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 2021 **Newsletter** VOL. 48, NO. 1

President's Message

"Damn the torpedoes! Full speed ahead!"

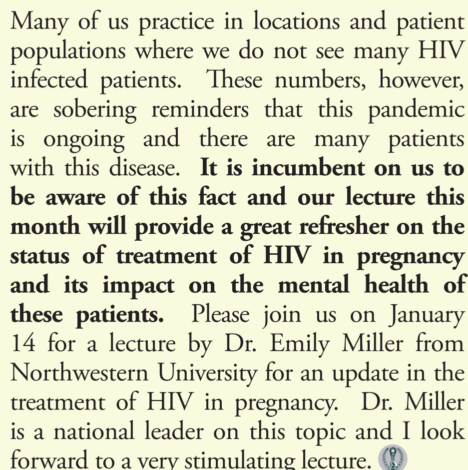
DONALD DEBRAKELEER, DO
PRESIDENT: OBSTETRICAL SOCIETY OF PHILADELPHIA

As Admiral David Farragut led the sea battle to take control of the confederate port of Mobile Bay in 1864, physicians and health care providers continue to provide leadership in battling the COVID pandemic. These selfless health care providers that have put themselves in harm's way for the last year are now the first "patients" that have volunteered to take the vaccines, now approved for emergency use, from Pfizer and Moderna. We trust the science that has brought us the vaccines and know how important wide scale immunization is to end this pandemic but there are still some unknowns out there without large scale data available yet. **(Please sign up for the CDC data collection and help provide the data.)** I am proud to be part of this group of people, who truly have become heroes, putting the good of society and their patients before their own well-being in lining up for the vaccine in large numbers.

So, we embark on 2021 with a renewed sense of hope. We have weathered the storm well as the Obstetrical Society. We have been at the tip of the spear being the doctors and nurses to treat thousands of patients that have been shown to frequently be asymptomatic carriers or actively infected carriers of COVID. It appears that most, if not all, of our members have been able to stay healthy. Babies keep coming and there will probably be even more over the next few months. We have been able to continue our mission and conduct our business virtually with success. We have an exciting list of lectures for the spring, starting this month with the care of pregnant patients with HIV.

HIV is a very timely topic, following on the heels of the year 2020 where the COVID pandemic, racial injustice and bigotry captured the headlines on a daily basis. HIV captures all these issues. A pandemic that started in the United States in the gay community. A community that was marginalized and severely discriminated against to the point that some segments of society felt HIV was "just punishment". This will forever remain a dark mark on our society and the many physicians that refused to treat these patients. It quickly spread to another segment of society that was easy to discriminate against, substance abusers and the poverty stricken. Fortunately, we have come a long way since those dark times in the 1980's. We still have a long way to go. **While other pandemics come and go, we are still living with the HIV pandemic forty years into it. According to the WHO, there have been over 33 million lives lost and there are currently 38 million people living with HIV. In 2019, 690,000 people died from HIV and there were 1.7 million people newly infected with the virus.** Some of the blame for this were gaps in care caused by COVID.

Many of us practice in locations and patient populations where we do not see many HIV infected patients. These numbers, however, are sobering reminders that this pandemic is ongoing and there are many patients with this disease. **It is incumbent on us to be aware of this fact and our lecture this month will provide a great refresher on the status of treatment of HIV in pregnancy and its impact on the mental health of these patients.** Please join us on January 14 for a lecture by Dr. Emily Miller from Northwestern University for an update in the treatment of HIV in pregnancy. Dr. Miller is a national leader on this topic and I look forward to a very stimulating lecture.



Upcoming Lecture

EMILY S. MILLER, MD, MPH, ASSISTANT PROFESSOR OF OBSTETRICS AND GYNECOLOGY (MFM) AND PSYCHIATRY AND BEHAVIORAL SCIENCES, NORTHWESTERN MEDICINE

Thursday, January 14, 2021
7:00 PM

"Perinatal depression: actionable tips for the busy OB/GYN"

See page 4 for details.

With an introduction presented by Kathleen Brady, MD, Medical Director/Medical Epidemiologist AIDS Activities Coordinating Office, Phila. Dept of Public Health:

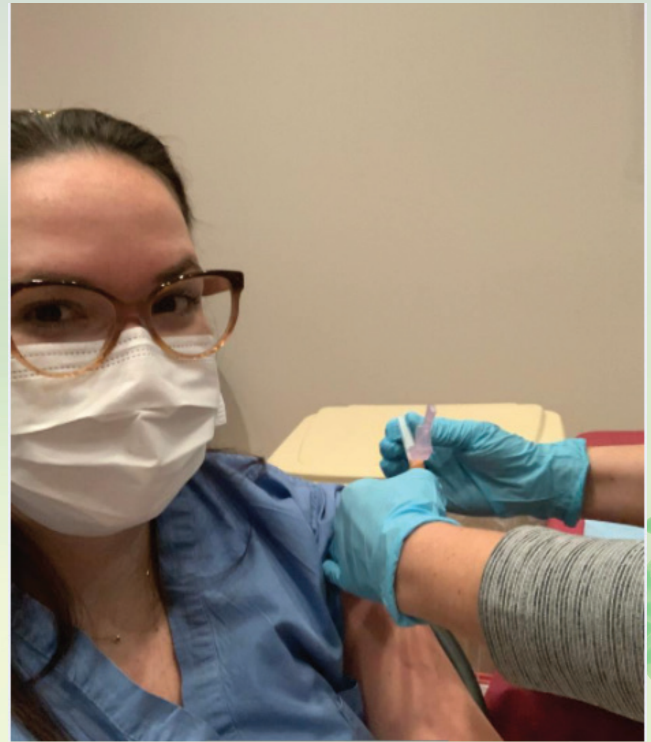
A review of Philadelphia-specific statistics on perinatal HIV and its intersection with mental and behavioral health issues

IN THIS *Issue*

PAGE 1	President's Message
PAGE 2	Vaccine Recipients
PAGE 4	January Meeting Flyer
PAGE 7	Zapo's Pearls
PAGE 9	2020-21 Meeting Schedule
PAGE 10	Share Expertise
PAGE 14	2020 Council

STARTING THE NEW YEAR OFF WITH A ~~BANG~~ – SHOT!!!

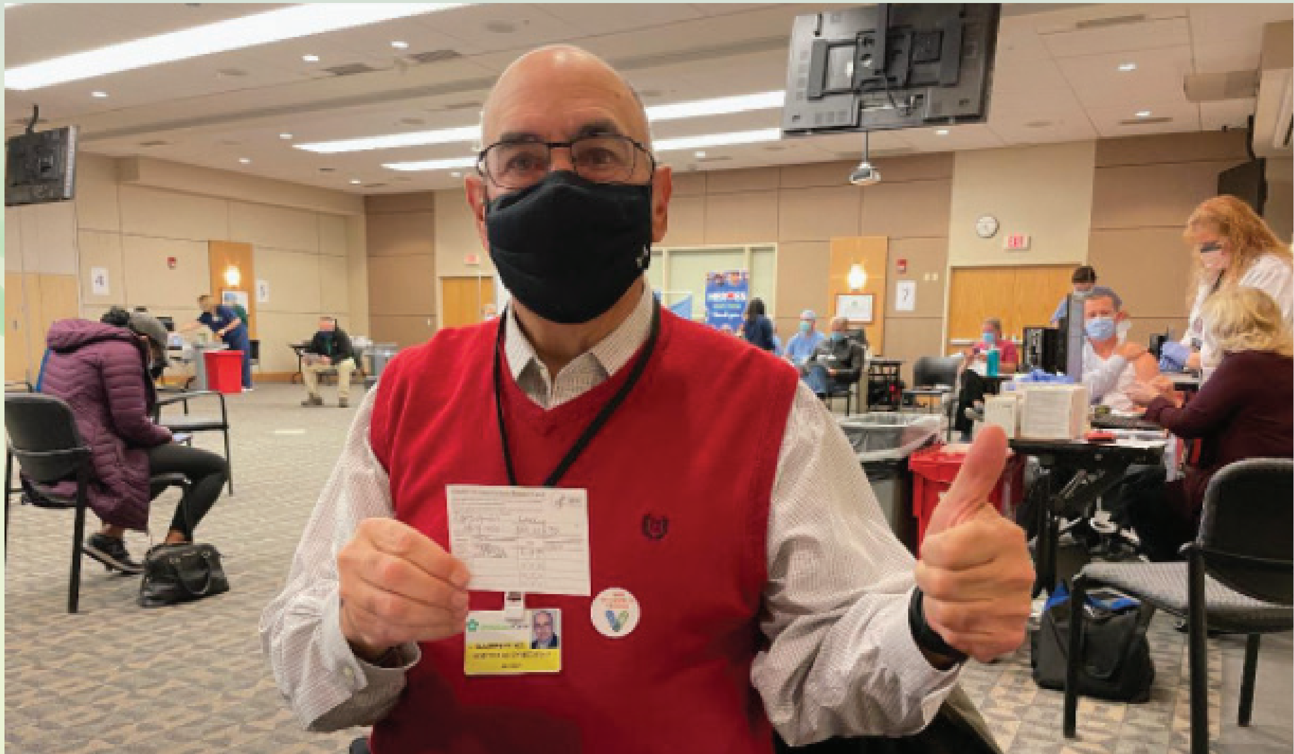
MARK B. WOODLAND, MS, MD, FACOG
CHAIR & CLINICAL PROFESSOR OBGYN, READING HOSPITAL/TOWER HEALTH
INTERIM ACADEMIC CHAIR, OBGYN DREXEL UNIVERSITY COLLEGE OF MEDICINE



ARLEEN AYALA-CRESPO, MD
TEMPLE UNIVERSITY HOSPITAL
ASSISTANT PROFESSOR
SDEPARTMENT OF OBSTETRICS AND GYNECOLOGY

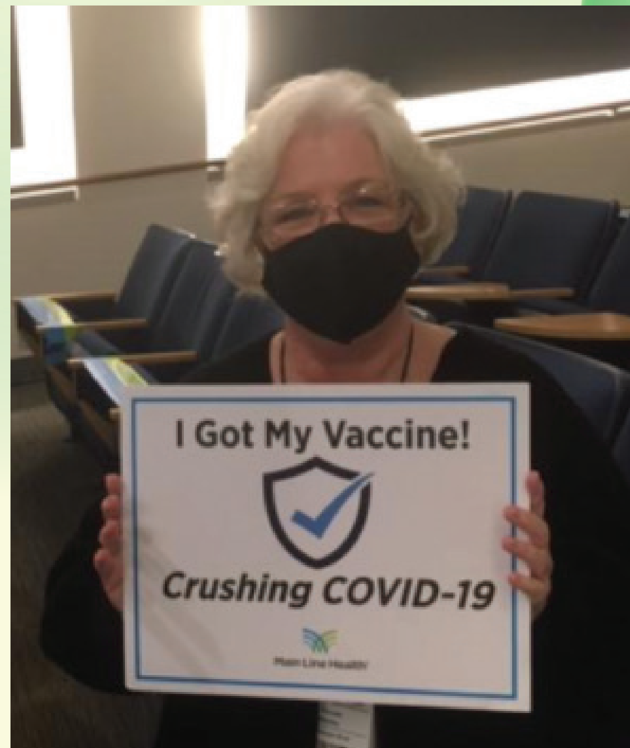
JOAN ZEIDMAN, MD
BRYN MAWR WOMEN'S HEALTH, AXIA

STARTING THE NEW YEAR OFF WITH A ~~BANG~~ – SHOT!!!



LARRY GLAZERMAN, MD
MEDICAL DIRECTOR
HIGHMARK BLUE SHIELD

LUISA GALDI, DO
VIRTUA VOORHEES HOSPITAL



TERI WISELEY, CMM
EXECUTIVE SECRETARY
OBSTETRICAL SOCIETY OF PHILADELPHIA

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."

EMILY S. MILLER, MD, MPH,
ASSISTANT PROFESSOR OF OBSTETRICS AND GYNECOLOGY (MFM)
AND PSYCHIATRY AND BEHAVIORAL SCIENCES,
NORTHWESTERN MEDICINE

Topic:	**Perinatal depression: actionable tips for the busy OB/GYN**
Introduction:	A review of Philadelphia-specific statistics on perinatal HIV and its intersection with mental and behavioral health issues' *Presented by Kathleen Brady, MD, Medical Director/Medical Epidemiologist AIDS Activities Coordinating Office, Phila. Dept of Public Health*
Date:	Thursday, January 14, 2021
Time:	7:00 PM

This will be a Zoom Meeting – to register click link:

https://us02web.zoom.us/webinar/register/6316100733686/WN_yXICQyd_TrOz0zKRylNaVQ

An email invitation will also be sent to each member and Emeritus and through a link on the website at www.obphila.org

Foster Collegiality

Zamo's Pearls

PAUL ZAMOSTIEN, M.D.
PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA

Below are some examples of daily emails sent to people all over the country. This started as daily clinical Pearls sent to our 12 residents at Crozer-Chester Medical Center in 2015. ***Zamo's Pearls of the Day*** are now sent to well over 600 attendings, fellows, residents, nurse practitioners and midwives across the country. Members of the Obstetrical Society interested in being added to the list are welcomed, as well as your colleagues, residents, fellows, or whomever. There are no charges, no sponsors, and no advertising.

This is a sampling of recent editions of ***Zamo's Pearls of the Day.*** If you would like to be added to the daily email list, or have any of your residents or other colleagues added, contact Paul Zamostien, MD at: pzamo@comcast.net.

- **Ovarian hormones diffuse freely into cells, but activity within a cell depends on the presence of specific hormone receptors or estrogen-binding proteins. There are 2 distinct estrogen receptors - ER-alpha and ER-beta.**
- **Concentrations of these 2 ER's vary in different body tissues, with states of health, and with age. In general, there are more ER-alpha receptors in the reproductive system (uterus, breast) and liver, whereas ER-beta receptors are more prevalent in other tissues (bone, blood vessels, lungs). Both are present in the ovary and CNS.**
- **17B estradiol binds to both ER's while phytoestrogens have a higher affinity for ER-beta.**
- **There are similarly two progesterone receptors, PR-alpha and PR-beta. The PR-alpha are mainly in the uterus and ovaries while PR-beta is in the breasts.**

* NAMS, *Menopause Practice*, 3rd edition, 2007, p. 25.

JAMES ERNEST AYRE (1910-1965):

James Ayre was born in Tilsonburg, Ontario and graduated from the University of Alberta, Edmonton. After a short stint in general practice, he trained in Ob Gyn at the Royal Victoria Hospital, Montreal. He became a lecturer at McGill University and director of the Gyn cytology lab at the Royal Victoria Hospital.

He spent time with Papanicolaou learning cytology techniques and then worked on refining the collection of cells from the cervix. He designed a wooden spatula with different shaped ends to accommodate the variable architecture of the squamo-columnar junction. He stated that "previous cytology smear techniques consisted of the aspiration of cells which had already been exfoliated. The spatula technique is a means of collecting the cells before their exfoliation."

His claims were ridiculed in Canada at the time. He did not patent his spatula which is still used today.

For patients with uterine serous cancers, assessment of human epidermal growth factor receptor 2 (HER2) status is essential in addition to histologic analysis. For patients with uterine serous carcinomas that overexpress HER2, trastuzumab added to carboplatin and paclitaxel has been shown to prolong progression-free survival.

- **The effect of this three-drug regimen was greater in women with uterine serous carcinoma who were undergoing primary treatment than in those with recurrent disease**

* K. Lu, MD and R. Broaddus, MD, PhD, *NEJM*, November 19, 2020, pp. 2053-2064

Foster Collegiality

PROTHROMBIN G20210 MUTATION:

– The Prothrombin G20210A mutation, also known as Prothrombin gene mutation (PGM), is a point mutation that results in elevated circulating prothrombin levels. It is the second most common inherited thrombophilia after factor V Leiden, present in approximately 3% of the European population.

– PGM accounts for 17% of cases of VTE in pregnancy and has a prevalence of 3.6% in Caucasians, 3.5% in Hispanics, 0-1.7% in African Americans, and 0-0.6% in American Indians. It is inherited as an autosomal dominant trait. Women with a combination of factor V Leiden and PGM have a 4-5% risk of VTE, even without a personal or positive family history of VTE.

– Without a history of VTE, the risk of VTE in pregnancy is less than 1% for heterozygous carriers. Prophylactic anticoagulation is not recommended in pregnancy, including low dose ASA. With a history of VTE, the risk increases to at least 10%.

– Avoid estrogen containing contraceptive methods in these patients. All progestin-only birth control methods are preferable, with oral preparations seemingly better than injectable due to possible prothrombotic effects of DMPA. All progestin-only methods are MEC 2 - advantages generally outweigh theoretical or proven risks.

* ACOG Practice Bulletin # 197, 2018.

* UpToDate

– For patients with cervical cancer, fertility-sparing surgery should be restricted to low-risk reproductive-aged patients with stage IA1 to IB2 with low-risk histology - squamous cell carcinoma, adenocarcinoma, or adenosquamous carcinoma.

– Size matters. With node-negative disease, patients with stage IB1 had a recurrence rate after fertility-sparing surgery of 17% in those with tumor size greater than 2 cm, compared with only 4% in those with IB1, tumor size less than 2 cm.

– Uterine-preserving surgical options include cervical conization, simple trachelectomy, and radical trachelectomy.

– In a retrospective study, 14 of 15 patients developed cervical stenosis after radical trachelectomy when a device (Foley catheter or tailed IUD) was not placed in the cavity.

* R. Nitecki, MD et al, *Green Journal*, December 2020, pp. 1157-1169.

1) With laparoscopic surgery, mesenteric and omental injuries are the most commonly injured vessels on initial entry, but the inferior epigastric vessels are the most common overall vascular injury at the time of laparoscopy. Injury to the inferior epigastric vessels in the lower quadrants should be avoided by placing secondary trocars under direct vision.

– 33% of injuries occurred with the use of the Veres needle, 50% with placement of an umbilical trocar, and 17% with placement of an additional trocar.

– Nearly half of bowel injuries are not recognized at the time of surgery. Bowel injury can be detected on a CT scan with oral contrast.

* K. Pepin, MD, MPH, *Contemporary OBGYN*, November 2020, pp. 20-23.

2) GALLSTONE DISEASE DURING PREGNANCY:

– During pregnancy, elevated estrogen increases cholesterol secretion, and progesterone reduces bile acid secretion and delays gallbladder emptying, leading to the supersaturation of bile with cholesterol and predisposition to gallstone formation.

– Most pregnant women with gallstones are asymptomatic, with the stones incidentally found on abdominal imaging. Asymptomatic patients require no further evaluation or intervention.

– Ultrasonography is the first choice imaging modality for suspected biliary symptoms.

– Conservative management can initially be attempted for biliary colic with bowel rest, IV hydration, and pain control. In cases of biliary colic that fail to respond to conservative management, cholecystectomy should be offered. The preponderance of evidence shows that pregnant patients with complicated gallstone disease should undergo cholecystectomy regardless of trimester. A laparoscopic approach is recommended by the Society of American GI and Endoscopic Surgeons.

* S. Schwulst, MD and M. Son, MD, *JAMA Surgery*, December 2020, pp.1162-1163.

Foster Collegiality

New CDC recommendations for treatment of gonorrhea.

– Gonococcal infections have increased 63% since 2014.

– Updated GC treatment guidelines:

 – a single 500 mg IM dose of ceftriaxone for uncomplicated GC. Patients weighing over 300 pounds should receive 1 gram of ceftriaxone. When a cephalosporin allergy is present, gentamicin 240 mg IM plus a single dose of 2 grams azithromycin should be given.

AND

 – Oral doxycycline 100 mg twice daily for 7 days if chlamydial infection has not been excluded.

– A test of cure is unnecessary for persons with uncomplicated urogenital or rectal GC. For persons with pharyngeal GC, a test-of-cure is recommended 7-14 days after initial treatment.

– For expedited partner therapy, the partner may be treated with a single 800 mg oral dose of cefixime. If chlamydia has not been excluded in the patient, add oral doxycycline 100 mg twice daily for 7 days.

CDC MMWR, December 18, 2020/ 69(50),1911-1916.

If you are like me, statistical evaluation of studies is a definite weak point.

P-Value - This term is the probability of obtaining the observed Relative Risk (RR) or Odds Ratio (OR) by chance alone. A P-value of 0.01 means that there is a 1% mathematical probability that the observed difference between 2 groups occurred by chance.

– By convention, P is generally deemed significant if below 0.05. This means that if 20 outcomes are evaluated, one of these outcomes is likely to show a positive result just due to chance alone.

– A study can be statistically significant and not clinically significant. However, if it is not statistically significant, it cannot reach clinical significance.

Confidence Interval (CI) - CI is more clinically useful than the P-value. A 95% CI gives the range of values that have a 95% probability of containing the true RR or OR. When a 95% CI does not contain the number 1.0 (e g, 0.40 - 0.80 or 1.12 - 1.37), the measured RR or OR is significant by at least < 0.05.

* North American Menopause Society, *Menopause Practice - A Clinician's Guide*, 3rd edition, 2007.

– The use of combined oral contraceptive pills with lamotrogine (Lamictal) has been shown to reduce lamotrigine concentrations by 50%, increasing the risk of seizures. Lamotrigine levels rise during the pill-free interval ,which could contribute to adverse effects. Dose adjustments with lamotrigine may be needed or extended cycle use of contraception can be considered, or both.

– Dosages of less than 200 mg of topiramate (Topamax) do not affect levels of oral contraceptive pills containing 35 micrograms ethinyl estradiol.

– All methods of emergency contraception can be used without restriction in adolescents and young women with seizure disorders or those using antiepileptic drugs.

* ACOG Committee Opinion # 806, May 2020.

A NEW BEGINNING, 2021

IMAGE: FULL MOON RISING OVER READING SHOWING THE FAMOUS PAGODA AND THE NEWLY REFINISHED PENN STREET BRIDGE.

TAKEN ON DECEMBER 29, 2020

TECHNICAL INFORMATION: 6 SHOT EXPOSURE BLEND IMAGE AT ISO 100, F/8, SHUTTER SPEEDS 1/4-1/60 SECOND, PLANNED USING THE PHOTOPILLS APP TAKEN WITH A CANON R5 CAMERA & CANON RF 28-70MM LENS AT 50MM.

Vincent A. Pellegrini, M.D.
Emeritus Member

For permission to share images, email Dr. Pellegrini at vap123@aol.com

Appointments

Robert L. Berk, MD, FACOG has assumed the position of OBGYN Department Chair at Capital Health Medical Center in Hopewell, NJ.

2020-21 Meeting Schedule

January 14, 2021 Zoom Meeting	***Perinatal depression: actionable tips for the busy OB/GYN*** Emily S. Miller, MD, MPH, Assistant Professor of Obstetrics and Gynecology (MFM) and Psychiatry and Behavioral Sciences Northwestern Medicine
February 11, 2021 Venue TBA	***Prenatal Diagnosis: The Next Step*** Ronald Wapner, M.D. Director, Reproductive Genetics Columbia University, New York, NY
March 11, 2021 Venue TBA	***Transgender Surgery and the Impact on the Gynecology Office*** Christine McGinn, D.O. Papillon Center for Gender Wellness
April 16, 2020 Venue TBA	***President's Night – Innovation in OBGYN and our Role in Stewardship*** Donald J. DeBrakeleer, D.O., Axia Women's Health, Chief, Female Pelvic Medicine and Reconstructive Surgery, Einstein Health System
	Resident Education Day To be announced

Reflecting on COVID: Through the Lens of an OB/GYN Resident

JONATHAN BUERGER, MD
OB/GYN PGY-3, READING HOSPITAL/TOWER HEALTH

Introduction:

One of the constants seen in the medical profession is change. New research and technology bring evolving medical care with the goal of improving patient outcomes. However, with change, often comes challenges. Not only can medical advances bring about practice adaptation, but so too can prevalent disease processes. Periods of medical advancement have often been defined by pandemics such as SARS, influenza, HIV, and most recently COVID-19. As a medical provider caring for patients during the ongoing COVID pandemic, I have had first-hand experience into both the obstacles and triumphs that these evolving times have presented to the medical community.

COVID's Impact:

The terms "healthcare heroes," "essential workers," and "front line warriors" have frequented the news as the COVID pandemic has continued to progress. No less, did the term "sacrifice" play association to these groups of people. While the general public sacrifices their everyday livelihood to quarantine and social-distance, health care professionals have been forced to act in a more direct way. We step through the threshold of the hospital entrance, a sense of unknown and uncertainty occupying our minds, often wondering how many additional patients on our unit had been diagnosed, or if there would be enough masks and personal protective equipment to go around. Not only have we sacrificed our personal health, but we also worry about putting our loved ones at risk. For those of my associates who live with family members deemed to be at high risk of more significant disease morbidity, they often stay alone in hotels or other places of residence to protect the ones they love most. Nevertheless, we realize it is these such sacrifices that will help to combat the virus' plan of action.

To combat the fear and anxiety surrounding the Coronavirus pandemic, we have found reassurance in feelings of teamwork and togetherness. As with each new day comes a briefing with updates on the latest numbers, trends and research. Furthermore, this information brings ever-changing protocols, guidelines and recommendations on a seemingly daily basis. However, even in the face of the unknown, we find a sense of comfort in knowing that everyone continues to learn together. A sense of camaraderie amongst our team knowing that we are taking a risk together to care for our patients. We provide each other with the newest data and recommendations from around the world. Through technology, we stay connected and share our experiences with the virus in the hope that our knowledge can help someone who has not encountered the same. As a collective group, we share responsibilities. We step in to cover when necessity closes a team members quarantine door, not only to protect ourselves, but more importantly, those at highest risk around us. Fear not alone, but rather strength in numbers.

Through the difficulty of enduring the uncertainty and the isolation, we are reminded of the importance of what we do. As health care workers, it is our duty and our oath to care for those who fall ill. To show compassion and love when a patient feels that hope is lost. To put the patient's needs first, even if that means risking our own. We comfort those patients who are scared to even approach the hospital in fear of contracting COVID, when their health may depend on it. We share in patient's fear even though we, as well, are scared. Regardless of the Coronavirus, we are accustomed to the hardships and the triumphs that working in the medical field can bring. Whether we comfort a patient during their last breath, or see a mother leave the NICU with her previously born, premature infant, we have intimately impacted the lives of those patients whom we have cared for. This reminds us of why we do what we do.

Conclusion:

Changes to medical protocols, treatment guidelines and disease processes shape the medical profession on a day-to-day basis. The ongoing COVID pandemic has shown just that, as it has affected medical systems not only within this country, but across the entire world. With change, comes challenges and obstacles that everyone must endure. However, change also reminds us of such fundamental properties of sacrifice, teamwork and compassion that endure during times of uncertainty and great unknown. It is these overarching principles that persist despite the hardship and challenges that medicine can bring. It is these principles that drove us all into this profession to care for others.

FaithCare: A Historical Perspective, Opportunities to Serve, and Testimonies from the Field

ABIGAIL C. SCHNATZ
REBEKAH E. SCHNATZ
PETER F. SCHNATZ, D.O.

FaithCare is a nonprofit (501c-3) organization[1] comprised of individuals interested in the healthcare field and in serving needy people with care, consideration, and love. Although we spring from Christian roots, we welcome persons of all faiths as we seek to deliver care with compassion[2], a quality universal to all major religions. The goal of FaithCare is to integrate faith into the practice of medicine by providing excellent healthcare, locally through wellness centers, and internationally through medical missions and the development of permanent healthcare facilities. We recognize that an individual's life philosophy and faith perspective have a powerful influence in overall health and wellness, and seek to bring health, hope and healing to and through the healthcare community, providing transforming love locally and internationally. As a ministry, and as individuals, we strive to support the caregiver while serving the underserved.

FaithCare began in 1994, first to encourage others in the healthcare field, to network, and to fellowship with one another. Chapters encourage members through fellowship meetings, discussions of medical topics from a spiritual perspective, educational initiatives, and by participation in the other phases of the ministry, community outreach and international missions.

Out of this movement and momentum grew the desire to give back to the community through health fairs, patient visitations, community forums, caroling to hospitalized or nursing home patients at holiday times, and other opportunities to make a difference. The FaithCare-PA chapter provides a chance to become involved, making an impact in our local community. FaithCare has opened free medical clinics, associated with local chapters, providing services to the needy and those without insurance.

In October 2019, ground was broken in the village of Kuje, Abuja, Nigeria to build a fully functional FaithCare medical teaching center. FaithCare is currently embarking on a 1-million-dollar capital campaign to establish hospitals in Nigeria and Haiti.* We hope to bring sustainable medical care to countless needy Nigerians, and also bring quality education to medical students and residents from both the U.S. and Nigeria.

In addition to the local outreach opportunities, FaithCare sponsors approximately 4 to 6 international trips per year. We have informational packets available for the trips which can be found on the website[3]. A FaithCare medical project lasts between 1 and 2 weeks, depending on the location. On a typical 2-week medical project, the team will see anywhere from 3,000 to 6,000 patients and perform up to 500 surgical procedures.

The FaithCare team often treats conditions, such as malnutrition, diarrhea, malaria, and a multitude of other infectious diseases, medical conditions, and surgical cases. One of the most common gynecologic conditions is uterine fibroids. For many impoverished women in remote villages, these conditions go untreated and can become life-threatening. FaithCare once removed a greater than 75-lb. fibroid whose mass was causing the patient to starve to death.

In 1997, FaithCare sensed a calling to pursue medical missions, the third and final phase of the ministry. After a pilot project in Nigeria, West Africa, FaithCare began yearly medical outreach opportunities. These trips and international expansion have

continued over the years. Accordingly, FaithCare has had missionary outreaches to Nigeria, Siberia, Haiti, the Dominican Republic, and Jamaica. The international projects

include medical consultations as well as surgical*, ophthalmologic**, dental care, and spiritual counseling. Having recently celebrated it's twenty-sixth anniversary, FaithCare has served hundreds of thousands of patients. Because all three phases of our organization are open to all people, regardless of religious affiliation, we are developing an effective means of training healthcare providers to incorporate the spiritual dimension into health care.

Since its inception, volunteers with a broad array of backgrounds and medical skills have participated in multiple projects both in the USA and overseas. In addition to these volunteers, FaithCare is working to have a long-term and sustainable impact in the overseas communities where we serve, by recruiting local volunteers and praying for the establishment of fully functional hospitals. Accordingly, our projects often include many national volunteers from the countries where we work.

Joining a FaithCare project could be a life changing experience and you might become a better doctor because of it. The experience will help hone your skills, because you will not have high-tech equipment to rely on and you will not have consultants available as we do here. Most importantly, you will undoubtedly feel joy for being able to help demonstrate compassion by being a part of a team providing physical, emotional, and spiritual healing. As Albert Schweitzer once said: "One thing I know: the only ones who will be truly happy are those who will have sought and found how to serve."

To learn more about the FaithCare Nigerian building project and/or how to donate[4], see: https://www.faithcare.net/capital-campaign

*including lifesaving and life-changing surgeries

**including lens implants, cataract removal, and provision of eyeglasses

Share Expertise

Similar to the "impressive" 75-pound fibroid removal referred to earlier, here is an example of a very simple case we treated, yet still life altering:

M. M. was a 30-year-old woman who had a 10 cm solid tumor growing from her ear (see left photo). The mass was not only uncomfortable but had caused significant social embarrassment and ridicule. After we removed the tumor, we showed her a picture of herself. At first, she did not understand, because it didn't look like her. When we explained that she was looking at herself and that the tumor was gone, she began to smile and laugh with great joy (see right photo – patient consented to photograph).

Besides the tremendous impact we are making in the lives of the needy, we are also making a meaningful impact in the lives of those who participate and volunteer.

Testimony from Author: Abigail Schnatz:

I was blessed with the opportunity to go on my first mission trip with FaithCare to Haiti in 2019. We set up our clinic and medical care in Ferrier, Haiti, which is the poorest town in Haiti. I was able to help in four surgeries. One of the surgeries was a hysterectomy, there were two hernia repairs, and in the final I helped with a lump removal. This was such a wonderful experience for me, and I appreciate all the people who helped to make this possible. I also worked in the pharmacy, mixing medications, packing pills, and much more. Overall, this was a trip I will never forget, and I look forward to serving again.

In February 2020, I was able to go on my second medical mission trip to Nigeria, instead of Haiti. Most young people who consider going on a medical mission trip like this might wonder what they would be able to do, since they aren't medically trained. As a sophomore in high school, I was able to help in the eye center, triage, and with logistics. I was able to learn how to do the visual acuity testing in the eye center and I gave medications to the patients. When I helped in triage, I would take the patients' blood pressure and heart rate. There were even times when I would observe some of the surgeries. This was a great experience for me, and I really enjoyed my time in Africa. Along with learning new medical techniques, like how to take blood pressure, I was able to see the culture and the lives of the people living there. I would recommend this experience to anyone and everyone.

Testimony from Author: Rebekah Schnatz:

I had the privilege of accompanying the FaithCare team on the 2019 medical mission trip to Haiti. This was my second mission trip to Haiti, and I had an amazing experience. I had the unique opportunity of going with one of my sisters, Abby, and my dad. There were about 15 people on our team, some had medical training, and some were general helpers. We also had about 15 Haitian doctors and nurses join us in a very poor Haitian town known as Ferrier.

Our guest house was in the middle of the city, and it took us about ten minutes to walk from the guest house to the site where we set up the clinic and medical care. We used a schoolhouse for various rooms (triage, consulting, pharmacy, and counseling), and the small building next to the schoolhouse for the operating room. As a general helper, I helped mainly with triage and pharmacy, but I also helped the surgeons in the operating room. This was fascinating for me to assist with surgery and was one of my favorite parts of the trip, especially since I want to do something in the medical field in the future. By the end of the week, the team saw over 1,100 patients and did over 50 surgeries. In addition, many people made a commitment to grow in a spiritual relationship with God. This was an incredible mission trip and I am so thankful for every member of our team and the memories we shared.

In February 2020, I had the opportunity to travel with FaithCare to the village of Enugu, Nigeria. As this was my third mission trip, it was interesting to see how it compared to my first two in Haiti. My favorite part of the trip was being able to help people who did not have the money or opportunity to help themselves. I enjoyed spreading love to many people in Enugu, but especially to the children. It was a lot of fun playing with them, learning their names, and seeing many of the same children daily.

Something that surprised me was how needy the Nigerian people are. Although I had heard of the need and desperation, it was much different to actually experience it and see it. In addition to the mental and emotional aspects of learning, I was able to gain more education about medicine itself, as I assisted with triage, pharmacy, consulting, eye exams, and even surgeries. This was an amazing aspect of the trip for me since I am very interested in pursuing the medical field. The most interesting part of the trip was being in the operating room, or as they called it, the "theatre." I helped the general surgeon with minor surgeries. I had the opportunity to scrub on a myomectomy my dad was performing. This was a fascinating experience, particularly the unique opportunity of being able to work alongside my dad on a few gynecological surgeries. Since this was my third year attending a FaithCare mission trip, and I am interested in both medicine and missions, I hope to attend more trips in the future.

Testimonies from additional individuals who have been on FaithCare international trips:

"This mission was my lifelong dream . . . I've gained so much knowledge & have learned so much . . ."; "I am truly blessed to be a part of this great mission. Although I came with the initial goal to help change the lives of others, it was my life that changed…this whole experience has been amazing…";

"I compare my experiences with FaithCare to labor…It is a difficult and sometimes uncomfortable process & you need to find your strength, courage, and faith to get you through. You also rely on the people around you to support you through this process and use various coping techniques to get you through. As with labor, after all the sweat and hard work, you have this beautiful prize at the end - the memories of life changing experiences that you had, and the great satisfaction that hopefully you touched many people, helped make their lives just a little better, and shared a bit of the blessings that have been given to us. As with labor, as soon as it is over, you forget all the discomforts that you experienced, only remembering the good, and are ready to do it all over again!"

Photo by https://www.faithcare.net/

> ***Imagine the joy of being used to significantly impact someone's life . . . . .***
>
> ***Meeting a need that otherwise may not be met.***
>
> ***– Peter F. Schnatz, D.O.***

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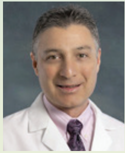

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