.1–5 miles away and 9.3% lived >5 miles away. Distance to the nearest bus stop was not significantly associated with inadequate prenatal care ($p=0.451$), delayed prenatal care initiation after 20 weeks gestation ($p=0.647$), prenatal visit count ($p=0.117$), or BMI ($p=0.306$). No significant associations were identified between transportation distance and tobacco use, illicit drug use, chronic hypertension, severe preeclampsia/eclampsia,

preterm birth, NICU admission, low birth weight, SGA, or RDS (all $p > 0.05$). Ethnicity distribution differed significantly across transportation groups ($p < 0.001$). Alcohol use was also significantly associated with greater transportation distance, with the highest rates observed among individuals living > 5 miles from a bus stop (12.0%, $p = 0.025$).

Conclusion: In this cohort, proximity to public transportation demonstrated limited association with prenatal care utilization and most maternal or neonatal outcomes. Distance to the nearest bus stop was not significantly associated with prenatal care adequacy, delayed prenatal care initiation, prenatal visit count, BMI, or the majority of obstetric complications evaluated. Although alcohol use differed significantly across transportation-distance groups, overall findings suggest that proximity to public transportation alone may not adequately capture transportation-related barriers to prenatal care access in this population. Additional studies incorporating broader socioeconomic and transportation access variables are warranted.

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Prenatal Care and Maternal Outcomes by Distance to Bus Stop

Variable	<1 Mile	1.1–5 Miles	>5 Miles	p-value
Inadequate prenatal care, n (%)	99 (49.3)	19 (44.2)	15 (60.0)	0.451
Late prenatal care (>20 weeks), n (%)	52 (25.9)	13 (30.2)	5 (20.0)	0.647
Severe preeclampsia/eclampsia, n (%)	29 (14.4)	3 (7.0)	4 (16.0)	0.395
Chorioamnionitis, n (%)	13 (6.5)	3 (7.0)	1 (4.0)	0.875
Postpartum hemorrhage >1000 mL, n (%)	6 (3.0)	0 (0.0)	0 (0.0)	0.354

Poster #10

Maternal Outcomes of Elective Inductions in Nulliparous Adolescents

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Introduction: Management of elective inductions of labor is rooted in maximizing maternal and fetal wellbeing while minimizing morbidity and mortality. Most studies suggest there is no increased risk in cesarean rates among patients undergoing elective inductions in the 39th week of gestation. Most studies evaluate individuals aged 20–28-years old with extrapolation of findings to additional age groups. The adolescent age group is particularly important to evaluate, as serial cesarean sections increase risk of intra-abdominal adhesive disease and placenta accreta spectrum. If this age group is exposed to cesarean sections earlier in their lives, this may increase the total number of cesarean deliveries and increase morbidity. Therefore, factors increasing the risk of cesarean delivery need to be understood.

Objectives: The adolescent population has not been directly examined in studies examining outcomes of elective inductions of labor. Given the increasing rates of both adolescent deliveries and cesarean deliveries, this is a unique population in need of guidance to aid provider recommendations. This study sought to evaluate whether elective inductions of labor increase the risk of cesarean delivery in nulliparous adolescents.

Methods: A retrospective cohort study was performed including adolescent nulliparous patients who delivered from January 2018-2024 at the University of Kentucky. IRB approval was obtained via the University of Kentucky. Data from delivery admission and maternal diagnoses (postpartum hemorrhage, OASIS injury, intra-amniotic infection, hypertension) were reviewed. Those who underwent elective induction of labor between 39w0d-39w6d were included in the induction group, and all other patients that delivered at >40w gestation were included in the expectant management group. Inclusion criteria included nulliparous patients ≤ 21 years of age with singleton pregnancies at gestational age >39w0d. Exclusion criteria included any patient with a contraindication to labor, fetal demise, anticoagulation use or cerclage placement in current pregnancy. Primary outcome was mode of delivery with secondary outcomes assessing

maternal morbidity. The primary outcome was evaluated utilizing Fisher's Exact Test and confirmed with multinomial logistic regression, binary outcomes assessed with chi-square tests or Fisher's exact test and cervical assessment compared using Wilcoxon rank-sum test.

Results: There were no baseline differences in group demographics. The expectant management group (n=143) had more advanced cervical dilation and effacement compared to induction group, (n=73) ($p < 0.01$). There was no difference in rate of cesarean or operative delivery ($p = 0.46$), or maternal complications ($p > 0.11$) between groups, though in sub analysis of those aged 20-21, those undergoing induction of labor trended towards less incidence of hypertensive disorder ($p = 0.08$).

Conclusion: There was no increased rate of cesarean delivery or maternal morbidity in 39w nulliparous adolescent patients undergoing elective induction of labor. This study was limited by small sample size that limited the ability to detect statistically significant relationships. Further studies are needed to further evaluate outcomes in this at-risk population.

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Table One: Delivery Mode by Management Group

Delivery mode	Expectant (%)	Induction (%)	OR [CI]
Cesarean Section	34 (23.8)	12 (16.4)	0.62 [0.3-1.3]
Operative Vaginal Delivery	10 (7.0)	5 (6.8)	0.88 [0.29-2.72]
Spontaneous Vaginal Delivery	99 (69.2)	56 (76.7)	

Poster #11

Patient Preferences for Management of Abnormal Pap Smears

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Objective: The purpose of this study was to clarify patient preferences for management of abnormal cervical cancer screening. In order to appropriately counsel patients about management options, it is imperative to engage in patient-centered discussions and better understand patient values.

Methods: This was an observational study utilizing a decision guide an embedded survey to ascertain patient preferences regarding abnormal Pap smear management. Eligible participants included patients over the age of 18 with an abnormal pap smear result requiring colposcopy. No private health information (PHI) was collected during this study. The survey included a guide to educate patients and help them prioritize treatment options, focusing on the choice between an excisional procedure or surveillance with colposcopy. The study's decision guide also provided evidence-based information to help patients evaluate both options. The final portion of the survey was divided into two sections: a "fact check" to assess baseline knowledge of the options and a readiness assessment to determine if the patient felt prepared to make a decision or required additional information. Upon the completion of data collection, it was uploaded to the REDCap database. Each of the four primary study questions were stratified by demographic variables, and a Fisher Exact Test was used to calculate p-values.

Results: The survey used three targeted questions to evaluate patient priorities. The first question asked patients to determine whether undergoing a procedure or avoiding a procedure was most important. Of the 25 responses, a majority (n= 14) of patients indicated that having a procedure was their most important priority. The second question evaluated if they were worried specifically about procedural pain. Of the 27 responses, nine identified pain as their primary concern, while seven patients were somewhat worried. Additionally, five patients expressed equal concern, and six indicated they were less concerned about experiencing pain during a procedure. The third question evaluated the preference for immediate removal of abnormal cells versus the option of avoiding a procedure through surveillance. Of the 26 responses, a significant majority (n=21) identified the

expeditious removal of abnormal cells as their most important priority.

Conclusion: Analysis of the data collected revealed no statistically significant differences in preferences across demographic variables. This suggests the patients' preferences regarding procedural intervention and surveillance remain consistent regardless of age, education level, or future reproductive place. Overall, the findings indicate the majority of patients were amenable to undergoing a procedure and resolution of cervical dysplasia was their highest priority. Notably, many patients demonstrated a limited understanding of pap smears; more than 60% of patients were unaware of their pap smear results at the time of their colposcopy. The survey's knowledge check revealed a fundamental lack of understanding regarding cervical dysplasia. This illustrates the need for robust patient counseling and educational materials to improve patient understanding and decision-making.

Poster #12

Obstetrical Risk Factors for Newborns Based on 10-Minute Apgar Scores

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Objective: To determine potential risk factors that are associated with a lower 5 and 10-minute Apgar score (≤ 4) including umbilical cord entanglement, obesity, hypertension, and maternal diabetes.

Methods: A retrospective analysis of 90 newborns with gestational age ≥ 35 weeks across the United States born between 1987 – present was performed by JM as a causation expert. Data collection included analyzing closed court cases of proven newborn asphyxia ischemic encephalopathy, and extracting data on factors including social history, pregnancy and birth complications, placental pathology, Apgar scores, seizures, cord and newborn blood gas levels and lab values. We identified four known risk factors: umbilical cord entanglement (16 mothers), obesity (28), hypertension (26), and maternal diabetes (17). Next, we compared 5 minute and 10 minute APGAR scores of mothers who had stated risk factors, to those who did not by calculating the odds ratio. We assessed significance within the four risk factor groups through a Fischer test.

Results: Overall, asphyxiated newborns of diabetic mothers demonstrated increased odds of Apgar scores ≤ 4 at both 5 minutes (odds ratio of 2.08) and 10 minutes (odds ratio of 4.07) compared with non-diabetic mothers. Asphyxiated newborns born to obese mothers had increased odds of Apgar scores ≤ 4 at both 5 minutes (odds ratio of 1.26) and 10 minutes (odds ratio of 2.22) compared with non-obese mothers.

Infants of hypertensive mothers had decreased odds of Apgar scores ≤ 4 at both 5 minutes (odds ratio of 0.43) and 10 minutes (odds ratio of 0.77) compared with non-hypertensive mothers. Newborns with cord entanglement had decreased odds with a downward trend over time of newborn Apgar scores ≤ 4 at both 5 minutes (odds ratio of 0.52) and 10 minutes (odds ratio of 0.37) compared with newborns born without cord entanglement. Table 1 includes percentages of

each risk factor group with Apgar scores ≤ 4 , CI, and p values.

Conclusions: Overall, maternal diabetes and obesity demonstrated the strongest positive associations with low Apgar scores (≤ 4) at both 5 and 10 minutes, suggesting that these maternal comorbidities may be associated with increased newborn depression after delivery. In contrast, hypertensive disorders showed a weakly negative association with low Apgar scores, while cord entanglement was also associated with lower observed rates of low Apgar scores in this cohort. The inverse associations observed for hypertensive disorders and cord entanglement should be interpreted with caution. In particular, hypertensive disorders may prompt closer monitoring and expedited delivery, while cord entanglement is often a common and transient finding that does not result in persistent newborn depression. However, none of these associations, including maternal diabetes or obesity, reached statistical significance, likely due to limited sample size. Nonetheless, findings suggest that diabetes and obesity may be clinically relevant risk factors for persistently low Apgar scores in newborns with confirmed asphyxia and therefore require increased vigilance in labor and delivery to avoid devastating newborn neurological outcomes and allegations of medical malpractice.

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Table 1

	Positive Risk Factor	Negative Risk Factor	Odds Ratio	95% CL	P-Value
Diabetes					
<i>Apgar 5 Min</i>	70.6	53.6	2.08	0.65 - 6.69	0.277
<i>Apgar 10 Min</i>	84.6	57.5	4.07	0.83 - 19.92	0.106
Hypertension					
<i>Apgar 5 Min</i>	42.3	63.3	0.43	0.16 - 1.12	0.097
<i>Apgar 10 Min</i>	58.8	65.1	0.77	0.26 - 2.27	0.768
Obesity					
<i>Apgar 5 Min</i>	60.7	55.2	1.26	0.50 - 3.15	0.650
<i>Apgar 10 Min</i>	75.0	57.5	2.22	0.68 - 7.24	0.258
Cord Entanglement					
<i>Apgar 5 Min</i>	43.8	60.0	0.52	0.17 - 1.58	0.272
<i>Apgar 10 Min</i>	41.7	68.8	0.32	0.09 - 1.12	0.102

Poster #13

Sonographic Features of Fetal Brain Biometry in Pregnancies in PCOS Women

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Purpose: We evaluated differences in fetal brain biometric measurements between pregnancies complicated by polycystic ovary syndrome (PCOS) and controls at the time of routine 20-week ultrasound.

Methods: A retrospective cohort study was conducted using records from Texas Tech Health Sciences Center El Paso OBGYN clinics from 2016–2023. Pregnancies complicated by PCOS and/or hirsutism were compared with age-matched controls without PCOS. Pregnancies without a second-trimester anatomy ultrasound near 20 weeks gestation were excluded. Fetal brain biometric measurements including biparietal diameter (BPD), occipitofrontal diameter (OFD), head circumference (HC), transverse cerebellar diameter (CB), lateral ventricle width, cisterna magna (CM), and derived biometric ratios were collected.

Results: Significant differences in fetal brain biometry were observed between pregnancies complicated by PCOS and controls. Fetuses of mothers with PCOS demonstrated increased biparietal diameter (BPD) ($\beta=+2.12$, $p=0.030$), head circumference (HC) ($\beta=+6.84$, $p=0.024$), and cisterna magna (CM) measurements ($\beta=+0.72$, $p=0.035$).

Conclusion: Pregnancies complicated by PCOS demonstrated significant differences in fetal cranial biometric measurements on second-trimester ultrasound, particularly increased BPD, HC, and cisterna magna dimensions compared with controls.

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Table 1. Overall difference in brain biometric measurements between cases and controls

Outcome	N	Beta	95% CI		P-value
Biparietal Diameter	349	+2.12	0.21	4.03	0.030
Occipitofrontal Diameter	342	+1.48	-0.41	3.37	0.124
Head Circumference	348	+6.84	0.92	12.76	0.024
Cerebellum Transverse	335	+0.41	-0.28	1.10	0.244
Nuchal Fold	159	+0.22	-0.18	0.62	0.279
Cephalic Index	382	+0.009	-0.004	0.022	0.173
Ventricle Lateral	291	-0.06	-0.49	0.36	0.764
Cisterna Magna	330	+0.72	0.05	1.39	0.035

Poster #14

Understanding Decision Making in Contraceptive Use and Reproductive Health for Individuals with Chronic Kidney Disease

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Pregnancy is common in women with chronic kidney disease (CKD), but contraceptive use remains low, particularly among those with kidney failure. Pregnancy in this population is high-risk and associated with higher rates of maternal and fetal morbidity. Despite these risks, reproductive health counseling is not included in nephrology care, resulting in increased gaps in patient knowledge and informed decision-making. This study examined patient beliefs and experiences concerning contraceptive use, reproductive health, and barriers in women with CKD and kidney transplants.

Women of childbearing age with CKD were invited to participate in qualitative interviews to answer questions regarding their beliefs, experiences, and decisions regarding reproductive health, contraception, and family planning. Twelve participants were recruited from the Nephrology and Kidney Transplant Clinic at the University of Cincinnati. Interviews were audio-recorded, transcribed, and analyzed using thematic analysis.

Six themes emerged. First, reproductive decision-making was strongly shaped by medical vulnerability, including concerns about maternal health, medication safety, and ability to care for a child. Participants often described avoiding or delaying pregnancy because of chronic kidney disease, transplant recovery, or fear of harming a future child. Second, infertility, hysterectomy, sterilization, and completed childbearing carried important emotional meaning. Some participants described grief and loss after being told they could not have children, while others described acceptance or redefined motherhood through existing children, nieces, nephews, or grandchildren. Third, fertility-related counseling after transplant was inconsistent in timing and depth; some participants received counseling or written information, while others reported little or no discussion of fertility, assisted reproductive technology, or breastfeeding. Fourth, menstrual health was a major quality-of-life issue, with participants describing irregular cycles, heavy bleeding, pain, and symptoms affecting daily functioning. Fifth, sexual health was frequently shaped by illness and recovery rather than

discussed as an isolated issue. Reduced interest delayed sexual activity, anxiety, fatigue, and concern about worsening health were common. Finally, coordination between transplant and reproductive care was variable; some participants reported clear communication across providers, whereas others described reproductive concerns being deferred or addressed only when another specialist became involved.

Kidney disease and transplantation affect reproductive health in multidimensional ways that extend beyond pregnancy alone, including fertility decision-making, menstrual health, sexual well-being, and navigation of multiple care teams. The findings suggest that reproductive care in this population is often reactive rather than consistently integrated into kidney and transplant care. Patient-centered counseling across the reproductive lifespan, including fertility, contraception, menstrual concerns, sexual health, and breastfeeding, can improve continuity of care and better align counseling with patients' goals and lived experiences.

Poster #15

Perinatal Asphyxia in Obese vs Non-Obese Mothers Based on Cord Blood Gas Levels

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Objective: To compare cord blood gas levels to identify cases of acidemia between obese versus non-obese mothers in cases of confirmed perinatal asphyxia to determine relationship between body habitus and acidotic state in fetuses. Previous studies have shown an association between BMI and blood cord acidemia.

Methods: A retrospective analysis of 90 fetuses with gestational age greater than or equal to 35 weeks across the United States born between 1987 – present was performed by JM as a causation expert. For a variety of reasons, cord blood gas analysis was unavailable for 50 fetuses of the total 90. Data collection included analyzing closed, confirmed court cases of fetal asphyxia, and extracting data on factors including social history, pregnancy and birth complications, placental pathology, Apgar scores, seizures, cord and blood gas levels and lab values. We compared obese versus non-obese mothers (obesity ≥ 30 BMI), comparing arterial cord gas deficit (with a cutoff of ≤ -12), venous cord gas deficit (cutoff of ≤ -12), and arterial cord gas pH (cutoff ≤ 7.20) by calculating the odds ratio and assessing for significance with Fischer test.

Results: In obese vs non-obese women, there was a positive association between obesity and fetal acidemia in cord arterial blood gas pH, cord arterial blood base deficit, and cord venous blood base deficit. Obese mothers demonstrated increased odds of 3.79 of arterial blood gas pH ≤ 7.20 , signifying fetal acidemia, compared to non-obese mothers. Similarly, obese mothers demonstrated increased odds of 1.75 and 1.50 of arterial and venous cord blood gas base deficit ≤ -12 , respectively compared to non-obese mothers.

Conclusions: In this retrospective analysis of fetuses, maternal obesity was associated with higher odds of fetal acidemia across arterial pH, arterial base deficit, and venous base deficit measures. The strongest observed association was for cord arterial blood gas pH ≤ 7.20 , where fetuses born to

obese mothers had 3.79 times higher odds of acidemia compared with fetuses born to non-obese mothers. However, none of these associations reached statistical significance, likely due in part to the small sample size and limited available cord gas data. These findings suggest a possible relationship between maternal obesity and fetal acidemia, but larger studies are needed to clarify whether maternal obesity is an independent risk factor for fetal acidemia. Possible reasons for increased incidence of asphyxia in infants of obese mothers may include difficulty in fetal monitoring, as well as delay in expedited delivery by stat C-section.

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Table 1

	Odds Ratio	95% CL	P-Value
<i>Cord Arterial Blood Gas pH</i>	3.79	0.4 - 35.49	0.385
<i>Cord Arterial Blood Base Deficit</i>	1.75	0.35 - 8.71	0.69
<i>Cord Venous Blood Base Deficit</i>	1.50	0.27 - 8.45	0.685

Poster #16

Prenatal Care Utilization and Preterm Birth: A Dose-Response Relationship in an Urban Cohort

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Objective: The objective of our study was to explore the association between prenatal care utilization and risk of preterm delivery in an academic, urban, tertiary care center.

Methods: We conducted a retrospective cohort study of singleton pregnancies delivering between January 1, 2021, and December 31, 2023, using data from the electronic medical record (n=1,006). Exclusion criteria included multiple gestations, pregnancy loss at <20 weeks, or no prenatal care utilization. Prenatal care utilization was defined as the total number of documented prenatal visits and analyzed as a continuous variable. Secondary outcomes included gestational age at delivery, neonatal intensive care unit (NICU) admission, neonatal respiratory support, and birth weight. Multivariable logistic regression was used to evaluate the association between the number of prenatal visits and preterm birth, and linear regression was used to assess gestational age as a continuous outcome. Models adjusted for maternal age, race/ethnicity, gravidity, body mass index, tobacco use, insurance status, and pregestational comorbidities

Results: Preterm birth occurred in 13.4% (135/1,006) of pregnancies and included both spontaneous and iatrogenic deliveries. Patients with preterm birth had fewer prenatal visits compared to term deliveries (mean 7.1 vs 10.6). In adjusted analysis, each additional prenatal visit was associated with a 24% reduction in the odds of preterm birth (aOR 0.76 per visit, $p < 0.001$) and a corresponding increase in gestational age at delivery ($\beta = +0.17$ weeks per visit, $p < 0.001$), exhibiting a dose-response relationship.

As expected, preterm birth was associated with markedly increased neonatal morbidity including higher rates of NICU admission (60.7% vs 11.9%), respiratory support (44.4% vs 10.3%), and lower mean birth weight (2330 g vs 3330 g). Independent predictors of preterm birth included prior abortions (aOR 5.52, $p = 0.011$), higher number of living

children (aOR 5.03, $p = 0.009$), and other pregestational chronic medical conditions (aOR 2.71, $p = 0.011$).

Disparities were evident across patient populations. Hispanic patients represented a greater proportion of preterm births (46.7% vs 37.1%) and had lower gestational age at delivery in adjusted models ($\beta = -0.23$ weeks, $p=0.038$) despite having a similar number of prenatal visits overall compared to non-Hispanic patients (10.0 vs 10.2 visits). Patients with public insurance were also overrepresented among preterm births (47.4% vs 38.7%).

Conclusion: Lower prenatal care utilization is independently associated with increased risk of preterm birth and earlier gestational age at delivery in a dose-dependent manner. These findings support the importance of preconception counseling and prenatal care as potentially modifiable factors in preterm birth risk. Persistent disparities in perinatal outcomes highlight the need for further efforts to close these gaps. Improving equitable access to and continuity of prenatal care may represent an important target for reducing preterm birth.

Poster #17
Withdrawn

Poster #18

Identifying Attitudes and Knowledge Gaps Regarding Fertility and Oocyte Cryopreservation Among Professional Students at Ohio University

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Introduction: Delayed childbearing impacts conversations regarding infertility and oocyte cryopreservation. Understanding knowledge gaps can direct conversations about fertility and infertility treatments. Social media has also emerged in the healthcare space, and its role is often unclear. This study aims to: 1) evaluate knowledge gaps of female fertility among professional students at Ohio University and 2) identify how social media may impact their knowledge and awareness.

Methods: A cross-sectional survey of professional students attending Ohio University was conducted via electronic questionnaire in REDCap. Descriptive and categorical analyses used to compare group frequencies. This study was modeled on a prior study completed in Missouri.

Results: 105 participants (82% female) completed the survey. 90% were under 35 years of age. A majority of participants desired children in the future; most wanted to conceive with their partners. A majority of participants identified an ideal age for personal childbearing as 25-34 years of age. Finances were the most important factor influencing timing of childbearing. 100% of participants recognized that egg quality decreases with age, however only approximately half correctly identified the age of fertility decline and a similar percentage overestimated fecundability at age 30. Only 20% of participants correctly identified the general rate of infertility at 1 in 6. Nearly 80% of participants had viewed infertility discussions on social media, most presented by a nonhealthcare/unknown individual. Half of all participants reported their opinions or understanding of infertility were to some degree likely to be influenced by social media. 30% of participants selected unsure to somewhat likely to take medical advice from social media.

Conclusion: Students demonstrated several knowledge gaps related to infertility and oocyte cryopreservation. Most information consumed on social media came from

nonhealthcare/unknown individuals yet could be influential. Many students felt formal education would be helpful, leading to a potential direction for future educational efforts.

Poster #19

Feasibility of a Remote Blood Pressure Monitoring in Pregnant Women of Color at Increased Risk of Pre-eclampsia

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Rutgers Robert Wood Johnson Medical School, New Brunswick, NJ

Objective: The United States has the highest maternal mortality rate among industrialized nations, largely driven by cardiovascular conditions such as preeclampsia, which disproportionately affects women of color. Traditional screening methods for hypertension in pregnancy rely on office-based BP measurements, which can be confounded by white coat syndrome or by poor attendance to prenatal visits. Adjunctive self-measured BP monitoring has strong support, and ACOG recommends self-measured BP monitoring in pregnant women with pre-existing hypertensive disorders. The goal of this study is to assess the feasibility of twice daily blood pressure (BP) monitoring for early detection of hypertensive disorders in pregnant women of color at increased risk for pre-eclampsia.

Methods: Pregnant patients who self-identify as women of color who were below 24 weeks gestation were recruited at a prenatal visit. They were given a BP monitor free of charge and trained on how to use it. Once enrolled, they received a text message twice a day with a link to record their BP readings. Participants were asked to continue measuring and recording their BP from time of enrollment until twelve weeks after delivery. Participants were given \$50 once at the time of enrollment and again at the conclusion of their time in the study. They were also offered nutrition screening, social determinants of health screening, and student navigators for support.

Results: Twenty-two participants were initially enrolled in the study. Two were unfortunately lost to follow-up due to moving out of state. Of the twenty participants actively enrolled, ten submitted a BP reading at least once during their pregnancy. Of those ten, six participants submitted readings at least once a day for a month or more, and two of these participants did so for six months or more through delivery. The average length of participation in this study was 38 days. Of the ten who submitted readings, five submitted more than 50 readings and three submitted more than 100 readings. The average number of readings per participant was 40.5 readings.

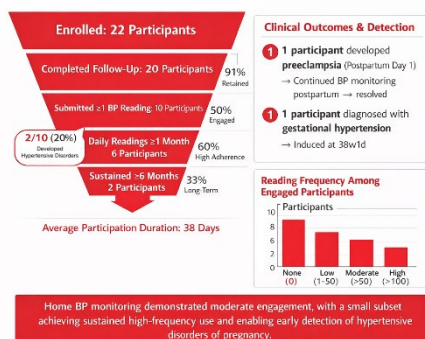
Of the ten participants who regularly took BP readings, one participant developed preeclampsia on postpartum day one. She was treated in the hospital and continued to measure her BP for several weeks after diagnosis, with subsequent resolution of her high BP. Another participant was diagnosed with gestational hypertension in her third trimester after seeing elevated readings at home as a part of this study, and she was induced at 38 weeks 1 day gestation due to gestational hypertension.

Conclusion: Twice daily home BP monitoring during pregnancy demonstrated moderate participant engagement. Importantly, it enabled the early identification of hypertensive disorders in 2 of 10 engaged participants, including one case of postpartum preeclampsia and one case of gestational hypertension that prompted timely clinical intervention. This suggests that even with variable adherence, remote BP monitoring can serve as a valuable tool for the surveillance and earlier diagnosis of hypertensive complications during pregnancy. Efforts are currently underway to understand what barriers were in place for participant engagement via post-participation surveys and outreach.

References: Available upon request.

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Poster #20

Effect of Fluid Restriction on Outcomes Following Hysterectomy

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Abstract Body: In September 2024, Hurricane Helene damaged one of the largest IV fluid manufacturing plants in the United States. This resulted in a fluid shortage that led to restriction of fluid use in many institutions. This study retrospectively analyzed outcomes of patients who underwent hysterectomy during the fluid shortage in comparison to non-fluid restricted controls. The aim of the study was to evaluate impact of fluid use on incidence of post-operative AKI, adequate urine output, vasopressor requirement, blood transfusion, and post-operative nausea/vomiting. A total of 428 patients were included in the study. Patients were divided into restricted and non-restricted groups based on total IV fluids used during surgery. Data was analyzed with use of Firth's penalized logistic regression. Ultimately, data analysis showed no statistically significant difference in rates of post-operative AKI (P=.213), adequate urine output (P=.8311), vasopressor requirement (P=.4655), blood transfusion (P=.0544), or post-operative nausea/vomiting (P=.3244) between the two groups.

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Outcome of Interest	Sublevel(s)	Restricted (n = 227)	Liberal (n = 201)	Adjusted Odds Ratio (liberal vs restricted)	Adjusted p-value (Fluid effect)
AKI	0	225 (99.1%)	196 (98%)	2.7847	0.213
	1	2 (0.9%)	4 (2%)	.	
UOP adequate?	0	52 (23.7%)	43 (22.2%)	1.0516	0.8311
	1	167 (76.3%)	151 (77.8%)	.	
Vasopressors	0	91 (40.1%)	75 (37.5%)	1.1568	0.4655
	1	136 (59.9%)	125 (62.5%)	.	
Transfusion any	0	223 (98.7%)	191 (96%)	3.3744	0.0544
	1	3 (1.3%)	8 (4%)	.	
N/V	0	210 (92.5%)	179 (89.5%)	1.3936	0.3244
	1	17 (7.5%)	21 (10.5%)	.	
Hicus/SBO	0	227 (100%)	193 (96.5%)	15.9922	0.0014
	1	0 (0%)	7 (3.5%)	.	

Outcomes were binary and modeled using Firth's penalized logistic regression. All regression models included group (restricted as reference level) as the primary predictor and were adjusted for CHF as a covariate, due to a statistically significant difference in CHF between the restricted and liberal groups. Counts and percentages of observed values are reported by group, along with adjusted odds ratios and p values for the group effect. All analyses were completed in R 4.5.2 (R Foundation for Statistical Computing; Vienna, Austria).

Poster #21

Mobile-Integrated Health for Postpartum Hypertension: A Pilot Study in an At-Risk Population

Symone McClain, MD¹, Yanil Ramirez, MD¹, Nia Byrd, MD¹, Kali Marie Sandord, DO², Jamie Joseph, PhD¹, Mary Condon, MSN, CNM¹, Gregory L Goyert, MD¹, D'Angela Pitts, MD¹

Henry Ford Health, MI¹, Trinity Health, Grand Rapids, MI²

Objective: Hypertension (HTN) in pregnancy is a significant contributor to maternal morbidity and mortality, especially amongst Black patients, which continues into the postpartum period. ACOG guidelines recommend continued surveillance of HTN in the postpartum period including a blood pressure check in 7-10 days for women with a hypertensive disorder and in 72 hours for women with severe preeclampsia. Adherence to these guidelines can be difficult given barriers to care and competing priorities after delivery. This study aimed to evaluate the implementation of a mobile blood pressure monitoring program and its impact on adequate postpartum management of HTN.

Methods: A retrospective chart review of patients who met criteria to participate in the mobile-integrated health (MIH) postpartum HTN program was done from January 2023-January 2024. Criteria to participate in this program included a documented barrier to transportation, limited prenatal care, and a patient reported inability to follow up in person. The primary objective was to assess if participation in the MIH program improved blood pressure follow up for patients with diagnosed hypertensive disorders. The secondary outcome analyzed includes attendance at a postpartum visit within 6 weeks. Demographic variables include race and age.

Results : A total of 79 patients were included in this analysis, 46 of whom utilized MIH services after referral (58.2%). 33 patients were seen within ACOG timelines (41.8%), while 28 patients were not. (35.4%) .Multivariate logistic regressions did not show that utilization of MIH impacted mothers following up within ACOG timelines for blood pressure checks or attending their postpartum visit ($p = 0.54$ and 0.81 respectively). However, the number of prenatal visits attended by patients was shown to be significantly associated with higher odds of patients attending their postpartum visit (aOR: 1.043, $p = 0.0045$). There were no significant association between race and MIH postpartum blood pressure follow up according to ACOG guidelines ($p = 0.6889$).

Conclusion: Despite the lack of significant association, there was a 58.2%% utilization rate of MIH services. Given the small sample size of this study, future longitudinal studies with more robust sample sizes should be performed to further evaluate implementation of a mobile blood pressure monitoring resource and patient adherence.

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Table 1. The association between participation in MIH and blood pressure follow-up within ACOG guidelines

Variables	Odds Ratio	95% CI	p-value
Seen by MIH	1.104	(0.803, 1.518)	0.5436
Maternal Age	0.997	(0.978, 1.015)	0.7167
Race			0.9155
Caucasian	1.019	(0.64, 1.624)	0.9368
Other	1.076	(0.754, 1.536)	0.6889

Poster #22

Timing Matters: Comparing Doula Care Starting Prenatally vs During Labor Among Publicly Insured Patients

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Henry Ford Health, Detroit, MI¹, WSUSOM, Detroit, MI², Endeavor Health, Chicago, IL³

Objective: Doula care is linked to improved perinatal outcomes, but the optimal timing of doula engagement remains unclear. We compared clinical and social characteristics among publicly insured individuals who engaged in doula care prenatally versus during labor and delivery (L&D).

Methods: We conducted a retrospective cohort study of patients who delivered at a Detroit health system between March 2023 and July 2024. Patients were eligible for free doula services if publicly insured and met ≥ 1 social determinant of health (SDoH) criterion. Referrals occurred prenatally or on L&D. Prenatal doula care included labor preparation, SDoh resource navigation, and labor support; L&D doula care involved only intrapartum support. We compared demographic and clinical data across those who declined doula care, initiated care prenatally, or engaged doulas at delivery.

Results: Among 123 eligible patients, 63 declined doula care, 34 initiated care prenatally, and 26 initiated at delivery. Those receiving prenatal doula care were more likely to identify as Black (97%) and report housing (58%) and transportation insecurity (55%) compared to those with L&D-only care. Breastfeeding rates were higher in the prenatal group (77% vs. 65%), and NICU admission was slightly more frequent (29% vs. 23%), though differences were not significant. Housing insecurity approached significance ($p=0.07$).

Conclusion: In an under-resourced, publicly insured population, patients who initiated doula care in the prenatal period had greater social risk and higher breastfeeding rates than those engaging doulas at delivery. While differences were not statistically significant, the observed trends may reflect clinically relevant variation. These findings underscore the value of early doula referrals. Larger studies are needed to determine optimal timing and clinical impact of doula engagement.

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Table 1. Doula Timing Patient Characteristics

	Eligible, no doula (n=63) n(%) / mean (sd)	Eligible, initiated PN (n=34) n(%) / mean (sd)	Eligible, initiated L&D (n=26) n(%) / mean (sd)	p-value
Demographics				
Age	27.8 (6.0)	27.6 (6.6)	28.4 (6.1)	0.90
race/ethnicity				0.21
Black	52 (83%)	33 (97%)	21 (81%)	
Hispanic	3 (4.8%)	0 (0%)	1 (3.8%)	
White	4 (6.3%)	0 (0%)	0 (0%)	
Others	4 (6.3%)	1 (2.9%)	4 (15%)	
Insecurities				
food insecurity	14 (22%)	7 (23%)	2 (8.7%)	0.28
housing insecurity	20 (33%)	18 (58%)	9 (41%)	0.07
transportation insecurity	22 (36%)	17 (55%)	12 (55%)	0.14
Pregnancy risk factors				
Depressive symptoms (EPDS)	6.6 (6.7)	7.3 (6.9)	4.6 (5.7)	0.55
Chronic hypertension	9 (14%)	5 (15%)	5 (19%)	0.80
Pre-pregnancy Diabetes	2 (6.1%)	1 (7.7%)	0 (0%)	1.00
Pre-pregnancy BMI	30 (8)	31 (8)	33 (10)	1.00
Birth outcomes				
Cesarean delivery	14 (25%)	11 (34%)	7 (27%)	0.80
NICU admission	7 (13%)	9 (29%)	6 (23%)	0.15
Breastfeeding	37 (66%)	24 (77%)	17 (65%)	0.49
Quantitative Blood loss (mL)	448 (392)	672 (842)	476 (453)	0.21
Birthweight grams	3,042 (624)	3,061 (787)	2,791 (604)	0.23
Gestational age at delivery(weeks)	38.13 (2.64)	37.97 (2.38)	37.56 (2.35)	0.64

Poster #23

Improving Resident Satisfaction and Efficiency in the Labor and Delivery Unit

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Background: Efforts to improve resident wellness have increased in recent years, yet research in this area remains limited. Medical documentation in Electronic Health Records (EHR) remains one of the main reasons for burnout. There are no studies exploring voice activated dictation services in the obstetrics setting outside of dictation of operative notes.

Objective: To determine which method of documentation (dictation vs typing) residents are most satisfied with and to determine if dictation software changes residents' satisfaction with documentation in EHR.

Methods: A mixed methods study was conducted at a single-site, academic institution. A single class of OBGYN residents participated. Quantitative measures were collected through a validated survey on satisfaction with EHR pre- and post-intervention. In addition, semi-structured interviews were conducted with residents to add qualitative measures.

Results: The dataset included pre- and post-intervention surveys of a class (n=7) of residents. Survey response rates were 100% for pre- and post-intervention. There were no statistically significant changes after addition of dictation software except for one response "The amount of time to document using EMR is acceptable" where residents were more likely to agree after having access to dictation software (p=0.01). Six themes were identified from the semi-structured interview transcripts of 3 residents (43%) including: efficiency improvements, quality of documentation, comparison with traditional typing, future considerations, use in other contexts, and challenges/limitations.

Conclusions: Residents favored use of dictation services to increase efficiency in documentation in the OB Emergency Care Center. While dictation was favorable compared to typing, overall satisfaction with EHR was unchanged.

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Question	Response	Pre- Dictation	Post- Dictation	Weighted Score Pre- Dictation	Weighted Score Post- Dictation	Total Weighted Score Pre- Dictation	Total Weighted Score Post- Dictation	pp
1	strongly agree	1	2	2	4	8	8	0.71768564
easy to use	agree	6	5	6	5			
	disagree	0	0	0	0			
	strongly disagree	0	0	0	0			
2	strongly agree	1	1	2	2	4	4	1
quick to use	agree	4	4	4	4			
	disagree	2	2	-2	-2			
	strongly disagree	0	0	0	0			
3	strongly agree	1	1	2	2	3	6	0.215188943
easy to write	agree	4	5	4	5			
	disagree	1	1	-1	-1			
	strongly disagree	1	0	-2	0			
4	strongly agree	2	0	4	0	5	5	1
easy to read	agree	3	9	3	9			
	disagree	2	1	-2	-1			
	strongly disagree	0	0	0	0			
5	strongly agree	0	1	0	2	-7	-1	0.013846833
time doc	agree	1	2	1	2			
	disagree	4	3	-4	-3			
	strongly disagree	2	1	-4	-2			
6	strongly agree	0	0	0	0	0	4	0.181690114
time read	agree	4	6	4	6			
	disagree	2	0	-2	0			
	strongly disagree	1	1	-2	-2			

Question	Response	Pre- Dictation	Post- Dictation	Weighted Score Pre- Dictation	Weighted Score Post- Dictation	Total Weighted Score Pre- Dictation	Total Weighted Score Post- Dictation	pp
7	strongly agree	1	0	2	0	5	5	1
clear	agree	5	0	5	0			
	disagree	0	1	0	-1			
	strongly disagree	1	0	-2	0			
8	strongly agree	1	1	2	2	8	6	0.181690114
img	agree	6	5	6	5			
	disagree	0	1	0	-1			
	strongly disagree	0	0	0	0			
9	strongly agree	3	5	6	10	10	10	1
save time	agree	4	2	4	2			
	disagree	0	0	0	0			
	strongly disagree	0	1	0	-2			
10	strongly agree	3	4	6	8	10	11	0.717685644
shared ppt	agree	4	3	4	3			
	disagree	0	0	0	0			
	strongly disagree	0	0	0	0			
11	strongly agree	2	1	4	2	7	6	0.717685644
shared form	agree	4	5	4	5			
	disagree	1	1	-1	-1			
	strongly disagree	0	0	0	0			
12	strongly agree	1	2	2	4	8	5	0.547222502
ppt care	agree	6	3	6	3			
	disagree	0	2	0	-2			
	strongly disagree	0	0	0	0			
13	strongly agree	1	0	2	0	6	3	0.215188943
form care	agree	5	5	5	5			
	disagree	1	2	-1	-2			
	strongly disagree	0	0	0	0			

Question	Response	Pre-Dictation	Post-Dictation	Weighted Score Pre-Dictation	Weighted Score Post-Dictation	Total Weighted Score Pre-Dictation	Total Weighted Score Post-Dictation	p*
14	strongly agree	3	4	6	8	10	11	0.717685644
	agree	4	3	4	3			
	disagree	0	0	0	0			
	strongly disagree	0	0	0	0			
15	strongly agree	4	3	8	6	9	10	0.788779982
	agree	2	4	2	4			
	disagree	1	0	-1	0			
	strongly disagree	0	0	0	0			
16	strongly agree	4	5	8	10	11	12	0.717685644
	agree	3	2	3	2			
	disagree	0	0	0	0			
	strongly disagree	0	0	0	0			
17	strongly agree	3	4	6	8	10	11	0.717685644
	agree	4	3	4	3			
	disagree	0	0	0	0			
	strongly disagree	0	0	0	0			
18	strongly agree	3	5	6	10	10	12	0.717685644
	agree	4	2	4	2			
	disagree	0	0	0	0			
	strongly disagree	0	0	0	0			
19	strongly agree	3	2	6	4	8	5	0.215189943
	agree	3	3	3	3			
	disagree	1	2	-1	-2			
	strongly disagree	0	0	0	0			
20	strongly agree	1	0	2	0	3	1	0.637618091
	agree	4	4	4	4			
	disagree	1	3	-1	-3			
	strongly disagree	1	0	-2	0			

21	strongly agree	1	0	2	0	0	5	0.3415176
	accurate agree	3	6	3	6			
	disagree	3	1	-3	-1			
	strongly disagree	1	0	-2	0			
22	strongly agree	0	1	0	2	-4	-6	0.905186273
	conclude agree	3	0	3	0			
	disagree	1	5	-1	-5			
	strongly disagree	3	1	-6	-2			
23	strongly agree	1	2	2	4	4	5	0.717685644
	security agree	4	3	4	3			
	disagree	2	2	-2	-2			
	strongly disagree	0	0	0	0			
24	strongly agree	1	2	2	4	4	5	0.717685644
	confident agree	4	3	4	3			
	disagree	2	2	-2	-2			
	strongly disagree	0	0	0	0			

Poster #24

Incidental Finding of Malignant Peritoneal Mesothelioma During a Routine Gynecologic Procedure

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Case Report: Malignant peritoneal mesothelioma (MPM) is a rare, aggressive malignancy arising from mesothelial cells lining the peritoneal cavity. It is frequently diagnosed at an advanced stage because of its nonspecific clinical presentation. In the United States, MPM accounts for approximately 10.5% of all mesothelioma cases, making the peritoneum the second most common site after the pleura, with an average of 322 cases reported annually.

Asbestos exposure is the most well-established risk factor for MPM, although the association is less pronounced than in pleural mesothelioma, particularly among females. Additional risk factors include prior radiation therapy, exposure to other mineral fibers, simian virus 40 infection, chronic peritonitis, and germline mutations in the BRCA-associated protein 1 (BAP1) gene.

Mesothelioma incidence increases with age, with a median age at diagnosis of 76 years in males and 72 years in females across all anatomical sites. For MPM specifically, 80.2% of cases occur in individuals aged 50 years or older, 55.4% occur in males, and 75.2% of affected individuals identify as white.

We report an asymptomatic Caucasian woman in her mid-to-late 30s who was incidentally diagnosed with MPM during elective laparoscopic salpingectomy for permanent contraception. Intraoperative findings of abnormal peritoneal lesions prompted biopsy, and immunohistochemical analysis confirmed epithelioid MPM, with tumor cells positive for calretinin, D2-40, CK7, and WT1. Expression of BAP1 and MTAP was retained, reducing the likelihood of a germline mutation.

Environmental history revealed probable asbestos exposure during adolescence. Laboratory studies were largely unremarkable except for an elevated CA-125 level of 83.2 U/mL on postoperative day 18. She was urgently referred to surgical oncology and evaluated on postoperative day 42, when CA-125 had increased to 226 U/mL. CA 19-9 and carcinoembryonic antigen were within normal limits at 21 U/mL and 2.1 ng/mL, respectively. Imaging demonstrated cystic changes within both ovaries but no evidence of metastatic disease.

Approximately 2 months after the salpingectomy, she underwent cytoreductive surgery including omentectomy, bilateral oophorectomy, appendectomy, and pelvic and right diaphragmatic peritonectomies, followed by hyperthermic intraperitoneal chemotherapy with carboplatin. Pathologic evaluation revealed well-differentiated mesothelioma involving the uterus, falciform ligament, left ovary, right mesorectal peritoneum, and right diaphragm. Both ovaries contained benign cystic follicles, and focal endometriosis was identified in the right mesorectal peritoneum. Pathologic examination of the appendix also revealed an incidental well-differentiated neuroendocrine tumor measuring 2.5 mm at the distal tip with extension into the muscularis propria.

This case highlights a rare malignancy associated with environmental asbestos exposure in a woman in her 30s and underscores the persistent public health risk posed by legacy asbestos-containing materials in structures that remain in use. It also emphasizes the importance of careful intraoperative inspection even in younger patients and in procedures where pathology is not initially suspected.

Poster #25

Disseminated Herpes Simplex Virus (HSV) Infection in Pregnancy Presenting with Hypothermia: A Case Series

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Objective: To describe the clinical presentation, diagnostic challenges, and outcomes of disseminated herpes simplex virus (HSV) infection in pregnancy, with a focus on intermittent hypothermia as a potential early marker of severe systemic disease.

Methods: We present a case series of three pregnant patients diagnosed with disseminated HSV-2 infection during the late second and third trimesters. Clinical presentation, laboratory findings, diagnostic workup, management, and maternal–fetal outcomes were reviewed.

Results: All three patients presented with non-specific symptoms, including fever, malaise, and transaminitis, and underwent extensive evaluation with initial empiric broad-spectrum antibiotics. Notably, each patient developed intermittent hypothermia (lowest recorded temperatures 91.5–93.6°F) during hospitalization, often following febrile episodes. Diagnosis of disseminated HSV-2 infection was delayed in all cases and ultimately confirmed by polymerase chain reaction (PCR) testing from serum, cervical lesions, or amniotic fluid. One patient developed HSV hepatitis with acute liver failure requiring intensive care and transfer to a transplant center. Another case involved vertical transmission with confirmed intra-amniotic infection, resulting in pregnancy termination. The third patient was diagnosed postpartum after neonatal symptoms prompted maternal testing. Initiation of intravenous acyclovir led to rapid clinical improvement in all cases, with full maternal recovery. Neonatal and fetal outcomes varied, including NICU admission and intrauterine fetal demise following transplacental infection.

Conclusion: Disseminated HSV in pregnancy is a rare but life-threatening condition that often presents with non-specific symptoms, leading to delayed diagnosis. Intermittent hypothermia may represent an underrecognized clinical marker of severe systemic viral infection in this population. Recognition of this pattern, particularly in the setting of fever and transaminitis, should prompt early consideration of HSV

and initiation of empiric antiviral therapy. Increased awareness may reduce diagnostic delays and improve maternal and neonatal outcomes.

Poster #26

Navigating Obstetrical Trauma in the Setting of Uterine Rupture and Spinal Fracture: A Case Report

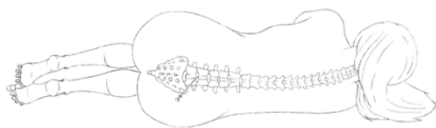
Lilly P Deljoo, BS, Emily Major, MD, Stewart Carter, MD, Justin M Jatczak, MD

University of Louisville, Louisville, KY

Case Report: Intrapartum trauma with spinal instability may require delivery by Cesarean Section (CS). While regional anesthesia is typically preferred in CS, general anesthesia may be necessary in emergent presentations which require rapid induction of anesthesia. We report a case wherein a patient presented with uterine rupture and spinal instability following a motor vehicle accident and received regional anesthesia prior to CS. A 27-year-old multiparous female at 37 + 6 weeks of gestation presented to the Emergency Department after a high-speed motor vehicle accident with significant abdominal pain and contractions, and a positive seatbelt sign was noted on examination. CT imaging revealed multiple spinal fractures and an apical pneumothorax. A spinal block was placed with the patient in the lateral decubitus position, after which she was logrolled to the dorsal position for surgery. A cesarean section was then performed, resulting in the delivery of a viable female infant. The adapted logrolling technique provided effective surgical anesthesia without contributing to further spinal injury or resulting in additional maternal complications. The patient was discharged without postpartum complications. Informed consent for publication was obtained from the patient. This case emphasizes the need for comprehensive clinical assessment when administering anesthesia in obstetrical trauma with spinal instability. Obstetricians and Gynecologists are uniquely positioned within the multidisciplinary team to advocate for optimal maternal and fetal outcomes.

Table or Graph:

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Poster #27

Prolonged Expectant Management of Severe Mitral Stenosis and Pulmonary Hypertension in Pregnancy: A Multidisciplinary Case Report

Alexander M Harrison Sr, MD, James Damron, MD, Ashley S Boerrigter, MD

University of Kentucky, Lexington, KY

Background: Severe mitral stenosis with pulmonary hypertension in pregnancy is associated with substantial maternal morbidity and is classified as a high-risk cardiac condition by major societies. Worsening symptoms have historically prompted early delivery due to concern for hemodynamic decompensation; however, data guiding optimal timing in clinically stabilized patients remain limited.

Case: A 34-year-old G4P2012 presented at 24 5/7 weeks' gestation with dyspnea and cough. Evaluation demonstrated severe mitral stenosis (mean gradient 21 mmHg) and pulmonary hypertension, including a dilated pulmonary trunk on CT (3.5 cm), attributed to prior rheumatic fever. Risk stratification included mWHO IV and CARPREG II score of 4. She improved with diuresis and was discharged on metoprolol and furosemide with close follow-up.

At 29 4/7 weeks, she re-presented with worsening dyspnea and hemoptysis, again stabilizing with aggressive diuresis. Given sustained hemodynamic stability, unchanged echocardiographic findings (mean gradient 18 mmHg), and patient preference to continue the pregnancy, a multidisciplinary team elected inpatient expectant management. Delivery timing was selected to balance maternal risk with fetal maturity.

She underwent scheduled primary Cesarean delivery at 34 1/7 weeks under low-dose combined spinal-epidural anesthesia to optimize hemodynamic control. Maternal and neonatal outcomes were favorable, and recovery was uncomplicated.

Discussion: Severe mitral stenosis with pulmonary hypertension confers high risk for maternal decompensation, particularly with the increased heart rate and volume shifts of pregnancy. While early delivery is often recommended with worsening symptoms, emerging experience suggests outcomes are driven more by clinical stability than gestational age alone, supporting individualized management in specialized centers. This case highlights that carefully selected patients who achieve sustained hemodynamic stability may tolerate continued pregnancy under close

multidisciplinary surveillance including maternal fetal medicine, obstetric anesthesia, neonatology, and cardiac anesthesia.

Conclusion: In clinically stable patients with severe mitral stenosis and pulmonary hypertension, expectant management to 34 weeks may be feasible with intensive multidisciplinary care, allowing for improved fetal maturity without compromising maternal safety.

References: Available upon request.

Poster #28

Neuraxial Anesthesia in a Pregnant Patient with Type III von Willebrand Disease: A Multidisciplinary Case Report

Alexander M Harrison Sr, MD, James Damron, MD, Ashley S Boerrigter, MD

University of Kentucky, Lexington, KY

Background: Type III von Willebrand disease (VWD) is a rare, severe bleeding disorder characterized by near-absence of von Willebrand factor and low factor VIII levels, conferring high risk of hemorrhage in pregnancy. Neuraxial anesthesia is considered high-risk due to concern for spinal or epidural hematoma, and data guiding its use are limited.

Case: A 20-year-old G1P0 with type III VWD presented for prenatal care at 7 2/7 weeks. She received twice-weekly von Willebrand factor replacement (Wilate) under hematology guidance. Her multidisciplinary care team included Maternal-Fetal Medicine, and Obstetric Anesthesia, and Hematology.

Following shared decision-making, a primary cesarean delivery at 37 5/7 weeks was planned under spinal anesthesia after factor optimization to minimize risks of prematurity, and reduce risk of spontaneous labor. She received Humate-P 50 VWF:RCo units/kg preoperatively with confirmation of normalized von Willebrand factor and factor VIII levels. A single-shot spinal anesthetic was placed without complication.

Delivery was overall uncomplicated. Uterotonics (oxytocin, methergine, misoprostol) and topical hemostatic agents were used due to uterine atony and increased bleeding at the hysterotomy. A repeat Humate-P dose (25 units/kg) was administered postoperatively, and postpartum care included hematology co-management with serial laboratory monitoring.

At four weeks postpartum, the patient presented with vaginal bleeding and was found to have a fluid collection consistent with uterine dehiscence. This was managed conservatively with transfusion of 1 unit packed red blood cells, and factor replacement. She recovered without further complications.

Discussion: Type III VWD carries significant risk of obstetric and anesthetic bleeding complications. While neuraxial anesthesia poses theoretical risk of epidural hematoma, existing literature emphasizes risk mitigation through factor correction, laboratory confirmation, and multidisciplinary coordination rather than absolute avoidance. This case demonstrates successful spinal anesthesia following normalization of hemostatic parameters.

Conclusion: Neuraxial anesthesia may be feasible in carefully selected patients with type III VWD after aggressive factor replacement and multidisciplinary planning, supporting individualized management in high-risk obstetric patients.

References: Available upon request.

Poster #29

Gravid Intrauterine Pregnancy with Complete Ventral Wall Hernia Emplacement

Madeline E Comeau, BS¹, Thomas F Arnold, MD², Rachel Peterson, MD³

University of North Dakota School of Medicine and Health Sciences, Southeast Campus, Fargo, ND¹, University of North Dakota School of Medicine and Health Sciences, Southwest Campus, Bismarck, ND²

Objective: To (1) report a case of gravid intrauterine pregnancy within a ventral wall hernia with a cesarean delivery and concomitant ventral wall defect repair (2) to discuss the risk factors of having a viable pregnancy within a ventral wall hernia and its management and (3) to review the current guidelines on management of gravid uterine herniation into ventral wall hernia.

Methods: Case report.

Results: We present a 34-year-old G94334 female that presented to clinic at 33w3d for pain and premature contractions. Throughout the third trimester of this pregnancy, the patient was experiencing pain and cramping and described feeling like her “baby was going to fall out.” Due to diffuse abdominal pain, premature contractions, and concern for uterine rupture given the history of repeat cesarean deliveries, prompt cesarean delivery was recommended. Past medical history was significant for breast cancer, obesity, polycystic ovary syndrome (PCOS), prior cesarean section (x5), preterm delivery, and a large ventral wall hernia.

The patient was admitted to labor and delivery, and shortly after, experienced spontaneous rupture of membranes. A cesarean delivery was indicated due to the history of multiple prior cesarean sections and a known incisional hernia. Cesarean delivery was completed and once finished, ventral wall fascial defect was repaired by general surgery. The procedure was uncomplicated and both obstetric and neonatal patients were healthy. Postoperative course was complicated by wound infection two weeks later.

Conclusion: Gravid uterine herniation through a ventral wall fascial defect is a rare complication of pregnancy. This case illustrates a successful concomitant cesarean delivery and ventral wall defect repair with minimal postoperative complications. Early identification of hernia in pregnancy as well as managing comorbid conditions in this case prompted favorable outcomes. Thorough patient education regarding the

possibility of future gestations is warranted in such cases weighing risks of uterine rupture, method of hernia repair, and rate of recurrence of hernia.

Literature review shows few cases of intrauterine pregnancies within incisional and umbilical hernias, but such cases have not been managed by cesarean delivery. Guidelines for managing hernias during pregnancy exist, but do not account for gravid herniation into the ventral wall defect as described in this case. Clinical guidelines for managing similar cases are not yet available and support the need for further case collection and research to be continued.

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Poster #30

Fertility-Sparing Management of Ectopic Pregnancy in Resource-Limited Rural Areas: A Case Report

Reese H Siegle, BS¹, Christian H Siegle, BS², John C Siegle, MD³, Dennis J Lutz, MD¹

University of North Dakota School of Medicine and Health Sciences, Northwest Campus, Minot, ND¹, Oklahoma State University College of Osteopathic Medicine, Tulsa, OK², University of Oklahoma College of Medicine, Oklahoma City, OK³

Introduction: Gynecologic surgeons began aggressively addressing tubal factors as a significant etiology for infertility in the 1970s. Approaches to managing ectopic pregnancy began changing in the early 1980s, with 95% of ectopic pregnancies being identified as located within the fallopian tube. Initially, tubal surgery carried a 30% (i.e., linear salpingotomy and salpingostomy) success rate of achieving future pregnancy and a 25% risk of future ectopic pregnancy. In the mid-late 1980s, in vitro fertilization (IVF) became more popular treatment for patients with tubal factor infertility. Conservative management has become less common, with most clinicians preferring definitive management with salpingectomy, given the development assistive reproductive technology.

Presentation: This patient is a 32-year-old female (G7 P2,0,4,2) with an extensive history of PID and recurrent ectopic pregnancies. She first presented at age 15 with chlamydial PID, undergoing laparoscopy, which revealed bilateral tubal clubbing and Fitz-Hugh-Curtis lesions. At age 25, she underwent a laparoscopy and left salpingectomy for PID and a hydrosalpinx, respectively. She had 3 ectopic pregnancies, undergoing two salpingotomies and one course of methotrexate for each, respectively. She had another ectopic pregnancy, which was treated with methotrexate.

Intervention: This case highlights various approaches to managing ectopic pregnancy under challenging circumstances. This patient was not willing to undergo medical therapy for her first two ectopic pregnancies. Additionally, she declined definitive surgical therapy due to financial concerns regarding IVF. These factors resulted in her undergoing two salpingotomies for the management of her ectopic pregnancies.

Comparison: We compared the standard of care for recurrent ectopic pregnancy to tubal sparing surgery. With barriers to

IVF, women of low socioeconomic status (SES) or rural backgrounds may decline definitive treatment. With strides in the development of IVF, tubal-sparing approaches have become less common; however, not all patients will have this privilege.

Outcome: In this case, the conservative management of four ectopic pregnancies in a patient with one fallopian tube resulted in spared fertility. After her first laparoscopy for PID, this patient went on to have a successful intrauterine pregnancy (IUP) and vaginal delivery. This patient went on to have another IUP through the remaining tube after two linear salpingotomies and methotrexate therapy for three ectopic pregnancies. Additionally, after the delivery of this child, she would achieve another successful IUP after methotrexate therapy for a fourth ectopic pregnancy.

Conclusions: This case highlights the utility of early recognition, aggressive medical management, and conservative tubal surgery in resource-strained rural settings with limited access to IVF. Although salpingectomy has rapidly become the treatment of choice for ectopic pregnancy, maintaining competency in tubal-sparing surgery techniques remains important for preserving patient autonomy and reproductive options for those facing financial or geographic barriers to assisted reproductive technology.

Poster #31

Ectopic Abdominal Hidradenitis Suppurativa During Pregnancy Managed with Combined Panniculectomy and Cesarean Delivery

Christian H Siegle, BS¹, Reese H Siegle, BS², John C Siegle, MD³, John Wesly Mooring, MD, Thomas F Arnold, MD⁵, Dennis J Lutz, MD⁶, Merideth Hemphill, BS¹

Oklahoma State University College of Osteopathic Medicine, Tulsa, OK¹, University of North Dakota School of Medicine & Health Sciences, Northwest Campus, Minot, ND², University of Oklahoma College of Medicine, Oklahoma State University College of Osteopathic Medicine, Oklahoma City, Tulsa, OK³, Southern Oklahoma Pathology Associates, Ada, OK⁴, University of North Dakota School of Medicine & Health Sciences, Southwest Campus, Dickinson, ND⁵, University of North Dakota School of Medicine & Health Sciences, Northwest Campus, Minot, ND⁶

Background: Hidradenitis suppurativa (HS) is a chronic inflammatory dermatologic condition characterized by recurrent nodules, abscesses, and sinus tract formation involving apocrine gland-bearing skin, most commonly affecting intertriginous regions. HS disproportionately affects women of reproductive age, and pregnancy may worsen disease activity because of hormonal and mechanical factors. Ectopic HS involving atypical sites outside classic intertriginous regions is rare and may complicate diagnosis and management during pregnancy.

Case: A 30-year-old G1P0 woman with obesity (body mass index 37.1 kg/m²) and a history of HS presented during pregnancy with a progressively enlarging abdominal wall lesion involving the left lower quadrant and extending across the midline. The lesion measured 10.5 × 6 × 5 cm on pathological examination. During the third trimester, the lesion became increasingly inflamed with purulent drainage and surrounding induration, initially raising concern for superficial soft tissue infection or abscess. Wound cultures yielded methicillin-resistant *Staphylococcus aureus* (MRSA), and oral vancomycin therapy was initiated at 36 weeks' gestation; however, minimal improvement was observed, increasing suspicion for an underlying inflammatory process rather than isolated infection.

Persistent breech presentation further complicated management. External cephalic version was discussed but declined, and the patient elected planned cesarean delivery at 39 weeks' gestation. Because of lesion size and location, multidisciplinary surgical planning was undertaken to

determine the safest operative approach while simultaneously addressing the symptomatic lesion and desired cosmetic outcome. Surgical options included a right paramedian vertical incision to avoid the lesion or a low transverse Pfannenstiel incision combined with panniculectomy and lesion excision. Following shared decision-making, the patient elected combined panniculectomy and Pfannenstiel incision to optimize exposure, reduce future disease burden, and improve cosmetic outcome.

Preoperative intravenous vancomycin was administered. A transverse panniculectomy with excision of the abdominal wall mass down to the rectus fascia was performed, followed by cesarean delivery through a low transverse uterine incision with uncomplicated breech extraction of a healthy neonate. Histopathologic examination demonstrated follicular occlusion, sinus tract formation, chronic inflammation, and fibrosis consistent with HS. Postoperative recovery was uncomplicated without wound infection, dehiscence, or recurrence at 6-week and 3-month follow-up. Maternal and neonatal outcomes remained favorable.

Conclusion: This case highlights a rare ectopic abdominal presentation of HS during pregnancy initially mimicking refractory soft tissue infection. It additionally demonstrates the feasibility of combined panniculectomy and cesarean delivery as a surgical management strategy in carefully selected patients. Early recognition, multidisciplinary planning, and shared decision-making are essential to optimizing maternal and neonatal outcomes in atypical presentations of HS during pregnancy.

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Poster #32

An Uncommon Cause of Fetal Hydrops

Ashley O Ikwuezunma, MD, Lisa E Moore, MD

Texas Tech Permian Basin, Odessa, TX

Case Report: Fetal hydrops is an in-utero condition that is characterized by an abnormal accumulation of fluid within the fetus. The diagnosis requires fluid collection within two separate locations such as pericardial effusion, pleural effusion, ascites, generalized edema or skin edema, polyhydramnios, etc. Early recognition is crucial due to the significant perinatal morbidity and mortality. While fetal hydrops is easily recognized by ultrasound, the etiologies are broad and require a complete and systemic diagnostic approach.

This case discusses a 27 year old G5P3013 who presented with fetal hydrops at 31 weeks gestation. Her prenatal care before this point was routine including normal genetic screening. Initial workup included ruling out common causes such as alloimmunization, fetal anemia, infection including TORCH/Parvo titers, and cardiovascular causes. This patient had a thorough workup that included genetic and antibody screening which resulted as normal findings. The peak systolic velocity from the MCA was 39cm/s at 0.92MOM indicating no evidence of fetal anemia. Certain infections are known to be associated with fetal hydrops specifically, parvovirus and other TORCH infections. All titers were negative. Fetal echocardiography showed a structurally normal heart, borderline enlarged right heart, and no pericardial effusion essentially ruling out a cardiac abnormality as the cause.

The cause of the fetal hydrops remained unknown, however the distribution of fluid peaked clinical interest. While the fluid accumulation was noted within multiple locations, there was a significant amount within the pleura compared to the other fluid sites. A fetal shunt was placed in the pleural cavity to allow the lungs to develop and though the fluid was extracted, reaccumulation occurred within a week. However, it is important to note the shunt was displaced and unclear when it was displaced during this week. The increasing pleural effusion and the flattened diaphragm lead to suspicion of a thoracic abnormality as the origin of cause. Thoracic abnormalities are a less common cause of fetal hydrops. The Increased intrathoracic pressure can contribute to hydrops due to obstruction of venous return. Specific thoracic causes are commonly due to structural abnormalities, however there were no obvious anatomical abnormalities or lesions noted on the ultrasound. Currently, the suspected diagnosis is a form of

thoracic compression. This leads us to question if the actual distribution of fluid should be considered in the diagnostic approach.

This case highlights the complexity of fetal hydrops and the importance of a comprehensive workup. Some causes of fetal hydrops are reversible and with appropriate management can significantly improve neonatal outcomes. However, in certain situations the exact cause may not be discovered until after delivery. However, MFM management allows for optimized delivery preparation including discussions with the mother, appropriate immediate neonatal testing, and necessary in-utero fetal intervention options.

Poster #33

Application of Direct and Indirect Nondisclosure PGT-M in Families at Risk for BRCA1

Brandon B Wagner, BS¹, Agnes Machaj, MS, LCGC², Savanie Maithripala, MS, LCGC,³ Svetlana Rechitsky, PhD³, Andrew F Wagner, MD³

Midwestern University Chicago College of Osteopathic Medicine, Downers Grove, IL¹, Reproductive Genetic Innovations, Northbrook, IL², Northwestern University Feinberg School of Medicine, Chicago, IL³

Introduction: Preimplantation Genetic Testing for monogenic conditions (PGT-M) is an assisted reproductive technology clinical option that allows couples or individuals who are carriers of genetic conditions to avoid producing offspring who would inherit those conditions. This is performed by sampling cells from the trophectoderm of embryos and amplifying their DNA to determine the presence or absence of pathogenic variant(s) (PV). Nondisclosure PGT-M is a further option for those who are at-risk for a genetic condition and do not wish to know their carrier status, but do not want to pass on the condition. With additional genetic information from an affected family member, their embryos are tested and either recommended for transfer or not, without disclosing carrier status. To ensure nondisclosure, the patient “receive[s] no information about the number of oocytes obtained, nor the number of embryos formed, nor the number of embryos available for transfer.” Originally, nondisclosure testing was created for couples at risk for Huntington Disease (HD). It is now no longer restricted to HD and is used in other adult-onset inherited conditions such as HBOC, early-onset Alzheimer’s Disease, and amyotrophic lateral sclerosis.

Case I: We present two cases of nondisclosure PGT-M for BRCA1 PVs. Family 1 has a history of the c.68_69del PV in the male partner’s deceased mother. They wished to have a non-affected child, but did not want to know his carrier status. They used a direct nondisclosure method that explicitly tested the couple’s DNA for the presence or absence of the PV. Linkage analysis, a laboratory technique that uses allelic markers to track maternal or paternal inheritance, was used to predict the embryos’ genotypes (affected or normal).

Case II: Family 2 has a history of the c.5266dup PV in the female partner and likely her father. For conception, they needed to use an oocyte donor and wished to have a related donor, her sister. The sister’s carrier status is unknown, and she did not wish to learn it, so indirect nondisclosure PGT-M

was used. Unlike direct nondisclosure, indirect nondisclosure does not explicitly test the DNA of each involved for the presence or absence of the PV. Instead, linkage analysis is used against a known haplotype from an affected relative to determine if an embryo is affected.

Implications: These cases illustrate the complexity and challenges of balancing patients' wishes for their own confidentiality with their desire to have unaffected children. Some inherited adult-onset conditions carry stigma and/or implications for the individual's life that the person may not be ready to learn about. Nondisclosure PGT-M provides them with a method to avoid those stigmata while preventing the risk of that condition in their children. These cases require detailed and thoughtful genetic counseling, with careful coordination between the PGT laboratory and the IVF center, to maintain patient confidentiality and autonomy. As carrier screening and genetic testing become more commonplace in primary care and OB/GYN offices, these issues will similarly become more prevalent in how people choose to grow their families.

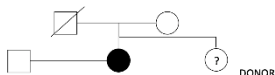
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Family 1: Direct Non-Disclosure



Family 2: Indirect Non-Disclosure



Central Prize Award

2005

“Impact of Chromic Catgut Versus Polyglactin 910 Versus Fast-Absorbing Polyglactin 910 Sutures for Perineal Repairs: A Randomized Control Trial”

Emmanuel Bujold, M.D.

Sainte-Justine Hospital, University Montreal
Montreal, Quebec

2006

“Comparison of the Adequacy of the Conventional Smears to Liquid-Based Preparations on Vaginal Cuffs”

Kory A. Harward, D.O.

Aultman Health Foundation/NEOUCOM
Canton, Ohio

2007

“Triggering Receptors of Myeloid Cells (TREM)-1: A Novel Marker of Infection Associated Spontaneous Preterm Birth”

Stephen J. Fortunato, M.D.

Centennial Women's Hospital
Nashville, Tennessee

2008

“Yolk Sac on Transvaginal Ultrasound as a Prognostic Indicator in the Treatment of Ectopic Pregnancy with Single-Dose Methotrexate”

Gary H. Lipscomb, M.D.

University of Tennessee
Memphis, Tennessee

2009

“Soluble Fms-Like Tyrosine-1 (sFlt-1) Production is Enhanced During Hypertension in Response to Tumor Necrosis Factor-alpha (TNF- α) and Agonistic Autoantibodies to the Angiotension II Type I Receptor (ATI-AA)”

Marc R. Parrish, D.O.

University of Mississippi Medical Center
Jackson, Mississippi

Central Prize Award

2010

“The Impact of Genotype on Nifedipine Pharmacokinetics When Used as a Tocolytic”

David M. Haas, M.D.

Indiana University School of Medicine
Indianapolis, Indiana

2011

“Reducing Postpartum Hemorrhage with Removal of Placenta at 10 vs 15 Minutes: A Randomized Clinical Trial”

Everett F. Magann, M.D.

University of Arkansas for Medical Sciences
Little Rock, Arkansas

2012

“Harnessing the Electronic Health Record for the Provision of Population-Based Preconception Care”

Heather L. Straub, M.D.

Northshore University HealthSystem
Evanston, Illinois

2013

"Cost Effectiveness and Clinical Utility of Repeated Syphilis Screening in the Third Trimester in a High-Risk Population”

Linda-Dalal J. Shiber, M.D.

MetroHealth/Case Western Reserve University
Cleveland, Ohio

2014

“A Study of Preterm Neonates: Delayed Cord Clamping vs. Delayed Cord Clamping plus Cord Stripping, a Prospective Randomized Trial. Is Cord Stripping Beneficial?”

Margaret S. Krueger, D.O.

Univ. South Alabama Children's and Women's Hospital
Mobile, Alabama

Central Prize Award

2015

“Randomized Clinical Trial of Medical Therapy
vs. Radiofrequency Endometrial Ablation in the
Initial Treatment of Heavy Menstrual Bleeding:
Treatment Outcomes and Life Quality Assessment”

Sherif A. Shazly, M.B., B.Ch.

Mayo Clinic
Rochester, Minnesota

2016

“The Risk of Expectant Management of Low Risk
Pregnancy at Term and Optimal Timing of Delivery:
A National Population-Based Study”

Gustavo Vilchez, M.D.

University of Missouri - Kansas City
Kansas City, Missouri

2017

“Association Between Gestational
Weight Gain Adequacy and Composite
Maternal and Neonatal Morbidity”

Han-Yang Chen, Ph.D.

The University of Texas Health Science Center
Houston, Texas

2018

“A Comparison of Vaginal Versus Buccal Misoprostol
for Term Cervical Ripening in Women for Labor
Induction at Term (the IMPROVE Trial): A Triple
Masked Randomized Controlled Trial”

David M. Haas, M.D.

Indiana University School of Medicine
Indianapolis, Indiana

2019

“The Relationship Between Glucose Testing in an
Index Pregnancy and Outcomes in a Subsequent
Pregnancy: Implications for Testing Guidelines”

Emmet Hirsch, M.D.

NorthShore University HealthSystem
Evanston, Illinois

Central Prize Award

2020

“Adverse Outcomes Associated with Pregnancy
Conception Methods Among Low-Risk Pregnancies”

Morgen S. Doty, D.O.

McGovern Medical School-UTHealth
Houston, Texas

2021

“Comparing Newborn Outcomes After Prenatal
Exposure to Individual Antidepressants”

Claire E. Marks, MS3

Indiana University School of Medicine
Indianapolis, Indiana

2022

“Factors that Influence the Choice for Neonatal
Resuscitation in Periviable Deliveries”

Jessica A. Young, M.D.

Ascension St. Vincent Hospital
Indianapolis, Indiana

2023

“Female Infertility and Obesity Across the United
States: A Geographic Cross-Sectional Analysis”

Raegan B. Abadie, MS2

Louisiana State University Health Sciences Center
Shreveport, Louisiana

2024

“Theoretical vs. Actual Access to Care”

Mark I. Evans, M.D.

Icahn School of Medicine at Mount Sinai
and Fetal Medicine Foundation of America
New York, New York

2025

“Addition of Misoprostol to Double-Balloon
Catheter for Cervical Ripening Associated
with Improved Obstetric Outcomes”

Allison Li, B.S.

Indiana University School of Medicine
Indianapolis, Indiana

Central Prize Award

2026

**“Irritable Bowel Syndrome–Like Presentation of
Ovarian Cancer and Associated Secondary Health
Outcomes in a National Propensity-Matched Study”**

Varsha K. Vedapudi, B.S.

University of Toledo
Toledo, Ohio

President's Certificate of Merit Award

2005

“Detection of Gestational Diabetes Mellitus by
Homeostatic Indices of Insulin Sensitivity:
A Preliminary Study”

Robert P. Kauffman, M.D.

Texas Tech University School Medicine
Amarillo, Texas

2006

“The Clinical Utility of Maternal Depression
Screening Before and After Delivery”

Trent E.J. Gordon, M.S.

Evanston Northwestern Healthcare
Evanston, Illinois

2007

“In Vitro Chemotaxis of Human Bone
Marrow-Derived Mesenchymal Stem Cells
Following Exposure to Soluble Factors from
Epithelial Ovarian Carcinoma Cell Lines”

Neelima Vegesna, M.D.

Southern Illinois University School of Medicine
Springfield, Illinois

2008

“In Vitro Vascular Reactivity in a Mouse Model of
Preeclampsia Induced by Over-Expression of sFlt-1”

Fangxian Lu, M.D.

University of Texas Medical Branch
Galveston, Texas

2009

“Mild Preeclampsia Near Term: Deliver or Deliberate?
The Prospective Randomized PreNaTe Trial”

Michelle Y. Owens, M.D.

University of Mississippi Medical Center
Jackson, Mississippi

President's Certificate of Merit Award

2010

“Cervical Ripening for Induction of Labor:
A Prospective Randomized Trial of Misoprostol versus
Oxytocin in Conjunction with Foley Balloon”

Erica R. Downey, M.D.

Aultman Hospital
Canton, Ohio

2011

“Knowledge Gap of Recommendations in ACOG
Practice Bulletins: A Survey of Members of Central
Association of Obstetricians and Gynecologists”

Suneet P. Chauhan, M.D.

Eastern Virginia Medical School
Norfolk, Virginia

2012

“Peripartum Complications with Cesarean Delivery: A
Review of Maternal-Fetal Medicine Unit Publications”

Ibrahim A.I. Hammad, M.D.

Eastern Virginia Medical School
Norfolk, Virginia

2013

"Obstetric Recommendations in ACOG Practice
Bulletins vs UpToDate: A Comparison”

Emily N. Myer, M.D.

Eastern Virginia Medical School
Norfolk, Virginia

2014

“The Effects of Metformin on Postpartum Weight
Retention in Women with Gestational Diabetes:
A Randomized, Placebo-Controlled Trial”

Jerrie S. Refuerzo, M.D.

University of Texas Health Science Center
Houston, Texas

President's Certificate of Merit Award

2015

“Acute FeTal Behavioral Response to Prenatal
Yoga: A Single Blinded, Randomized
Controlled Trial (TRY Yoga Study)”

Shilpa Babbar, M.D.

University of Missouri Kansas City
Kansas City, Missouri

2016

“Assessment of Twin Fetal Growth:
Use of Singletons versus
Twin-Specific Nomograms”

Hector Mendez-Figueroa, M.D.

University of Texas Health Science Center
Houston, Texas

2017

“Preoperative Cesarean Section
Intravenous Acetaminophen
Treatment for Postoperative
Pain Control: A Randomized
Double-Blinded Placebo Control Trial”

Sarah K. Shelton, M.D.

University of Tennessee Medical Center
Knoxville, Tennessee

2018

“Intention to Treat: Obstetrical Management
at the Threshold of Viability”

Tiffany R. Tonismae, M.D.

Indiana University School of Medicine
Indianapolis, Indiana

2019

“Increases in Albumin-Adjusted Serum Calcium
Over Time Predict Ovarian Cancer”

Gary G. Schwartz, Ph.D., M.P.H., Ph.D.

UND School of Medicine and Health Sciences
Grand Forks, North Dakota

President's Certificate of Merit Award

2020

“Enhanced Recovery After
Scheduled Cesarean Delivery”
Lisette D. Tanner, M.D., M.P.H.
McGovern Medical School-UTHealth
Houston, Texas

2021

“Long-Term Childhood Outcomes for Babies
Born at Term Who Were Exposed to
Antenatal Corticosteroids”
Samantha J. Osteen, M.D., M.S.
Indiana University School of Medicine
Indianapolis, Indiana

2022

“Association of Gabapentin Concentrations with
Opioid Use After Cesarean Delivery”
David M. Haas, M.D., M.S.
Indiana University School of Medicine
Indianapolis, Indiana

2023

“Comprehensive Circulating DNA Profiling in
Maternal Plasma Enabled the Identification of a
Molecular Signature for the Detection of Fetal Growth
Disorders at the First Pregnancy Trimester”
Rene G. Cortese, Ph.D.
University Missouri School of Medicine
Columbia, Missouri

2024

“Identification of Molecular Signatures for
the Detection of Fetal Growth Disorders at the
First Gestational Trimester in Circulating DNA
Isolated from Urine Samples”
Rene G. Cortese, Ph.D.
University of Missouri School of Medicine
Columbia, Missouri

President's Certificate of Merit Award

2025

**“Evaluating Serial Serum Levels of Endocan and
Syndecan in Infants Born to Women with
Hypertensive Disorders of Pregnancy”**

Ria Ravi, B.S.

Loyola University of Chicago
Stritch School of Medicine
Maywood, Illinois

2026

**“Cervical Screening Inequities in
AI/AN Women: Comparing IHS
and Private Insurance Coverage”**

Karrah Peterson, B.S.

UND School of Medicine and Health Sciences
Grand Forks, North Dakota

Community Hospital Award

2005

“Multilocus Interactions as Maternal TNF- α ,
IL-6 and IL-6R Genes Predict Spontaneous
Preterm Labor in European-American Women”

Stephen F. Fortunato, M.D.

Centennial Women's Hospital
Nashville, Tennessee

2006

“Amniotic Fluid Interleukin (IL)-1 and IL-8
Concentrations: Racial Disparity in
Spontaneous Preterm Birth”

Stephen J. Fortunato, M.D.

Centennial Women's Hospital
Nashville, Tennessee

2007

“Racial Disparity in Maternal-Fetal Genetic
Epistasis in Spontaneous Preterm Birth”

Stephen J. Fortunato, M.D.

Centennial Women's Hospital
Nashville, Tennessee

2008

“Distinct Pathophysiologic Pathways Induced
by In Vitro Infection and Cigarette Smoke
in Normal Human Fetal Membranes”

Stephen J. Fortunato, M.D.

Centennial Women's Hospital
Nashville, Tennessee

2009

“C-Reactive Protein and the
Outcome of Emergency Cerclage”

Sogol Jahedi, M.D.

Advocate Lutheran General Hospital
Park Ridge, Illinois

Community Hospital Award

2010

“Aberrant Fetal Growth and Mortality
(Early, Late, and Postneonatal):
An Analysis of Milwaukee Births, 1996-2007”

Suneet P. Chauhan, M.D.

University of Wisconsin School of Medicine
Milwaukee, Wisconsin

2011

“Group B Streptococcus Colonization
Leads to Early-Term Births”

Stephen J. Fortunato, M.D.

The Perinatal Research Center
Nashville, Tennessee

2012

“Development of an OB Dashboard: Measuring
What Matters in Perinatal Quality and Safety”

Gregory L. Goyert, M.D.

Henry Ford Health System
Detroit, Michigan

2013

"Human Lysophosphatidylcholine
Acyl-transferase 1 mRNA is Found in
Amniotic Fluid and Maternal Serum”

Robert A. Welch, M.D.

Providence Hospital & Medical Centers
Southfield, Michigan

2014

“Prospective Comparison of Efficacy, Outcomes,
and Cost of Laparoscopic, Vaginal,
and Robotic Approaches to Hysterectomy
in a Community Institution”

Dana M. Benden, M.D.

Gundersen Health System
La Crosse, Wisconsin

Community Hospital Award

2015

“A Randomized Control Trial of Foley
Catheter Placement for Induction of Labor:
Stylette vs. No Stylette”

Marie M. Forgie, D.O.

Aurora Sinai Medical Center
Milwaukee, Wisconsin

2016

“Severe Maternal Morbidity and
Hospital Cost Among Hospitalized
Deliveries in the United States”

Han-Yang Chen, Ph.D.

Aurora Health Care
Milwaukee, Wisconsin

2017

“Management of the Third Stage of Labor in Second
Trimester Deliveries: How Long is Too Long?”

Jessica A. Behrens, D.O.

Aurora Sinai Medical Center
Milwaukee, Wisconsin

2018

“Newborn Birth Weight or Body Mass Index:
Predictors of the Duration of Neonatal
Brachial Plexus Palsy”

Leen Al-Hafez, M.D.

Houston Methodist Hospital
Houston, Texas

2019

“To Treat or Not to Treat: Effect of One
Elevated Glucose Tolerance Test Value”

Leah A. Hong, M.D.

Henry Ford Health System
Detroit, Michigan

Community Hospital Award

2020

“Group B Streptococcus Rectovaginal Colonization
and Resistance Patterns in HIV Positive
Compared to HIV Negative Pregnant Patients”

Nicholas A. Callais, B.S.

Louisiana State University Health Sciences Center
Shreveport, Louisiana

2021

“Efficacy of a Pilot Program for Obstructive
Sleep Apnea Screening in Pregnancy”

Nicolina Smith, DO

Henry Ford Health System
Detroit, Michigan

2022

“Maternal and Infant Morbidity
and Mortality in Extremely Premature Infants
– A Single Centered Study in Detroit Michigan
Between 23-26 Weeks of Gestation”

Mariam K. Ayyash, M.D., MSCR

Henry Ford Health
Dearborn, Michigan

2023

“Effects of COVID-19 Infection on
Fetal Growth in Pregnancy”

Olaide A. Ashimi Balogun, M.D.

Obstetrix Maternal-Fetal Medicine Specialist Houston
Houston, Texas

2024

“Simulation Improves Ob-Gyn Resident Comfort
Providing Pregnancy Options Counseling”

Emily Lluch, M.D.

Orlando Health Bayfront Hospital
St. Petersburg, Florida

Community Hospital Award

2025

**“Proteinuria in Pregnancy: A Key Factor
in Chronic Hypertension Management”**

Symone E. McClain, M.D.

Henry Ford Hospital
Detroit, Michigan

2026

**“Evaluation of the Adherence to Established
Guidelines for Labor Arrest Disorders and
Category II Fetal Heart Tones in Nulliparous,
Term, Singleton, Vertex Cesarean Births”**

Laurel L. Pietrzak, D.O.

Aurora Sinai Medical Center
Advocate Health
Milwaukee, Wisconsin

Young Investigator Award

2005

“Pregnancy Loss After First Trimester
Viability in Patients with Sickle Cell Trait:
Time for A Reappraisal?”

Michelle Y. Taylor, M.D.

University of Mississippi Medical Center
Jackson, Mississippi

2006

“An Evaluation of Health Care Providers'
Sexual Violence Screening Practices”

Heather L. Littleton, Ph.D.

University of Texas Medical Branch
Galveston, Texas

2007

“Autologous Platelet Gel in Reduction of Pfannenstiel
Cesarean Incision Drainage in Obese Women:
A Randomized Controlled Trial”

Alexis G. Johnston, D.O.

Aultman Hospital
Canton, Ohio

2008

“Vascular Function in the Offspring Later in Life in a
Mouse Model of Maternal Obesity and Preeclampsia”

Egle Bytautiene, M.D.

University of Texas Medical Branch
Galveston, Texas

2009

“Extended Antibiotic Prophylaxis for Prevention of
Surgical Site Infections in Morbidly Obese Women
Undergoing Combined Hysterectomy and Medically
Indicated Panniculectomy: A Cohort Study”

Sherif A. El-Nashar, M.D.

Mayo Clinic
Rochester, Minnesota

Young Investigator Award

2010

“Phenazopyridine Does Not Improve
Catheter-Associated Discomfort Following
Gynecologic Surgery: Results of a
Randomized Controlled Trial”

Charles K. Anderson, M.D.

Loyola Univ. Medical Center
Maywood, Illinois

2011

“Racial Difference in Gestational Age Specific
Neonatal Morbidity: Further Evidence for
Different Gestational Lengths”

Ryan W. Loftin, M.D.

University of Cincinnati
Cincinnati, Ohio

2012

“Knowledge of Nutrition During Pregnancy:
A Survey of CAOG Members”

Stephanie T. Trexler, M.D.

Eastern Virginia Medical School
Norfolk, Virginia

2013

"When is the Optimal Time to Deliver
Women with Stable Placenta Previa?"

Laura A. Hart, M.D.

UT Health - University of Texas Medical School
Houston, Texas

2014

“Differential Morbidity Among Preterm Small versus
Appropriate for Gestational Age: Perhaps Unverifiable”

Caroline C. Marrs, M.D.

University of Texas Health Science Center at Houston
Houston, Texas

Young Investigator Award

2015

“Body Mass Index and Magnesium Sulfate
Neuroprotection: A Secondary Analysis From a
Multicenter Randomized Control Trial”

Gustavo Vilchez, M.D.

Wayne State University
Detroit Medical Center
Detroit, Michigan

2016

“Diabetes During Pregnancy: Influence of
Body Mass Index on Composite Morbidity”

Amy E. O'Neil Dudley, M.D., MPH

McGovern Medical School- UTHealth
Houston, Texas

2017

Among Diabetics Sonographic Estimated Fetal Weight
and Composite Neonatal Morbidity: Suspected
Appropriate versus Large for Gestational Age

Leen Al-hafez, M.D.

Houston Methodist Hospital
Houston, Texas

2018

“Hypertension Among Women of Reproductive Age:
Impact of 2017 American College of
Cardiology/American Heart Association High
Blood Pressure Guideline”

Han-Yang Chen, Ph.D.

University of Texas Health Science Center
Houston, Texas

2019

“The Influence of Insufficient Prenatal
Care on Severe Maternal Morbidity.”

Michael William DeGrandis, BA

University of Cincinnati Medical School
Cincinnati, Ohio

Young Investigator Award

2020

“Labor Induction with Prostaglandin E1 versus E2:
A Comparison of Outcomes”

Matthew J. Bicocca, M.D.

McGovern Medical School-UTHealth
Houston, Texas

2021

“Discontinuation of Oxytocin in the Second
Stage of Labor and its Association
with Postpartum Hemorrhage”

Caitlin A. MacGregor, M.D.

NorthShore University HealthSystem
Evanston, Illinois

2022

“Optimal Glucose Testing for the Detection
and Diagnosis of Prediabetes and Type II
Diabetes Mellitus in Reproductive Age Women
with Polycystic Ovarian Syndrome”

Wenqi A. Ouyang, M.D.

Southern Illinois University School Medicine
Springfield, Illinois

2023

“Implementation of an Outpatient Cervical
Ripening Program: Outcomes and
Provider and Patient Perspectives”

Katherine H. Zhu, M.D.

University of Chicago Medical Center
Chicago, Illinois

2024

“A Functional MRI Method to Characterize
Uterine Contractility and Menstrual Pain”

Kendra Juliette, B.S.

Wayne State University School of Medicine
Endeavor Health
Detroit, Michigan

Young Investigator Award

2025

“Evaluation of the Accuracy of Fetal Weight Prediction
Technology in Predicting Fetal Macrosomia”

Margaret T. Manning, M.D.

University of Louisville
Louisville, Kentucky

2026

“Evaluation of Fertility Counseling
at the Initial Oncologic Visit”

Nikita R. Peramsetty, M.D.

University of Kansas Medical Center
Kansas City, Missouri

Distinguished Professor Lectureship Honoring

George W. Morley, M.D.

**“Approaching Invasive Gyn Disease via
Minimally Invasive Technology”**

Introduction by

Rudi Ansbacher, M.D.

Presented by

R. Kevin Reynolds, M.D.

University of Michigan Medical Center

Ann Arbor, Michigan

October 18, 2005

**GEORGE W. MORLEY, M.D
(1923 – 2005)**

Dr. George Morley was one of America’s most distinguished gynecologic oncology surgeons and truly a memorable leader in the specialty. He spent his entire academic career at The University of Michigan, Ann Arbor where he was revered by students, house staff, colleagues and patients. Although Dr. Morley was widely published, it was in the operating room where he is fondly remembered for being a patient and effective teacher who inspired and motivated through talent and effervescent enthusiasm. Many of the principles he held most dear he collected in his beloved “Morleyisms,” a booklet of sayings he used to help with his mentoring and philosophy of living life to the fullest. Dr. Morley often said “I got to treat, and to train to treat – what more could anyone ask for.” a fitting epitaph for this great physician and humanitarian.

Dr. George W. Morley Memorial Paper

2006

“Endometrial Cells Identified in Cervical
Cytology in Women $\geq$ 40 Years of Age:
Criteria for Appropriate Endometrial Evaluation”

Heather N. Beal, M.D.

Southern Illinois University School of Medicine
Springfield, Illinois

2007

“Family History as a Risk Factor for
Pelvic Organ Prolapse”

Mary T. McLennan, M.D.

St. Louis University
St. Louis, Missouri

2008

“Laparoscopically-Assisted Uterine
Fibroid Cryoablation (UFC)”

Harriette L. Hampton, M.D.

University of Mississippi
Jackson, Mississippi

2009

“Activity of Dasatinib a Novel Small Molecule
Kinase Inhibitor of Both the SRC and ABL
Proteins in Human Endometrial Cancer Cells
Along With SRC Expression in a Large
Cohort of Surgically Staged Nonendometroid
(Type II) Endometrial Cancers”

Boris J.N. Winterhoff, M.D.

Mayo Clinic
Rochester, Minnesota

2010

“Radical Parametrectomy for Cervical
Cancer Found on Pathological Examination of
Extrafascial Hysterectomy: A Cohort Study
& A Systemic Review of the Literature”

Sherif A. El-Nashar, M.D.

Mayo Clinic
Rochester, Minnesota

Dr. George W. Morley Memorial Paper

2011

“The Impact of the Mismanagement of
Atypical Glandular Cell Pap Tests”

Jessica J. Shank, M.D.

University of Michigan
Ann Arbor, Michigan

2012

“Hysterectomy Trends Since 2003:
The Impact of Technology on Traditional Routes”

Katherine E. Kowalczyk, D.O.

Grand Rapids Medical Education Partners
Grand Rapids, Michigan

2013

"Utilization of an Ex Vivo Human Placental
Perfusion Model to Predict Potential Fetal
Exposure to Carboplatin During Pregnancy”

Judith A. Smith, Pharm.D.

UT MD Anderson Cancer Center
Houston, Texas

2014

“A Prospective Study on the Incidence of
Post-Operative Lymphedema in Women
with Endometrial Cancer”

Elizabeth E. Hopp, M.D.

Medical College of Wisconsin
Milwaukee, Wisconsin

2015

“Tumor Diameter as a Predictor of Lymphatic
Dissemination in Endometrioid Endometrial Cancer”

Danielle M. Greer, Ph.D.

Center for Urban Population Health
Aurora UW Medical Group
Milwaukee, Wisconsin

Dr. George W. Morley Memorial Paper

2016

**“Outcomes of Vaginal Hysterectomy With and Without
Perceived Contraindications to Vaginal Surgery”**

Jennifer J. Schmitt, D.O.

Mayo Clinic
Rochester, Minnesota

2017

**“Initial Impact of a Cervical Cancer Screening and
Tracking Program Within a Community Health
System's Electronic Health Record”**

Alexa R. Lowry, B.S.

Univ. of Wisconsin School of Medicine & Public Health
La Crosse, Wisconsin

2018

**“Chronic Diseases, Self-Reported Health Status
and Prescription Opioid Analgesic
Use Among Women of Reproductive Age”**

Han-Yang Chen, Ph.D.

University of Texas Health Science Center
Houston, Texas

2019

**“A System-Level Approach to Improving Cervical
Cancer Screening Rates & Surveillance:
Implementation of an Electronic Health Record
Tracking System in a Community Health System”**

Courtney K. Pfeuti, B.A.

Univ. of Wisconsin School of Medicine & Public Health
Madison, Wisconsin

2020

**“AHCC Supplementation to Support the Immune
System in the Elimination of Persistent Human
Papillomavirus Infections in Women “**

Judith A. Smith, Pharm.D.

McGovern Medical School-UTHealth
Houston, Texas

Dr. George W. Morley Memorial Paper

2021

**“Prevalence and Outcomes of Positive Cervical
Cancer Screening in Female Renal Transplant
Waitlist Candidates: A Single Center Experience”**

Julia T. Berry, MS4

University of Toledo College of Medicine
Toledo, Ohio

2022

**“Evaluation of Socio-Economic and
Immune Factors Related to Endometrial Cancer”**

Aneesh S. Chawla, M.D.

Southern Illinois University School Medicine
Springfield, Illinois

2023

**“Aiming for Zero: Success of the Hysterectomy
Surgical Site Infection Prevention Bundle”**

Ushma J. Patel, M.D.

University of Wisconsin
Madison, Wisconsin

2024

**“Use of Indocyanine Green (ICG) in the Detection of
Fibrosis and Inflammatory Changes Related to
Endometriosis: A Retrospective Cohort Study”**

Christopher-Armand Z. Mabini, D.O.

Ascension Healthcare – St. Francis Hospital
Evanston, Illinois

2025

**“An Alternative Approach to Vaginal
Expansion-Utilizing Estrogen Coated
3-D Printed Vaginal Expansion Sleeves”**

Ashlyn G. Gotberg, B.S.

Louisiana State University Health Sciences Center
Shreveport, Louisiana

Dr. George W. Morley Memorial Paper

2026

**“Is There a Need for Vaginitis Screening
in the Era of Preoperative Antibiotics?”**

Aaron D. Adams, M.D.

University of Louisville School of Medicine
Louisville, Kentucky

Distinguished Professor Lectureship Honoring

Jack A. Pritchard, M.D.

“Dr. Pritchard: The Man and His Legacy”

Introduction by

Norman F. Gant, Jr., M.D.

Presented by

Larry C. Gilstrap, III, M.D.

American Board of Obstetrics and Gynecology

Dallas, Texas

October 17, 2006

**JACK A. PRITCHARD, M.D.
(1921 – 2002)**

Dr. Jack Pritchard is considered by many to be the “father of modern obstetrics.” At age 33 Dr. Pritchard became Chair of Ob-Gyn at the University of Texas Southwestern and Chief of Ob-Gyn at Parkland Hospital in Dallas, where he dedicated his career to being a relentless champion of patient care as the classic “triple threat:” teacher, researcher and clinician. As a pioneer in evidence-based medicine, the most important member of his life-long research team was his wife, Signe. In 1969 Dr. Pritchard became the editor of the 14th Edition of *Williams Obstetrics*, crafting this century old classic to remain as relevant today as in the past. Jack Pritchard’s greatest legacy “lies in the countless thousands of ob-gyn’s, those trained and those to follow, and in the countless millions of women and infants, some yet unborn, who will be enriched by his priceless contributions to the art and science of ob-gyn.”

Dr. Jack A. Pritchard

Memorial Paper

2006

“Expectant Management of Preterm Premature
Rupture of Membranes and Non-Vertex
Presentations: What Are the Risks?”

David F. Lewis, Jr., M.D.

Louisiana State University Health Sciences Center
Shreveport, Louisiana

2007

“Comparison of Intracervical Foley Bulb
Methodologist for Cervical Ripening:
A Randomized Clinical Trial”

Jason M. Hoppe, D.O.

Aultman Hospital
Canton, Ohio

2008

“Overestimation of Fetal Weight
by Ultrasound: Does It Increase
Cesarean Delivery for Labor Arrest?”

Jerrie S. Refuerzo, M.D.

University Texas Health Science Center
Houston, Texas

2009

“Randomized Clinical Trial Evaluating the
Frequency of Membrane Sweeping with an
Unfavorable Cervix at 39 Weeks”

Everett F. Magann, M.D.

Navel Medical Center - Portsmouth
Portsmouth, Virginia

2010

“Study of Obstetric Foley
Techniques (The SOFT Trial):
A Randomized Controlled Trial ”

Megan J. Dejong, M.D.

Loyola University Medical Center
Maywood, Illinois

Dr. Jack A. Pritchard

Memorial Paper

2011

“Cost-Effectiveness of Routine
Third Trimester Antibody Screening in
Rh Negative Pregnancies”

Jill E. Minger, M.D.

MetroHealth Medical Center
South Euclid, Ohio

2012

“Outcomes in Cephalic versus Non-cephalic
Fetuses in the Setting of Preterm Premature
Rupture of Membranes”

Jean R. Goodman, M.D.

University of Oklahoma Health Sciences Center
Oklahoma City, Oklahoma

2013

"Circulating Cell-Free Nucleic Acid (CCFNA)
Screening for Fetal Aneuploidy: Changing the
Landscape of Prenatal Screening and Diagnosis”

Lee P. Shulman, MD

Feinberg School Medicine/Northwestern University
Chicago, Illinois

2014

“Maternal and Cord Blood Levels
of Docosahexaenoic Acid (DHA)
After Commercially Available Supplementation”

Steffen A. Brown, M.D.

University of New Mexico School of Medicine
Albuquerque, New Mexico

2015

“UltraSound Examinations to Improve Detection
of Fetal Growth Restriction in Uncomplicated
Pregnancies: A Pilot, Multi-Center R
andomized Clinical Trial (USE RCT)”

Ibrahim A. Hammad, M.D.

Eastern Virginia Medical School
Norfolk, Virginia

Dr. Jack A. Pritchard

Memorial Paper

2016

“Racial/Ethnic Disparity in Magnesium Sulfate
Adverse Effects: A Sub-Group Analysis of a
Multicenter Randomized Controlled Trial”

Gustavo Vilchez, M.D.

University of Missouri - Kansas City
Kansas City, Missouri

2017

“Risk of Neonatal and Infant Mortality in Twins and
Singletons by Gestational Age in the United States”

Han-Yang Chen, Ph.D.

The University of Texas Health Science Center
Houston, Texas

2018

“Persistence and Extent of Neonatal Brachial
Plexus Palsy: Association with Number of
Maneuvers and Duration of Shoulder Dystocia”

Morgen S. Doty, D.O.

University of Texas Health Science Center
Houston, Texas

2019

“Adverse Outcomes Among Low-Risk Pregnancies
at 39 to 41 Weeks: Stratified by Fetal Growth “

Hector Mendez-Figueroa, M.D.

Baylor College of Medicine
Houston, Texas

2020

“Marijuana Use in Pregnancy
and the Risk of Preterm Birth”

Rachel Gilbert, D.O.

Louisiana State University Health Sciences Center
Shreveport, Louisiana

Dr. Jack A. Pritchard

Memorial Paper

2021

“Association Between Preterm Neonate
Endocan Levels and Maternal Obesity”

Emily A. Holthaus, M.D.

Loyola University Medical Center
Maywood, Illinois

2022

“National Chorioamnionitis Trends: Geospatial
Analysis of Vulnerable Communities”

Joanne M. Chan, B.S.

Carle Illinois College of Medicine
Champaign, Illinois

and

“Racial Bias in Cesarean Decision Making”

Sara E. Edwards, M.D.

University of Illinois at Chicago
Chicago, Illinois

2023

“An Updated Systematic Review on Prediction Models
for Successful External Cephalic Version”

Peggy K. Palsgaard, B.S.

University of Illinois at Urbana-Champaign
Carle Illinois College of Medicine
Urbana, Illinois

2024

“Comparison in Latency Based on Amniotic
Fluid Index (AFI) in Patients with Preterm
Prelabor Rupture of Membranes (PPROM)”

David M. Greiner, M.D.

University of Nebraska Medical Center
Omaha, Nebraska

Dr. Jack A. Pritchard

Memorial Paper

2025

“Infant Feeding Practices and Maternal
Sleep Outcomes in Early Postpartum”

Jasmine T. Rios, M.P.H.

University of Chicago
Pritzker School of Medicine
Chicago, Illinois

2026

“Evaluation of Saposin C-Dioleoylphosphatidylserine
Nanovesicles for Drug Delivery to the Placenta”

Ameya Gourisetty

University of Cincinnati
Cincinnati, Ohio

Distinguished Professor Lectureship Honoring

Kermit E. Krantz, M.D.

“Dr. Krantz: The MMK and So Much More”

Introduction by

Tom G. Sullivan, M.D.

Presented by

John W. Calkins, M.D.

University of Kansas Medical Center

Kansas City, Kansas

October 20, 2008

**KERMIT E. KRANTZ, M.D.
(1923 – 2007)**

Dr. Kermit Krantz was the world-renowned forefather of urogynecology and pelvic reconstructive surgery who is best known as the co-developer of the Marshall-Marchetti-Krantz (MMK) procedure for urinary stress incontinence. Trained as an anatomist, Dr. Krantz also invented the expandable women's tampon still used today. An identical twin who was orphaned by age 13, Kermit Krantz spent 31 years as Chairman of Ob-Gyn at The University of Kansas Medical Center in Kansas City where he championed patient rights above all else. At the University Hospital he is credited with desegregating labor, delivery and the nursery. A brilliant diagnostician and devoted researcher who is fondly remembered for his irrepressible personality, Dr. Krantz was equally esteemed by the clinicians he trained and the countless patients he cared for.

Dr. Kermit E. Krantz

Memorial Paper

2008

“Glycine Absorption in Operative Hysteroscopy:
The Impact of Anesthesia”

Marie-Eve Bergeron, M.D.

Centre Hospitalier Universitaire de Quebec
Quebec, Canada

2009

“Bethesda 2001 Plus Reflex HPV DNA
Testing Versus Bethesda 1991:
Impact on Triage, Cost and Efficacy”

William J. Todia, M.D.

MetroHealth/Case Western Reserve University
Cleveland, Ohio

2010

“Resolution of Chronic Pelvic Pain After
Hysterectomy and Alternative Treatments:
Does Depression Make a Difference?”

Lee A. Learman, M.D., Ph.D.

Indiana University School of Medicine
Indianapolis, Indiana

2011

“Cervical Cancer Screening in the
United States 1993-2010: Characteristics of
Women Who are Never Screened”

Suneet P. Chauhan, M.D.

Eastern Virginia Medical School
Norfolk, Virginia

2012

“Burnout Among the Alumni from
the University of Kansas
Obstetrics and Gynecology Residency Programs”

Kimberly A. Brey, M.D.

University of Kansas School of Medicine
Kansas City, Kansas

Dr. Kermit E. Krantz

Memorial Paper

2013

“Cervical Cytology and Histology in Women
Following Solid Organ Transplant,
A Longitudinal Cohort”

Margaret E. Long, M.D.

Mayo Clinic
Rochester, Minnesota

2014

“Evaluation of Ethics Education in Obstetrics &
Gynecology Residency Programs:
A Survey of Ob/Gyn Residency Program Directors”

John J. Byrne, M.D., MPH

University of Chicago
Chicago, Illinois

2015

“Molecular Evaluation of Fetal and Newborn Skeletal
Dysplasia: Applying Next Generation Sequencing
(NGS) to Providing Accurate Diagnostic Information”

Lee P. Shulman, M.D.

Feinberg School of Medicine/ Northwestern University
Chicago, Illinois

2016

“Correlates of Long-Acting Reversible Contraception
versus Sterilization Use in Advanced Maternal Age”

Shelby N. Apodaca, M.D.

Texas Tech University - El Paso
El Paso, Texas

2017

“Randomized Clinical Trial: Diathermy versus
Scalpel in Abdominal Wall Incisions
During Repeat Cesarean Delivery”

Martin J. Caliendo, M.D.

Women and Children's Hosp. of Buffalo
Buffalo, New York

Dr. Kermit E. Krantz

Memorial Paper

2018

“How Long is Too Long? Intraoperative Time Intervals and Umbilical Artery pH Depression at Scheduled Cesarean”

Rebecca R. Rimsza, M.D.

Saint Louis University School of Medicine
St. Louis, Missouri

2019

“Increasing Selection of Preconception Expanded Carrier Screening and Its Impact on Preimplantation Genetic Diagnosis (PGT-M)”

Lee P. Shulman, M.D.

Feinberg School of Medicine
Chicago, Illinois

2020

“Integration of Evidence from Randomized Controlled Trials into Clinical Guidelines by the American College of Obstetricians and Gynecologists”

Rigoberto Gutierrez, MS3

Memorial Hermann Southwest Hospital
Houston, Texas

2021

“Implementation of a Standardized Surgical Site Infection Prevention Bundle to Decrease the Rate of Surgical Site Infections in Open Gynecologic Surgical Cases and Cesarean Sections”

Shruti Vaidyanathan, MS4

Louisiana State University Health Sciences Center
Shreveport, Louisiana

2022

“Homeopathic Treatments of Vulvovaginal Candidiasis on Youtube”

Breia L. Reed, M.S.

Meharry Medical College
Nashville, Tennessee

Dr. Kermit E. Krantz

Memorial Paper

2023

“Validation of Patient Self-Collection with
Evalyn Brush Compared to Provider
Collected Sample for HPV Testing”

Margaret E. Long, M.D.

Mayo Clinic
Rochester, Minnesota

2024

“Clinical Evaluation of Effectiveness and
Safety of Amberen® and Smart-B®
Complex in Perimenopausal Women”

Lee P. Shulman, M.D.

Feinberg School of Medicine of Northwestern Univ.
Chicago, Illinois

2025

“Trimesters of Change: Pelvic Floor
and Sexual Health in Community
Hospital Pregnancy Care”

Maira I. Qayyum, M.D.

Louisiana State University Health Sciences Center
Shreveport, Louisiana

2026

“A Study of Phthalates in Association with
Cardiovascular Biomarkers and Reproductive
Hormones in a Hispanic Community”

Heba Ahmed, B.S.

Texas Tech University Health Sciences Center
El Paso, Texas

**Dr. Bryan D. Cowan
FAR (Fellows and Residents)
Research Network Award**

INAUGURATED 2012

Suneet P. Chauhan, M.D., P.I.

**BRYAN D. COWAN, M.D.
(1949 – 2011)**

Dr. Bryan Cowan was President of the Central Association of Obstetricians and Gynecologists at its 75th Annual Meeting in 2008. His distinguished career in reproductive endocrinology culminated as Chair of the Department of Obstetrics and Gynecology at the University of Mississippi Medical Center in Jackson. A lifelong dedication to mentoring and scholarship instilled a respect for research in all the residents and fellows he trained. Following Dr. Cowan's premature death, the CAOG and his wife, Dr. Harriette Hampton, have jointly established this research network to honor his legacy and to encourage future women's health care research.

Dr. Bryan D. Cowan
FAR (Fellows and Residents)
Research Network Award

2012

“Neonatal Brachial Plexus Palsy with Vaginal Birth
After Cesarean: A Case Control Study”

Ibrahim A. I. Hammad, M.D.

Eastern Virginia Medical School
Norfolk, Virginia

2013

"Shoulder Dystocia is Strongly Associated
With a Large Fetal Abdominal-Head
Circumference Size Difference”

Theresa M. Conyac, M.D.

NorthShore University HealthSystem
Evanston, Illinois

2014

“Tocolysis in Patients with Advanced Preterm Labor:
A Randomized Clinical Trail”

Ann R. Tucker, M.S.

University Mississippi Medical Center
Jackson, Mississippi

2015

“Use of Scoring Systems to Predict
Prolonged Hospitalization and Severity
of Acute Pyelonephritis in Pregnancy”

Amy M. Valent, D.O.

University of Cincinnati
Cincinnati, Ohio

2016

“Histologic Chorioamnionitis with Funisitis
and Likelihood of Suspected Triple I
at Term: A Case-Control Study”

Morgen S. Doty, D.O.

Saint Peter's University Hospital
New Brunswick, New Jersey

Dr. Bryan D. Cowan
FAR (Fellows and Residents)
Research Network Award

2017 and 2018
No Candidate Research Papers

2019
“Cesarean Section Does Not Improve Survival
Outcomes Less Than 25 Weeks Gestational Age”
Tiffany R. Tonismae, M.D.
Indiana University School of Medicine
Indianapolis, Indiana

2020
No Candidate Research Papers

2021
No Candidate Research Papers

2022
“Utilization of Enhanced Recovery After Surgery
(ERAS) Protocol in Gynecologic Surgery”
Rachel L. Hartman, M.D.
HCA Florida Brandon Hospital
Brandon, Florida

2023
“Development and Evaluation of a
Cesarean Hysterectomy Simulation Model”
Geoffrey Chen, M.D.
Adventist Health White Memorial
Los Angeles, California

2024
“First Trimester Herbicide Concentrations and
Gestational Diabetes in Nulliparas”
Kevin L. Moss, B.S.
Indiana University School of Medicine
Indianapolis, Indiana

Dr. Bryan D. Cowan
FAR (Fellows and Residents)
Research Network Award

2025

“Postpartum Depression Following a
Substance-Exposed Pregnancy: The Roles of
Age, Race/Ethnicity, and Mental Health History”

Miranda C. Manzo, B.S.

University of Michigan
Central Michigan University College of Medicine
Ann Arbor, Michigan

2026

“The Association of Urine Glyphosate
Concentrations with Pregnancy Loss in Nulliparas”

Leah Bode Langford, M.D.

Indiana University
Indianapolis, Indiana

Central Poster Awards

2005

“Variation in Expression of VEGF and VEGF Receptors in Ovarian Cancer Cell Lines”

Lisa M. Little, M.D.

Southern Illinois University School of Medicine
Springfield, Illinois

“Inquiry Into Shoulder Pain Following Laparoscopy”

David J. Mitchell, M.D.

Aultman Health Foundation
Canton, Ohio

2006

“The Impact of Combined Antibiotic Prophylaxis in Twin Pregnancies Complicated by Preterm Premature Rupture of Membranes”

Amy Farrell, M.D.

St. Louis University School of Medicine
St. Louis, Missouri

“Findings in Patients With an HCG Below 2000 mIU/ml Undergoing D&C to Exclude Ectopic Pregnancy”

Gary H. Lipscomb, M.D.

University of Tennessee Health Science Center
Memphis, Tennessee

2007

“The Impact of Maternal Obesity on Satisfactory Detailed Anatomic Ultrasound Image Acquisition”

Fadi R. Khoury, M.D.

CASE-MetroHealth Medical Center
Cleveland, Ohio

“Thrombotic Thrombocytopenic Purpura (TTP) in the Pregnant or Puerperal Patient 1955-2006: Primary of Recurrent Disease Sometimes Associated with Preeclampsia/HELLP Syndrome”

James N. Martin, Jr., M.D.

University of Mississippi Medical Center
Jackson, Mississippi

Central Poster Awards

2008

“The Neonatologist in Alleged Perinatal Asphyxia:
The Obstetrician’s Best Friend”

Jonathan K. Muraskas, M.D.

Loyola University Medical Center
Maywood, Illinois

“Utilization of Delayed Umbilical Cord
Clamping Among SMFM Membership”

Jessica L. Nyholm, M.D.

University of Minnesota
Minneapolis, Minnesota

2009

“Non-Gynecologic Disease Detected at the
Time of Gynecologic Surgery:
A Continuing Diagnostic Challenge”

Allan A. Adajar, M.D.

St. Francis Hospital
Evanston, Illinois

"Early Return of Bowel Function After
Gynecologic Surgery Using Chewing Gum”

James M. Clark, M.D.

Aultman Health Foundation
Canton, Ohio

"Vaginal Cleansing Before Cesarean Delivery
to Reduce Postoperative Infectious Morbidities:
A Randomized Controlled Trial”

David M. Haas, M.D.

Indiana University School of Medicine
Indianapolis, Indiana

"Fetal Gastroschisis:
Epidemiological Characteristics
and Maternal-Fetal Outcomes”

Kiran B. Tam Tam, M.D.

University of Mississippi Medical Center
Jackson, Mississippi

Central Poster Awards

2010

“Outcomes Study: A Prospective/Observational Study of 2,331 Pubic Bone Stabilization Sling Procedures for Stress Urinary Incontinence. Is This Procedure Equal to other Anti-Incontinent Procedures?”

Stephen H. Cruikshank, M.D.

West Virginia University School of Medicine
(Charleston Campus)
Charleston, West Virginia

“Absence of the Fourth Ventricle in First-Trimester Fetuses: The Intracranial Translucency (IT) as a Potential Screening Tool for Fetal Neural Tube Defects in the Late First Trimester”

Norman A. Ginsberg, M.D.

Feinberg School of Medicine
Northwestern University
Chicago, Illinois

“The Effect of Antenatal Corticosteroids on Maternal Serum Glucose Values in Women with Gestational and Pre-gestational Diabetes”

Allison E. Kreiner, M.D.

Akron General Medical Center
Akron, Ohio

“Unaffected Women with BRCA 1/2 Mutations and Their Use of Family History in Making Decisions Concerning Prophylactic Surgery”

Carly J. Stewart, B.A.

Feinberg School of Medicine
Northwestern University
Chicago, Illinois

Central Poster Awards

2011

"Diagnostic Accuracy of Saline
Infusion Sonohysterography in Patients
with Endometrial Polyps"

Riva N. Branch, M.D.

Advocate Illinois Masonic Medical Center
Chicago, Illinois

"Birth Attendant and Neonatal Mortality
in Newborns Delivered at 37 Weeks or Later:
United States, 2000-2004"

Han-Yang Chen, M.S.

Center for Urban Population Health & Univ. Wisconsin
Madison, School of Medicine & Public Health
Madison, Wisconsin

"Cesarean Section and the Effect on Bladder Capacity"

Jessica Fischetti-Galvin, D.O.

Jersey Shore University Medical Center
Neptune, New Jersey

"Uterine Rupture and Perinatal
Morbidity and Mortality Associated with Oxytocin
Use in a Trial of Labor with a Prior Uterine Scar"

Elliot M. Levine, M.D.

Illinois Masonic Medical Center
Chicago, Illinois

Central Poster Awards

2012

“An Unusual and Rare Presentation of
Problems in a Community Hospital Can
Place a Patient at Significant Risk:
A Report of a Ten Year Old Female with a
Pelvic Mass and Pain with Subsequent
Surgery, Discharge, and an Acute
Abdomen Three Weeks Later”

Michael G. Flax, M.D.

University of New Mexico
Albuquerque, New Mexico

“Gestational Length:
How Long is too Long?”

Norman A. Ginsberg, M.D.

Northwestern Feinberg School of Medicine
Chicago, Illinois

“What Prevents Eligible Patients from
Receiving Progesterone Therapy to
Prevent Recurrent Preterm Birth”

Amanda Meyer, M.D.

Advocate Lutheran General Hospital
Park Ridge, Illinois

“Outcomes of Different Routes of
Hysterectomy by Uterine Weight in
Overweight and Obese Patients”

Danish S. Siddiqui, M.D.

Aurora Sinai Medical Center
Milwaukee Wisconsin

Central Poster Awards

2013

"The Impact of Diminished Ovarian Reserve
on IVF Delivery Rates"

Tamara A. Adducci, M.D.

Medical College of Wisconsin
Milwaukee, Wisconsin

"Decreasing the Abdominal Approach with
Evolution of Robotic Surgery Program for
Treatment of Endometrial Cancer Patients
in a Community Institution"

Dana M. Benden, M.D.

Gundersen Lutheran Medical Center
La Crosse, Wisconsin

"Retained Products of Conception in Patients with a
Negative Urine hCG: A Case Series Report"

Carlos M. Fernandez, M.D.

Advocate Illinois Masonic Medical Center
Chicago, Illinois

"Neonatal Brachial Plexus Palsy in
Cesarean Section"

Gloria T. Too, M.D.

Eastern Virginia Medical School
Norfolk, Virginia

Central Poster Awards

2014

“Clinico-Pathological Findings of Hysterectomy Specimens in Women with Abnormal Uterine Bleeding: Are We Taking Full Advantage of Minimally Invasive Techniques?”

Morgan A. Morton, M.D.

University of Nebraska Medical Center
Omaha, Nebraska

“Variation in Management Strategies and Outcomes Between Sterilized and Non-Sterilized Patients with Abnormal Uterine Bleeding”

Steven J. Radtke, M.D.

Southern Illinois Univ. School of Medicine
Springfield, Illinois

“The Use of Prostaglandin E₁ in Peripartum Patients with Asthma”

Megan C. Rooney Thompson, M.D.

University of Tennessee Medical Center
Knoxville, Tennessee

“Cervical Length Screening: Are Cervical Portio Measurements Acceptable for Screening?”

Melissa L. Verchio, M.D.

Aultman Hospital
Canton, Ohio

Central Poster Awards

2015

“Management of a Live Cervical
Ectopic Pregnancy”

Carlos M. Fernandez, M.D.

Advocate Illinois Masonic Medical Center
Chicago, Illinois

“Diagnosing Pulmonary Embolism in Pregnancy: Are
Biomarkers and Clinical Prediction Models Useful?”

Rachel Fournogerakis, M.D.

Advocate Lutheran General Hospital
Park Ridge, Illinois

“Risk Stratification and Prophylaxis
of Venous Thromboembolic Events
in Obstetrics and Gynecology”

Elliot M. Levine, M.D.

Advocate Illinois Masonic Medical Center
Chicago, Illinois

“Incidence of Chorioamnionitis and
Risk of Neonatal Infection”

Angela D. Yates, M.D.

University of Tennessee Medical Center
Knoxville, Tennessee

Central Poster Awards

2016

“Development of a Novel Antibody-Based Assay for
Simultaneous Identification of a Pathogen and
Determination of its Antimicrobial Susceptibility”

Jonathan P. Faro, M.D./Ph.D.

The Woman's Hospital of Texas
Houston, Texas

“Decidualized Endometrioma of Pregnancy:
A Cause for Concern”

Carlos M. Fernandez, M.D.

Illinois Masonic Medical Center
Chicago, Illinois

“Decline in Frequency of Acute PID
Following Preventative Screening”

Elliot M. Levine, M.D.

Illinois Masonic Medical Center
Chicago, Illinois

“Obstetric Triage: A Model for
Analysis of an Acute Care Service”

Megan L. Smith, M.D.

Aultman Hospital
Canton, Ohio

Central Poster Awards

2017

“Clinical Variance of the NTSV Metric”

Melissa Dennis, M.D.

Advocate Illinois Masonic Medical Center
Chicago, Illinois

“Radiofrequency Volumetric Thermal
Ablation of Uterine Leiomyomata:
Comparison with Other Methods”

Elliot M. Levine, M.D.

Advocate Illinois Masonic Medical Center
Chicago, Illinois

“The Effects of Volume and Timing of Blood
Loss on Cefazolin Adipose Concentrations
Using a Validated Physiologic Model”

Avinash S. Patil, M.D.

Valley Perinatal Services
Phoenix, Arizona

“Maternal Complications Associated
with Periviable Delivery”

Robert M. Rossi, M.D.

University of Cincinnati College of Medicine
Cincinnati, Ohio

Central Poster Awards

2018

“Ectopic Pregnancy: Consideration of Vascularity
Index as a Novel Diagnostic Criterion”

Carlos M. Fernandez, M.D.

Advocate Illinois Masonic Medical Center
Chicago, Illinois

“Obstetric Model of Induction of Labor: Does Time of
Labor Induction Affect Patient Satisfaction?”

Bryant L. Johnson, D.O.

Aultman Hospital
Canton, Ohio

“Cesarean Scar Pregnancy Management
Protocol Essential to Reducing Maternal
Morbidity and Mortality”

Dennis J. Lutz, M.D.

UND School of Medicine and Health Sciences
Minot, North Dakota

“Live Intraligamentous Pregnancy at 36 Weeks”

Francesca Popper, M.D.

Advocate Illinois Masonic Medical Center
Chicago, Illinois

Central Poster Awards

2019

“HPV Vaccination: Optimizing Rates in Our
Ambulatory Clinic at Aultman Hospital”

Brennan N. Anderson, D.O.

Aultman Hospital/NEOMED
Canton, Ohio

“Are There Specific Antepartum Factors and Labor
Complications That Predict Elevated
Immediate Postpartum Edinburgh
Postnatal Depression Scale Scores?”

Katherine V. Ayo, M.D.

Indiana University School of Medicine
Indianapolis, Indiana

“Migration of Angular Pregnancy to
Centric Position: A Case Report”

Katherine M. Tadros, D.O.

Advocate Illinois Masonic Hospital
Chicago, Illinois

“Contraception Planning in a Designated
Obstetrical Opioid Use Disorder Clinic”

Craig V. Towers, M.D.

University of Tennessee Medical Center
Knoxville, Tennessee

Central Poster Awards

2020

“A Novel Approach to Treating Cervical Ectopic
Pregnancy with IV Methotrexate”

Fatima Ali, D.O.

Hackensack Meridian Jersey Shore
University Medical Center
Neptune, New Jersey

“Assessment of Gynecologic Needs for Women
Who Access Harm Reduction Services Through
Mobile Van Outreach in Chicago”

Rebecca Commito, M.D.

University of Illinois at Chicago
Chicago, Illinois

“US-PCG Consumer Involvement
and Outreach Efforts”

Nimisha Kumar, BS

Indiana University School of Medicine
Indianapolis, Indiana

“Association Between Maternal Obesity
Class, Adherence to Labor Guidelines
and Perinatal Outcomes”

Ahmed S. Z. Moustafa, M.D.

Hurley Medical Center/Michigan State University
Grand Blanc, Michigan

Central Poster Awards

2021

“Unexplained Persistently Elevated
Quantitative β -hCG in Post-Menopausal
Female Remote from Total Laparoscopic
Hysterectomy-Bilateral Salpingo-Oophorectomy”

David A. Billings, M.D.

UND School of Medicine and Health Sciences
Minot, North Dakota

“Incidence and Characteristics of Women
Presenting to the Emergency Department
with Abnormal Uterine Bleeding”

Nicolette Codispoti, M.S., M.P.H.

Loyola University Chicago
Stritch School of Medicine
Chicago, Illinois

“Successful Laparoscopic Management of Type II
Cesarean Scar Pregnancy: A Case Series”

Carlos M. Fernandez, M.D.

Advocate Illinois Masonic Medical Center
Chicago, Illinois

“Implementing the Use of Vaginal Preparation Prior to
C-Sections to Decrease Postpartum Endometritis”

Camille C. Imbo-Nloga, M.D.

Brandon Regional Hospital
Brandon, Florida

Central Poster Awards

2022

“Twin-Twin Transfusion Syndrome in the
Setting of COVID-19 Pneumonia: A Case Report”

Callie J. Hamai, B.A.

University of Missouri
Columbia, Missouri

“The Face of Wellness, Diversity,
Equity & Inclusion: A National Review of
Obstetrics & Gynecology Programs”

Malik T. Mays, B.A.

University of Toledo
College of Medicine and Life Sciences
Toledo, Ohio

“Vaginal Cuff Dehiscence with Small Bowel Prolapse
10 Years after Vaginal Hysterectomy”

Brandon K. Morehart, MS4

UND School of Medicine and Health Sciences
Grand Forks, North Dakota

“Sorrows and the Joys of Tomorrow: Analyzing
Maternal Events During Delivery and Post-Partum in
the COVID-19 Pandemic Through Utilizing the EPDS”

Ala Addin Sid Ahmed, M.S., MS4

Wayne State University School of Medicine
Detroit, Michigan

Central Poster Awards

2023

“Cannabis Hyperemesis Syndrome:
An Underrecognized Cause of
Nausea and Vomiting in Pregnancy”
Elizabeth A. Forsythe Riley, M.D.
University of Missouri – Kansas City
Kansas City, Missouri

“Etiologies of Sex-Discordance in
Monochorionic Diamniotic Gestations”
Dennis J. Lutz, M.D.
UND School of Medicine and Health Sciences
Minot, North Dakota

“Quality Improvement Initiative to Optimize
Management of Pregnancy of Unknown Location”
Megan I. McNitt-Johnson, M.D.
Henry Ford Hospital
Detroit, Michigan

“Males in Obstetrics and Gynecology:
Then, Now and Tomorrow”
Sharon T. Phelan, M.D.
University of New Mexico
Albuquerque, New Mexico

Central Poster Awards

2024

“MenoPatch: Advancing Transdermal
Hormone Replacement Therapy
for Menopausal Symptom Management”

Ameek K. Bindra, B.A.

Carle Illinois College of Medicine
University of Illinois at Urbana - Champaign
Urbana, Illinois

“Perinatal Outcomes Associated with
Prenatal Cannabis Exposure in a
High-Risk Obstetric Population”

Kristina M. Gambino, M.D.

Louisiana State University Health Sciences Center
Shreveport, Louisiana

“Identification of Tryptophan Catabolic
Alterations in Endometrial
Tumor Microenvironments”

Sarah M. Nelson, B.S.

Southern Illinois University School of Medicine
Springfield, Illinois

“Once versus Twice Daily Iron
Supplementation in Pregnancy”

Jasmine D. Walker, B.A.

University of Missouri School of Medicine
Columbia, Missouri

Central Poster Awards

2025

“Bridging the Divide: A Multi-institutional
Curriculum to Integrate Private Practice
Physicians into Academic Health Systems”

Erik J. Belanger, B.S.

Louisiana State University Health Sciences Center
Shreveport, Louisiana

“Racial/Ethnic Health Outcome Disparity in
Maternal Mortality: Addressing the Problem”

Elliot M. Levine, M.D.

Rosalind Franklin University Chicago Medical School
Chicago, Illinois

“The Neglected Curriculum: A Systematic Review
of Financial Literacy in Medical Training”

Jyothi U. Patil

PCDS

Paradise Valley, Arizona

“No Place Like Home: A Retrospective Analysis
of Increasing Home Birth Rates in North Dakota’s
Maternity Desert (2015–2024)”

Alyssa J. Thielges, B.S.

UND School of Medicine and Health Sciences
Minot, North Dakota

Annual Meetings & Presiding Presidents

1929

St. Louis, Missouri

Washington Univ-Barnes

Palmer Findley, M.D. (Pro Tem)*

1930

Excelsior Springs, Missouri

The Elms Hotel

*Palmer Findley, M.D.**

1931

Chicago, Illinois

Shoreland Hotel

*Fred J. Taussig, M.D.**

1932

Memphis, Tennessee

Peabody Hotel

*Rudolph W. Holmes, M.D.**

1933

Milwaukee, Wisconsin

Hotel Schroeder

*Norman F. Miller, M.D.**

*Percy W. Toombs, M.D.**

1934

New Orleans, Louisiana

Roosevelt Hotel

*Everett D. Plass, M.D.**

1935

Omaha, Nebraska

Fontenelle Hotel

*Willard R Cooke, M.D.**

1936

Detroit, Michigan

Hotel Statler

*Buford G. Hamilton, M.D.**

1937

Dallas, Texas

Adolphus Hotel

*Jean P. Pratt, M.D.**

*Deceased

1938

Minneapolis, Minnesota

Radisson Hotel

*Robert D. Mussey, M.D. **

1939

Kansas City, Missouri

Muehlenbach Hotel

*Ralph A. Reis, M.D. **

1940

Indianapolis, Indiana

Lincoln Hotel

*Jennings C. Litzenberg, M.D. **

1941

New Orleans, Louisiana

Roosevelt Hotel

*Thomas B. Sellers, M.D. **

1942-1945

No Meetings, World War II

1946

Chicago, Illinois

Drake Hotel

*John H. Moore, M.D. **

1947

Louisville, Kentucky

Brown Hotel

*Earl C. Sage, M.D. **

1948

Denver, Colorado

Shirley Savoy Hotel

*William Mengert, M.D. **

1949

Oklahoma City, Oklahoma

Hall of Mirrors, Municipal Auditorium

*George Kamperman, M.D. **

1950

Milwaukee, Wisconsin

Hotel Schroeder

*Lawrence M. Randall, M.D. **

*Deceased

1951

Detroit, Michigan

Hotel Statler

*Russell J. Moe, M.D. **

1952

Memphis, Tennessee

Peabody Hotel

*John I. Brewer, M.D. **

1953

Houston, Texas

Shamrock Hotel

*W. O. Johnson, M.D. **

1954

St. Louis, Missouri

Jefferson Hotel

*Harold C. Mack, M.D. **

1955

Columbus, Ohio

Deshler-Hilton

*Frank L. McPhail, M.D. **

1956

New Orleans, Louisiana

Roosevelt Hotel

*Harold L. Gainey, M.D. **

1957

Omaha, Nebraska

Sheraton-Fontanelle

*Arthur B. Hunt, M.D. **

1958

Minneapolis, Minnesota

Leamington Hotel

*Herbert E. Schmitz, M.D. **

1959

Chicago, Illinois

Drake Hotel

*Axel N. Arneson, M.D. **

*Deceased

1960

Kansas City, Missouri

Muehlenbach Hotel

*Isadore Dyer, M.D. **

1961

Cleveland, Ohio

Statler-Hilton

*Edwin J. DeCosta, M.D. **

1962

Dallas, Texas

Sheraton-Dallas

*Richard D. Bryant, M.D. **

1963

Denver, Colorado

Denver Hilton

*Zeph J.R. Hollenbeck, M.D. **

1964

Milwaukee, Wisconsin

Schroeder Hotel

*Kenneth E. Cox, M.D. **

1965

Cincinnati, Ohio

Netherland Hotel

*Herman L. Gardner, M.D. **

1966

Biloxi, Mississippi

Broadwater Beach Hotel

*William C. Keettel, M.D. **

1967

Detroit, Michigan

Sheraton-Cadillac

*C. Paul Hodgkinson, M.D. **

1968

Oklahoma City, Oklahoma

Skirvin Hotel

*C. Gordon Johnson, M.D. **

*Deceased

1969

Memphis, Tennessee
Sheraton-Peabody
*Frederick J. Hofmeister, M.D.**

1970

Chicago, Illinois
Drake Hotel
*George J. L. Wulff, Jr., M.D.**

1971

White Sulphur Springs, West Virginia
The Greenbrier
*Thomas W. McElin, M.D.**

1972

St. Louis, Missouri
Stouffer's Riverfront Inn
*James S. Krieger, M.D.**

1973

Scottsdale, Arizona
Camelback Inn/Mountain Shadows
*David G. Decker, M.D.**

1974

New Orleans, Louisiana
Royal Sonesta
*Russell J. Paalman, M.D.**

1975

Colorado Springs, Colorado
The Broadmoor
*Brooks Ranney, M.D.**

1976

Houston, Texas
Shamrock Hilton
*Raymond H. Kaufman, M.D.**

1977

Biloxi, Mississippi
Broadwater Beach Hotel
*Clifford P. Goplerud, M.D.**

*Deceased

1978

Kansas City, Missouri

Crown Center

*William B. Goddard, M.D.**

1979

White Sulphur Springs, West Virginia

The Greenbrier

*John B. Nettles, M.D.**

1980

Minneapolis, Minnesota

Radisson South

*Tommy N. Evans, M.D.**

1981

Scottsdale, Arizona

Camelback Inn/Mountain Shadows

*David G. Anderson, M.D.**

1982

San Antonio, Texas

Hilton Palacio Del Rio

*Warren H. Pearse, M.D.**

1983

Colorado Springs, Colorado

The Broadmoor

*Sam P. Patterson, M.D.**

1984

Detroit, Michigan

Westin Renaissance Center

*Kenneth J. Vander Kolk, M.D.**

1985

New Orleans, Louisiana

Fairmont Hotel

*George D. Malkasian, Jr., M.D.**

1986

Milwaukee, Wisconsin

Hyatt Regency

*Joseph C. Scott, Jr., M.D.**

*Deceased

1987

Tarpon Springs, Florida

Innisbrook

Stacy R. Stephens, M.D.

1988

Salt Lake City, Utah

Marriott Hotel

*Preston V. Dilts, Jr., M.D.**

1989

Scottsdale, Arizona

Camelback Inn/Mountain Shadows

*James H. Maxwell, M.D.**

1990

Louisville, Kentucky

The Galt House

L. Russell Malinak, M.D.

1991

Colorado Springs, Colorado

The Broadmoor

*James P. Youngblood, M.D.**

1992

Chicago, Illinois

Westin Hotel

*John J. Sciarra, M.D., PhD**

1993

White Sulphur Springs, West Virginia

The Greenbrier

*Willam R. Anderson, M.D.**

1994

Memphis, Tennessee

Peabody Hotel

Bruce H. Drukker, M.D.

1995

Palm Desert, California

Marriott's Desert Springs

Melvin V. Gerbie, M.D.

*Deceased

1996

Houston, Texas

Lincoln Post Oak

James G. Blythe, M.D.

1997

Scottsdale, Arizona

The Scottsdale Princess

Karl C. Podratz, M.D., PhD

1998

Kansas City, Missouri

Westin Crown Center

Washington C. Hill, M.D.

1999

Maui, Hawaii

Ritz Carlton Kapalua

*John C. Morrison, M.D.**

2000

Chicago, Illinois

Fairmont Hotel

Robert J. Sokol, M.D.

2001

No Meeting – Cancelled After 9/11

2002

Las Vegas, Nevada

Bally's Hotel & Casino

Paul G. Tomich, M.D.

2003

La Jolla, California

Torrey Pines - Hilton

*Sherman Elias, M.D.**

2004

Washington, D.C.

Omni Shoreham Hotel

Abbey B. Berenson, M.D.

*Deceased

2005

Scottsdale, Arizona
Camelback Inn Resort
Stephen H. Cruikshank, M.D.

2006

Las Vegas, Nevada
The Venetian Resort
Jerry J. St. Pierre, M.D.

2007

Chicago, Illinois
The Drake Hotel
Mark I. Evans, M.D.

2008

New Orleans, Louisiana
The Ritz Carlton
*Bryan D. Cowan, M.D.**

2009

Maui, Hawaii
The Grand Wailea
Dennis J. Lutz, M.D.

2010

Las Vegas, Nevada
The Venetian Resort
*Christine H. Comstock, M.D.**

2011

Nassau, Bahamas
The Atlantis Resort
Gayle L. Olson, M.D.

2012

Chicago, Illinois
The Drake Hotel
John W. Calkins, M.D.

2013

Napa, California
Charleston Marriott
Stephen J. Fortunato, M.D.

*Deceased

2014

Albuquerque, New Mexico
The Tamaya Resort
*Kirk D. Ramin, M.D.**

2015

Charleston, South Carolina
Charleston Marriott
Barbara V. Parilla, M.D.

2016

Las Vegas, Nevada
The Venetian Resort
Roger P. Smith, M.D.

2017

Scottsdale, Arizona
Scottsdale Plaza Resort
David F. Lewis, M.D.

2018

Minneapolis, Minnesota
Radisson Blu Mall of America
Lee P. Shulman, M.D.

2019

Cancun, Mexico
Pyramid at The Grand Oasis
Vanessa M. Barnabei, M.D., Ph.D.

2020

Virtual Meeting Only
Cancelled by COVID-19 Pandemic
Suneet P. Chauhan, M.D., Hon. D.Sc.

2021

Napa, California
The Meritage Resort
J. Coffy Pieternelle, M.D.

*Deceased

2022

Charleston, South Carolina

Charleston Marriott

James W. Van Hook, M.D.

2023

Nashville, Tennessee

Omni

Andrew F. Wagner, M.D.

2024

Indianapolis, Indiana

Hyatt Regency

David M. Haas, M.D., M.S.

2025

Las Vegas, Nevada

Caesars Palace

Jean R. Goodman, M.D., M.B.A.

2026

Punta Cana, Dominican Republic

Meliá Caribe Beach Resort

Thomas F. Arnold, M.D.

*Deceased

Keynote Speaker

2005

“Aging is Everybody’s Business”

Suzanne R. Kunkel, Ph.D.

Oxford, Ohio

2006

“Ethnobotany: The Quest for New Cures”

Paul A. Cox, Ph.D.

Provo, Utah

2007

**“Government and Politics in
Women’s Healthcare”**

Ruth S. Hanft, Ph.D.

Washington, D.C.

2008

No Designated Keynote Speaker

2009

**“The Future of Women's Health Care:
I Once Was A Doctor”**

Norman F. Gant, Jr., M.D.

Dallas, Texas

2010

**“Counseling Patients for
Cardiovascular Risk”**

Barry A. Franklin, Ph.D.

William Beaumont Hospital Health Center

Royal Oak, Michigan

2011

“Obstetrical Trials that Changed Clinical Practice”

Catherine Y. Spong, M.D.

Bethesda, Maryland

2012

**“Healthcare Disparities for Women Worldwide: Report
from a Year as Jefferson Fellow”**

Douglas W. Laube, M.D.

University of Wisconsin Medical School

Madison, Wisconsin

Keynote Speaker

2013

“Putting the ‘M’ Back in
Maternal Fetal Medicine”

Larry C. Gilstrap, III, M.D.

American Board Ob-Gyn
Dallas, Texas

2014

“Future Changes in the Practice of
Obstetrics and Gynecology”

Willam F. Rayburn, M.D.

University of New Mexico
Albuquerque, New Mexico

2015

“Cancer Survivorship:
Navigating the Aftermath”

Sigrun Hallmeyer, M.D.

Oncology Specialists, SC
Park Ridge, Illinois

2016

“The Second Victim”

Patrice M. Weiss, M.D.

Virginia Tech Carilion School Medicine
Roanoke, Virginia

2017

“The New Labor Guidelines:
Better or Not?”

Thomas J. Garite M.D.

E. J. Quilligan Professor Emeritus
University of California, Irvine
Littleton, Colorado

2018

“50 Years of Progress in Ob-Gyn
Genetic Testing”

Joe Leigh Simpson, M.D.

Florida International
University College of Medicine
Miami, Florida

Keynote Speaker

2019

“Global Women’s Health Challenges”

John J. Sciarra, M.D., Ph.D.

Northwestern University

Chicago, Illinois

2020

No Designated Keynote Speaker

COVID-19 Virtual Meeting

2021

“Resistance to Change”

Mark I. Evans, M.D.

Comprehensive Genetics

New York, New York

2022

“Delivery of Medicine in Rural Areas”

Donna D. Johnson, M.D.

Medical University of South Carolina

Charleston, South Carolina

2023

“Do You See Me? Paintings of Postpartum

Trauma and Healing," One Physician's

Approach for Patient Advocacy

S. Abbās Shobeiri, M.D., M.B.A.

Inova Health System

Falls Church, Virginia

2024

“Hope for Maternal-Child Health Across the Globe:

How the U.S. and Global Partners

are Creating a Brighter Future”

Jeanne A. Conry, M.D., Ph.D.

The Environmental Health

Leadership Foundation

Granite City, California

Keynote Speaker

2025

“Maternal Mortality and the
Need for Cardio-Obstetrics”

Karen L. Florio, D.O., M.P.H.

University of Missouri-Columbia
Columbia, Missouri

2026

“What is Your Legacy”

Thomas M. Gellhaus, M.D.

University of Iowa Carver College of Medicine
Iowa City, Iowa

CAOG VISIONARY AWARD

Inaugurated in 2007 to recognize visionary leadership and “game changing” contributions which have fundamentally altered both the structure and the stature of the Central Association of Obstetricians & Gynecologists. By its very definition this award is bestowed infrequently with great admiration for exceptional dedication and service.

RECIPIENTS

Karl C. Podratz, M.D., Ph.D.

Awarded 2007

“As President in 1997 his vision introduced the CAOG to a professional management model as institutional support waned and he also promoted the current election process for officers and trustees.”

Mark I. Evans, M.D.

Awarded 2009

“As President in 2007 his vision championed both academic and community excellence which translated into and promoted the vigorous clinically oriented portion of the scientific program enjoyed annually.”

Dennis J. Lutz, M.D.

Awarded 2015

“As CAOG Managing Director since 2005 and as President in 2009 his vision firmly established today's financial viability and operational templates while his prodigious corporate memory instilled an enduring legacy of tradition, academic rigor & collegiality.”

CAOG VISIONARY AWARD (cont)

Barbara V. Parilla, M.D.

Awarded 2018

“As President in 2015 and Vice President and Trustee before that, her vision and unwaivering leadership actively promoted mentoring and role modeling as essential to optimal training in the speciality of obstetrics, gynecology and women’s health care.”

David F. Lewis, M.D.

Awarded 2021

“As the last six-year Secretery-Treasurer and President in 2017 his vision promoted the scholarly protocols currently enjoyed, including the Fellows and Residents (FAR) Research Network available to the specialty.”

“PTO Endowment Fund”

In 1994 the CAOG established the PTO Fund (Presidents-Trustees-Officers) and solicited voluntary contributions from all past presidents, past board members and past officers to supplement the operating funds. Since 1999 the serving officers and board members have also been annually asked to each contribute generously so the Fund continued to grow.

In 2005 the Board created a permanent “PTO Endowment Fund” with interest income providing stipends for the annual scientific awards. Donations are annually solicited to continue to grow that fund. All contributors are recognized in both the quarterly CAOG Newsletter and the Annual Program Book. Thanks again to these 2026 special supporters.

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2010 - 2026

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Thanks to these great CAOG supporters for their hoarding habits and generosity:

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2027

**HYATT REGENCY
TAMAYA RESORT**

Albuquerque, New Mexico

October 7,8,9,10

Thurs., Fri.,
Sat. & Sun.

2028

LOCATION TBD

Mid-October

Wed., Thurs.,
Fri. & Sat.

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OBSTETRICIANS & GYNECOLOGISTS

CAOG

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