Georgia Obstetrical and Gynecological Society, Inc.

OBGyn News

PROMOTING EXCELLENCE IN WOMEN'S HEALTHCARE in GEORGIA

OCTOBER 2021 • VOLUME 15, NUMBER 4

Message From Our President

Cary Perry, MD
President
2021-2022

It is an honor and a pleasure to assume the role as president of this Society. This has, indeed, been (another) long and unusual year. 2020 saw so many changes with the onset of a novel virus that tore through our state and country, only to circle back, having mutated into an even more deadly version of itself, to torture us all some more in 2021. This was the year we were supposed to recover, resume some semblance of normalcy, and proceed with plans for life, work, and goals. That is what we had hoped as individuals, as well as communities and groups. As the year wore on, we realized that nothing could be normal as we fought to educate, inform, protect, heal, and save our patients and those communities from the ravages of this fourth wave. When I think about these past few months, this is what I am most proud of and what amazes me daily—the tenacity and devotion of my colleagues. Each of you have answered endless questions about a lifesaving vaccine and calmed the concerns of your patients as they chose to take advantage of this miraculous protection based on your advice. So many of you have reassured your patients to continue to protect themselves and their families through distancing, masking, and making difficult decisions to forego trips, parties, and family events. Still others have been there in the intensive care units and emergency departments, performing emergency cesarean sections on mothers whose premature infants are safer in a NICU than in utero as those mothers suffer horrifying decompensation from their infections. You've seen people die, but you have helped people live, and for that we will never be able to thank you enough.

Just as my physician colleagues have continued to practice exemplary medicine during this pandemic, I feel that we as a Society have capably continued our mission. I want to thank Dr. Melissa Kottke for her remarkable leadership and devotion during this trying past year. As I insinuated, it was supposed to be a year when we regained some normalcy, but it was anything but. Dr. Kottke took up the challenge of completing our organizational restructuring initiated by Drs. Ray and Scott during their tenures. Through this more focused committee structure, we will be better able to nimbly meet the many challenges of the function of our Society as we continue to respond to the ever-expanding needs of our membership and our patients. She continues to contribute as she will lead our special projects committee in the coming year to focus specifically on examining the GOGS by-laws and make recommendations that keep our Society functioning professionally and smoothly. She will also lend her voice and talents to both the Legislative and Communications committees. Thank you for your tireless efforts, Dr. Kottke!

Another huge thank you goes to Dr. Champa Woodham and the Annual Meeting committee. So many hours were spent in planning and preparation, all in hopes of holding a safe, enjoyable, and educational in-person meeting in August. When it became evident that this simply couldn't occur safely, our leadership made the difficult but appropriate decision to pivot to a completely virtual meeting. Given the format, the meeting was ultimately split into two parts, with the first part, which occurred in August, a wonderful success. I look forward to completing our final five sessions over the coming weeks and appreciate the flexibility and participation of our wonderful speakers this year. Their content was excellent and thoroughly enjoyed by all. I urge all members to join us for the upcoming Part 2, including our Residents' Poster presentations to round out this program in November. I would be dishonest if I didn't say how anxiously I am anticipating next summer's Annual Meeting to be held at The Cloister at Sea Island. I pray we will all be able to be together and enjoy the fellowship and friends we have all so desperately missed these past two years.

I look forward to continuing to try to emulate the level of excellence exemplified by my predecessors. We continue to have many challenges to champion in the legislature as we run with the expansion of postpartum Medicaid coverage and continue to work toward our long-term goal of one year of coverage. We will also continue to keep a watchful eye on the ever changing bills proposed each session that may affect our ability to deliver timely and

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Administrative Office
2925 Premiere Parkway, Suite 100
Duluth, GA 30097
Telephone: 770 904-0719
Fax: 770 904-5251
www.gaobgyn.org

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OBGyn NEWS, October 2021

Message From Our President *(Continued from page 1)*

appropriate care to our patients, or that may attempt to subvert what should be a sacred physician-patient relationship. It is our goal as a Society to advocate for the needs of all patients, especially those who may be marginalized or less able to advocate for themselves. The Society's work in cooperation with the Maternal Mortality Review Committee and the Department of Public Health has lent a better understanding of this disparity as we try to define areas of concern which may be addressed by thoughtful and cogent plans of actions supporting safer and better levels of care at each and every hospital that cares for delivering mothers in Georgia. The implementation of AIM bundles for hemorrhage and hypertension have proven successful but we still have more work to do and encourage our members to champion this vital work in their communities.

Education remains a huge part of our mission. The Society strongly supports the continued growth of our training programs here in Georgia, and we are happy to welcome our new program based in Gainesville through Northeast Georgia Medical Center, where they will welcome their first residents in 2023. I encourage our membership to reach out and become involved in some way in fostering the training of future OB/Gyns in Georgia. Volunteer to be a rotation site for a MS3. If you live near a medical school or training program and have an interest in teaching or proctoring, reach out to faculty. Mentor a young pre-med or medical student. Take the time and interest in nurturing a young physician. Your time and effort may go far in terms of influencing a future star in our field, and the people working tirelessly in graduate medical education and residency training do welcome the interest and help. We plan to continue to focus on more resident-centric events in the future, again in hopes that we can retain some of the wonderfully talented folks coming out of our state's training programs.

Retention of residents is not only optimal, it is necessary if we are to ever fill the needs in our underserved rural communities I look forward to working with and supporting the ECHO program in hopes of engaging all partners in support of these often underserved areas. We, of course, will continue our strong partnership with GaPQC and support of telehealth services in order to assure that every physician in every community has support and tools to bring care to every patient, as expediently and equitably as possible.

Lastly, I encourage each and every one of our members to explore what this Society means to them. What value does it bring to you and your practice? If you have ideas for how we can better support you, your patients, and our colleagues, please share them with me. If you have a unique idea or a new challenge for us to implement or take on, let us know. I believe we will need to continue to evolve and change in the future if we are to remain successful at meeting our mission, and we can only do that with your vision, energy, and ideas. Please stay involved and engaged. Thank you so much for this wonderful opportunity, and I look forward to our year together.

Saving Tomorrow Today

Victoria Green, MD, JD, MBA
Emory University School of Medicine

If I told you, I had developed a pill that would decrease the risk of sudden infant death syndrome (SIDS). You would likely consider offering it to your patients. As Georgia has the 21st highest obesity rate in the nation and the eighth highest obesity rate for youth ages 10-17 affecting nearly 1 in 3 Georgians with greatest prevalence amongst women[1]; If I said, I had a pill (with no side effects) that decreased the rate of obesity, you would consider offering it to your patients.

It is known that those living in the South suffer disparate burdens of chronic disease with increased rates of obesity, diabetes, hypertension and cardiovascular disease. Specifically Georgia ranks 40th in prevalence of diabetes with 12.6% of Georgians affected. Georgia ranks 33rd for HTN prevalence with 33.1% of Georgians suffering with hypertension. Nearly 285 Georgians die per 100,000 population from cardiovascular disease resulting in a rank of 38th for our state. What if the pill that I developed, that reduced the risk of SIDS was the same pill that reduced obesity and also reduces the risk of diabetes. You would then consider me a genius! However, in this case, I am espousing the benefits of feeding infants' breastmilk.

Breastfeeding is widely acknowledged as the most complete form of infant nutrition and is touted by the American Academy of Pediatrics as the "ideal method of feeding and nurturing infants". Breastfeeding provides a range of benefits for the infant's growth, immunity and development including fewer cases or severity of diarrhea, respiratory injection and ear infections. Even the formula industry touts "closest to breastmilk" on their best products. Why don't we just provide the "gold standard" that formula compares to i.e. breast milk?

Optimal rates of breastfeeding would have immense impact on infant health in Georgia since in 2012, nearly seven babies died for every 1000 live births. Although that is an astounding statistic, it is an improvement from the prior year. Georgia ranks 43rd in infant mortality, 47th in low birth weight, 45th in preterm birth, 34th in premature infant death and 40th overall in the health of women and their children.[2]

Breastfeeding also has health benefits for the mother including reduced risks of premenopausal breast cancer, earlier return to pre pregnancy weight, reduction of postpartum bleeding and reduced risk of osteoporosis. Studies have shown that suboptimal breastfeeding results in 911 additional childhood deaths[3], 4981 cases of breast cancer, 53,847 cases of hypertension, and 13, 946 cases of myocardial infarction[4]. Foreshadowing a significant societal economic burden totally nearly $31.6 billion resulting from premature deaths and pediatric disease.

As this seems to be the "wonder drug" with lifelong benefits to the patient, her child and society, why then don't all women breastfeed? We know there may be specific reasons why this is not possible however we also know that women want to provide the best they can for their child. Studies have shown that having their physician discuss breastfeeding is one of most powerful reasons for a women's choice to feed her child breast milk.

Physicians and providers may say that we asked and explained the multitude of benefits, however the patient said "No". That may be true, however if we notified our patient of the need for cesarean section and she said "No", we wouldn't stop there. If we asked our patient to take her antihypertensive medication and she said "No", we wouldn't stop there. Nor would we say that it's simply "her choice" to refuse a cesarean section or to take her medication. No, just as with all of the medical decisions mentioned above, the choice of infant feeding is also just as much a *medical* decision as others. Moreover, it is a medical decision that affects the patient *and* her baby for a lifetime. Authors has supported this ethical dilemma stating that "Given the documented short- and long-term medical and neurodevelopmental advantages of breastfeeding, infant nutrition should be considered a public health issue and not only a lifestyle choice."[5]

Thus, if the women chooses not to feed her child breast milk (either directly through feeding from the breast or by using a breast pump and feeding breast milk from a bottle) after you have had a discussion of the benefits, you should ask the reasons why and then attempt to allay any fears and concerns. Ask open ended questions such as "What have you heard about breastfeeding?" Providers must be respectful of their patient's choice however we must also ensure that it is an informed choice. We have all experienced patients arriving at our practice from another colleague whom you know to be experienced and knowledgeable however the patient often has questions that you know were likely reviewed and answered by your colleague. Thus, despite having accurate information, patients often need repetition and reassurance.

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Georgia OBGyn
GEORGIA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

WEBINAR INFORMATION

Friday, December 3, 2021

9 am - 12 noon

4 CEU credits available
Only registered/paid attendees can apply for CEU credits

Webinar link will be emailed in your confirmation. This link (and any materials provided by Steve) will be sent again to all registered/paid attendees via email 2 days before event (EOD on 12.1.2021)

Cost per person:
$35 for Members of GOGS
$50 for Non-Members of GOGS

Register: Use QR Code or https://conta.cc/3uu1c2F

Registration ends Monday 11.29.2021

Video of webinar will be emailed to each registered / paid attendee apx 1 week after meeting

***DISCOUNTED CODE BOOKS**

Discounted code books are available through InHealth Professional Services. Mention **"Georgia OBGyn"** to receiving discount. (Discout only available by email or phone, NOT internet).

Contact Jennifer at 800.253.4945 or jennifer.staples@inguagehsi.com

CONTACT INFORMATION

Contact Nicole Reaves at GOGS 770.904.5298 or nreaves@gaobgyn.org

Georgia Obstetrical and Gynecological Society, Inc.
Cary Perry, MD
President
2021-2022

Georgia Section The American College of Obstetricians and Gynecologists
Ruth Cline, MD
Chair

GOGS WINTER SESSION CPT CODING WEBINAR FRIDAY, DEC 3, 2021 • 9AM-12PM

- CPT AND ICD-10CM CODING UPDATES FOR 2022
- E/M CODING UPDATES FOR 2022
- 4 CEU CREDITS AVAILABLE

FEATURING:
STEVE ADAMS, MCS, COS, CPC, CPMA, CRC, CPC-1, CEMC, PCS, FCS, COA
INHEALTH PROFESSIONAL SERVICES

Have your 2022 CPT and 2022 ICD-10CM books and we'll look at how to use software applications, the internet, and the alpha and tabular index to locate common ICD-10CM codes to code for the most common codes that you'll use in the day-today operation of your OB patient services.*

SCHEDULE

9:00 AM - 10:30 AM

OBGYN CPT & ICD-10CM Coding Update for 2022

We will look at the new OBGYN:

1. CPT Codes
2. HPCS Codes
3. Modifiers
4. Preventive Services
5. ICD-10CM Changes for 2022

10:30 AM - 10:45 AM

BREAK

View important information from the Georgia Department of Health

10:45 AM - 12:00 PM

EVALUATION AND MANAGEMENT CODING UPDATE FOR 2022

In 2022, several changes were made to the Evaluation and Management codes for inpatient and outpatient services. During this workshop, we will look at the E/M changes that will impact OBGYNs moving forward in 2022. We'll look at office, consults, observation, and inpatient services and how they were impacted with these updates.

1. Review E/M coding for outpatient and inpatient services for 2022
2. Find out if there are deleted E/M services for 2022 and what will replace them
3. Get a refresher on E/M coding for 99202-99215
4. Learn if time requirements will change in 2022 for any E/M services

THANK YOU TO OUR PARTNERS

INHEALTH PROFESSIONAL SERVICES
The Doctors Company TDC GROUP
DPH Georgia Department of Public Health

Jeff Korotkin, MD
GOGS Golf Tournament Chair

Georgia OB-Gyn Society Annual Golf Tournament

Wednesday, September 22, 2021
Bears Best, Suwanee, GA 30024

Thank you to the GOGS physicians and supporters who came out to play a round of 18 at Bear's Best Atlanta on Wednesday, September 22. The sun peaked through just in time for our first in-person event of the year. Congratulations to all the winners. A special thank you to all of our sponsors. I look forward to seeing you next spring for the 2022 annual tournament.

Zack Myers, Adam Haywood, Michael Osborne & Will Albritton
**1st Place - GROSS *Longest Drive: Zack Myers*

Drs. McLendon, Straub, Ralsten & Toledo
**1st Place - NET*

Al Lobuglio, Dr. Brown & Dr. Lyon
**2nd Place - NET*

Morgan Nix, Drs. Taylor Sholes & Thomas Sholes
**Closest to Pin: Dr. Taylor Sholes*

Mike Moskal, Peter Pyun, Rick Marainacci & Ryan Grieb
**2nd Place - GROSS*

Dr. Hadley, Chanda Hadley, Dr. Scott & Shane Snyder

Drs. Suarez, Korotkin, Zane & Robbins

Drs. Toledo, Straub & Ralsten

Drs. Joffe & Bello, David Crane & Wade McKenzie

Charles Coleman, Howell Coleman, Jeff Gray & Matthew Walker

Dr. Joffe, Wade McKenzie, David Crane & Dr. Bello

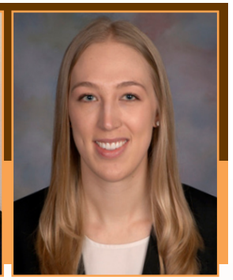
Dr. Hadley and daughter Chanda Hadley

Dr. Thomas Sholes & Dr. Taylor Sholes

Dr. Scott, Shane Snyder, Dr. Hadley & Chanda Hadley

Drs. Suarez, Zane, Robbins & Korotkin

Placenta Accreta Spectrum:
Review of Evidence-Based Diagnosis and Management



By: Carolynn M. Dude, MD, PhD, *Assistant Professor, Division of Maternal-Fetal Medicine, Emory University School of Medicine Department of Gynecology and Obstetrics*
Alexandra D. Forrest, MD, *PGY-3 Resident, Emory University School of Medicine Department of Gynecology and Obstetrics*

Placenta accreta spectrum (PAS) is a spectrum of pathology related to abnormal placentation and encompasses the diagnoses of placenta accreta, increta, and percreta. The prevalence of PAS has significantly increased over the past several decades. Clinical risk factors for development include cesarean delivery, dilation and curettage, myomectomy, uterine artery embolization, in vitro fertilization, and advanced maternal age.

Ultrasound is the preferred imaging modality for antenatal diagnosis of PAS, with sensitivity and specificity >90%. Optimal timing and number of ultrasounds is unclear, however early diagnosis is important to allow for delivery planning. MRI has also been used historically as an adjunct to ultrasound for the diagnosis of PAS. Recent studies, however, have established that this imaging modality is of little clinical value due to high cost, need for specialized interpretation, and limited diagnostic accuracy beyond ultrasound alone. If a patient is diagnosed with PAS antenatally they should receive care at a level III or higher maternal facility that employs a multidisciplinary approach due to clear benefit of this as compared to siloed management. Multidisciplinary teams should include an experienced obstetrician, Maternal-Fetal Medicine specialist, pelvic surgeon, anesthesiologist, urologist, trauma or general surgeon, interventional radiologist, and neonatologist.

Cesarean hysterectomy remains the gold standard for management of PAS. Delivery is recommended between 34 weeks 0 days and 35 weeks 6 days gestation. It is advised that patients be placed in the dorsal lithotomy position for manipulation of the cervix and assessment of vaginal blood loss. A midline vertical incision is advocated to allow for easier visualization, though consideration may be given to alternative transverse skin incisions based on suspected depth of invasion and surgeon preference. The uterine incision should attempt to avoid the placenta and a fundal incision may be made. Following delivery of the neonate, the placenta should be left in situ and the hysterotomy closed rapidly. Potential anesthetic considerations include pre-operative placement of two large bore peripheral IVs and an arterial line. Neuraxial anesthesia is acceptable, but the team should be prepared to convert to general anesthesia. In the setting of massive blood loss requiring transfusion, there is a recommendation from ACOG and SMFM to employ a range of 1:1:1 to 1:2:4 strategy of packed red blood cells: fresh frozen plasma: platelets. Post-operative disposition following cesarean hysterectomy is to the ICU in approximately 50% of cases, therefore the delivery hospital should have both neonatal and maternal ICU services available.

A variety of adjunctive measures have been described to optimize outcomes related to cesarean hysterectomies including ureteral stents, uterine artery embolization, and pelvic artery balloon catheters. The efficacy of ureteral stents has not been well proven in the literature, however complications associated with stent placement are overall low. It is therefore recommended by SMFM and ACOG that the use of ureteral stents be considered on a case-by-case basis as opposed to routinely. Similarly, data regarding efficacy of uterine artery embolization is lacking. Specifically, there has been no well-established evidence for prophylactic use. This technique can, however, be considered in the management of postpartum hemorrhage to avoid hysterectomy. Alternatively, the routine use of pelvic artery balloon catheters is not recommended due to lack of clear benefit and a demonstrated risk of serious complications including vascular damage leading to thrombosis or dissection.

Alternatives to cesarean hysterectomy are available and they include both alternative forms of hysterectomy as well as uterine-sparing procedures. Importantly, these are associated with complications including increased rates of delayed postpartum hemorrhage, longer hospitalizations, and need for multiple procedures, therefore cesarean hysterectomy remains the standard of care. Two different goals which may guide a patient and/or delivery team to proceed with these alternatives include fertility preservation and a desire to avoid immediate complications at the time of cesarean hysterectomy. These options include interval hysterectomy,

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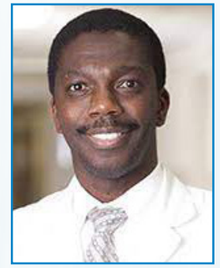
Join us for the GOGS 2021 Resident Poster Project Presentations on November 9, 2021!

Watch as residents from each OBGyn residency programs in Georgia present their poster and research projects. This yearly competition, sponsored by GOGS, provides an opportunity for residents to share their research with a network of OBGyn physicians. The judging panel, who has been selected due to their integrity, experience, and in-depth knowledge of obstetrics and gynecology, will select the winner of this competition shortly after in commences. The winner will be announced and have their poster featured in the next issue of the GOGS Newsletter and other social media platforms. I look forward to seeing you on November 9th!



Roland Matthews, MD
GOGS Education and Residency Involvement Committee Chair

Saving Tomorrow Today (Continued from page 4)

Provider suggestion and support of breastfeeding is a very powerful influencer.

Although framing your discussion as the benefits of breastfeeding, patients must also be aware of the risks of formula feeding including contamination of formula, increased allergies and asthma due to unfamiliar proteins, interference with bonding, increased risk of chronic disease including diabetes, lower scores on intelligence tests, manufacturing errors and warehouse contamination, adulteration of formula, phytoestrogens in formula, bisphenol A in feeding bottles, more diarrhea and respiratory infections, digestive problems, exposure of environmental contaminants and increased cost. Provide a brochure for at home reading and then present the topic for further discussion at the next visit.

Patients are often concerned regarding potential pain with breastfeeding. Pain is most often associated with improper latch, thus discussion in advance of latch techniques as well as beneficial hospital lactation support postpartum can allay concerns.

Feeding an infant breast milk for months or years, seems like a daunting task for many mothers. Thus, her difficulty may be in making a decision that seems very long term. Consider breaking breast milk feeding into smaller pieces. Instead of "are you going to breastfeed?" consider "How are you planning to feed your baby in the hospital?" Discuss the importance of colostrum in providing antibodies and improving the babies' ability to fight infections. Even short-term breast milk feeding is helpful to the infant.

Then consider prior to discharge, "How are you going to feed your baby until you go back to work (if appropriate)?" Discuss the availability of breast pumps which are covered under the Affordable Care Act and most commercial insurers. Also discuss proper milk storage.

If the mother expresses a desire to use breast milk, appropriate latch technique, early and often feeding to promote milk supply, breastfeeding positions, infant stomach size, hand expression, manual pump usage (have one in your office for modeling and explanation) and the detriment of supplementation to the milk supply should be discussed prenatally. One should review, what to expect in the hospital including rooming in, skin to skin, and feeding 8-12 times/24 hours.

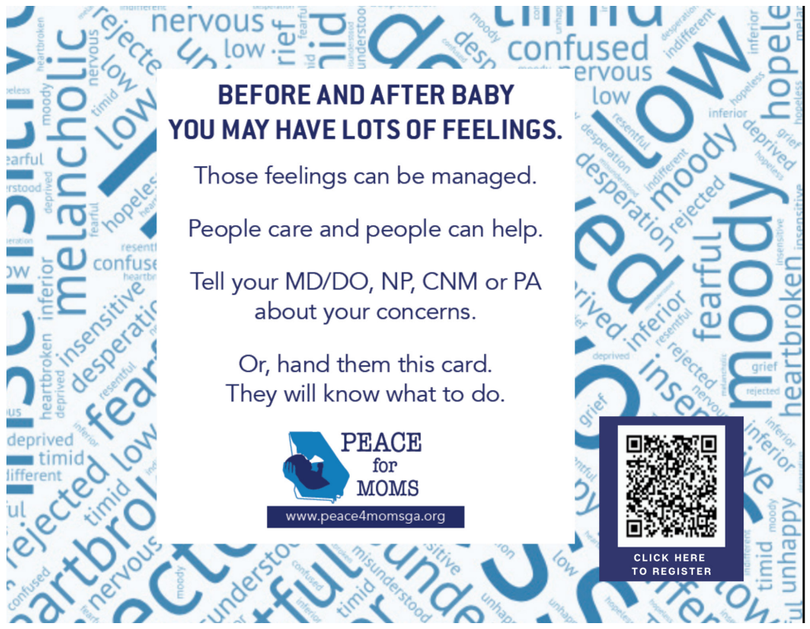
The most common reasons mothers fail to meet their breastfeeding goals is due to a perception of not producing enough milk or believing her milk production has stopped. Proactively discuss these areas during the prenatal period and discuss the physiology of supplementation which will quickly decrease milk production. Thus mothers will be prepared.

Additionally, consider collaborating with a lactation consultant or peer counselor prenatally from within the community or through your hospital. You can also often connect with a Lactation Consultant who will provide information and hands on support on site at your office or by referral.

Any mothers with concerns or physician exam features that would impact their ability to breastfeed (inverted nipples, prior breast reduction surgery) can be referred in advance of delivery for consultation.

Nursing, CMAs, CNMs, midlevel providers and all women's healthcare practitioners should be knowledgeable of breast milk feeding and common complications to assist patients. Educating Physicians and Practices in the Community (EPIC) is a free program through the Georgia American Academy of Pediatrics which can assist in onsite training of personnel and physicians across Georgia. Similar programs may be available in other District IV states or commonwealths.

1 *The state of Obesity.* www.stateofobesity.org/states/ga. Accessed September 27, 2019
2 Statistics and rankings obtained from *Americas Health Rankings*. Accessed 3/13/20 https://www.americashealthrankings.org
3 Bartick MC, Stuebe AM, Schwarz EB, et al. Cost analysis of maternal disease associated with suboptimal breastfeeding. *Obstet & Gyn.* 122(1): 111-9, 2013
4 Bartick MC, Schwarz EB, Green BD, et al. Suboptimal breastfeeding in the United States: Maternal and pediatric health outcomes and costs. *Maternal & Child Nutrition*. 13(1). 2017
5 Eidelman AI, Schanler RJ. Breastfeeding and the use of human milk. *Pediatrics*, 129(3), e827-e841. 2012



Placenta Accreta Spectrum (Continued from page 8)

gravid hysterectomy, expectant management, local placental resection, dilation and evacuation, and medical termination. Of note, methotrexate was previously advocated by some authors as an adjunctive method to hasten placental involution and resorption. This practice is now strongly advised against due to concerns about maternal and neonatal safety.

Overall, PAS is a rare but serious clinical scenario for which there is limited high-quality evidence to guide diagnosis and management. When the diagnosis is made antenatally, patients should be referred to a center with a multidisciplinary team. However, pre-operative diagnosis is still limited, and it is therefore imperative that all obstetricians be prepared to recognize and manage this complex disease process intraoperatively. Ultimately, efforts should focus on a reduction in the number of cesarean deliveries to decrease the incidence of PAS.

1 ACOG and SMFM. "Placenta Accreta Spectrum." *Obstetric Care Consensus*. 2018.
2 Collins et al. "Evidence-based guidelines for the management of abnormally invasive placenta: recommendations from the International Society for Abnormally Invasive Placenta." *Am J Obstet Gynecol*. 2019.
3 Silver et al. "Center of Excellence for Placenta Accreta." *Am J Obstet Gynecol*. 2014.

Georgia Obstetrical and Gynecological Society, Inc.

Administrative Office

2925 Premiere Parkway
Suite 100
Duluth, Georgia 30097

Telephone: 770 904-0719
Fax: 770 904-5251

If you would like to send a letter to the editor, please send it to info@gaobgyn.org or mail it to the Society's office.

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GEORGIA OBGYN SOCIETY

connections

MEMBERS CONNECTING

GOGS Members hard at work for the Society and for our Members!

GOGS Members, Drs. Winifred Soufi and Jane Ellis, attended the MAG House of Delegates meeting in October.

Pictured is Dr. Soufi along with Georgia State Representative Sharon Cooper and Georgia State Senator Kay Kirkpatrick.

Thank you Drs. Soufi and Ellis for making "connections" on behalf of the Society & Members!

Georgia OBGyn
GEORGIA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

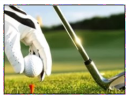
DATES TO REMEMBER

2021 — 2022

Coding Webinar
December 3, 2021
Currently taking registrations

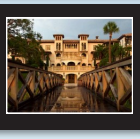
Legislative Day
March 3, 2022
Location TBA

Coding Webinar
May 2022
Date TBA



GOGS Golf Tournament
Spring 2022
Date & Location TBA

Annual Educational Meeting
August 25-28, 2022
The Cloister at Sea Island, Georgia



GaPQC Annual Meeting
Fall 2022
Date & Location TBA