The Obstetrical Society of Philadelphia

To embrace our legacy, foster collegiality, and share expertise to improve the health of women in Philadelphia and beyond

JANUARY 2019

Newsletter

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President's Message

The Obstetrical Society of Philadelphia; Let's continue to embrace our legacy, foster collegiality, and share expertise that improves the health of women in Philadelphia and beyond.

PETER F. SCHNATZ, D.O.

A few years ago, I wrote an article in our monthly newsletter with then resident Rebekah McCurdy, MD. The article was entitled: "Why are Fewer Men Entering the Profession of Obstetrics and Gynecology?".[1] Gender trends and gender biases have been an interesting topic in ObGyn, and in medicine in general. In this issue (see page 4), I write an article with one of our current residents, related to gender biases in the field of surgery. As Sonia Bhandari, one of our current interns at the Reading hospital, was a general surgery resident, she has a unique perspective on the topic.

I also want to remind you, and encourage you to attend, our joint PARES/OB Society Meeting. This will be the first meeting of the new calendar year, on January 10, 2019. Our speaker will be Marcelle Cedars, M.D., who is the Director of Reproductive Health at the University of California San Francisco. The title of her talk will be Reproductive Aging: Window on General Aging. Remember to not only come and enjoy a great night, but encourage as many of your students, residents, colleagues, and partners to join us.

Reference

1. McCurdy RJ and Schnatz PF. Why are Fewer Men Entering the Profession of Obstetrics and Gynecology? The Obstetrical Society of Philadelphia, Newsletter 2014;40(5):3-4.

Upcoming Lecture

Thursday, January 10, 2018, 6:00 PM

"Reproductive Aging: Window on General Aging"

We hope that you will be able to join us for our January meeting, when Marcelle I. Cedars, M.D., of the University of California, San Francisco, will discuss reproductive aging.

See page 8 for details.

IN THIS Issue

Department of Public Health
CITY OF PHILADELPHIA

Philadelphia Department of Public Health
Division of Disease Control

THOMAS A. FARLEY, MD, MPH
Health Commissioner

CAROLINE JOHNSON, MD
Deputy Health Commissioner

STEVEN ALLES, MD, MS
Director, Division of Disease Control

Health Advisory

Prevention of Congenital Syphilis in Philadelphia

October 29, 2018

Historically, congenital syphilis increases when cases of syphilis among women of childbearing age increase. From 2015-2017, the Philadelphia Department of Public Health (PDPH) has observed a 77% increase in reported early syphilis cases among women (80 reports in 2015 compared to 142 reports in 2017), the majority of which were among women of child bearing age. In 2017, there were 6 cases of congenital syphilis reported in the City of Philadelphia. Syphilis reports among women in 2018 have identified increases in certain risk factors. These include women who inject drugs, women who have sex with men who inject drugs, and women who exchange sex for drugs or money.

SUMMARY POINTS

- Syphilis rates are high in Philadelphia and increasing among women.
- Congenital syphilis is preventable through screening and treatment in pregnancy.
- Test women who are at high risk for syphilis early in the third trimester and treat promptly.

Congenital syphilis occurs when a mother infected with syphilis transmits the infection to her child during pregnancy. Congenital syphilis can cause severe illness in babies, including premature birth, low birth weight, birth defects, blindness, and hearing loss. It can also lead to stillbirth and infant death. Prevention relies on early detection of unrecognized syphilis in the pregnant woman, detection of newly acquired syphilis during pregnancy, and ensuring completion of maternal treatment at least four weeks before delivery. In addition to screening at intervals indicated below, pregnant women presenting with any of the following symptoms should be tested for syphilis immediately: generalized maculo-papular rash, a palmar plantar rash, genital or rectal sore or lesion, moist papules in the genital or rectal regions and patchy hair loss. Testing and treatment are readily available.

The Philadelphia Department of Public Health recommends syphilis screening for:

- Women of childbearing age diagnosed with another sexually transmitted disease
- Women who are pregnant seen in Emergency Departments
- Women with multiple sexual partners, women who inject drugs, have sex with people who inject drugs, and women who exchange sex for drugs or money
- Pregnant women, in accordance with 28 PA Code 27.89, which mandates screening at the following times:
  - At the first prenatal appointment
  - At the third trimester of pregnancy (28-32 weeks gestation is best)
  - At the delivery of a child
  - At the delivery of a still born child

Treat syphilis in pregnant women as soon as the infection is identified. Pregnant women should be treated with a penicillin regimen appropriate for their stage of infection. Penicillin (benzathine penicillin G [Bicillin LA] 2.4 mu IM) is the only therapy proven to be effective in pregnancy. Pregnant women with a history of allergy to penicillin should be desensitized and treated with penicillin. **Treatment at least 30 days before delivery is 98% effective at preventing congenital syphilis.** Additional information regarding the diagnosis and treatment of syphilis is available at www.cdc.gov/std/**treatment** or by calling the health department at (215) 685- 6737.

Message #: PDPH-HAN-00280V-10-29-18
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S. Leon Israel Award

The S. Leon Israel Award was established to recognize excellence in research in the discipline of obstetrics and gynecology. The award is open to all current obstetrics and gynecology residents in programs associated with the Obstetrical Society of Philadelphia. Original research manuscripts not published prior to April 1, 2019 will be accepted for review.

The resident must be the first author, but not necessarily the only author of the paper. It is expected that the resident will have primary responsibility for the literature review, implementation of the study and final drafting of the discussion section. Review articles will not be accepted. Papers should be written in a scientific format to include title, authors, institution, abstract, introduction, materials and methods, results, and discussion and should conform to the instructions for the American Journal of Obstetrics and Gynecology.

Two copies should be submitted. One copy should have all institution and author information removed. The award and stipend ($500.00) will be conferred at the Annual Resident Day Bowl and Symposium on Friday, April 26, 2019. The author of the winning paper will be asked to present a brief summary of his/her work at the Resident Day Symposium and at President's Night, Thursday, May 9, 2019.

Manuscripts must be received no later than April 1, 2019 to allow adequate time for review. Any manuscripts received after April 1, 2019 will be ineligible for consideration.

Manuscripts should be submitted to:
Teri Wiseley, CMM, Executive Secretary
via email to obphila@yahoo.com

Women in Surgery

SONIA BHANDARI, MD [SB] SPENT TIME AS A SURGICAL RESIDENT BEFORE ENTERING THE OBGYN RESIDENCY TRAINING PROGRAM AT THE READING HOSPITAL.

PETER F. SCHNATZ, DO [PFS]; IS THE PRESIDENT OF THE OBSTETRICAL SOCIETY OF PHILADELPHIA AND THE OBGYN RESIDENCY PROGRAM DIRECTOR AT READING HOSPITAL.

Author, SB, once came across an anecdote written by Dr. Elisabeth McLemore, a surgeon at UC San Diego, which illuminated the perception of gender differences in today's society and the social norms that have warped the way we view the roles of men and women. The story went as follows: A prominent surgeon was driving home with his son when they found themselves in a terrible car accident, both were taken to different hospitals requiring emergent surgeries. The surgeon on call after seeing the child stated, "I cannot operate on my son." McLemore explained that she immediately thought the young patient was the son of a same-sex couple, however in actuality the surgeon-on-call was the patient's mother.[1] As a prior general surgery resident, I [SB] was surprised to see myself also failing to realize that the surgeon was indeed a female. The reasoning behind this misperception stands on a multilevel dynamic foundation.

Prior to 1970, women made up only 6% or less of the medical school class.[2]

Today nearly half of medical school classes across the nation are made up of women, but the ratio of women to men entering surgical specialties is still significantly less than 50%. One explanation is a paucity of female mentors that medical students come across during their careers. Effective mentors play significant roles in their mentees lives, providing training guidance, advice, and a network of contacts that may assist in career advancement. A study by Snyder et al found that male medical students were far more likely to find a mentor of their same gender in the field of surgery.[3] Another study showed that women were less likely to approach men for advice and therefore were less likely to consider, and pursue, a career in surgery.[4] As a medical student, I (author S.B.) had no female surgical attendings, and working under dominating male personalities was many-a-time intimidating and impeded what could have been strong learning experiences. Often, I was given more menial tasks during the surgical cases, such as retracting tissue, as opposed to my male medical student colleges who may be given a chance to suture or close tissue. Interestingly, Carr et al went on to show that many women ranked discrimination as a top factor that hindered their academic career.[5] Women many times feel objectified, demeaned, or judged on a sexual bias by a male surgeon who may play a vital role in the surgical career process.

However, the sexual bias for women extended well beyond the early stages of their careers as medical students. Wright et al showed that at a large university hospital, the distribution of male and female faculty members differed significantly according to their rank.6 When studied, it was noted women were predominantly in the nontenure track at the assistant professor level, whereas men were more likely to be full time professors or tenured.[6] Author SB notes; During my general surgery residency interviews it was the norm to see male surgeons holding the leadership positions. But honestly gender influencers can go either way. Most of the female residents whom I [SB] worked with overcompensated for not being male and therefore didn't want to have any natural female qualities, such as being comforting or supportive. Some may say those are in fact the very personalities that are attracted to surgery, but from my experience I've seen that this is the personality that helps them fit in. I would encourage female residents to reach out to medical students and mentor them, thereby improving the general atmosphere and culture of their program and the field of surgery in general.

Unfortunately, these societal norms spread from their careers to their family lives. Turner et al showed that despite the total number of general surgeons becoming pregnant during training has increased in recent years, there still exists substantial bias.[7] Negative attitudes exist towards pregnant women from their male and female peers, thus forcing most women to delay their childbearing until after their residency was completed.

Furthermore, Zhuge et al showed that women physicians earned 63 cents for every dollar earned by male physicians.[7] Another study showed women earned 11% less than men after adjusting for factors that may skew the data otherwise.[7]

Open dialogue about this topic and these concerns are beginning to emerge. Now women surgeons across the nation can post their thoughts on an open blog. The American College of Surgeons (ACS) sponsors an open blog of positivity for Women Surgeons to discuss a wide array of topics from family issues to their time in the OR. The ACS Women in Surgery Committee furthermore enables women surgeons to develop their 'individual potential as professionals.'[8] These avenues empower women and help to nourish growth and camaraderie. We aim to hold a mirror up to society and help healthcare providers understand that negativity in the work force creates hindrance to growth. We aim to create an equal playing field where males and females alike have equal opportunities to progress free of bias and judgement.

References

1. McLemore et al. Women in Surgery: Bright, Sharp, Brave, and Temperate. The Permanente Journal 2012 Summer,16(3):54-59.
2. Zhuge et al. Is There Still a Glass Ceiling for Women in Academic Surgery? *Annals of Surgery* 2011 April,253(2):637-643.
3. Snyder et al. Specific interventions to increase women's interest in surgery. *J Am Coll Surg*. 2008;207(6):942-947.
4. Reckelhoff JF. How to choose a mentor. *Physiologist*. 2008;51(4):152-154.
5. Carr PL et al. A "ton of feathers": gender discrimination in academic medical careers and how to manage it. *J Women's Health (Larchmt)*. 2003;12(10):1009-1018.
6. Ash AS et al. Compensation and advancement of women in academic medicine: is there equity? *Ann Intern Med*. 2004;141(3):205-212.
7. Turner et al. Pregnancy Among Women Surgeons. *Arch Surg*. 2012;147(5):474-479. Published online February 20, 2012. Doi:10.1001/archsurg.2011.1693
8. American College of Surgeons. Women in Surgery Committee, 2018, https://www.facs.org/about-acs/governance/acs-committees/women-in-surgery-committee. Accessed 3 July 2018.

Cap-Score™ prospectively predicts probability of pregnancy

JAY SCHINFELD[1] | FADY SHARARA[2] | RANDY MORRIS[3] | GIANPIERO D. PALERMO[4] | ZEV ROSENWAKS[4] | ERIC SEAMAN5 | STEVE HIRSHBERG[6] | JOHN COOK[7] | CRISTINA CARDONA[8] | G. CHARLES OSTERMEIER[8] | ALEXANDER J. TRAVIS[8,9]

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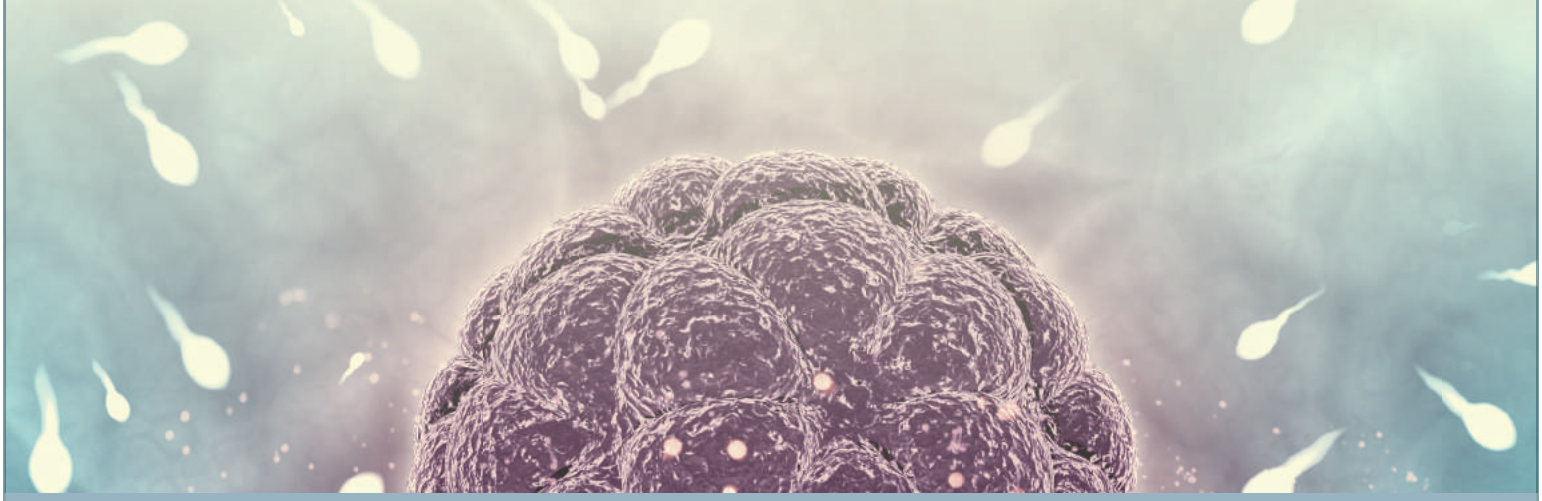
Funding information

Semen analysis (SA) poorly predicts male fertility, because it does not assess sperm fertilizing ability. The percentage of capacitated sperm determined by GM1 localization ("Cap-Score™"), differs between cohorts of fertile and potentially infertile men, and retrospectively, between men conceiving or failing to conceive by intrauterine insemination (IUI). Here, we prospectively tested whether Cap-Score can predict male fertility with the outcome being clinical pregnancy within ≤3 IUI cycles. Cap-Score and SA were performed (n = 208) with outcomes initially available for 91 men. Men were predicted to have either low (n = 47) or high (n = 44) chance of generating pregnancy using previously-defined Cap-Score reference ranges. Absolute and cumulative pregnancy rates were reduced in men predicted to have low pregnancy rates versus high ([absolute: 10.6% vs. 29.5%; p = 0.04]; [cumulative: 4.3% vs. 18.2%, 9.9% vs. 29.1%, and 14.0% vs. 32.8% for cycles 1–3; n = 91, 64, and 41; p = 0.02]). Only Cap-Score, not male/female age or SA results, differed significantly between outcome groups. Logistic regression evaluated Cap-Score and SA results relative to the probability of generating pregnancy (PGP) for men who were successful in, or completed, three IUI cycles (n=57). Cap-Score was significantly related to PGP (p = 0.01). The model fit was then tested with 67 additional patients (n = 124; five clinics); the equation changed minimally, but fit improved (p < 0.001; margin of error: 4%). The Akaike Information Criterion found the best model used Cap-Score as the only predictor. These data show that Cap-Score provides a practical, predictive assessment of male fertility, with applications in assisted reproduction and treatment of male infertility.

To read the full article click here
https://onlinelibrary.wiley.com/doi/10.1002/mrd.23057



2019 Meeting Schedule

Dinner Meetings

January 10, 2019	***Joint PARES/OB Society Meeting*** Marcelle Cedars, M.D., Director, Reproductive Health, University of California San Francisco
March 14, 2019	***Sexual Dysfunction: screening, interventions & basics*** Sheryl Kingsberg, PhD, Div. Chief, OB/GYN Behavioral Health, UH Cleveland Medical Center
April 11, 2019	***Controversial issues in menopausal patient care*** Barbara Levy, MD
May 9, 2019	***President's Night*** Peter F. Schnatz, DO, Reading Hospital

NEW VENUE FOR THE DINNER MEETINGS IS THE NATIONAL LIBERTY MUSEUM, 321 CHESTNUT STREET. DISCOUNTED PARKING AT THE BOURSE GARAGE ON 4TH STREET BETWEEN MARKET AND CHESTNUT.

Resident Education Day

Friday, April 26, 2019 at Lankenau Hospital

January Meeting

The Obstetrical Society of Philadelphia

OUR MISSION: "TO EMBRACE OUR LEGACY, FOSTER COLLEGIALITY, AND SHARE EXPERTISE TO IMPROVE THE HEALTH OF WOMEN IN PHILADELPHIA AND BEYOND."

MARCELLE I. CEDARS, M.D.
PROFESSOR AND DIRECTOR
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Topic:	**Reproductive Aging: Window on General Aging**
Date:	Thursday, January 10, 2019
Location:	***A blast from the past… Back to the National Liberty Museum*** ***The National Liberty Museum*** ***321 Chestnut Street, Philadelphia***
Time:	6:00 PM Cocktails, 6:30 PM Dinner and Program

Discounted parking available in the Bourse Garage!

Payment by check or *online* at www.obphila.org
We cannot accept payments at the door.

Members - $60.00 Non-members $70.00

RSVP's are due no later than Wednesday, January 2.

Please make your check payable to The Obstetrical Society of Philadelphia
308 Rolling Creek Road, Swarthmore, PA 19081.

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