Although the full term newborn infant remains dependent for nutrition and nurturing on his or her mother for months before being able to move about independently, for years before becoming socially independent, and for decades before becoming a full functioning and contributing member of society having infants and children of his or her own, the infant has an amazing level of physiological, neurological and social competence.

The gestation of the human infant from conception to competence can be characterized as flowing from genetic determinism, through the safety of the physical environment, providing oxygen and nutrients via division, multiplication and elaboration to the fully formed and functioning neonate. The protective physical environment of the thick-walled uterus and buffering of the amniotic fluid barrier, along with the filtering capacity of the placenta, serve to prevent potential physical and chemical injuries and insults from adversely affecting the delicate emerging physical body parts and physiological systems – all of which are perfectly timed! (See figure 1.)

The importance of assuring health and well-being of the pregnant woman is fundamental to assuring a healthy fetus and newborn infant. This forms the basis for the critically necessary prenatal care provided by obstetricians, other health providers, family members and society at large. Not only is it necessary for the pregnant woman to have good nutrition and care for her physical condition, but the Biblical injunction to the mother of Samson to avoid wine or strong drink during her pregnancy (Judges 13:4), demonstrates our longstanding awareness of harm that can be caused by potential toxins during pregnancy.

It was not too long ago, in the 1970s, that David Smith and Ken Lyons-Jones first described Fetal Alcohol Syndrome as a condition with a set of congenital anomalies and neurodevelopmental disorders associated with maternal ingestion of significant amounts of alcohol during pregnancy. So, the protection of the pregnant mother-to-be and her baby-to-be requires not only the assurance of good nutrition and healthy behaviors, but avoidance of potentially harmful toxins and behaviors.

In this paper we will examine two scenarios – one in which there is an impact on organ development and one which has an impact on a physiological system. The impact on physical development, particularly of the skeleton, limbs or ear, may be obvious at birth, while anatomical changes in the heart or kidneys may be obvious at birth if severe enough, but, if milder, may only become a problem later in life. Disorders of nervous system, immune system and, especially, reproductive system may only manifest much later in life.

**Continued on page 6**

---

**Figure 1: Windows of Vulnerability**

<table>
<thead>
<tr>
<th>Vulnerable System</th>
<th>Timeperiod</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain</td>
<td>3 wks - 20 yrs</td>
</tr>
<tr>
<td>Ear</td>
<td>4-20 wks</td>
</tr>
<tr>
<td>Kidneys</td>
<td>4-40 wks</td>
</tr>
<tr>
<td>Heart</td>
<td>3-8 wks</td>
</tr>
<tr>
<td>Limbs</td>
<td>4-8 wks</td>
</tr>
<tr>
<td>Immune system</td>
<td>8-40 wks; competence &amp; memory birth-10yrs</td>
</tr>
<tr>
<td>Skeleton</td>
<td>1-12 wks</td>
</tr>
<tr>
<td>Lungs</td>
<td>3-40 wks; alveoli birth-10 yrs</td>
</tr>
<tr>
<td>Reproductive system</td>
<td>7-40 wks; maturation in puberty</td>
</tr>
<tr>
<td>Week 1-16</td>
<td>Birth – 25 years</td>
</tr>
</tbody>
</table>


Figure 1 demonstrates timing and order of developing organs and organizations of the fetus and infant. There can be different times when different phases of development are vulnerable, and the vulnerability of a particular organ or physiological system will be dependent on the timing and nature of the insult.
**President’s Column**

**Goals Achieved and Goals Ahead**

It has been my pleasure to serve as your president for the past year, and it has been both a challenge and fun. Together, we have achieved some pivotal goals, but there is still much to do to continue our progress.

The Georgia Primary Care Coalition, which includes our Society as well as state associations representing pediatricians, family physicians, internists and osteopaths, effectively collaborated to achieve the first Medicaid increase in 15 years for OBGyns. Working together with colleagues to achieve common goals in the state legislative arena was certainly critical to attaining this success. Our other creative solutions will need to be developed and deployed. Our Society’s Board of Directors welcomes your thoughts on these issues as we move forward. We not only represent you, we need your active participation!

The first Maternal Mortality Case Review report, an in-depth study of 2012 maternal deaths in Georgia, was just released and I hope you have reviewed your mailed copy. Dr. Michael Lindsay and a group of healthcare and public services colleagues will continue to review all maternal deaths in Georgia to help us improve outcomes statewide. One of the key findings was the magnitude obesity plays in many maternal deaths. In your daily women’s health practice, please always document height and weight and consider actions you can take to decrease the BMIs you document. Then, identify available cardiologists and/or perinatologists and refer women who are pregnant or of child bearing age who are obese with increased risk of cardiomyopathy, help change these actions alone will outcomes for the positive. With medical advances, new challenges arise. Greater numbers of special needs children are living to adulthood, bringing with them the need to leave their pediatrician and find an appropriate adult physician. “Transition of Care” for these special young adults is the focus of an exciting new conference being planned by Georgia’s pediatricians and our adult primary care partners. Dr. Penny Castellano is involved planning this meeting, which will be on September 26, 2015. We look forward to some of you attending as we are and will be providing OBGyn care to this increasing population.

The Society is growing and changing! The staff, under leadership of Executive Director Pat Cota, has expanded over the last few years; bringing the need for additional space. Therefore, the Society relocated to a larger office in Duluth, Georgia this past spring. The new building is large enough to hold our fledgling Georgia OBGyn Foundation, which Past President Dr. Ruth Cline is patiently guiding through its gestation and birth. With increased awareness and your support, the Foundation can be a strong force for OBGyns and improved health for Georgia’s women.

In addition, Amanda Kowal, our Communications and Marketing Coordinator, is leaving the Society at the end of August to move to South Carolina. Simone Jameson of Snellville will be our new Communications and Marketing Coordinator.

Lastly, please know it has truly been my honor to lead this organization for the past year. I look forward to remaining active within the Society and committed to improving healthcare for women throughout our state.
W with each year that passes, I find the period of time between the beginning and end of a year seemingly moves closer together. More and more, it is difficult for me to postpone or put off anything, with any real hope of doing it later. A new day arrives, and I find myself packing as much into a twenty-four hour period as I can. The tomorrow or much into a twenty-four hour period as real hope of doing it later. A new day seemingly moves closer together.

year I have only to recall a speech, numerous colleagues (well-known and our convention. The synergy created of information I carried away from still marvel at the depth and wealth our Gynecological Society and Georgia of presentation! From casual feature presentations, clinical sessions, meeting attendees will have no lack go! And, I encourage each of you to do away from it all! The Annual Education Meeting will give me all three presents.

you there! See you there!

August 27-30, 2015, for what I registration forms, and make plans Meeting will be just the rejuvenation service to every patient in our practice. So, let’s do it now! Let’s fill out the recredentialing decisions to receive credentialing and recredentialing decisions. The CVO’s new functionality will be added recredentialing by dialing 1-800-766-4456. There will be a transition period for the new CVO. The transition period is as follows: 1. Effective August 1, 2015, all new provider applications seeking enrollment with one or more CMOs will be credited through the new CVO. 2. From August 1, 2015 through November 30, 2015, the CMOS will continue to process all existing applications seeking initial credentialing for those providers that submitted an application prior to August 1, 2015. 3. From August 1, 2015 through November 30, 2015, the CMOs will continue to recredential all providers currently enrolled in their respective CMO. 4. Effective December 1, 2015, all providers will be recredited and recredential through the new CVO. Beginning December 1, 2015, the CMOs will no longer perform credentialing or recredentialing services for enrolled providers. The CMOs will be responsible for the delegated credentialing and recredentialing for Independent Practice Associations (IPA) and Provider Hospital Organizations (PHO).

If you have additional questions, please review the Frequently Asked Questions (FAQs) posted on the DCH web site at http://dch.georgia.gov/dch-frequently-asked-questions. You can also email questions to Georgia Medicaid at cvo.dch@gate. Contact PAHPT Now! For more information and testimonials by PAHPT enrollees PAHPT is the simple, quality solution built specifically for the medical community. Physicians’ Alliance of America (PAA) has been serving practices for over 22 years. PAA sponsors PAHPT as a physicians. Is saving members thousands on their health plans!

OBGyn NEWS, August 2015
A Drug Primarily Affecting Physical Development: Thalidomide

Our scientific awareness of the potential hazards of toxins during pregnancy began dramatically in the 1950s with the story of the drug called Thalidomide. This story is instructive at many levels, and, therefore, deserves detailed review. Thalidomide was developed and tested in the early 1950s by a West German pharmaceutical company and marketed in 1957 as a prescription-free, over-the-counter drug used as a sedative particularly beneficial for pregnant women – ostensibly to help them relax and sleep better. It was found to reduce the nausea of morning sickness and proclaimed as a “wonder drug” that would also “cure” insomnia, colds and headaches. Furthermore, it was advertised as “completely safe” for everyone, including mothers and their child, “even during pregnancy,” as its developers “could not find a dose high enough to kill a rat.” Interestingly, although Thalidomide was tested on laboratory animals, it was never tested during pregnancy.

By 1960, Thalidomide was marketed in 24 countries with sales nearing 1 million per month, matching those of aspirin. Also by 1960, reports began to emerge about possible side effects during pregnancy and birth damage. In 1961 the correlation was made between the use of Thalidomide by the pregnant woman at the time of birth of infants with limb reduction anomalies. At that point, the drug was taken off the market, but not before an estimated 10-20,000 infants had been affected worldwide. By March of 1962, the drug was banned in most countries where it was previously sold.

Through this welcome experience, we, as a society, learned an important lesson that changed the field of Teratology by acutely and dramatically raising our awareness of the potential hazards of chemicals and medications on the physical development of the fetus. As a result, regulations became more stringent on testing drugs for safety during pregnancy.

Another interesting side story of the Thalidomide disaster was that the drug was never widely used in the USA as it had been in Europe and the UK. The reason was Dr. Frances Oldham Kelsey, who had just started to work at the FDA in 1960, took a bold stance and refused to approve the release of Thalidomide in the United States, despite widespread use in Europe and despite strong corporate pressure, citing concerns around possible side effects and inadequate testing. For this bold action, Dr. Kelsey received the President’s Award for Distinguished Federal Civil Service, the highest honor given to a civilian in the United States, from President John F Kennedy. Upon bestowing the award, President Kennedy said, “Her exceptional judgment in evaluating a new drug for safety for human use has prevented a major tragedy of birth deformities in the United States. Through her ability and steadfast confidence in her professional decision, she has made an outstanding contribution to the protection of the health of the American people.”

Dr. Kelsey helped shape and enforce amendments to FDA drug regulation laws to institutionalize protection of patients in drug investigations. The amendments required drugs be shown to be both safe and effective, as informed consent is obtained from patients when used in clinical trials, and adverse reactions are reported to the FDA.

A Drug Primarily Affecting Physiological Systems: Diethylstilbestrol (DES)

Diethylstilbestrol (DES) is a “synthetic estrogen” created in 1938 and prescribed to pregnant women to prevent miscarriages and avoid other pregnancy problems. In 1953, published research showed that DES actually did not prevent miscarriages or premature births at all. Yet, despite this finding, it was still prescribed until 1971. In 1971, reports emerged that girls and young women whose mothers had taken DES during pregnancy were at risk for developing a rare form of vaginal cancer. This led the FDA to issue a Drug Bulletin advising physicians to stop prescribing DES to pregnant women, but not before an estimated 5-10 million pregnant women and their children were exposed to DES! As a result of this finding, several cohort studies were established in the 1970s, identifying about 15,000 women who had taken DES during pregnancy who followed and continue to be followed in about 8 different longitudinal studies. In these studies, not only are the women who took the drug during pregnancy being studied, but also their offspring, male as well as female. And now, the third generation is being studied.

When comparing the impact of these two drugs, in the story of Thalidomide, the toxic effects were direct and readily recognizable within the space of 4 years and the drug was banned, but not before 20,000 pregnancies were affected. In the case of DES, the impact was only seen in the next generation, so it took about 40 years and 5-10 million pregnancies before a connection was made! A factor of 10 times the number of years, impacting more than 100 times the number of pregnancies!

The Intrauterine Environment and Fetal Vulnerability

Continued from page 1

Results Demonstrated by the Studies

Women prescribed DES while pregnant are at increased risk for developing breast cancer. The findings noted an increased breast cancer risk of approximately 30% for women prescribed DES while pregnant. That means when considering breast cancer risks across a lifetime, one in six women prescribed DES during pregnancy will get breast cancer. In comparison, only one in eight unexposed women will get breast cancer across their lifetime.

DES daughters who took DES during their pregnancies are 40 times more likely to develop Clear Cell Adenocarcinoma (CCA) of the vagina and cervix. Before the use of DES, CCA of the vagina and cervix only occurred in women past childbearing age. In contrast, DES Daughters have been diagnosed with CCA of the vagina and cervix as early as age 8 up to their late teens and early 20s, even into the 30s and 40s.

Some studies have shown up to one-third of DES Daughters have some form of reproductive tract abnormality of the cervix, uterus, or fallopian tubes, including vaginal agenesis or cervical changes. Many of these changes are harmless and had no effect on physical development, risk of disease, or ability to conceive a child. However, some DES Daughters experienced health problems as a result of reproductive tract abnormalities.

DES Daughters are at an increased risk of reproductive problems, including complications during pregnancy and infertility.

Should We Be Concerned?

Testicular Cancer

Breast Cancer

Approximately 20% of DES Daughters experience pre-term labor, compared with 8% of unexposed women.

Other Pregnancy Complications: DES Daughters are also at an increased risk for other complications during pregnancy, including ectopic pregnancy and miscarriage. Estimates of a DES Daughter’s risk for an ectopic pregnancy range from 3-5 times higher than the risk for a woman not exposed to DES. DES Daughters are also more likely to experience miscarriage than unexposed women. The most recent study found almost 20% of DES Daughters had a miscarriage during their first pregnancy. About 10% of unexposed women experience a miscarriage during their first pregnancy. Infertility: 24% of DES Daughters were unable to become pregnant, compared with 18% of women not exposed to DES. Additionally, 28% of DES Daughters have tried for 12 months to become pregnant without success, compared with 16% of women not exposed to DES. DES exposure was more strongly associated with infertility caused by uterine problems (such as the shape of the uterus). Few studies have focused on men; however, there has been an increase in Non-Cancerous Epididymal Cysts, which, in one study, demonstrated in four-fold increased likelihood. Some studies have suggested other genital anomalies and possibly infertility, but these have not been conclusively substantiated.

Third-generation children (the offspring of DES Daughters and Sons) are just beginning to reach the age when relevant health problems (such as reproductive tract problems), can present there are no conclusive findings on the third generation. However, animal studies are pointing increased risk of cancerous lesions. Time will tell if this is important in humans.

In the next newsletter, Dr. Rubin will further explore Endocrine Disruptors, the impact on women and their children, and the steps physicians can take to help identify patients who were exposed to these chemicals or help patients avoid exposure.

Dr. Robin Sharpe is President of Innovative Solutions for Disadvantage and Disability; Research Associate Professor of Pediatrics, for Morehouse School of Medicine; Co-Director of Southeast Pediatric Environmental Health Specialty Unit, Emory University; and Medical Director of Developmental Pediatrics Specialists.
to public health in all states, but is known at the time of delivery. It is important to test "e" antigen (HBeAg) positive. More are both hepatitis B surface antigen (HBsAg) positive. Perinatal infection occurs in 70%–90% of infants born to mothers who are hepatitis B surface antigen (HBsAg) positive and hepatitis B little or A (HBsAg) positive. More than 90% of infants who are infected perinatally will develop chronic HBV infection. Laboratories should test pregnant women for HBsAg, as mother-to-baby transmission can be prevented if the mother’s HBV status is known at the time of delivery. HBsAg-positive tests are reportable to public health in all states, but pregnancy status is rarely reported. To address this issue, the Centers for Disease Control and Prevention (CDC) and partners from health departments, commercial laboratories, and the American College of Obstetricians and Gynecologists (ACOG) and other professional organizations have worked together to include pregnancy status in laboratory test reports sent to health departments. These efforts were guided by recommendations of the Council of State and Territorial Epidemiologists (CSTE) to improve identification of HBsAg-positive pregnant women.

Four major commercial laboratories are participating in this effort: ARUP Laboratories, Mayo Medical Laboratories, and Quest Diagnostics. Each laboratory now offers designated HBsAg tests for pregnant women as a stand-alone assay and/or as part of a prenatal/obstetric panel to facilitate reporting HBsAg-positive women to health departments. A summary of the available prenatal HBsAg tests can be found in the table below. When ordering an HBsAg screening test for a pregnant or postpartum patient from ARUP Laboratories, Mayo Medical Laboratories, or Quest Diagnostics, please choose a test designated as "Prenatal." The success of timely identification and confirmatory testing for HBsAg-positive pregnant women is dependent on physician and hospital uptake of the designated prenatal HBsAg tests ordered from these laboratories.

As the GA MMRC reviews cases from multiple years, trends and recommendations have become more evident. But already the committee has seen some areas where a few simple steps may improve medical care. The committee noticed obesity was a contributing factor in many cases. A greater need for monitoring blood pressures and referring patients to a maternal fetal medicine (MFM) or cardiologist was identified.

In addition, in quite a few cases, the patient's height, weight and body mass index (BMI) were included in their medical records, neither at the doctor's office nor the hospital. From these findings the MMRC recommends the following actions:

- With blood pressure readings greater than 130/90, screen for HBV.
- If hypertension continues, refer to a maternal fetal medicine (MFM) or internal medicine or cardiologist.
- The internal medicine physician and the cardiologist will not be primary, but will be excellent consultants for the obstetrician and the patient.
- Measure height and weight. Obtain a pre-pregnancy baseline weight. Use height and pre-pregnancy weight to calculate BMI. The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) and the National Heart, Lung and Blood Institute (NHLBI) have a calculator at https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/index.cfm

<table>
<thead>
<tr>
<th>Laboratory</th>
<th>Test Option</th>
<th>Test Name</th>
<th>Test Code/CPT Code</th>
<th>Web Link</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standalone</td>
<td>Hepatitis B Virus Surface Antigen (HBsAg) Elevated, Prenatal</td>
<td>200737/87340**</td>
<td><a href="http://labcorp.test.com/Tests/Pub/007373">http://labcorp.test.com/Tests/Pub/007373</a></td>
</tr>
<tr>
<td>Mayo Medical Laboratories</td>
<td>Panel</td>
<td>Prenatal Profiles (with Hepatitis B Surface Antigen (HBsAg) Elevated)</td>
<td>202945/8005</td>
<td>[Enter test code or CPT code to search for test]</td>
</tr>
<tr>
<td></td>
<td>Standalone</td>
<td>Hepatitis Profile III (HBV Prenatal Profile)</td>
<td>265397/87340**</td>
<td>[Enter test code or CPT code to search for test]</td>
</tr>
<tr>
<td>Quest Diagnostics</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>


New Guidance for Prenatal HBsAg Tests Available at Commercial Laboratories

**A labor and delivery test code ID table may automatically provide a confirmation of pregnancy status. The "Additional" component of the "Laboratory Test Option" is the "Prenatal Reference Panel" addendum. Additional test code CD/ID might not be associated with any other component tests in this laboratory panel.

A Blood Pressure Quiz

As GA MMRC continues its work, it will provide additional evidenced based findings aimed at reducing maternal deaths. Please take time to look at the blood pressure screening form and also share all copies to health care providers to widen their view and importance of blood pressure screening. Permission for use of this test was received from the author: Julie Baumann, Director, Wisconsin Coverdell Stroke Prevention Program, Chronic Disease Prevention Unit, Wisconsin Department of Health Services.

The following quiz is based on blood pressure measurement guidelines published by the American Heart Association Council for High Blood Pressure Research. This is not an exhaustive test of blood pressure measurement competency. Rather, these questions are intended to help stimulate your thinking about your blood pressure measurement and its improvement.

1. How many blood pressure (BP) readings are recommended each time you measure blood pressure?
   A. One
   B. Two
   C. As many as there is time for the same number as taken at the last patient visit
   D. No limit

2. What is the correct way to take a blood pressure reading?
   A. You should never measure blood pressure at the wrong time
   B. You can always measure blood pressure as you wish
   C. As many as there is time for the same number as taken at the last patient visit
   D. You should measure blood pressure only once

3. What should you do if you take two blood pressure readings that differ by more than 15 mmHg systolic or 10 mmHg diastolic?
   A. Leave the blood pressure cuff on and record both readings
   B. Redo the blood pressure readings
   C. Tell the patient to take a deep breath and try again
   D. Ask the patient if they have any allergies to medication

4. How should you take blood pressure readings?
   A. Always measure blood pressure from both arms
   B. Only measure blood pressure from the right arm
   C. Only measure blood pressure from the left arm
   D. Measure blood pressure from the arm contralateral to the side of the heart

5. What is the correct frequency for rechecking healthcare professionals on blood pressure measurement techniques?
   A. Every two years
   B. Every two months
   C. Every six months
   D. Every three months

6. Which of the following is/are true?
   A. The patient should talk during the measurement
   B. The patient should relax for at least thirty seconds before taking the measurement
   C. If you're not using a mercury column instrument, you should use a white blood pressure reading of 133.3
   D. If the difference between the two readings is greater than 15 mmHg systolic or 10 mmHg diastolic, you should take another reading

7. When selecting the correct cuff size, the patient should be measured through the smallest (the shorter dimension) to ensure all 33% of the upper arm
   A. 30%
   B. 40%
   C. 50%
   D. 70%

8. What is the correct time to wait before taking a blood pressure reading?
   A. At least five minutes
   B. At least six minutes
   C. At least seven minutes
   D. At least ten minutes

9. What is the correct frequency for rechecking healthcare professionals on blood pressure measurement techniques?
   A. Every two years
   B. Every two months
   C. Every six months
   D. Every three months

10. Which of the following is true?
    A. A patient should take diuretics during the measurement
    B. The patient should not drink coffee before the measurement
    C. The patient should sit with their feet off their seat while taking the measurement
    D. A urinary bladder distention can cause a significant error in blood pressure measurement

11. Blood pressure measurement guidelines recommend which of the following?
    A. Use the bell of the stethoscope above the brachial artery
    B. Use the bell of the stethoscope on the lower arm
    C. Wear a watch without constrictive clothing
    D. If the blood pressure is below 10 at all thirty points above the point where the palpable

12. All of the above

Please see page 11 for our answers.
10

News from Around the State

World Breastfeeding Week
WBW is August 1 – 7, 2015 and this year’s theme revisits a theme from 1993, Breastfeeding and Work: Let’s Make It Work! Much has been achieved in 22 years of global action supporting breastfeeding and work, but much still needs to be achieved. For more information on how you can celebrate WBW, visit http://worldbreastfeedingweek.org/.

2015 GOGS Annual Meeting
Register today for the 2015 Georgia OBGyn Society’s Annual Meeting, August 27-30 at The Ritz-Carlton, Amelia Island, FL by filling out the registration form in your Annual Meeting ad or by obtaining a registration form at www.goggs.org. For registration information or questions, call 770-451-0020 or email jrice@gaaap.org or call 404-881-5091. CME Credits will be available for this event.

The 29th Annual GPA Conference
The Georgia Perinatal Association’s annual meeting will be September 23-25, 2015 at the King & Prince Beach & Golf Resort, St. Simons Island. This year’s theme is “Promoting Safer Maternal and Infant Outcomes in Georgia.” The conference is for: Perinatal health advocates, providers, administrators, physicians, nutritionists, nurses, midwives, nurse practitioners, paternal social workers, and others in perinatal care. To register, visit: https://jlh.formstack.com/forms/29th_annual_conference.

HMHB Georgia Conference
The 2015 Healthy Minds, Healthy Babies Annual Meeting is October 6, 2015, 8 am – 4 pm at Gwinnett Technical College, Busbee Banquet Hall, 5150 Sugarloaf Pkwy, Lawrenceville, GA 30043. This year’s theme is “Maternal and Child Health Disparities: What Does the Research Say?” Early registration is $85 by 9/18/15. For additional information, call 770-451-0020 or email ayanna.rutherford@hmhbga.org. To register, visit: http://hmhbga.org/en/events/annual-meeting/2015-2015-registration. Special hotel rates are available at the Hampton for $139/night. Go to: http://goo.gl/KV202F.

ACOG District IV Annual Meeting
Save the date for ACOG Districts I, II and III’s combined Annual Meeting, October 9-11, 2015 at the Sheraton Boston Hotel, Boston Massachusetts. For additional information, visit http://www.acog.org/Education-and-Events/Annual-District-Meetings.

Early Elective Delivery Rates Decline in Georgia
Georgia’s rates have declined to Elective Deliveries (ED) in Georgia! The state has reduced EED rates from 33% to less than 2% over the last 18 months and less than 1% for the past 6 months, according to Lyenne Hall, blood pressure measurement, test answers. For more details about a specific procedure, refer to the AHA Blood Pressure Measurement Guidelines on the pages noted.

B (Number of Measurements, page 149)
2. C (Subject Preparation, page 149)
3. D (Important Points for Clinical Blood Pressure Measurement, page 151)
4. E (Effects of Arm Position, page 159)
5. F (Changes in Systolic Blood Pressure, page 151)
6. G (Refraining, page 153)
7. H (Technique, page 151)
8. I (Number of Measurements, page 151)
9. J (Effects of Arm Position, page 159)

For the advancement of women’s health in Georgia. In 1992, Mr. Lane was elected life member of the Association of Managers of OB/GYN where he served as president. He received the 2009 Distinguished Service Award from the OB/GYN Society. Mr. Lane was an active member of the First Baptist Church of Morrow.

Mr. Lane is survived by his wife Sally Granade Lane, two sons, Jeffrey Granade Lane, his wife Sally Lane, and Jay Timothy Lane, 4 grandchildren, Amanda Lane Witt, her husband David L. Witt, David Lane, Drew Lane and 1 great grandchild, Henry D. Witt, and former daughter-in-law Terri Cheaves Lane.

This program is available to your practice free of charge.

The Georgia chapter of the American Academy of Pediatrics is accredited by the Medical Association of Georgia to offer continuing medical education to physicians. The Georgia chapter of the American Academy of Pediatrics designates this Live Activity Session for a maximum of 4 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The continuing medical education activity was approved by the Georgia Nurses Association, an accredited sponsor by the American Nurse Credentialing Center’s Commendation as Accreditor.

Physician led, peer-to-peer education in your office

Breastfeeding Program
• Immunizations Program
Earn CME & contact hours
To schedule a program for your office call EPIC Breastfeeding: 404-881-5068 EPIC Immunizations: 404-881-5054 or visit www.gaepic.org to complete a request form.
Don’t miss the... Simulation Lab!!

A few Sim Lab Highlights:

- Ultrasound Demos with Live Models
- Suture Tying Station
- Immediate Post-Pardom LARC Placement
- Imaging for Colposcopy

GOGS Annual Meeting
Thursday, August 27 at 1:30 pm

CME Applies