COMMITMENT EXCELLENCE INTEGRITY

"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 2024

MEFACOOG ANNUAL REPORT

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Message from the Chair

Marydonna Ravasio, DO, FACOOG (Dist)

Dear Members of the American College of Osteopathic Obstetricians and Gynecologists (ACOOG),

I truly hope that my letter finds you well.

As the chairperson of the Medical Education Foundation of the ACOOG (MEFACOOG), I would like to take a moment of your time to briefly review the vital role of our foundation and to update you regarding our recent activities.

The mission of MEFACOOG is fostering continual improvements in women's healthcare through dedication to quality education and research. We also strive to reinforce and educate everyone on the importance of Osteopathic Principles and Practices within the OB/GYN community. The Foundation has been a beacon of hope and a pillar of support for countless individuals aspiring to be effective in Women's Health. Through scholarships, grants and innovative workshops, we have empowered students, residents, researchers, and professionals to pursue their dreams and contribute to the betterment of healthcare. The Foundation ensures that financial constraints do not hinder the pursuit of knowledge and excellence in medical education.

MEFACOOG continues to contribute to the Resident Reporter program by providing financial support for the residents to attend our annual conference. The scholarship recipients pick a lecture from the conference, provide a summary, and the top submissions are then published in this annual report. Additionally, resident and student research projects are displayed in the Poster Presentations at the annual conference. Awards are provided for this program, as well. MEFACOOG also supports various workshops at the conferences including the OMT workshop.

I have led a Call to Action which started at our conference in Palm Springs and continues via our website. We are amid the MEFACOOG Monthly Donation campaign. Those members who have committed to recurrent monthly donations for a year have received a small token of our appreciation. Many of you have generously responded to this Call to Action, and I am extremely grateful. The impact of your support extends far beyond the immediate recipients of our scholarships and programs. Your tax-deductible donations contribute to a ripple effect that benefits the entire healthcare system. Your generosity has been the lifeblood of our foundation, and it is through your unwavering commitment that we have achieved so much.

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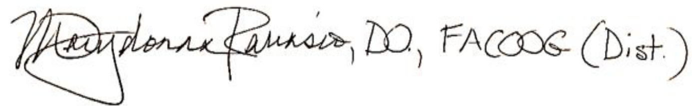
Lastly, if you have any questions or suggestions for how we can further serve our members, please reach out to me or any member of the Foundation's leadership team. We are here to support you.

Thank you again for your continued dedication,



Marydonna Ravasio, DO, MS, FACOOG (Dist)
MEFACOOG Chair 2024-2025

MEFACOOG Board 2024-2025

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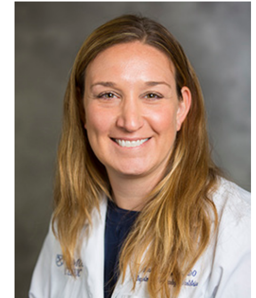

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MEFACOOG/Resident Reporter Scholarship Program

The Resident Reporter Program at the 91st Annual Conference received commendable contributions from the residents who participated. The top papers given monetary awards and publication in the MEFACOOG Annual Report were:

Logan Jepson, DO,
JPS Hospital
Fort Worth, TX

Start planning your research project today!

The MEFACOOG Research Grant—offering up to $5,000—is available to osteopathic physicians, as well as residents or fellows enrolled in an ACGME-accredited program with osteopathic recognition.

Let me know if you'd like a more formal, promotional, or casual tone!

MEFACOOG/Resident Reporter Scholarship Program

Planning the Birthday Party: OB Care in a post-ARRIVE Trial Era

Logan Jepson, DO

Article based upon a lecture by Corinna Muller, DO, FACOOG, MBA

Medicine is a constantly evolving and changing field. With a seemingly endless stream of new research and data, changes in the way physicians practice are inevitable in order to stay apace. Changes can happen for many reasons, to save time, to save money, but perhaps most importantly, because these changes are found to be in the best interest of the patients that we, as physicians, serve. A sentinel study resulting in a major change in practice patterns is the ARRIVE Trial. The lecture provided by Corinna Muller, DO provided a unique perspective on the period leading up to and since the ARRIVE Trial came out and what this hallmark study has done for the field of Obstetrics and Gynecology.

It is important to define induction of labor and the goals of induction of labor. As defined in ACOG Practice Bulletin No. 107, the goal of induction of labor is to "achieve vaginal delivery by stimulating uterine contractions before the spontaneous onset of labor." [7] Induction can be achieved through a number of modalities. Induction often begins with cervical ripening agents such as misoprostol or dinoprostone or with mechanical dilators such as the Cook's or Foley Balloon. Interventions such as artificial rupture of membranes can often be utilized in the augmentation of labor. Finally, a staple in the induction process is Pitocin which helps to stimulate contractions. Some combination of these interventions is oftentimes used to achieve vaginal delivery before natural onset of labor. Induction of labor has become increasingly commonplace within the realm of Obstetrics and Gynecology. Per an article published in 2019, inductions of labor have increased significantly over the course of the past 30 years, citing an increase from 10% to 26% in 2019.[8] With inductions becoming increasingly common, it becomes vital to understand the role that they serve within the specialty of Obstetrics and Gynecology and the benefits that they offer the patients.

Within the field of Obstetrics and Gynecology, as with any medical specialty, there remains room for improvement and growth. Two major metrics within Obstetrics and Gynecology which remain especially prevalent to this day and which the ARRIVE Trial uses as metrics, are the rate of stillbirths and the cesarean rate. The rate of stillbirth, which is a pregnancy greater than 20 weeks gestation resulting in death of fetus prior to delivery, in the United States is 5.73 per 1000. This translates to 1 in 175 pregnancies, accounting for about 21,000 stillbirths per year.[5] The prevalence of stillbirths occurring has had the medical field searching for ways to prevent this and improve outcomes. Another constant source of stress and focus within the field is the seemingly constant rise in number

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of Cesarean Deliveries performed. In a JAMA Health Forum Article titled Rate of First-time Cesarean Deliveries on the Rise in the US, by Joan Stephenson, PhD, recent statistics regarding Cesarean Section rates in this country were brought to light. There was a 60% increase between the years of 1996 and 2009 and then an additional increase from 31.8% in 2020 to 32.1% in 2021.[6] These percentages are significant since a cesarean delivery is a major surgery resulting in prolonged recovery for the mother, increased costs to the new parents, and increased costs to the health center performing the delivery as well. These topics serve as valuable metrics within the ARRIVE trial.

This study examined labor induction versus expectant management of low-risk nulliparous women at 39 weeks gestation. The primary outcome being investigated was neonatal death or severe neonatal complication, including the need for respiratory support within 72 hours after birth, Apgar score of 3 or less at 5 minutes, hypoxic–ischemic encephalopathy, seizure, infection (confirmed sepsis or pneumonia), meconium aspiration syndrome, birth trauma (bone fracture, neurologic injury, or retinal hemorrhage), intracranial or subgaleal hemorrhage, or hypotension requiring vasopressor support. The main secondary maternal outcome was cesarean delivery. Ultimately, the study showed a 20% reduction in the primary outcome in the induction group versus expectant management group. The primary perinatal outcome occurred in 4.3% of the neonates in the induction group and in 5.4% in the expectant-management group. The induction group also had a lower incidence of cesarean deliveries by about 16%.[1] Given the detrimental effect of neonatal death, severe neonatal complications and cesarean sections on mother's and families, the reductions seen in the study have been examined and considered thoroughly.

Dr. Muller provided an interesting and insightful history of studies performed prior to the ARRIVE Trial, namely a study titled *Association Between Temporal Changes in Neonatal Mortality and Spontaneous and Clinician-Initiated Deliveries in the United States, 2006-2013* by Ananth et al. This trial touches on trends in gestational age-specific neonatal mortality and whether they are distinct for spontaneous and clinician-indicated deliveries. Results of this study showed that neonatal mortality rates declined in cases of spontaneous labor as gestational age increased. Amongst clinician-initiated deliveries, neonatal mortality rate remained unchanged until gestational ages of 39-40 weeks, during which time a decrease in neonatal mortality was seen in those who were induced.[2] This study provided those in attendance with a framework that had been set prior to the ARRIVE Trial and some known trends entering the trial.

Dr. Muller proposed advantages to an e arly delivery which included decreasing risk of developing conditions in pregnancy that are only remedied by delivery, decreasing incidence of pre-existing medical complications in pregnancy, and decrease in risk of stillbirth and adverse perinatal/

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maternal outcomes. She also effectively illustrated the dangers of swinging too far in the other direction and electively inducing labor prior to 39 weeks, resulting in increased NICU admissions, increased incidence of TTN, increased incidence of RDS, amongst others.[3]

The lecture transitioned from pre-ARRIVE Trial findings to findings since the ARRIVE Trial was published, indicating possible changes in practice patterns. In a post-ARRIVE Trial study by Jelks et al, an increase in the rates of 39-week induction of labor and elective induction of labor was seen amongst nulliparous, multiparous, and TOLAC patients. Several of the trends in this study differed from the ARRIVE trial. The rate of Cesarean deliveries and other neonatal and maternal morbidities were unchanged, median time from admission to delivery was increased amongst the induction group, and incidence of chorioamnionitis increased.[4] This lends towards the fact that there remains significant room for further studies with regards to this topic.

Despite the magnitude and importance of these studies, Dr. Muller continues to stress the importance of clinical judgment and looking at each patient individually when putting together a plan of care. It is important to use the most recent studies and data along with our intuition and knowledge as obstetricians. As Dr. Muller points out, the goal is to reduce risk to the best of our abilities using all the tools at our disposal and the ARRIVE Trial and the information that it has provided is a valuable tool.

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MEFACOOG Annual Report

- Year 2024 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, 2024. 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 91st Annual Conference of the ACOOG hosted three funded lectureships. The Distinguished Fellows Lecture was presented by Elizabeth Cherot, MD, MBA. The Sages of ACOOG Unity Lecture was given by Laura Dalton, DO, FACOOG (Dist), FACOG. The MEFACOOG Distinguished Lecture was presented by Amanda Calvin, DO. The Past President's Honorary Lectureship was presented by Misty Holmes, BSEE, MS at the 2024 Advances in Women's Health Conference.

The National Student Society of the ACOOG met for the sixteenth during the ACOOG 2024 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, 2024

Support	
Corporate Contributions	$67,000
Individual Contributions	$40,671
Fund Raising	0.00
Interest & Dividends	$36,085
Realized & Unrealized	$31,667
In-Kind Contributions	$51,947
Total Support	**$227,370**
Expenses	
Program Services	$13,820
Support Services	$98,956
Total Expenses	**$112,776**
Net Assets, Beginning of Year	$773,908
Change in Net Assets	$114,594
Net Assets, End of Year	**$848,502**

Statement of Financial Position

Year Ended December 31, 2024

Assets	
Current Assets	
Cash	$85,600
Investments	$759,491
Account Receivable	$10,425
Total Assets	**$855,516**
Liabilities and Net Assets	
Accounts Payable	$7,013
Without Donor Restrictions	$770,546
With Donor Restrictions	$77,957
Net Assets	$848,503
Total Liabilities and Net Assets	**$855,516**

MEFACOOG Awards for Excellence

91st Annual Conference Posters – 1st Place Winner

Cesarean Section Skin Prep – Does skin preparation pattern affect skin bacterial burden, in patients with BMI greater than 30

Gabriela Gaudier MD,
Megan Piacquadio DO,
Sean Cronin MD,
Kate Stampler DO FACOG

Jeferson Einstein Hospital Philadelphia

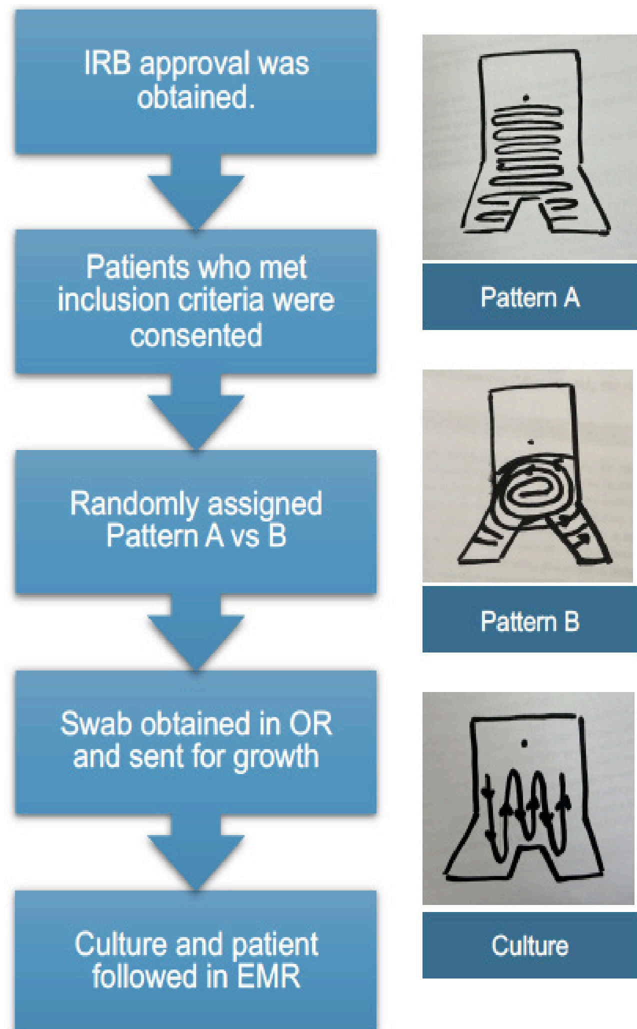
INTRODUCTION:

- No optimal skin preparation (prep) pattern for cesarean delivery exists
- No ChloraPrep® manufacturer guidelines for optimal prep pattern exist
- Many practitioners using random patterns

OBJECTIVES

- Primary objective: To investigate if different skin prep patterns affect bacterial skin burden, specifically in patients with BMI greater than 30
- Secondary objectives: to identify any difference in postoperative wound infection

METHODS



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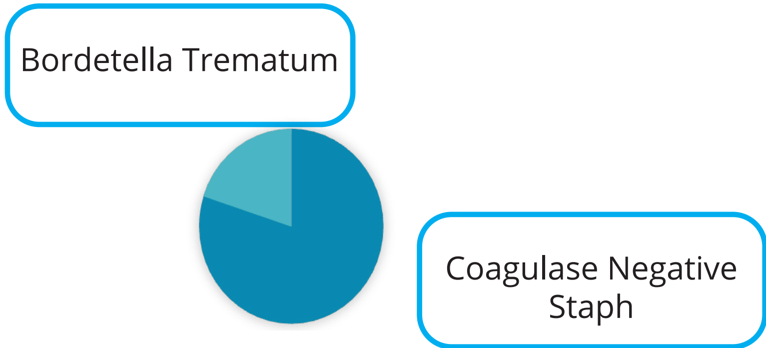
Total Culture Growth	5 (n = 64)
A	2 (94.2% negative)
B	3 (89.6% negative)



	Median Age	Median BMI	Race	Comor-bid Dx	Post-Op Infection
A n = 35	26	34.5	Black 57% Hispanic 23% White 14% Other 6%	Diabetes 14% HTN 34% Smoker 3%	5.7%
B n = 29	31	35.3	Black 59% Hispanic 20% White 7% Other 14%	Diabetes 24% HTN 31% Smoker 17%	6.8%

CONCLUSION

There was no significant difference in infection rate in either of the two prep patterns meaning most prep patterns are likely appropriate to be used prior to a c-section.

Prep pattern may not be a modifiable practice for infection reduction but larger studies are needed

MEFACOOG Awards for Excellence

91st Annual Conference Posters – 2nd Place Winner

Impact of an IUD Insertion Clinic on Medical Students' Knowledge, Attitude, and Perceived Self-Efficacy regarding IUDs

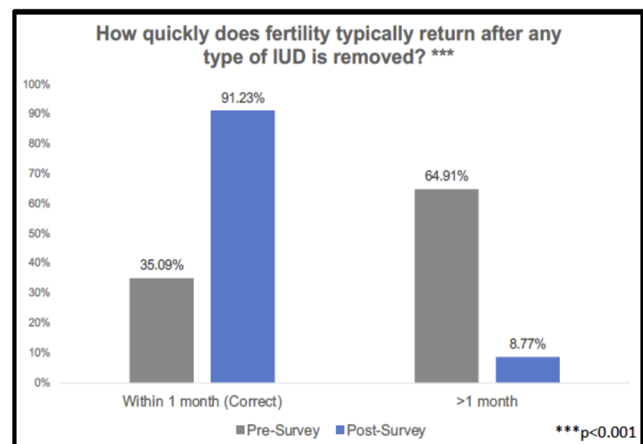
Alexandria Betit OMS-III,
Lucy Page Kelly OMS-III,
Sameeksha Malhotra OMS-III, Sedona Robrahn OMS-III, Rahul Garg PhD, and Praful Patel MD, FACOG

Southeast Healht Alabama Colle of Osteopathic Medicine

BACKGROUND

- Intrauterine Devices (IUDs) are effective methods of contraception [1] and have increased in popularity by 6.2% annually among females from 2006 to 2017 [2].
- Despite high effectiveness of IUDs, provider knowledge regarding IUDs remains insufficient [3].
- There is a lack of effective IUD education in medical curriculum and clinician education [4].
- There is a need for enhanced IUD medical
- education to strengthen clinicians' contraceptive counseling and prevent unintended pregnancies.
- IUD insertion simulation training has been shown to significantly improve medical students'
- comfort, knowledge, and attitudes about IUDs [5, 6].
- However, such clinics have not been conducted at
- osteopathic medical schools, where a majority of graduates enter primary care [7] and can provide safe and effective birth control methods to the community.
- We investigated the impact of an IUD insertion
- educational clinic on osteopathic preclinical medical students' knowledge,

FIG 1. and FIG 2. Impact of IUD Clinic on Osteopathic Medical Students' Knowledge regarding IUDs.



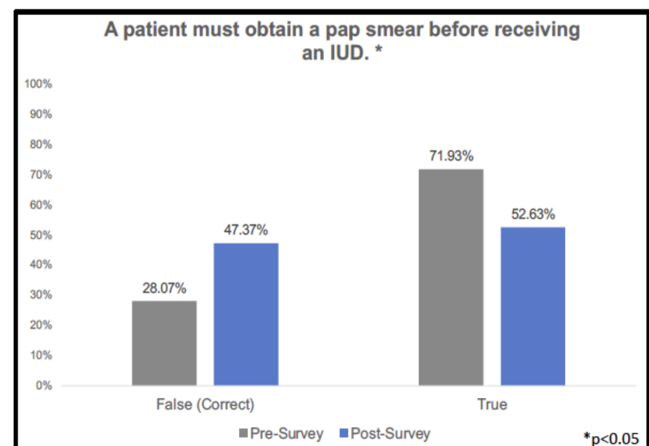


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FIG 3. Impact of IUD Clinic on Osteopathic Medical Students' Knowledge regarding IUDs.

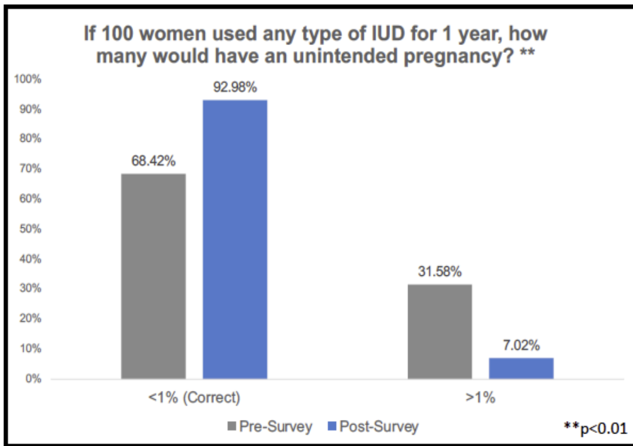
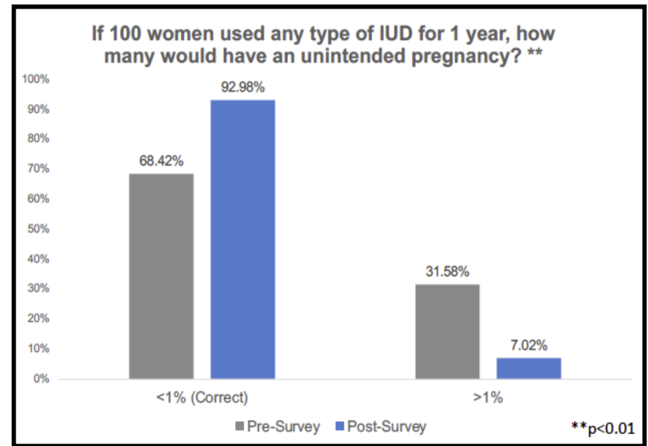


FIG 5. and FIG 6. Impact of IUD Clinic on Osteopathic Medical Students' Perceived Self-Efficacy regarding IUDs.



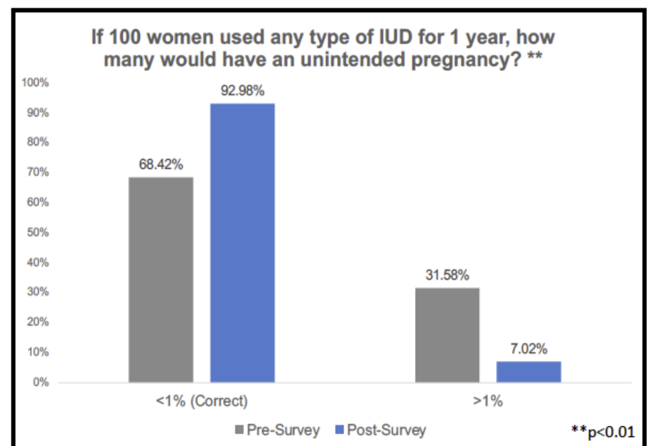
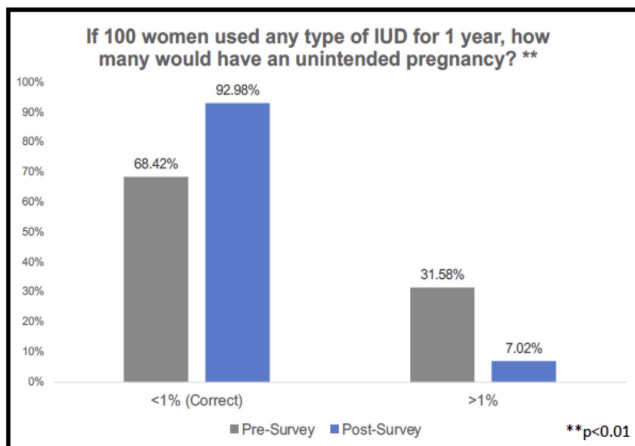


FIG 4. Impact of IUD Clinic on Osteopathic Medical Students' Attitudes regarding IUDs.



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CONCLUSION

- Our IUD clinic successfully improved students' IUD knowledge, similar to previous IUD clinics involving allopathic medical students [5,6].
- Effectiveness of such clinics indicate the possible benefits of short, simulated IUD training in prospective medical school curriculums as well as the positive impact on comfortability of clinician counseling in future practice [5].
- An educational insertion clinic in an osteopathic medical school improved students' attitude towards the ability of clinicians to counsel and place IUDs.
- Future physicians' awareness that various
- healthcare professionals are able to provide these services could increase the availability of IUDs to more diverse populations. This could then reduce the current rate of unintended pregnancies, which comprises half of all pregnancies in the United States [8].
- Simulated training enhanced student comfortability regarding IUD placement, which may encourage future clinicians' to recommend IUDs to patients without contraindications [6].
- This study suggests that an IUD insertion clinic is an effective model to enhance osteopathic preclinical medical students' knowledge, attitudes, and perceived self-efficacy pertaining to IUDs.

REFERENCES

MEFACOOG Awards for Excellence

91h Annual Conference Posters – 3rd Place Winner

Non-Target Embolization of the Labia Following Bilateral Iliac Embolization for Postoperative Vaginal Cuff Bleeding

Elizabeth Dawson DO, Marco Goldberg, Levi Rudick, Kate Stampler, DO, FACOG, Jay Goldberg MD

Jefferson Einstein Hospital, Philadelphia

PATIENT CASE

A 41-year-old woman underwent a robotic total laparoscopic hysterectomy due to symptomatic adenomyosis with a 12-week size uterus. EBL was 50 ml. No intraoperative complications were noted. She was discharged on POD #1.

TIMELINE

POD #33: bleeding noted at vaginal cuff, returned to OR for vaginal cuff repair of a 1.5 cm midline superficial defect

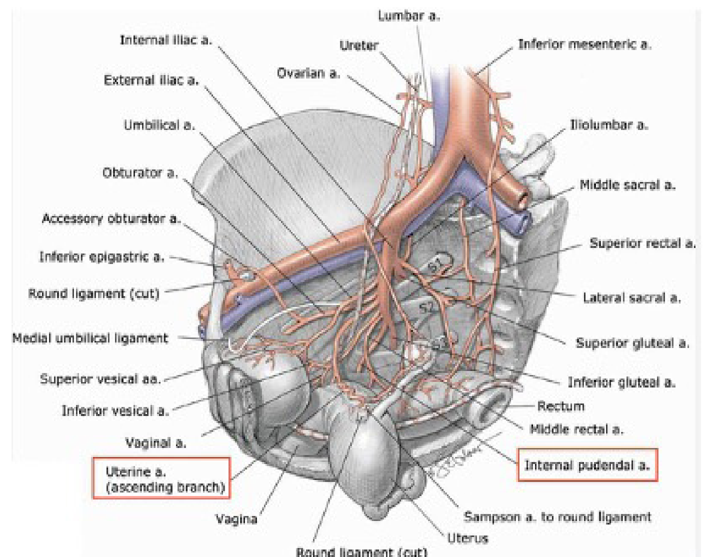
POD #50: continued vaginal cuff bleeding, underwent bilateral embolization of the anterior divisions of the internal Iliac arteries which was successful in stopping the vaginal cuff bleeding.

POD #3 following the embolization: presented to ED with severe right labia minora pain. A tender, erythematous 2 cm area on her right labia minora was noted. She was admitted for antibiotics and pain control. Doscharged on HD #2

Over the next two weeks, her labial pain had almost completely resolved.

CONCLUSION

This patient's localized labia minora pain was the result of nontarget labial embolization during bilateral internal Iliac artery embolization. The internal pudendal artery and uterine artery are adjacent to each other, branching off the anterior portion of the internal iliac artery. The internal pudendal artery supplies the labia minora. Most likely, injection of embolic material into the ligated uterine artery resulted in the reflux of particles into the right internal pudendal artery, producing ischemia in the branches supplying the labia.



William's Gy necology , 4th Edition: Chapter 38, Page 801

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INTERESTING POINTS

- Labial nontarget embolization was successfully managed with pain medication
- Non-target embolization has been reported following uterine artery embolization as a primary
- fibroid treatment
- No similar cases in patients who had previously undergone hysterectomy followed by embolization.

This case of non-target embolization of the labia following bilateral iliac embolization for postoperative vaginal cuff bleeding a unique presentation and clinical scenario that was successfully managed.

CALL FOR VOLUNTEERS

MEDICAL EDUCATION FOUNDATION OF ACOOG

Are you looking for a new way to be involved? Do you enjoy developing innovative educational programs or social philanthropy? Being a MEFACOOG Board Member could be for you! MEFACOOG volunteer leaders can be physicians, educators, non-physician clinicians, spouses/family of ACOOG members, health care industry supporters….anyone with a passion for women's health!

Several positions will be open for nomination this year and we need your expertise. The MEFACOOG Board of Trustees meets twice per year with one meeting usually conducted by phone or web conference. The primary, in-person meeting of the MEFACOOG Board coincides with the ACOOG Annual Conference.

Key MEFACOOG activities include:

- Community Service Projects-past projects include work at a youth community center in Chicago, home repairs in New Orleans for Katrina recovery effort, blood drives, and support for a residential home for pregnant mothers in crisis.
- Resident and Postgraduate Fellow Research Awards and Grants
- Resident Reporter Scholarships provide an opportunity for residents to attend an ACOOG conference and potential article publication
- Resident Education Resources
- Endowed lectureships for CME (Lifelong Learning for attending physicians)
- Support for Osteopathic Continuous Certification (Lifelong Learning, Practice Performance Improvement for attending physicians)
- Fundraising events such as the 'Evening with the Stars' planetarium function and Cirque Du Soleil Mystere

This is just an overview of the potential that exists with MEFACOOG.
We welcome new opportunities, new leaders, and new ideas!
If you are interested in **MEFACOOG Board of Trustees** service,
please forward a statement of interest and a brief bio or CV to
Valerie Bakies Lile, CAE by email to vblile@acoog.org or by fax to (817)377-0439
by **December 1st**.

Eric J. Carlson, DO Resident Reporter Scholarship Program

The Eric J. Carlson, DO Resident Reporter Scholarship Program provides a select group of residents the opportunity to attend a scientific meeting they otherwise may be unable to attend. The purpose of the program is to expose the residents to new scientific knowledge and technology in obstetrics and gynecology. The resident in turn, provides a written summary report on that lecture to ACOOG and then reports to the base institution and colleagues on information presented at the meeting . All Resident Reporter Scholarship Program recipients will be publication in the MEFACOOG Annual Report.

SUBMISSION DEADLINE

Abstracts: December 1st, 5 PM (Central Time)
Posters: February 15th, 5 PM (Central Time)

ACOOG Calendar of Events

2025 Advances in Women's Health
Oct. 30-Nov 2, 2025
RockyVistaUniversity
St George, Utah

Chairs:
Karen Kreig, DO and Mary Jo Hayde, DO

93rd Annual Conference
April 9-14, 2026
Omni Orlando Resort at ChampionsGate
Orlando, FL

2025 Advances in Women's Health

October 1-4, 2026
Omni Downtown
Fort Worth, Texas

Membership Donations

Cumulative October 1999 through December 31st, 2024

Chairman Level $50,000+

Eric Carlson, DO

Diamond Level $40,000+

William Bradford, DO *

Emerald Level $20,000+

Steve Buchanan, DO
Robert H. Debbs, DO
Ronal Librizzi, DO
Thomas Dardarian, DO *

Platinum Level $10,000+

Patricia F. Arnett, DO
David J. Boes, DO
Octavia M. Cannon, DO
Michael Geria, DO
Mark Kalchbrenner, DO
Paul Krueger, DO
Mark LeDuc, DO *
Jennifer Nichols, DO
James J. Perez, DO
Marydonna Ravasio, DO
Kedrin Van Steenwyk, DO
David L. Wolf, DO

Gold Level $5,000+

Catherine Bernardini, DO
Sheryl A. Bushman, DO
Anthony J. Cortese, DO
Lori Crites, RN, RDMS
Laura Souders Dalton, DO
Douglas C. Dedelow, DO
Carl Della Badia, DO
Sherman Dunn, DO
Jeannemarie Durocher
Kenneth Finkelstein, DO
David Forstein, DO
Daniel D. Gilman, DO
Lee W. Irving, DO
Anthony Johnson, DO
Joseph M. Kaczmarczyk, DO
John V. McInerney, DO
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