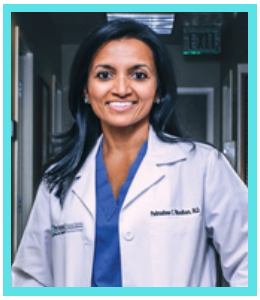
Georgia Obstetrical and Gynecological Society, Inc.

OCTOBER 2022 | VOLUME 16, NUMBER 5

OBGYN NEWS

Promoting Excellence In Women's Healthcare In Georgia



Welcome the 2022-2023 GOGS President, Dr. Champa Woodham

Cheers, everyone! I am Champa Woodham, your newly elected President of the Georgia Obstetrical and Gynecological Society. I was installed during the awards ceremony at the 71st Annual Educational and Scientific Meeting of the Society, held this year from August 25 -28, 2022 at The Cloister on Sea Island. I am currently the Director of the Regional Perinatal Center and Professor of Maternal-Fetal Medicine in the Department of Obstetrics and Gynecology at Augusta University - Medical College of Georgia.

After two years of cancellations due to COVID-19, it became clear early on that our members were anxiously awaiting both the educational and the social events for which GOGS has become known. More than 170 obstetricians, gynecologists and health care team members from across the southeast joined 70 exhibitors and sponsors for the premiere event of the summer. Attendees were eligible for 15.5 hours of AMA PRA Category 1 CME, including ABOG MOC Part IV Credit for our state-of-the-art Simulation Lab. For those of you who were unable to join us, I can only hope to relay the energy that was overflowing from the attendees at this year's meeting.

The Board of Directors and Advisory Council convened on Thursday morning prior to the official start of our annual meeting. This diverse group of talented clinicians discussed accomplishments from the past year, brainstormed new solutions for improving maternal and infant mortality throughout our state, and developed an agenda for the upcoming year.

Thursday's Simulation Lab offered hands-on training with products specific for our specialty. Physicians rotated between stations in the simulation room including a "spot-light area" to view featured products. That evening, everyone joined together for a welcome reception amongst the exhibitor displays. It was the first time many of us had seen our colleagues since the pandemic changed the way we work and live. The hugs and hellos were extra sweet.

GOGS Board of Directors, Advisory Council, Past Presidents, and Faculty were invited to the fabulous Forbes Farm for the annual dinner. Members and their spouses posed for photos overlooking the St. Simons marshland and enjoyed a night of food, drinks and camaraderie.

Day one of the meeting included lectures on reproductive endocrinology and infertility, uterine prolapse, and opioid use disorder in pregnancy. A special remembrance and champagne toast for former President, Dr. David Byck, was held that evening at the Beach Club. David's close friend and colleague Dr. Tony Royek gave a moving address. Dr. Cary Perry then bestowed upon David's wife, Dr. Peggy Byck, the GOGS Distinguished Service Award.

Day two started off addressing perinatal mood disorders, an update on the Georgia Maternal Mortality Review Committee, overactive bladder treatment, and a physical therapist's perspective on pelvic health. Attendees were invited to stay after the CME lectures to hear a breakout session, "The Implications and Effect of Dobbs vs. Jacksons Women's Health in Georgia and Future Legislative Positioning". A panel of four physicians, including Drs. Melissa Kottke, Cary Perry, Adrienne Zertuche and Jane Ellis, provided a run-through of HB 481 and offered many physicians an opportunity to ask questions for the first time about the implications and vagueness of the law.

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GOGS 2022-2023 Board of Directors

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

www.gaobgyn.org

QUICK LINKS

AWARENESS CAMPAIGNS
FOR THE MONTHS OF

October and November

October

BREAST CANCER AWARENESS MONTH

Win the fight against breast cancer.... It's time for early detection! Regular visits to a primary care provider are a necessary part of a health care routine. To learn more about breast cancer and prevention, visit: dph.georgia.gov/BCCP

NATIONAL MAMMOGRAPHY DAY (10/21)

Mammograms are a huge aspect of Breast Cancer Awareness Month, as millions of women across the globe are encouraged to attend Mammography screenings. According to the CDC, breast cancer is among the most common diagnosis in women, and screenings and exams are crucial for early detection and treatment To learn more, visit: https://www.cdc.gov/cancer/dcpc/resources/features/breastcancerawareness/index.htm.

DOMESTIC VIOLENCE MONTH

Intimate partner violence is a serious public health problem that affects millions of Americans. Intimate partner violence, also known as domestic violence, is abuse or aggression that occurs in a romantic relationship. To learn more, visit: https://www.cdc.gov/violenceprevention/index.html

November

BLADDER HEALTH MONTH

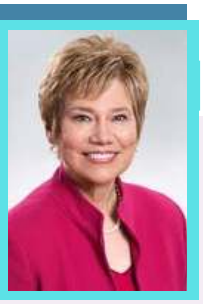
For something that affects close to 18 million women, it is surprising how many choose to suffer urinary incontinence in silence. Not only must these women contend with the physical symptoms, they have to bear a great deal of emotional pain as well. All of this stems from the misinformed idea that incontinence is an untreatable consequence of having had children or as a result of aging. Learn more by reading our featured article on page 10 and also by visiting NAFC at: https://nafc.org/womens-conditions/

NATIONAL MENOPAUSE AWARENESS MONTH

"World Menopause Awareness Month-Day highlights the importance of women, their families, and the clinical community celebrating and prioritizing the health and wellness of women as they age. It also gives us a valuable opportunity to draw attention to the characterization of menopause by the mass media," says Hadine Joffe, MD, board president of the North American Menopause Society (NAMS). Learn more by reading our featured article on page 12 and also by visiting NAMS at https://menopause.org/

Key Updates to Hepatitis B Testing (Rule 511-5-4)

Letter and Information from DPH Commissioner, Kathleen Toomey, MD, MPH



DPH

Kathleen E. Toomey, M.D., M.P.H., **Commissioner** | Brian Kemp, **Governor**

2 Peachtree Street, NW, 15th Floor
Atlanta, Georgia 30303-3142

dph.ga.gov

Dear Colleague:

Pregnant women infected with hepatitis B, hepatitis C, HIV, and syphilis can vertically transmit these infections to their infant(s) at birth. Detection of these infections in pregnancy allows providers to treat infected women to decrease the risk of perinatal transmission, to provide post-exposure prophylaxis to the exposed newborn(s) at birth, and to link infected women to care. The sequelae of these infections in newborns are developmental problems, chronic infections, and sometimes premature death.

The Georgia Department of Public Health amended its regulations in August 2022 to add additional testing requirements that align with the Centers for Disease Control and Prevention's (CDC) recommendations for prenatal screening. **Georgia Rules and Regulations 511-5-4** now mandates that all pregnant women be tested for hepatitis B, hepatitis C, HIV, and syphilis during each pregnancy.

Key updates to **Rule 511-5-4** include:

- **Addition of hepatitis B testing to the standard screenings for pregnant women**
  - HBV test at initial prenatal visit
  - HBV test at delivery for women not tested prenatally, or with signs or symptoms of HBV, or at high risk for HBV
- **Addition of hepatitis C testing to the standard screenings for pregnant women**
  - HCV test at initial prenatal visit
  - HCV test during the third trimester if the woman has known or potential exposure to HCV
  - HCV test at delivery for women not tested prenatally

Georgia law requires all Georgia physicians, laboratories, and other health care providers to report patients with these infections to the Georgia Department of Public Health (**Georgia Code O.C.G.A. § 31-12-2**). Both laboratory confirmed and clinical diagnoses are reportable within the specified time intervals.

As commissioner and as a physician, I urge you to make hepatitis B, hepatitis C, HIV, and syphilis testing part of your routine prenatal care – not just because it is mandated, but for the health and well-being of every mother and infant in Georgia. If you have any questions, please contact your local health office, or call the Georgia Department of Public Health at 1-866-PUB-HLTH (1-866-782-4584).

Thank you for all that you do to help protect the lives of all Georgians.

Sincerely,

Kathleen E. Toomey, M.D., M.P.H.
Commissioner and State Health Officer

Disease reporting requirements can be found by clicking **HERE** or visit:

https://dph.georgia.gov/epidemiology/disease-reporting

DPH

- To download a pdf of Dr. Toomey's letter, click **HERE**
- To download a pdf of the Serologic Testing Requirements flyer, click **HERE**

Serologic Testing Requirements
for Pregnant Women

FIRST PRENATAL VISIT

TEST ALL PREGNANT WOMEN:

Hepatitis B (HBV): HBsAg
Hepatitis B (HBV): HBsAg
Hepatitis C (HCV): anti-HCV with reflex to HCV RNA
HIV: HIV EIA or Rapid Assay (fingerstick preferred)
Syphilis: Non-treponemal (RPR) with reflex to treponemal test

THIRD TRIMESTER

TEST ALL PREGNANT WOMEN:

HIV: HIV EIA or Rapid Assay (fingerstick preferred) before **36 weeks**
Syphilis: Non-treponemal (RPR) with reflex to treponemal test ideally at **28 to 32 weeks** of gestation

TEST SELECT PREGNANT WOMEN AT CONTINUED RISK OR WITH KNOWN EXPOSURE:

Hepatitis C: anti-HCV with reflex to HCV RNA

AT DELIVERY

ASSESS ALL PREGNANT WOMEN:

Hepatitis B, Hepatitis C, HIV, and Syphilis testing

TEST SELECT PREGNANT WOMEN:

Hepatitis B (HBV): HBsAg
- No evidence of screening during pregnancy
- Persons at high risk
- Signs or symptoms of hepatitis

Hepatitis C (HCV): anti-HCV with reflex to HCV RNA
- No evidence of screening during pregnancy

HIV: HIV EIA or Rapid Assay (fingerstick preferred)
- No evidence of screening during pregnancy
- Persons at high risk
- Persons not tested in the third trimester

Syphilis: Non-treponemal (RPR) with reflex to treponemal test
- No evidence of screening during pregnancy
- Persons who deliver a stillborn infant(s)
- Persons at high risk
- Persons not tested in the third trimester

The Georgia Department of Public Health requires pregnant women to be tested for **hepatitis B, hepatitis C, HIV, and syphilis** every pregnancy (Rule 511-5-4). Positive test results for these infections must be reported to the Georgia Department of Public Health (Georgia Code O.C.G.A. § 31-12-2).

Welcome Incoming Interns - GA OBGyn Residency Programs

Joanna Gao, MD - PGY3, Emory University School of Medicine

On behalf of The Georgia OBGyn Society, I want to give a warm welcome to all of the incoming interns at Atrium Navicent Healthcare, Medical College of Georgia-Augusta, Emory University, Memorial Health University Medical Center, Morehouse School of Medicine, and WellStar-Kennestone! Having been in your shoes only two years ago, I can remember the excitement and nervousness as you introduce yourself as a doctor for the first time. As an OBGyn resident in Georgia, you are automatically a member of GOGs and we are here to help you navigate this large network of professional peers in Georgia, participate in educational meetings, and learn how to advocate for women's health care! We are so excited to have you join our profession and can't wait to help you grow and achieve your professional goals over the next four years in residency training.

ATRIUM NAVICENT

- Dr. Maya Crawford
- Dr. Elizabeth Lafranchise
- Dr. Bryar Thompson
- Dr. Steven Veselsky

MCG-Augusta University

- Dr. Lindsay Henry
- Dr. Rebecca Joseph
- Dr. Anatasia Navitski
- Dr. Christian Reinhardt
- Dr. Elizabeth Shake

Emory University

- Dr. Kerri Andre
- Dr. Gisel Bello
- Dr. Sara Brenner
- Dr. Natalia Jorge
- Dr. Tyler Gresham
- Dr. Lauren Holt
- Dr. Chad Richardson
- Dr. Zoe Roecker
- Dr. Kristin Swope

Memorial Health University

- Dr. Gabrielle Aiello
- Dr. Bailey Brown
- Dr. Ashton Fincher
- Dr. Jordan Mattern

Morehouse School of Medicine

- Dr. Alexandra Caldwell
- Dr. Katie Pieagle
- Dr. Tambari Piawah
- Dr. Deidre Wright

Wellstar Kennestone

- Dr. Kristen Ezeude
- Dr. Dedrick Anson
- Dr. Ashley Lall
- Dr. Clara Wynn

Captured Moments from the GOGS 2022 Annual Educational Meeting

Captured Moments from the GOGS 2022 Annual Educational Meeting

To request photos from this event, please email Nicole at nreaves@gaobgyn.org

Residency Poster Project 2022 - Winner Announced!

Chad Ray, MD - Chair, GOGS Educational Committee

During this year's annual meeting, The Society offered an oral abstract session for selected residents, one from each of the six training programs in Georgia, to further showcase scholarly activity. Scholarly activity is a requirement for resident education and accreditation of residency programs nationally. The Society would like to announce this year's winner of the GOGS Resident Research Project Award for 2022, Ashley Foreman. Dr. Foreman is a medical resident at Mercer University School of Medicine in Savannah/Memorial Health and currently serves the patients of of Memorial Health Hospital. Dr. Foreman's oral abstract, "Intracervical Foley Balloon Use in Pre-labor Rupture of Membranes: Rates of Maternal and Neonatal" can be found by clicking **HERE** or online at: https://tinyurl.com/GOGSAMForeman .

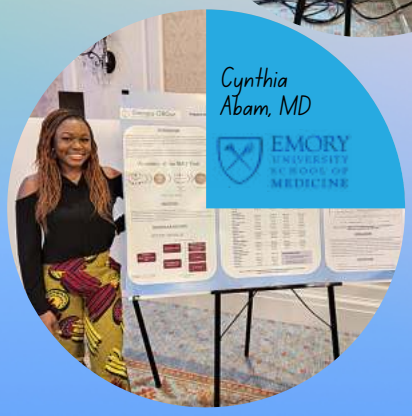
Dr. Foreman is currently a PGY-4 Resident. She was born in Columbia, South Carolina. Ashley received her BS from Furman University and then attended the University of South Carolina School of Medicine where she received her medical degree. Ashley enjoys spending time with her husband and her family. One of her favorite pastimes is snuggling up in a corner with a good cup of coffee and browsing Instagram!

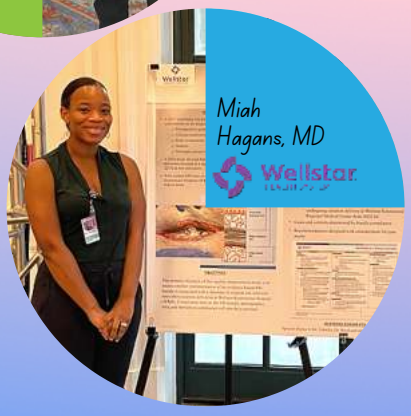
Congratulations, Dr. Foreman!

Categories for selection were based on originality, methodology, and impact. Thank you to Drs. Koroktin and Toledeo for judging all entries.

Thank You

To All The Residency Programs That Contributed To The 2022 Residency Poster Project





Georgia OBGyn Residency Programs Spotlight: Morehouse School of Medicine

Kiwita Phillips, MD - GOGS Educational Committee Member

Q: *What year did your residency year begin?*

A: **1997**

Q: *How many residency slots?*

A: **16**

Q: *What are you most proud of about your program?*

A: **We are a diverse, inclusive and passionate bunch. We've trained physicians from all over the country and the world. We train our doctors to be prepared for independent practice or fellowship. Residents have left our program to work in underserved areas in the state of Georgia and across the nation. We are Grady Proud. We are Morehouse proud.**

Q: *Who are the key contacts for your program?*

A: **Program Director** - *Kiwita Phillips, MD*
Associate Program Director - *Raimot Olanrewaju, MD*
Program Manager - *Kelli Hooper*
Program Assistant - *Alisa Ware*
Chair - *Roland Matthews, MD*

For more information, click on icons below or visit on-line:

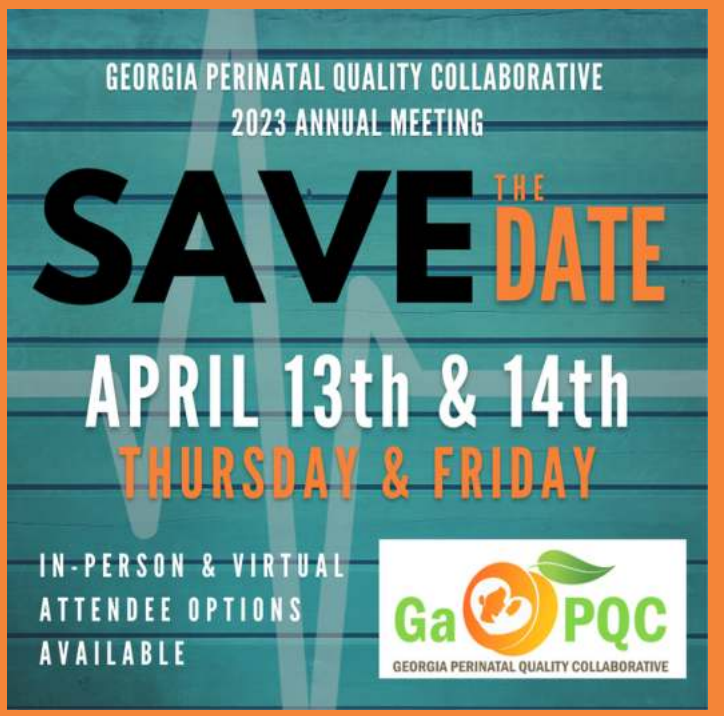
msm.edu/Education/GME/OBGYNResidencyProgram/index.php

instagram.com/msmobgyn/

youtu.be/gzTX9Vv72ns

THREE FUN FACTS ABOUT OUR PROGRAM:

1. We have 22 years of graduates - they have worked all over the United States, including Maine and South Dakota
2. Our Residents come from all of the world - Pakistan, Hong Kong, China, the Caribbean and even Southwest Georgia
3. Before Dr. Phillips, we had the same program director since 1997 - Dr. Franklyn Geary, Jr, MD



AGENDA AND REGISTRATION INFORMATION TO FOLLOW
FOR MORE INFORMATION VISIT: WWW.GEORGIAPQC.ORG
OR EMAIL: INFO@GEORGIAPQC.ORG

In Remembrance

John Hill, Jr., MD ***(02.14.42 - 09.28.22)***

It is with heavy hearts to announce the death of GOGS Past Pres-Past President, John Hill, Jr.,MD. Dr. Hill died peacefully on September 28th, 2022.

He graduated from Bass High School in Atlanta and received a Bachelor of Science degree in Chemistry from the University of Georgia where he was a member of Phi Kappa Phi and Phi Kappa Literary Society.

In 1964, he married his high school sweetheart, Judy Haynie, remaining married for 58 years. He received his M.D. from the Medical College of Georgia and following an internship at Macon (GA) General Hospital, he spent 2 years in the Navy at Camp Lejeune, NC. Following his service, he did a residency in OBGyn at Charlotte Memorial Hospital in Charlotte.

He came to Athens in 1974 and practiced as a member of Athens OBGYN until his retirement on Dec. 31, 2003. He served on the Board of Directors of the Georgia OBGYN Society for 40 years, serving in a number of capacities including president from 1995-1996, and in 2019 was honored to be presented The Georgia OBGYN Society's most prestigious award, The Distinguished Service Award, honoring his long service. Click **HERE** or go on-line at: www.lordandstephens.com/obituary/DrJohn-HillJr to view complete obituary.

Clinical Management of Overactive Bladder and Stress Urinary Incontinence

Barbara R. Henley, MD, and Annabelle Clark, MD

Urinary incontinence (UI) is an embarrassing and often debilitating disorder that affects 25-75% of women; however, only 45% of women with urinary incontinence seek help from a provider. Stress urinary incontinence (SUI) is the involuntary loss of urine with increased abdominal pressure (i.e., sneezing or coughing) or physical exertion; it effects nearly 16% of women. Overactive bladder (OAB) is defined as a syndrome characterized by urinary urgency, with or without urgency incontinence, usually with increased daytime frequency and nocturia in the absence of a urinary tract infection (UTI) or other obvious pathology [1]. OAB effects at least 16% of women aged 21-90.

The basic workup for UI in the office should include: a thorough history including assessment of symptoms severity and goals of treatment, physical exam including a cough stress test and assessment of urethral mobility, screening for UTI, and a post void residual to rule out retention and overflow incontinence. Urodynamic testing should be performed to evaluate lower urinary tract dysfunction for those in whom a clear diagnosis cannot be made on history and physical exam alone. Cystourethography may be considered in women with micro-scopic hematuria, acute onset or refractory urgency incontinence, recurrent UTI, or suspicion for fistula [1, 2].

The list of management options for UI in women is ever expanding. First line treatment for both OAB and SUI is behavioral modification and/or physical therapy. This includes: bladder training, pelvic floor muscle training with a trained pelvic floor physical therapist, urge strategies (active use of pelvic floor muscles for urge suppression), biofeedback, electrical stimulation, fluid management, dietary changes (avoidance of caffeine, cranberry juice, alcohol, and spicy food), weight loss, and smoking cessation. When these modifications are unsuccessful or a non-practical option for the patient, second and third line treatments should be considered.

Multiple medications are available for the treatment of OAB. Oral antimuscarinics reduce contraction of detrusor muscle. However, side effects are common and include dry mouth, dry eyes, constipation, and cognitive dysfunction particularly in the elderly. A transdermal oxybutynin patch is also available over-the-counter. A growing number of recent publications have raised concerns about anticholinergic medications in general and the associated risk of cognitive impairment, dementia, and Alzheimer disease. The American Urogynecologic Society recommends avoiding use for OAB in women over 70. A newer class of Beta 3 adrenergic medications have become available in the past decade; these cause relaxation of the detrusor muscle. Patients with OAB are often dissatisfied with medication regimens; there exists a high rate of discontinuation at 6 months and 1 year and a low rate of re-initiation.

Intravesical injection of onabotulinum toxin A has been approved for management of OAB since 2013. It is clinically indicated after failing one oral medication and can be performed in office. In pivotal studies, 57-63% of participants experienced ≥ 50% reduction and 23-31% saw 100% reduction in daily leakage episodes. Compared with antimuscarinic use, onabotulinum toxin A results in similar reduction of incontinence symptoms and a greater percentage of patients with complete resolution of incontinence. [1]

Neuromodulation techniques include percutaneous tibial nerve stimulation and sacral neuromodulation. Stimulation of the tibial nerve delivers retrograde neuromodulation to the sacral nerve plexus that controls bladder function, and it is thought to suppress neurogeneic detrusor activity. This therapy may be achieved via transcutaneous or percutaneous stimulation and several implantable devices will likely be available soon. Studies have proven no difference in quality of life outcomes between transcutaneous and percutaneous stimulation. Implantable stimulation is an emerging technology with promising results in pivotal studies. Sacral neuromodulation involves chronic modulation of the S3 nerve root. It consists of two components: an implantable programmable stimulator and a quadripolar lead in the S3 foramen. It is indicated for treatment of urgency urinary incontinence, urinary frequency, non-obstructive urinary retention, and refractory fecal incontinence. At five year follow up, 82% of participants saw ≥ 50% improvement in symptoms, and 45% were completely continent. Two FDA approved devices currently exist—the Medtronic Interstim™ and the Axonics→ Sacroneuromodulation System. Both devices are MRI compatible and have rechargeable and non-rechargeable options. Sacral neuromodulation is associated with very high (91-94%) patient satisfaction overall.

Medication management for SUI is much more limited. Duloxetine may increase urethral sphincter contraction during the storage phase of urination; however, its use is not widespread. No good evidence exists regarding the efficacy of alpha adrenergic medications, but their use may be appropriate in patients with other indications for these medications.

Objective evidence reporting the effectiveness of incontinence pessaries is not available. One randomized control trial reported higher patient satisfaction with behavioral modification than with pessary use. Incontinence pessaries may however be an acceptable treatment option in women who desire to avoid surgery and in whom adherence to behavioral modification or physical therapy is not likely.

Surgical management of SUI is largely accepted, and many office pro-

cedures and surgical options are available to patients. Urethral bulking involves injection of bulking agents into the urethral mucosa with the aim of achieving coaptation of the urethra during storage phase and during phases of increased abdominal pressure. The procedure is often performed under local anesthesia in an office setting, and is a viable option for women who prefer to avoid surgery or who have not completed childbearing. Placement of a midurethral sling has become the primary surgical treatment and standard of care for SUI. [3]. Substantial data exists demonstrating the safety and efficacy of synthetic mesh midurethral slings as a primary treatment for SUI. Pubovaginal fascial sling may be considered in women with severe SUI and a nonmobile urethra, urethral diverticula or fistula, or with complications from previously placed mesh sling [4]. Retropubic colposuspension (i.e., Burch urethropexy) requires direct visualization of the retropubic space, and can be performed through a mini laparotomy or with minimally invasive techniques. A less common surgical option is placement of an artificial urinary sphincter—a patient-controlled prosthesis designed to replace the normal functioning of the urinary sphincter. Several conditions must be met before this procedure may be considered, including a bladder that is able to adequately fill and empty at normal pressures and a patient who possesses both normal cognitive ability and dexterity. Infectious and erosive complications are common with this procedure and often result in device expulsion. Patients with recurrent UTI or previous pelvic radiation are poor candidates.

In conclusion, many options are available for the treatment of OAB and SUI. The decision regarding treatment modality should be made using a shared decision-making model and should include consideration of each patient's unique history, symptomatology, and treatment goals.

Authors' Affiliations:

Barbara R. Hensley, MD - *Associate Professor and Chief of Female Pelvic Medicine and Reconstructive Surgery at MCG - Augusta University*

Annabelle Clark - *PGY-3 OBGyn Resident at MCG - Augusta University*

REFERENCES:

- ACOG PB: Urinary incontinence in women
- ACOG CO 603: Eval of uncomplicated SUI in women
- AAFP
- Joint report: Terminology of surgical options

For complete reference information, click HERE

The Perimenopausal Well Adult Visit

Taniqua Miller, MD, FACOG, NCMP and Sasha Sherman WHNP-BC, NCMP

In celebration of Menopause Awareness Month in October and Healthy Aging Awareness Month in September, the Georgia OBGyn Society presents the top six questions to ask your midlife patients during an upcoming well adult visit:

1. Are you experiencing bothersome bleeding patterns?

a. Menstrual bleeding changes are the number one symptom experienced during the menopause transition.
b. While some patients may experience the spacing of menstrual cycle and lighter menstrual flow, a good proportion will notice increased in cycle frequency and duration, sometimes leading to anemia[1].
c. People who experience abnormal uterine bleeding also report a great deal of workplace stress as well as considerable financial consequences.[2]
d. Inquiring about bleeding patterns can set the stage for management, from medical management to progestin IUD placement or endometrial ablation. Furthermore, prompt screening of worrisome bleeding can detect concerning uterine pathologies, such as endometrial hyperplasia or cancer.

2. Are you experiencing hot flashes and/or night sweats?

a. Over 70% of patients will report some form of vasomotor symptoms associated with estrogen deficiency.[3] There are safe and easy to use hormonal and non-hormonal options for patients to ease symptoms and improve sleep and emotional well-being. It is also important to note that while some patients may not have been good candidates for estrogen-containing contraceptive options, there are hormonal estrogen therapies that are safe and compatible with medical comorbidities.
b. The **2022 NAMS Hormone Therapy Position Statement** strongly discourages discontinuing hormone therapy based on age alone. NAMS recommends reassessing needs for hormone therapy and reviewing risks, benefits, and hormone delivery at each visit.[4]

3. Are you sexually active?

a. Sexual health in midlife can be a healthy part of a fulfilling life. Sexual dysfunction is complex and includes issues in sexual interest, sexual arousal, difficulty with orgasm, or sexual pain.
b. Genitourinary syndrome of menopause is a common complaint among postmenopausal patients; yet, these patients seldom initiate discussion around troublesome symptoms. Asking about sexual activity opens the door for patients to share concerns about pain during sex, vaginal discomfort, libido, and arousal.
c. For patients who are not sexually active, it may be important to explore if this is by choice or due to pain or discomfort during intercourse or other sexual health concerns.
d. Although lower in prevalence, sexually transmitted infections can occur in postmenopausal patients and diagnosis is often delayed due to lack of appropriate screening.[5]

4. How do you get your heart beating or move your body?

a. Heart disease remains the leading cause of death in women.[6] The American Heart Association (AHA) recommends 30-minutes of moderate-intensity exercise for general cardiovascular health 5 days a week. If the patient has an elevated blood pressure or cholesterol, the AHA recommends 40 minutes of moderate-to-vigorous-intensity exercise 3 or 4 days a week.[7]
b. Encourage physical activity for patients to build a long-lasting relationship with movement.

5. Did you have any complications during your pregnancies?

a. Discussing history of complications in pregnancies can also help guide the discussion regarding prevention strategies for heart disease and diabetes in women with a history of gestational hypertensive disorders or gestational diabetes. Women with a history of preeclampsia have a twofold increased risk of developing major cardiovascular events and a nearly fourfold increased risk of developing hypertension.[8] A 2020 meta-analysis found an almost 10-fold increased risk of developing Type II diabetes mellitus in women with gestational diabetes versus health controls.[9]

MENOPAUSE
Awareness Month

To refer your patients to a national certified menopause practitioner, please visit the **North American Menopause Society's NCMP** database by clicking **HERE** or online at: https://tinyurl.com/NCMPDataB

b. An experience of postpartum depression (or previous episode of depressive disorder) remain the most significant risk factor for mood disorders in the menopausal transition.[10]

6. Do you experience any urinary leaking?

Much like genitourinary syndrome of menopause, incontinence is a common complaint for post-menopausal patients, with up to 40% of women in midlife and beyond experiencing active symptoms. Referral to pelvic floor physical therapists or female pelvic medicine and reconstructive surgeons can dramatically improve the quality of life of patients experiencing incontinence.

Authors' Affiliations:

Taniqua Miller, MD, FACOG, NCMP - *Assistant Professor, Emory*

Sasha Sherman WHNP-BC, NCMP - *Nurse Practitioner, Emory St. Josephs*

REFERENCES:

[1] Clinical Issues: Uterine Bleeding, In: North American Menopause Society, 6th Edition. Menopause Practice: A Clinician's Guide. Mayfeld Heights: The North American Menopause Society; 2019: 47-55.

[2] Côté I, Jacobs P, Cumming D. Work loss associated with increased menstrual loss in the United States. Obstet Gynecol. 2002 Oct;100(4):683-7.

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Welcome Dr. Champa Woodham, GOGS President

Continued from page 1

On Saturday evening, I was honored to bestow the Past-President medallion to Dr. Cary Perry for her outstanding work as the 2021-2022 President of GOGS. Dr. Perry established the Medicaid Extension Work Group during her presidency and has pledged to continue her efforts to define which portions of the 12-month postpartum Medicaid extension have been implemented and how GOGS can be a critical component of getting that messaging to the public.

And what a delight it was that night to present Dr. Jeff Korotkin with the 2020 GOGS Distinguished Service Award. The award is the highest level of recognition given by this Society for extraordinary efforts to improve women's health in Georgia. No one is more deserving than Jeff, as retirement has not stopped him one bit from his continued dedication to this work. The perfect evening ended with a crowd on the dance floor, led by yours truly.

Day three offered lectures on malpractice litigation, human milk feeding, and preimplantation genetic testing. We also held the third annual Resident Research competition, judged by. Drs. Jeff Korotkin and Andy Toledo. This year's winner, Ashley Foreman from HCA-Memorial Health in Savannah, GA, is featured on page 8.

If you did not have a chance to join us this year at The Cloister, or online, all of the lectures from this year's meeting, including the breakout session on Dobbs, can be found on the GOGS Website or YouTube channel at: **tinyurl.com/GOGSYTChannel**.

Be sure to save-the-date for next year's meeting, which will be held at the Westin Spa & Resort in Hilton Head, South Carolina on August 24-27, 2023 . Make sure to book your hotel room early as our room block fills fast! To book your room visit: **book.passkey.com/e/50359452**. More information about the GOGS 2023 meeting will be sent out in the spring.

In the coming days I will be sending out an opportunity for all GOGS members to join open committee positions. Committees allow GOGS to expand our capacity and increase engagement to achieve our mission.

We have a big year ahead of us and I can't wait to get started! If you have any questions, input or suggestions, I can be reached at my email **president@gaobgyn.org**. Please do not hesitate to reach out.

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