"The mission of the MEFACOOG is to foster continuing improvements in women's healthcare. The goals of the MEFACOOG are to support Continuing Medical Education – Undergraduate, Graduate and Postgraduate Research Programs; Faculty Development; and Development of Educational Networks in women's healthcare."

Medical Education Foundation of American College of Osteopathic Obstetricians & Gynecologists

Year of 2023

MEFACOOG ANNUAL REPORT

Inside This Issue

Message from the Chair

Thomas S. Dardarian, DO, FACOOG (Dist)

Dear Members of the American College of Osteopathic Obstetricians and Gynecologists,

I hope this message finds you well. As the Chair of the Medical Educational Foundation, I wanted to take a moment to provide you with an update on our recent activities and initiatives.

Firstly, I'd like to express my gratitude to all of you for your dedication and commitment to advancing the field of osteopathic obstetrics and gynecology. Your hard work and passion are instrumental in shaping the future of our specialty and improving healthcare outcomes for women across the nation.

Over the past few months, our Foundation has been diligently working on several key projects aimed at supporting education, research, and professional development within our community. These initiatives include:

Supporting Continuing Medical Education (CME) Programs: We have been working to support a series of high-quality CME programs tailored to the needs of our members. These programs will cover a wide range of topics, including the latest advancements in obstetrics and gynecology, evidence-based practices, and emerging trends in women's healthcare.

Foster Research: Our Foundation is committed to supporting the Resident Research Award program and the Resident Reporter Program.

Mentorship and Networking Opportunities: We recognize the importance of mentorship and networking in fostering professional growth and collaboration. To that end, we are always happy to connect with colleagues who share MEFACOOG's goals.

I encourage all of you to engage with the Foundation and take advantage of the resources and opportunities that we provide. Your support and participation are critical to the success of our efforts to advance the practice of osteopathic obstetrics and gynecology.

Lastly, If you have not done so this year, please consider donating to MEFACOOG. We rely heavily on donations from our members to fund the amazing projects listed above.

If you have any questions or suggestions for how we can further serve our members, please don't hesitate to reach out to me or any member of the Foundation's leadership team. We are here to support you in any way we can.

"Message from the Chair"

(Continued from Page 3)

Thank you again for your continued dedication to our specialty. Together, we will continue to make meaningful contributions to women's healthcare and improve the lives of countless patients.

Warm regards,

Thomas S. Dardarian, DO, FACOOG(Dist)
MEFACOOG Chair 2023-2024

Message from Executive Vice President

Michael Geria, DO, DO, FACOOG (Dist)

Dear Members of the Osteopathic OB/GYN Community,

The world is ever-changing, especially in the field of obstetrics and gynecology. The MEFACOOG remains dedicated to quality education and research programs that support your efforts.

The newest endowment, the Sages of ACOOG Unity Lecture, honors a leader in the profession, recognizing their specific areas of expertise and commitment to women's healthcare through relevant educational content. This program continues to be a huge success and will continue into the future.

The "Resident Reporter" program, which has been existence for over 25 years, will continue its efforts to engage young professionals within the organization.

Engaging young osteopathic physicians is more important than ever. Another way we can impact education is by continuing to recognize excellence in osteopathic research. MEFACOOG research awards and grants will continue to provide the foundation for bringing osteopathic education principles to the greater OBGYN community and create scholarly activity opportunities for residency and fellowship programs.

Providing exceptional educational experiences continues to be a priority, beginning with medical students, through postgraduate training, and in lifelong learning.

Thank You for your continued support.

Sincerely,

Michael J Geria, DO, MS, FACOOG(Dist)

MEFACOOG Board 2023-2024

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MEFACOOG/Resident Reporter Scholarship Program

The Resident Reporter Program at the 90th Annual Conference received commendable contributions from the residents who participated. The top papers given monetary awards and publication in the MEFACOOG Annual Report were:

Elham N Samani, MD - Garden City Hospital - Garden City, MI
"*Perinatal Mood & Anxiety Disorders*"
Article based upon a lecture by lecture by: Hannah Potvin, MD

Suzanne Young, DO - Kettering Health Network OBGYN Program - Kettering, OH
"*Obesity & Food Addiction - How Understanding the "why" can significantly improve the "will"*
Article based upon a lecture by lecture by: Dennis Atienza, DO, FACOOG, ABOM

Plan your research project now!

The MEFACOOG Research Grant of up to $5,000 is open to osteopathic physicians or any resident or fellow of an osteopathically recognized ACGME residency or fellowship training program.

MEFACOOG/Resident Reporter Scholarship Program

Perinatal Mood & Anxiety Disorders

Elham N Samani, MD

Article based upon a lecture by Hannah Potvin, MD

Perinatal mood and anxiety disorders are one of the most common public health issues that has a profound negative effect on women, families, and communities. Dr. Potvin's lecture was an overview of perinatal mood and anxiety disorders, including screening methods, differential diagnosis, and pharmacological and non-pharmacological treatments during Pregnancy and the Postpartum Period. Perinatal mood and anxiety disorders is an overarching term for any mood or anxiety disorder diagnosed while pregnant or postpartum[1,2]. During pregnancy, an individual undergoes physiological and psychological changes, which put them at a higher risk of mood and anxiety disorders. It is estimated that 15% to 21% of pregnant and postpartum women experience symptoms of perinatal mood and anxiety disorders. The most relevant factors associated with antenatal depression or anxiety are smoking, black/Latino ethnicity, unwanted or unplanned pregnancy, teen pregnancy, hyperemesis gravidarum, obstetrical complications, traumatic birth experience, breastfeeding problems, fetal loss, or infant in NICU, lack of a partner or social support, history of abuse or of domestic violence, personal history of mental illness, adverse events in life and high perceived stress[2,3].

During peripartum, approximately one in five women will develop an incident mental health condition; therefore, obstetricians and other obstetric care professionals are expected to encounter perinatal mental health conditions. The cost of untreated perinatal depression is estimated at $14.2 billion for all US Births or $32,000 per mother-child pair[4]. Many of these disorders are associated with less prenatal care, substance abuse, preterm delivery, and other poor obstetrical and neonatal outcomes. Despite these known risks, obstetrical providers often are reluctant to confront or fail to identify mental health issues during pregnancy. Lyell and colleagues found that the diagnosis of depression was not documented in nearly half of the records of affected women[5].

The most common type of perinatal mood and anxiety disorder is perinatal depression. Postpartum depression is diagnosed when at least five depressive symptoms are present for at least 2 weeks. Postpartum depression is considered when a patient has a major depressive episode along with the peripartum onset, and it is not classified as a separate disease per the Diagnostic and Statistical Manual of Mental Disorders (DSM–5). It is defined as a major depressive episode with the onset of pregnancy or within 4 weeks of delivery. The nine symptoms are present almost every day and represent a change from the previous routine. The diagnosis should include either depression or anhedonia (loss of interest) in addition to the five symptoms to be diagnosed.

(Continued on Page 9)

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- Depressed mood (subjective or observed) is present most of the day
- Loss of interest or pleasure, most of the day
- Insomnia or hypersomnia
- Psychomotor retardation or agitation
- Worthlessness or guilt
- Loss of energy or fatigue
- Suicidal ideation or attempt and recurrent thoughts of death
- Impaired concentration or indecisiveness
- Change in weight or appetite (weight change 5% over 1 month)

These symptoms can lead to significant distress and/or impairment. Furthermore, these symptoms are not attributable to a substance or medical condition. A psychotic disorder does not cause the episode, nor has there been a prior manic or hypomanic episode. Physical symptoms of anxiety, such as irritability, tension, concentration difficulties, and excessive and uncontrollable worries, may be mistaken as normal during pregnancy and postpartum [6]. It has recently been recommended that all obstetrical care providers complete a full assessment of mood and emotional well-being during the comprehensive postpartum visit[7]. Identification of psychiatric disorders in pregnancy can be challenging because changes in behavior and mood are often attributed to pregnancy. To differentiate these, Yonkers and associates recommend assessment of cognitive symptoms, for example, loss of concentration, excessive anxiety and insomnia, and sleep disturbance[8]. At Parkland Hospital, mental illness screening is completed at the first prenatal visit using a brief risk-based query and again postpartum using a recognized screening tool for postpartum depression. There are several screening methods, including but not limited to "Edinburgh Postnatal Depression Scale," "Patient Health Questionnaire 9," "Beck Depression Inventory," and "Zung Self-rating Depression Scale." There is no good screening tool specifically for anxiety[9]. Once a positive mental health screening result is identified, more assessment by either a mental health provider or mental health counselor[10]. During the evaluation, it is important to include drug and alcohol history, smoking habits, and all prescription and over-the-counter-drug medications[9,10].

According to the American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5), the onset of postpartum major depression can occur before or after parturition. Up to 75% of women may present with mild mood lability in the immediate postpartum period, which resolves within almost 2 weeks postpartum. Postpartum blues reportedly occurs in 50% to 80% of new mothers and occurs in the first few days after delivery. Women experience crying bouts, sadness, anxiety, irritability, sleep disturbance, appetite changes, confusion, and fatigue. It does not affect daily functioning or the ability to take care of the baby. Symptoms typically resolve within a few days to 1 to 2 weeks following delivery. Postpartum blues do not impair maternal function, and mothers can be treated with emotional support and reassurance. Major or minor depression develops postpartum in 10 to 20 percent of women during pregnancy or within 4 weeks of childbirth. Postpartum depression

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is defined by the same criteria as major depressive disorder. Postpartum psychosis is manifested by delusions, hallucinations, or suicidal ideas, occurring within 3 weeks of birth, whether for the first time or as part of a recurrent illness[11]. Postpartum psychosis has a complex multifactorial origin. Risk factors include a history of bipolar disorder, history of postpartum psychosis in a previous pregnancy, family history of psychosis or bipolar disorder, history of schizoaffective disorder or schizophrenia, and discontinuation of psychiatric medications during pregnancy. The overall prevalence is higher in patients suffering from affective disorders like bipolar one, two, and first-time pregnancy with a previous family or personal history of bipolar one disorder is considered the single most important risk factor[12]. Treatment modalities are classified as pharmacologic and nonpharmacologic.

The first line for prenatal depression and anxiety is an anti-depressant, mainly selective serotonin reuptake inhibitors. Recent studies revealed a risk of preterm birth, neonatal adaptation syndrome (NAS/PNAS), and cardiac or persistent pulmonary hypertension. Neonatal adaption syndrome occurs in about 30% of infants, and present with jitter, irritability, respiratory distress, weak cry, and difficulty feeding. Neonatal adaptation syndrome is self-limiting. A combination of therapy and antidepressant drugs is recommended for women with moderate to severe depression. Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, and sertraline are the first choice. Consider switching to serotonin-norepinephrine reuptake inhibitors (SNRIs) SSRIs is ineffective. Once an effective dose is reached, continue treatment for 6 to 12 months to prevent relapse of symptoms. The risk of cardiac defects was reported by taking Paroxetine & Venlafaxine during the first trimester. There are not enough data on Bupropion, Mirtazapine, and Trazodone. Pharmacologic recommendations for women who are lactating should include discussing the benefits of breastfeeding, the risks of antidepressant use during lactation, and the risks of untreated illness. Lorazepam is most commonly used as an anxiolytic, without a current link with cleft lip and palate [13,14].

Transdermal estradiol, brexanolone, electric convulsive therapy, transcranial magnetic stimulation, mind-body practice, nutrients, and supplements including Folic acid, vitamin D, Omega-3 fatty acids, probiotics, psychotherapy, bright light therapy, sleep interventions, social support are other treatment options. Brexanolone is a GABA receptor modulator with infusion requiring an inpatient stay with close monitoring. There are some common alternatives to avoid including S-adenosyl methionine (SAMe), melatonin, valerian, St. John's Wort, and Cannabis.

Non-medication management indicated mild depression based on clinical assessment, no suicidal ideation or attempts, ability to take care of self and infant, strong preference, engaged in therapy. Medication management is recommended for moderate-severe depression, suicidal ideation, difficulty with functioning or caring for self or neonate, psychotic symptoms, and comorbid anxiety disorders or symptoms[14,15].

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Taken together, perinatal mood and anxiety disorders are common which require timely and efficient management. Current best practice should involve a consensual process whereby patients are presented with the current knowledge, engaged in decision-making, and closely monitored regardless of their choice of treatment. Future research will more clearly elucidate the underlying pathogenesis, the potential long-term impact of perinatal mood and anxiety on the developing fetus, and how best to counsel pregnant women about the risks of untreated perinatal mood and anxiety versus the risks of psychopharmacologic treatment during pregnancy and lactation.

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MEFACOOG/Resident Reporter Scholarship Program

Obesity & Food Addiction - How Understanding the "why" can significantly improve the "will"

Suzanne Young, DO

Article based upon a lecture by Dennis Atienza, DO, FACOOG, ABOM

Obesity is a multifactorial disease and its recent trends and prevalence show a steep rise. Most health care providers are poorly equipped to treat obesity with limited training, time and resources. Patients who come for their annual exams may be seeking help to discuss this aspect of their health without feeling judged. One way to do this is with short simple conversations that address one of the main causes of the obesity epidemic - our addiction to ultra processed foods and refined sugars. The aha moments from these conversations may spur patients to make lifestyle and dietary modifications to help them achieve and sustain a healthier weight in the long term.

According to the World Health Organization (WHO), overweight and obesity are defined as abnormal or excessive fat accumulation that presents a risk to health[1]. A body mass index (BMI) is a measure of an adult's weight in relation to his or her height, specifically the adult's weight in kilograms divided by the square of his or her height in meters. A BMI over 25 kg/m2 is considered overweight, and over 30 kg/m2 is obese [1]. The Obesity Medicine Association (OMA) states, "Obesity is defined as a chronic, progressive, relapsing, and treatable multifactorial, neurobehavioral disease, wherein an increase in body fat promotes adipose tissue dysfunction and abnormal fat mass physical forces, resulting in adverse metabolic, biomechanical, and psychosocial health consequences" [2].

In 2013, the American Medical Association recognized obesity as a disease [2]. The June 2021 issue of Obstetrics and Gynecology stated that obstetrician-gynecologists are the leading experts in the health care of women, and obesity is the most common medical condition in women of reproductive age [3]. Obesity increases risk for cancer, type 2 diabetes, sleep apnea, hypertension, and depression [2]. The implications of obesity relative to pregnancy are often overlooked as obesity in women is such a common condition and there is a lack of specific evidence-based treatments[3].

Obesity trends among U.S. adults between 1985 and 2020 are startling. The Center for Disease Control's (CDC) Behavioral Risk Factor Surveillance System (BRFSS) collected selfreported height and weight data from U.S. adults through a series of telephone interviews[4]. In 1990, among states participating in the BRFSS, 10 states had a prevalence of obesity less than 10% and no state had a prevalence equal to or greater than 15%. By 2020, no state or territory had a prevalence of obesity less than 20%. Sixteen states (Alabama, Arkansas, Delaware, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Ohio,

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Oklahoma, South Carolina, Tennessee, Texas, and West Virginia) had a prevalence of obesity of 35% or greater[4].

A 2022 study found that the factor most closely linked to the obesity epidemic that appeared in the U.S. in 1976-1980 is ultra-processed foods (UPFs), i.e., foods with a high content of calories, salt, sugar, and fat but with very little whole foods[5]. Factors that probably contributed to the increased intake of UPFs include their relatively low cost and the increased popularity of fast-food restaurants[5]. These foods are highly addictive and do not lead to satiety[5]. Examples of these foods include soft drinks, fruit juices, cereal, processed grains, packaged snacks like chips, packaged cookies, packaged foods and meals, and fast foods. A 2021 review demonstrated that "the existing literature suggests biological and behavioral parallels between food addiction and substance addictions, with ultraprocessed foods high in both added fat and refined carbohydrates being most implicated in addictive-like eating"[6]. This is why we literally keep eating foods that make us keep eating.

In the standard American diet, 63% of calories come from refined or processed foods; 25% of calories come from animal-based foods; and 12% of calories come from plant-based foods[7]. Unfortunately, half of the plant based calories come from French fries[7]. That means only 6% of America's calories are coming from health-promoting fruits, vegetables, whole grains, nuts and seeds.

When physicians understand that the rising prevalence of overweight and obesity has multifactorial causes particularly food addiction, they can improve their own will to address, to educate, and to consider treatment options for their patients. When patients understand what caused their besity and what risks are associated with their obesity, they can improve their will to implement their own lifestyle and dietary changes to sustain a healthier weight in the long term.

However, are medical health care providers adequately equipped to understand, address, and treat obesity? A 2010 survey showed that medical students received an average of only 19.6 contact hours of nutrition instruction during the four years of medical school[8]. Most recently as 2019, a study reiterated that "nutrition education in medical school is… rudimentary at best" [9].

The American Board of Obesity Medicine (ABOM) was established in 2011 to certify physicians to treat and manage obesity, which is the most prevalent chronic disease in our society [10]. Obesity Medicine is one of the fastest growing fields in medicine; currently there are 248 obstetrician gynecologists who are also board certified in obesity medicine. However, this is only a fraction of the total obstetrician gynecologists in the United States [10, 11]. The Obesity Medicine Association developed a working document called The Obesity Algorithm that is updated annually to assist health care professionals to manage and care for patients with overweight

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and obesity[12]. Bariatric surgery and pharmacotherapy may help patients lose weight initially, however in order to maintain weight loss, patients will likely need to incorporate nutritional intervention, physical activity, and behavior therapy[12].

There are many mainstream acceptable diets and dietary patterns, including the Mediterranean diet, Dietary Approaches to Stop Hypertension (DASH) diet, Ketogenic diet, Paleolithic diet, vegetarian or vegan diet, many commercial diet programs, and intermittent fasting or time restricted eating [12]. The common denominator for these diets and dietary patterns is that they mostly eliminate processed foods and refined sugars and promote "clean" eating. Ultimately, an overweight or obese patient must choose to adapt a lifestyle that that will help them lose weight gradually and keep it off without feeling deprived and miserable, that they will keep doing after the weight goal is reached. Many factors should be considered, including individual food preferences, eating behaviors, and meal patterns; cultural background, traditions and food availability; time constraints and financial issues; and nutritional knowledge and cooking skills [12].

When asked if they are interested in the latest simple weight loss tips, those patients with overweight or obesity may be quick to respond with wanting to lose weight. A 2014 study found that physicians' direct discussion of their patients' weight status is associated with clinically significant weight loss and may be a targetable intervention[13].

Short simple conversations can address food addiction, processed foods and refined sugars, and grocery shopping[14]. Example conversations with your patient:

- "*Do you know how I know you're not a food addict? Because no one is addicted to apples, eggs, broccoli, or salmon, etc. What are we addicted to? Hamburger Helper, macaroni and cheese, pizza pockets, Oreos, etc. (processed foods)*."
- "*The decision to gain weight, or to not lose the weight you have, didn't happen when you put it in your mouth. The decision happened when you put it in your cart. If it's in your house, you're going to eat it!*"
- "*Remember a general rule of thumb - shop at the periphery - the outside aisles of the grocery store."*
- "*Fresh food may cost more, but you don't eat as much of it*."
- "*Would you eat a snack that contains thiamin mononitrate, sodium phosphate, imitation mozzarella cheese, titanium dioxide, and dozens of other chemicals, or would you rather have a Totino's pizza roll?*"
- "*Wait, don't you need a caloric deficit to lose weight? Imagine 20 grams of carbohydrates in two difference ways: half a bagel, or a plate full of vegetables*."
- "*Would you like to try a 21 Day Challenge? Eliminate processed foods for 21 days and see if you have more energy, less cravings, and weight loss*."

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These conversations may lead to aha moments for your patients that encourage them to make lifestyle and dietary modifications to help them reach and maintain a healthy weight.

Obesity is a multifactorial disease where biological, behavioral and environmental factors conspire to resist weight loss and promote weight gain. Obesity trends and prevalence show an alarming rise in just the last few decades. Most health care providers are not equipped with training, time and resources to treat obesity. We as health care providers must provide ways to discuss overweight and obesity without the perception of judgmental overtones. We can do this with short simple conversations. We cannot treat the epidemic of obesity without first addressing the main cause - America's addiction to ultra processed foods and refined sugars.

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MEFACOOG Annual Report - Year 2023 Support

The Medical Education Foundation relies on its members to support its mission.

The mission of the MEFACOOG is to foster continuing improvements in women's health care. The financial review below reflects the year ending December 31, 2023. Below are ongoing grants we hope to continue in the upcoming year.

- MEFACOOG Resident Reporter Scholarship Program-educating osteopathic OB/GYN residents at the ACOOG Annual Conference and reporting back to their programs and to the profession.
- MEFACOOG Awards for Excellence in Poster Presentation-encouraging research and rewarding dissemination via poster presentation at the ACOOG Annual conference.
- MEFACOOG Postgraduate Research Grant encouraging research in osteopathic OB/GYN residency and fellowship programs.

The 90th Annual Conference of the ACOOG hosted three funded lectureships. The Sages of ACOOG Unity Lecture was given by Ronald J. Librizzi, DO, FACOOG (Dist), FACOG. The MEFACOOG Distinguished Lecture was presented by Charles J. Lockwood, MD. The Distinguished Fellows Lecture was presented by Barbara E. Bierer, MD. The Past President's Honorary Lectureship was presented by Lois Ramondetta, MD at the 2023 Advances in Women's Health Conference.

The National Student Society of the ACOOG met for the fifteenth during the ACOOG 2023 Advances in Women's Health. These projects would not be possible without the support of you, the donors. Thank you for your continuing support.

Financial Review

Statement of Activities

Year Ended December 31, 2023

Support

Corporate Contributions	$10,000
Individual Contributions	$61,576
Fund Raising	0.00
Interest & Dividends	$24,495
Realized & Unrealized	$38,353
In-Kind Contributions	$51,396
Total Support	**$185,820**

Expenses

Program Services	$15,270
Support Services	$101,628
Total Expenses	**$116,898**

Net Assets, Beginning of Year	$664,985
Change in Net Assets	$68,922
Net Assets, End of Year	**$733,907**

Statement of Financial Position

Year Ended December 31, 2023

Assets

Current Assets

Cash	$34,983
Investments	$691,739
Account Receivable	$7,435
Total Assets	**$734,157**

Liabilities and Net Assets

Accounts Payable	$250
Without Donor Restrictions	$690,100
With Donor Restrictions	$43,807
Net Assets	$734,157
Total Liabilities and Net Assets	**$762,036**

MEFACOOG Awards for Excellence

90th Annual Conference Posters – 1st Place Winner

Endometrial Receptivity Testing and Subsequent Adjustment to Window of Implantation Timing Improve Pregnancy Success Rates of Women Undergoing Assisted Reproductive Technology

Zak Rose-Reneau, DO
Rachel Terry, BS, OMS III
Ryan Riggs, MD & Derica Anderson, BS

Oklahoma State University
CENTER FOR HEALT SCIENCE

INTRODUCTION

For decades, REI research focused solely on the creation of a viable embryo to increase pregnancy rates. Recently, research has identified the impact of endometrial adhesion molecule expression during the window of implantation (WOI) as playing a major role in embryo implantation.

METHODS

This is a retrospective case-control study of women undergoing assisted reproductive technology and the effects of the Igenomix © Endometrial Receptivity Assay (ERA) on pregnancy success rates following frozen embryo transfer.

RESULTS

ERA results showed 29 of 60 patients were normal, 20 of 60 patients were Early Receptive (WOI existing 12 hours later than expected), and 11 of 60 patients were Pre-Receptive (WOI existing 24 hours later than expected). Ninety-one percent of patients with a corrected abnormal ERA had successful pregnancies while only 72% achieved successful pregnancy without using ERA to assess for their WOI (p = < 0.01, OR 3.82).

Table 1: Patient Demographics

	Women with ERA testing	Women without ERA testing
Sample Size	60	47
Minimum Age (yrs)	27	25
Maximum Age (yrs)	43	36
Average Age (yrs)	34.6	34.4

Table 2: Comparison of successful pregnancies in patients with normal vs abnormal ERA test results after failed FET

	Successful Pregnancy	Unsuccessful Pregnancy	Pregnancy %
Normal ERA	16	13	55.2
Abnormal ERA	12	19	38.7
p = 0.24			
OR = 1.98			

Table 3: Comparison of Successful pregnancies in patients with corrected abnormal ERA vs. control group after failed FET

	Successful Pregnancy	Unsuccessful Pregnancy	Pregnancy %
Corrected ERA	20	2	90.9
Control Group	34	13	72.3
p = < 0.01			
OR = 3.82			

Table 4: List of major biomarkers associated with WOI and endometrial receptivity that are tested for by ERA

Avß3 Integrin
Leukemia Inhibitor Factor (LIF)
HOXA10
Glutathione Peroxidase 3
CD56+ NK Cells
NOTCH1

CONCLUSION

Endometrial Receptivity Assay testing has a significant impact on successful pregnancy rates among patients undergoing ART. Women should be encouraged to undergo ERA testing to ensure accurate timing of their WOI for embryo transfer. While numerous medication changes can

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be made by the physician to improve implantation success rates, if the WOI timing is not accounted for, those changes are for naught because the endometrium is not prepared to receive the embryo and subsequent embryo implantation into the endometrium will not occur. The use of ERA could save the patient tens-of-thousands of dollars and shave years off their time to achieve successful pregnancies.

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MEFACOOG Awards for Excellence

90th Annual Conference Posters – 2nd Place Winner

Novel detection methods for sexually transmitted infection (STIs) from M. genitalium

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Burrell College of Osteopathic Medicine

INTRODUCTION

Mycoplasma genitalium is a sexually transmitted pathogen, causing 25-35% of nongonococcal urethritis in males and linked to premature rupture of placental membranes in females [(1)]. This pathogen is difficult to culture, requiring an alternative identification method for diagnosis [(2)]. Loop-mediated isothermal amplification (LAMP) is a novel nucleic acid amplification technique that uses a set of 4 to 8 DNA primers, allowing for rapid target amplification and a viable detection method.

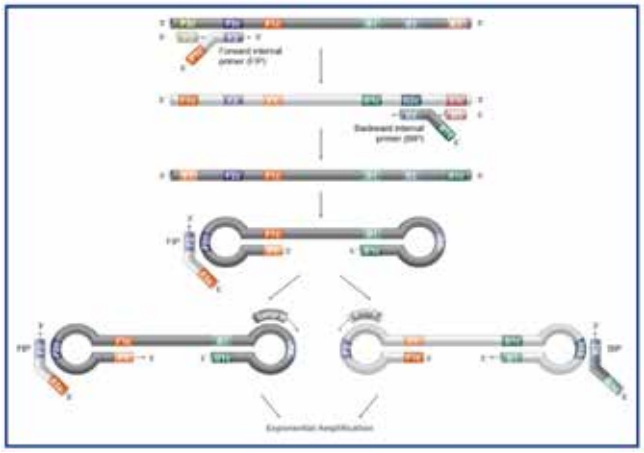

Figure 1. NEB Lamp Primer Reaction [(6)].
In comparison to PCR, LAMP uses an isothermal reaction that is progressed by a strand displacement DNA polymerase, BST 2.0, which allows for rapid amplification of target sequences using specific primer sequences for detection. BST 2.0 is the Large Fragment of *Bacillus stearothermophilus* DNA polymerase. It has 5'-3' DNA polymerase activity and strand displacement activity allowing for rapid amplification of our nucleic acid target.

Table 1. *M. genitalium* primer sequences (5'–3').

***M. genitalium pdhd* LAMP primers**	
F3	TGG ATA ATG GTC ACT TCA CTC
B3	ACA ACA CAA CTT ACA CCA CTA
FiP	TGG CTT TAG AGG GAG TAC CTA AGA AAA AGC AAA CTC AAC CCC AAT
BiP	TGA GTC AAT GAT AAA CCC AGC TTG TTG CAA CCG GAT CAA GAC
LF	TGT TGT AGT TGG GGG AGG T
LB	GCT TTT TCA ACC CCT GGT AAA G

RESULTS

The pdhD Color LAMP reaction allowed target detection of 15.97 genomic copies at a concentration of 1x10-2 pg/µL in 30 minutes (Figure 1). Controls that contained no target DNA or off-target DNA and did not result in any noticeable amplification (Figure 2 & 3). Fluorescent LAMP allowed detection of a much lower target DNA copy amount, 1.6 genomic copies, which equates to a concentration of 1x10- 7ng/µL, in a shorter amount of time (18 min) (Figure 4).

A preliminary lateral flow assay (LFA) experiment for the detection of *Mycoplasma genitalium* successfully detected *Mycoplasma genitalium* DNA but not the negative control *Mycoplasma hominis* (Figure 3) (ATCC 23114D).

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Tubes	Contents
1	No template control – WNV primers
2	No template control – *M. genitalium* primers
3	WNV *E* gene RNA target ($5x10^3$ copies/µL) + WNV primers
4	*M. genitalium pdhD* gene synthetic target DNA ($7.6x10^5$ copies/µL) + *M. genitalium* primers
5	*Staphylococcus aureus* (4432) clinical sample + *M. genitalium* primers

Figure 2. Colorimetric LAMP assay detecting M. genitalium and West Nile Virus (WNV). LAMP reactions in tubes 3, 4, and 5 contained 1 µL of each respective nucleic acid target. Negative reactions are indicated in pink and positive reactions are indicated by a change to yellow.

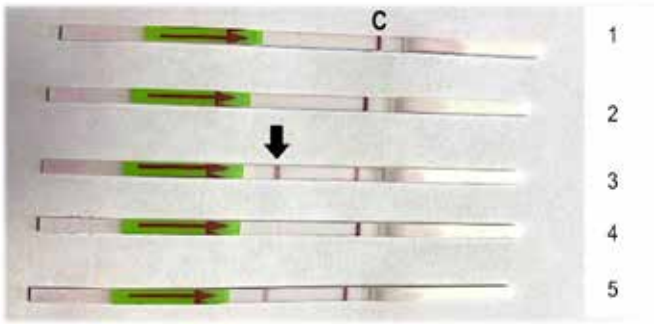

Figure 3. LFA reactions for M. genitalium primers against *M. hominis*. Reaction strip 3 shows LFA detection bands for *M. genitalium* primers with M. genitalium DNA target (arrow). Reaction strip 4 shows LFA detection bands for M. genitalium primers against *M. hominis* DNA target. 2 bands indicates a positive reaction. Strips 1 and 2 are no template controls.

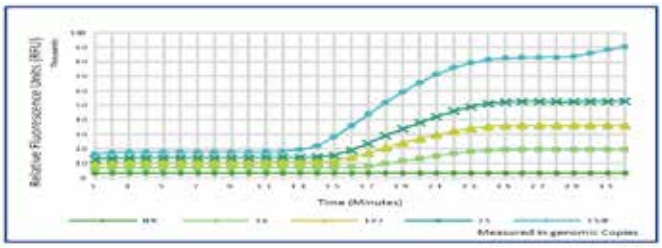

Figure 4. Relative fluorescence units by genomic copy amount graphed against reaction time. Amount of *M. genitalium* genome in optimization reactions.

METHODS

Primer sets were designed using available pdhD gene G37 strain of *M. genitalium* (L43967.2) [4]. Alignments of the pdhD genes of four *M. genitalium* types were performed using Clustal Omega [5]. LAMP primers (F3, B3, FIP, and BIP) were designed using NEB's LAMP Primer design tool and synthesized through Integrated DNA Technologies [6]. Loop primers (LF, LB) were designed separately to increase the specificity and sensitivity of the LAMP assay using the NEB LAMP Primer design tool [6]. The final primer set was chosen based on Δ*G* values. The specificity of all primers was confirmed using BLAST [7].

Colorimetric LAMP reactions were performed using the WarmStart® Colorimetric (or Fluorescent) LAMP 2X Master Mix (DNA & RNA) (M1800S) from New England Biolabs (NEB, Ipswich, MA, USA) or the WarmStart® Fluorescent LAMP/RT-LAMP Kit (E1708S) with LAMP Fluorescent Dye (NEB #B1700). Reaction mixes were prepared as described by the manufacturer (NEB) at 65ºC for 30 minutes. A lateral flow assay (LFA) using the Milenia HybriDetect LFA kit was also used Genomic copies were calculated based on the *M. genitalium* genome size (580,076 base pairs).

CONCLUSIONS

LAMP assays maintain the high sensitivity of normal PCR assays while allowing for a more rapid diagnosis with similar sensitivity, eliminating the need for thermal cycling [2]. To visualize our detection results, another method called LFA was used to compare

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our detection results to a close genomic relative, *Mycoplasma hominis*, which showed no detection.

We found that this assay is specific to *Mycoplasma genitalium* when compared to *Mycoplasma hominis*. The pdhD fluorescent LAMP was found to be more sensitive (1.6 genomic copies) than the Colorimetric LAMP assay (15.97 genomic copies). Fluorescent LAMP reactions were monitored for 32 minutes at 65°C with the fastest time to detection of 14 minutes containing the highest concentration of the target. Although the colorimetric method was rapid, it had the innate flaw of being indirect, whereas LFA is specific and a direct method of visualizing the product of amplification. Similarly, fluorescent lamp is a specific and direct method of measurement but requires cumbersome equipment.

Current work is underway to establish a point of care LAMP assay. We project that screening pregnant women for *Mycoplasma* and other organisms could potentially be a preventative measure precluding chorioamnionitis and possibly fetal loss.

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MEFACOOG Awards for Excellence

90th Annual Conference Posters – 3rd Place Winner

Proteomic Analysis Identifies Complement Factor H as a Novel Biomarker for Preeclampsia

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INTRODUCTION

Preeclampsia is the leading cause of maternal and fetal morbidity and mortality1. Despite decades of research, the pathophysiology of preeclampsia is still not fully understood[2]. Clinically useful biomarkers for predicting this condition are warranted[3].

OBJECTIVES

To identify novel biomarkers for preeclampsia involved in its etiology, pathophysiology, and prediction.

METHODS

Blood serum was obtained from pregnant women with preeclampsia and matched with healthy controls. Samples were subjected to nano liquid chromatography -tandem mass spectrometry analysis. Protein analysis was conducted using Mascot search engines. A p-value and a false discovery rate (FDR) of less than 0.05 were used to indicate statistical significance.

RESULTS

Sixteen preeclampsia and sixteenhealthy controls were selected. No significant differences were identified in main demographics and baseline obstetric data (Table). From 1,821 identified proteins in preeclampsia, 85 (4.2%) were significantly upregulated (abundance ratio>1.5, p<0.05), and 69(3.7%) were significantly downregulated. Complement activation was the functional pathway more significantly associated with preeclampsia. Complement factor H was the protein with the most significant abundance (Figure).

Table. Baseline Characteristics and Identified Biomarkers for Preeclampsia (N=32)

Baseline Data	Preeclampsia N=16	Controls N=16	p-value
	N (percentage) or Median (IQ range)		
Age	22.0 (19.0 - 29.0)	26.0 (22.0 - 28.0)	0.30
Body Mass Index	34.1 (30.4 - 46.8)	31.4 (28.8 - 33.6)	0.40
Gravidity	1 (1 - 2)	3 (2 - 4)	0.10
Parity	1 (1 - 2)	2 (1 - 2)	0.70
Gestational Age	37.0 (32.0 - 38.0)	37.0 (36.0 - 38.0)	0.06

Biomarkers for Preeclampsia			
Description	Protein Accession	Relative Difference	p-value
Complement factor H-related protein	B1AKG0	1.7	<0.001
Complement factor isoform	S2Z4I5	1.6	<0.001
Complement factor H	A8K5T0	1.6	<0.001

Abbreviations: N, number of cases; IQ, interquartile range.

CONCLUSION

Complement activation pathway was significantly dysregulated in antepartum preeclampsia. Complement factor H appears to be a potential novel biomarker

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significantly upregulated in preeclampsia. Further research in these specific protein subfamilies is warranted.

KEY REFERENCES

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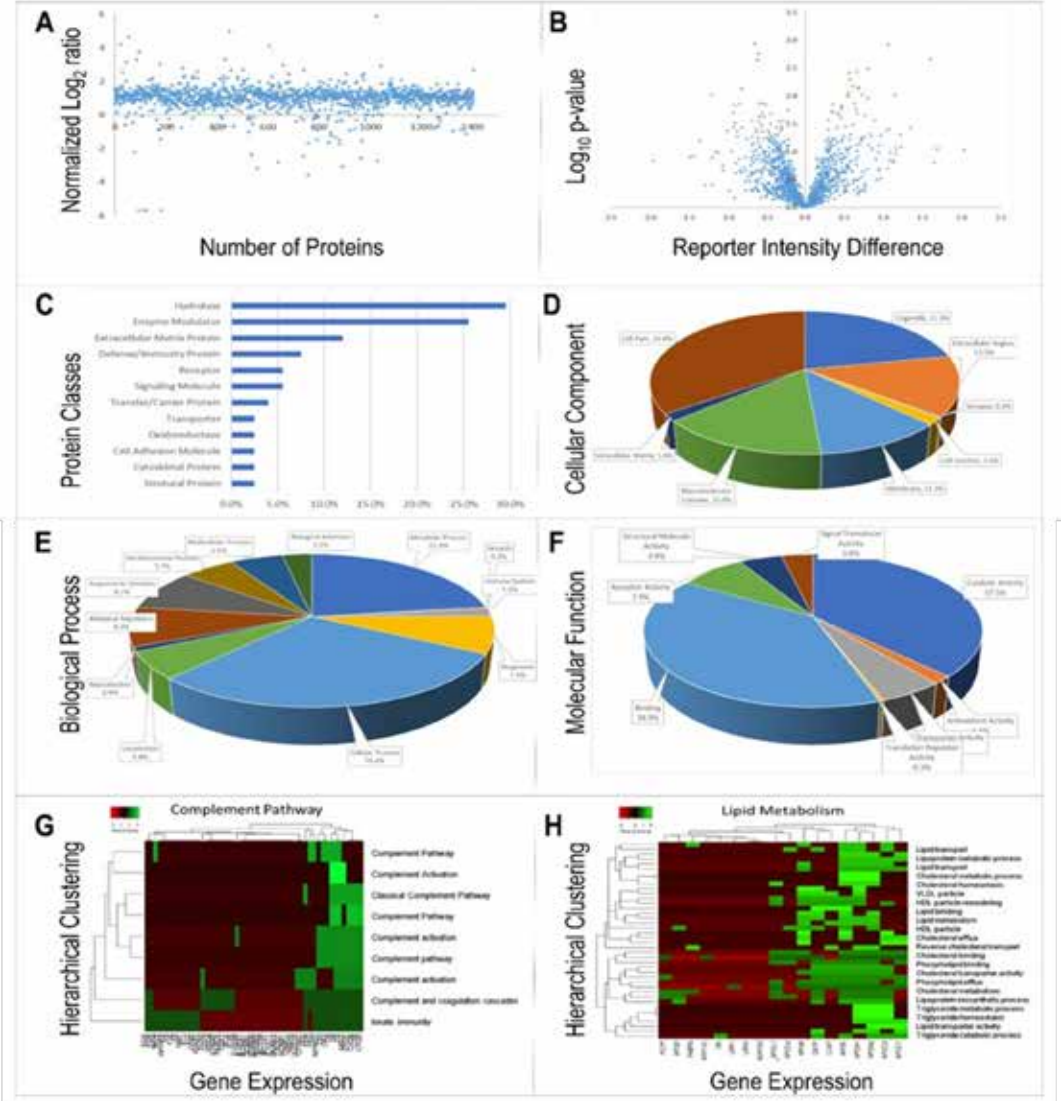
Figure. Data Visualization Analysis of the Sera Proteome in Preeclampsia.



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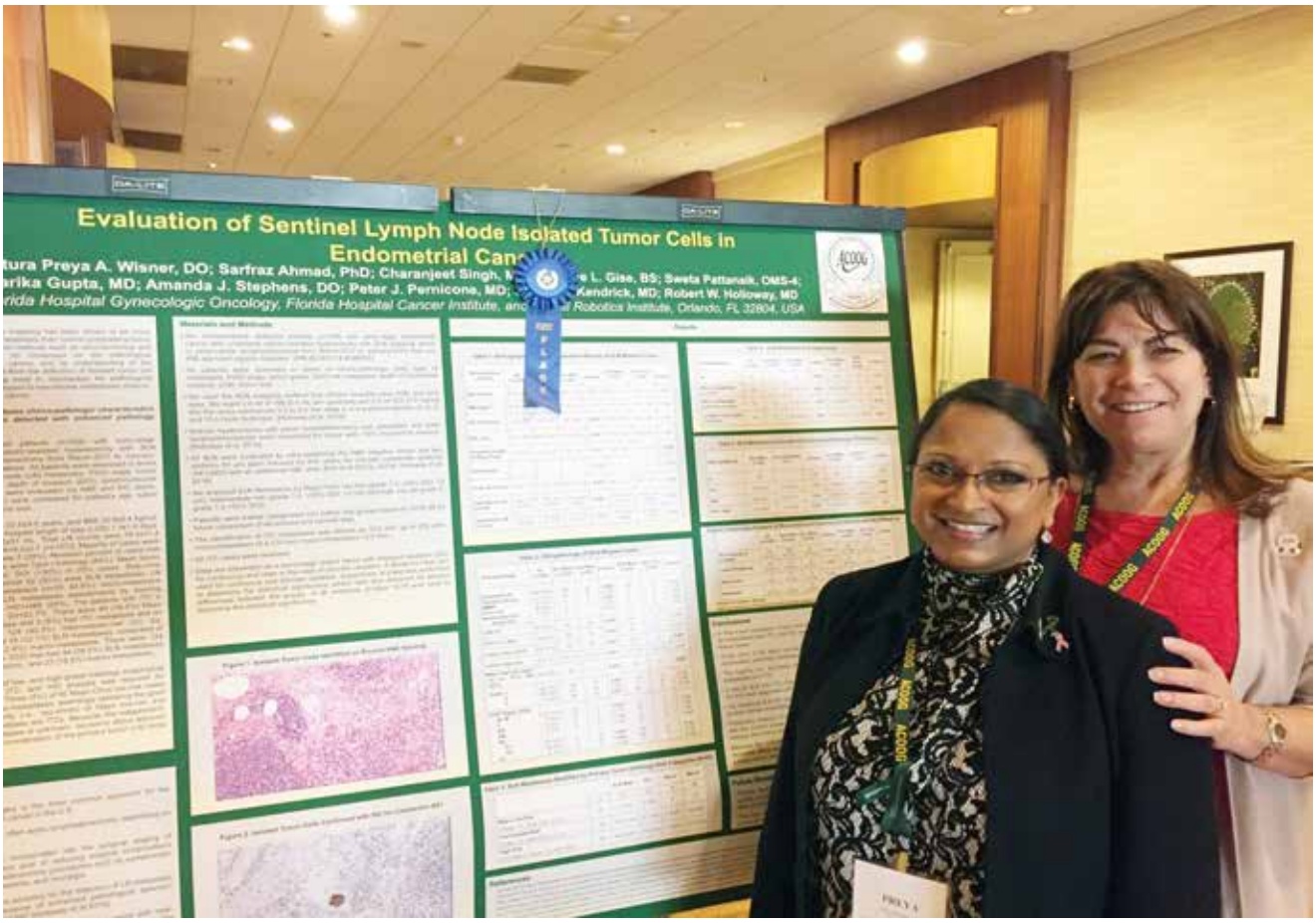

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Posters: February 15th, 5 PM (Central Time)

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