Georgia Obstetrical and Gynecological Society, Inc.

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OBGYN NEWS

Promoting Excellence In Women's Healthcare In Georgia

Maternal Mortality Reduction and Prevention Network Resolution

Jane Ellis, MD, PhD and Winnie Soufi, MD, PhD served as the Georgia OBGyn Society delegates to the 2023 Medical Association of Georgia (MAG) House of Delegates (HOD) meeting held at the Hyatt Regency in Savannah, GA on October 20-22. The HOD is the primary policy-making body of MAG. Its purpose is to give a means to express ideas and an opportunity to implement those ideas into action by creating policy regarding the practice of medicine in Georgia.

The Georgia OBGyn Society (GOGS) submitted the **Maternal Mortality Reduction and Prevention Network** resolution, which aims to create a network of obstetric and cardiac care providers coordinated across the state to provide quality prenatal and postpartum care for all pregnant/postpartum patients in Georgia who also require cardiac care.

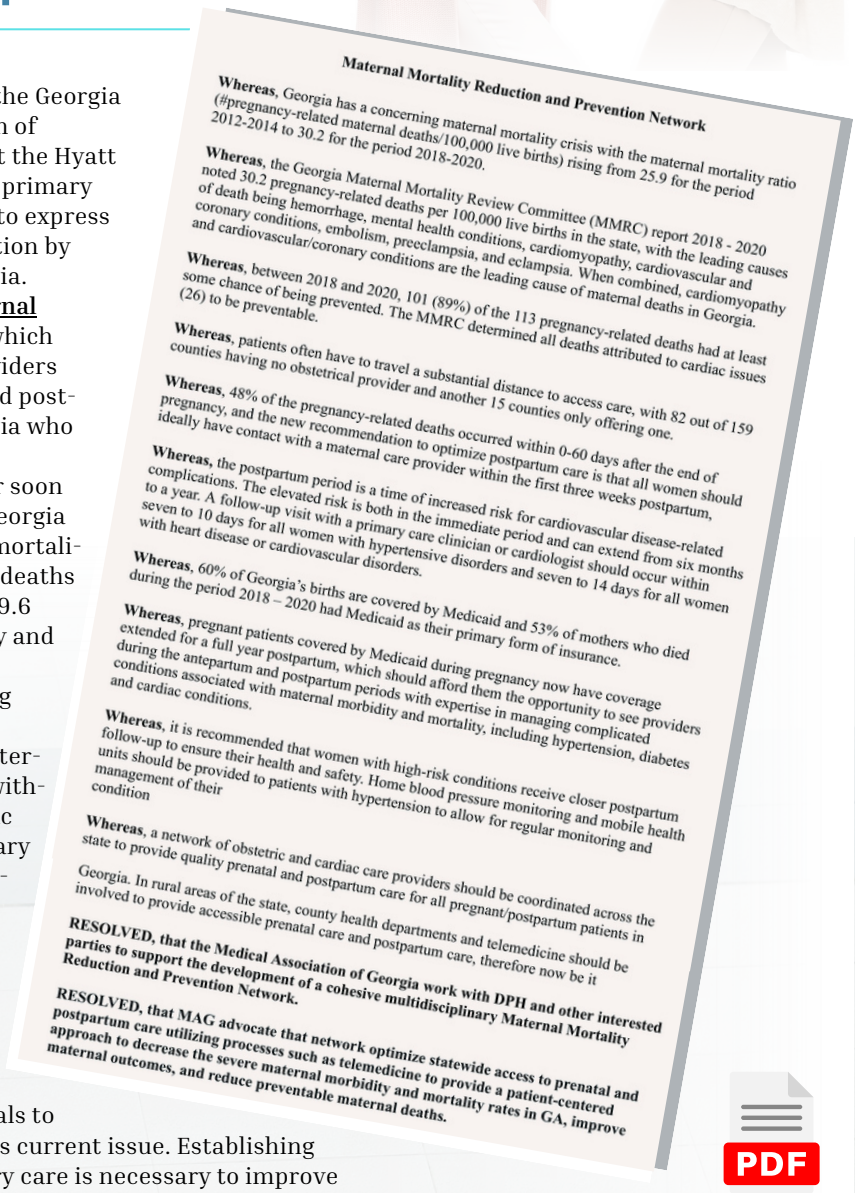
The death of a woman during pregnancy, at delivery, or soon after delivery is a tragedy and often a preventable event. Georgia has ranked 48th, 49th or 50th for maternal morbidity and mortality nationally, with a maternal mortality rate reaching 66.3 deaths per 100,000 live births, in contrast to the national rate of 29.6 from 2013-2017. Within Georgia, severe maternal morbidity and mortality (SMM) rates are significantly disparate based on social determinants of health, with the highest rates among Black, publicly insured, or uninsured.

Furthermore, according to the most recent Georgia Maternal Mortality Review (MMRC), 53% of maternal deaths are within 64 days postpartum, and 60% are due to maternal cardiac disease (cardiomyopathy, cardiovascular disease, pulmonary embolism, or preeclampsia). Maternal heart disease significantly threatens safe motherhood and women's long-term cardiovascular health. Therefore, understanding the clinical, social, and geographical determinants mitigating optimal maternal cardiac health is imperative.

While patient, family, and provider education is a crucial component of improving the identification of cardiovascular disease, the recent MMRC review suggests that patients with cardiac disease need more timely referrals to cardiologists. Education ALONE is not enough to impact this current issue. Establishing an effective leveled referral system from primary to tertiary care is necessary to improve maternal cardiometabolic health and, ultimately, maternal morbidity and mortality.

GOGS hopes that our Cardiology colleagues in Georgia will join us in an initiative to create a partnership across Cardiology and Obstetrics to create a referral network that will ultimately

(continued on page 7)



Maternal Mortality Reduction and Prevention Network

Whereas, Georgia has a concerning maternal mortality crisis with the maternal mortality ratio (#pregnancy-related maternal deaths/100,000 live births) rising from 25.9 for the period 2012-2014 to 30.2 for the period 2018-2020.

Whereas, the Georgia Maternal Mortality Review Committee (MMRC) report 2018 - 2020 noted 30.2 pregnancy-related deaths per 100,000 live births in the state, with the leading causes of death being hemorrhage, mental health conditions, cardiomyopathy, cardiovascular and coronary conditions, embolism, preeclampsia, and eclampsia. When combined, cardiomyopathy and cardiovascular/coronary conditions are the leading cause of maternal deaths in Georgia.

Whereas, between 2018 and 2020, 101 (89%) of the 113 pregnancy-related deaths had at least some chance of being prevented. The MMRC determined all deaths attributed to cardiac issues (26) to be preventable.

Whereas, patients often have to travel a substantial distance to access care, with 82 out of 159 counties having no obstetrical provider and another 15 counties only offering one.

Whereas, 48% of the pregnancy-related deaths occurred within 0-60 days after the end of pregnancy, and the new recommendation to optimize postpartum care is that all women should ideally have contact with a maternal care provider within the first three weeks postpartum,

Whereas, the postpartum period is a time of increased risk for cardiovascular disease-related complications. The elevated risk is both in the immediate period and can extend from six months to a year. A follow-up visit with a primary care clinician or cardiologist should occur within seven to 10 days for all women with hypertensive disorders and seven to 14 days for all women with heart disease or cardiovascular disorders.

Whereas, 60% of Georgia's births are covered by Medicaid and 53% of mothers who died during the period 2018 – 2020 had Medicaid as their primary form of insurance.

Whereas, pregnant patients covered by Medicaid during pregnancy now have coverage extended for a full year postpartum, which should afford them the opportunity to see providers during the antepartum and postpartum periods with expertise in managing complicated conditions associated with maternal morbidity and mortality, including hypertension, diabetes and cardiac conditions.

Whereas, it is recommended that women with high-risk conditions receive closer postpartum follow-up to ensure their health and safety. Home blood pressure monitoring and mobile health units should be provided to patients with hypertension to allow for regular monitoring and management of their condition

Whereas, a network of obstetric and cardiac care providers should be coordinated across the state to provide quality prenatal and postpartum care for all pregnant/postpartum patients in Georgia. In rural areas of the state, county health departments and telemedicine should be involved to provide accessible prenatal care and postpartum care, therefore now be it

RESOLVED, that the Medical Association of Georgia work with DPH and other interested parties to support the development of a cohesive multidisciplinary Maternal Mortality Reduction and Prevention Network.

RESOLVED, that MAG advocate that network optimize statewide access to prenatal and postpartum care utilizing processes such as telemedicine to provide a patient-centered approach to decrease the severe maternal morbidity and mortality rates in GA, improve maternal outcomes, and reduce preventable maternal deaths.

PDF

PDF available by clicking on the 'Dowload Now' button below or go to: https://tinyurl.com/MMRPNR23

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

www.gaobgyn.org

QUICK LINKS

AWARENESS CAMPAIGNS FOR THE MONTHS OF *December and January*

December

WORLD AIDS DAY (12/1)
With science-based HIV screening, prevention, and treatment we can help end the HIV epidemic. This #WorldAIDSDay, and every day, access free CDC tools and guidelines for your practice from CDC at https://bit.ly/3DHYEEb

NATIONAL INFLUENZA VACCINATION WEEK (12/6-12/12)
Worry less about flu during pregnancy by getting a flu shot. It can reduce a pregnant person's risk of hospitalization with flu by about 40%, while also protecting their baby from flu for several months after birth when they are too young to be vaccinated. Learn more at: https://www.cdc.gov/flu/highrisk/pregnant.htm

January

BIRTH DEFECTS PREVENTION MONTH

Awareness of birth defects across the lifespan helps provide individuals, parents, and families affected by birth defects the information they need to seek proper care. It also gives healthcare professionals the evidence they need to deliver the best care for patients across all stages of life. Although not all birth defects can be prevented, people can increase their chances of having a healthy baby by managing health conditions and adopting healthy behaviors before becoming pregnant. Obesity increases the risk for several serious birth defects and other pregnancy complications. To learn more, visit: **https://tinyurl.com/CDCBirthPrevetion**

HUMAN TRAFFICKING PREVENTION MONTH

Many individuals who have experienced trafficking come into contact with health care and social service professionals during and after their exploitation, but still remain unidentified. The FBI recently named Atlanta as one of the top fourteen cities with abnormally high rates of human trafficking. However, the issue is not limited to Atlanta. Human trafficking is taking place in every corner of our state. The Georgians for Refuge, Action, Compassion, and Education Commission (GRACE) was created to combat the threat of human trafficking in the State of Georgia and provides free, on-line training: **https://www.youtube.com/embed/uaXBI-qF9wc?rel=0**

CERVICAL CANCER AWARENESS MONTH

Cervical cancer was once a leading cause of cancer death for women in the United States. Today, screening and prevention have greatly reduced the impact of this form of cancer. To learn more, visit: **https://www.cdc.gov/cancer/cervical/**

Testosterone Treatment of Hypoactive Sexual Desire Disorder in Menopause

Cayman Bickerstaff, BS-Medical Student; Jennifer T. Allen, MD; Carolyn Zahler-Miller, MD | Medical College of GA-Wellstar MCG Health

Hypoactive Sexual Desire Disorder (HSDD) is one of multiple disorders under the categorization of Female Sexual Dysfunction (FSD) and is defined in the DSM-IV-TR as "persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity," resulting in "marked distress or interpersonal difficulty" [1]. HSDD's etiology is believed to be multi-factorial, though the decreased androgen production secondary to menopause is one of the biochemically implicated processes in its development [2].

Disruptions in sexual desire should be adequately addressed in all patients, including during the menopause transition and postmenopausal period. Although it is reported that up to 10% of women may suffer from HSDD, the actual incidence is likely higher [3]. Women with HSDD, as opposed to those with low libido, have increased levels of stress related to their lack of sexual desire, which can fundamentally affect their quality of life [3]. A postmenopausal patient diagnosed with HSDD not related to modifiable factors or comorbidities can be offered transdermal testosterone for treatment [4].

Testosterone is secreted by extraglandular compartments in the body (50%), the adrenal glands (25%) and ovaries (25%) [4]. Age-related decreases in ovarian and adrenal gland function after the early reproductive years lead to decreased circulating testosterone which then minimally increases in the postmenopausal period due to decreasing sex hormone binding globulin [4]. Furthermore, women that undergo menopause secondary to surgical oophorectomy see an average of a 50% greater decline in testosterone during menopause compared to women undergoing natural menopause [4].

In both males and females, testosterone has a role in influencing sexual behavior [5]. Despite this influence, data shows no link between testosterone levels and the presence or severity of HSDD [5]. Given this lack of an association, testosterone should not be used as a diagnostic tool for HSDD. However, there is a strong correlation between testosterone concentration during treatment of HSDD and improvement in female sexual desire [5]. There have been multiple studies showing that testosterone is both efficacious and safe to use for HSDD [6]. A double-blinded, placebo-controlled trial showed a transdermal testosterone patch of 300 micrograms of testosterone per day caused significant improvements in sexual function and desire with only primary side effects of acne and hair growth, without more serious androgenic effects (voice deepening, alopecia, lipid derangements) [6].

HSDD remains the only disorder of FSD with an indication for testosterone treatment in postmenopausal women [7]. Despite a significant body of research favoring exogenous testosterone, the use of testosterone for HSDD is not currently approved by the FDA. Therefore, informed consent should be obtained on every patient prior to commencing therapy and patients should understand that their testosterone replacement therapy is being used as an off-label treatment.

The recommendation by menopause specialists is to use transdermal formulations of testosterone (Testim 1%, Axiron 2%, Androgel 1% patches) due to the ability to easily titrate to therapeutic (premenopausal) ranges [2]. The appropriate starting daily dose is approximately one-tenth of the dose for men [5]. Pellets, compounded products, and injectable formulations are not recommended due to lack of safety data and potential for supraphysiologic levels leading to adverse effects.

A baseline total testosterone should be measured at time of consideration for therapy and a repeat level should be obtained after 3-6 weeks of therapy [7]. Women typically notice an improvement in their symptoms within 6-8 weeks of treatment [8]. Routine screening exams should occur every 6 months for signs of androgen excess, and an accompanying serum testosterone level should be ordered. If the patient does not see any improvements in sexual desire after 6 months, it is recommended that therapy be halted. A contraindication for the treatment of HSDD with testosterone is high levels of circulating androgens on initial evaluation [2].

After 6-12 months of successful treatment, it is recommended to temporarily stop the hormone replacement therapy to determine if continued treatment is necessary. While short-term data is promising, data evaluating long-term complications of testosterone replacement therapy for patients with HSDD is sparse.

There is insufficient level 1 evidence to guide recommendations regarding the use of testosterone in premenopausal women with HSDD. However, expert opinion based on limited data suggests that management of women with premature and early menopause should be the same as for postmenopausal women presenting with HSDD [8].

Treatment for HSDD in any patient should follow a multi-modal approach including education, lifestyle modifications, medication review, sex therapy and/or psychotherapy, and consideration of pharmacologic options, including testosterone, as appropriate.

FOLLOW THESE SUGGESTED LINKS:

ISSWSH — https://www.isswsh.org/

The Menopause Society — https://www.menopause.org

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REFERENCES:

Click **HERE** to view references for this article

Georgia OBGyn Residency Programs Spotlight: Emory

Agena Davenport-Nicholson, MD - Member of GOGS Educational Committee

EMORY UNIVERSITY SCHOOL OF MEDICINE

Q: *What year did your residency begin?*

A: 1926 with 1 resident

Q: *How many residency slots?*

A: 36 (9 per year)

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

A: We are extremely proud of we the diversity in our residency program both personally and professionally which makes our program stronger and trains our residents to be better equipped to care for patients from all walks of life. It is a privilege to care for the patients at Grady Memorial Hospital which is Atlanta's safety net hospital and level one Trauma Center. Our residents gain experience with taking care of very high risk conditions and traumas in pregnancy while managing various social determinants of Health that impact this vulnerable population.

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

A:

Program Director –
Agena Davenport-Nicholson, MD

Associate Program Directors –
Cherie Hill, MD
Austin Schirmer, MD

Program Manager –
Aimee Moynihan, MSEd, PhD

Vice Chair of Education –
Jessica Spencer, MD, MSc

Interim Chair –
Penny Castellano, MD

FUN FACTS ABOUT OURPROGRAM:

1. We have an annual kickball game against the Emory Pediatric Residency Program called the "Meconium Cup" and have won the last 4 years.
2. We have an annual resident retreat and are looking forward to our new tradition of "Shooting the Hooch" each year.
3. We are the oldest and largest OBGYN residency program in the state

For more information, visit on-line: https://med.emory.edu/departments/gynecology-obstetrics/education/residency/index.html https://www.facebook.com/EmoryGynecologyObstetrics https://www.instagram.com/emorygynobresidency https://www.instagram.com/emorygynob/

Advocacy - Get Involved Now!

Sandra Reed, MD - GOGS Past President; and J. Len Lichtenfeld, MD, MACP

Have you ever wondered why physicians go to the Georgia Capitol each year to have conversations with legislators? Why should we give up days in our office seeing patients? After all, we are physicians, not lobbyists. Isn't our responsibility caring for our patients?

Maybe in the late 1980's and early 1990's that was correct, but today there are so many bills that our legislators debate relating to medical care that we can no longer afford the luxury of being un-involved. Important issues like women's reproductive rights, physician payment, and Medicaid expansion are just a few of the critical issues facing federal and state legislators. In 2023 over 150 bills were submitted the Georgia legislature that involved some aspect of medicine and patient care. These bills affect our profession and the burdens we increasingly face when providing care to our patients.

It is easy to sit back and say, "I'm too busy" or "I have to make the RVUs or my employer will be upset and may cut my pay or not renew my contract." Or excuses like, "I don't know how to lobby." Or "I would have to take a day from my practice. Let someone else will do it." These are just a few of the comments I have heard through the years as to why physicians don't get involved in the legislative process.

Each legislator represents someone from their community who is involved in providing medical care however not every legislator is fortunate to have obstetric and/or gynecologic coverage in their community. Why? Because the rural hospitals in Georgia have either closed completely or shut down their obstetric units—and there are more closures to come. This is just one example of why we as physicians should get involved and educate our legislators about the obstacles our patients—their constituents face every day.

There will never be effective legislative and regulatory solutions to the burdens our communities face unless we have reasonable conversations based on personal experience. That's why physician involvement in advocacy is so important. No one knows more about the promise and problems of medical practice and healthcare than you do.

So how does one get involved?

- The Georgia legislature is in session for 40 days starting in January of each year. These are not all consecutive days as they have hearings, budget meetings and other activities during this time. Generally, the session is completed by late March or early April.
- The Georgia OB/GYN Society in association with The Patient Centered Physicians Coalition of Georgia will host a legislative day on January 30, 2024, where we gather with our legislators and regulators to discuss issues that are a priority for our profession ***(see graphic/link for more details and to register)***. The Medical Association of Georgia also has a legislative day that one can attend.
- If you have never been to the Capitol, this is an excellent opportunity learn firsthand about advocacy along with your peers in a "safe" environment. In addition to these organized days at the Capitol, you can visit or communicate with your legislators and their staff at any time during the session when an important topic is under consideration. If you have knowledge about the topic, offer to go with the Society's lobbyists and meet with the legislators individually or attend and perhaps testify at a committee hearing.
- If you do not know who your legislators are, look them up through this link: **(https://www.legis.ga.gov/find-my-legislator).** Get to know them in your community. Make an appointment to discuss a topic that is important to you. This is best done when the legislators are not in session.
- You can also email them and introduce yourself as a physician in their district. Explain who you are, share your specialty, and outline concerns you have about a topic or bill of interest. Offer to discuss any questions they may have regarding healthcare legislation and give them your contact information.
- You can also consider supporting your legislators financially, either through direct contributions or through your organization's political action committee (or—even better—both!). The reality is that legislators need to campaign regularly, and finances are an issue for them. Helping them achieve their goals can also help you achieve yours, especially if you believe they are reasonably close to representing your views on the issues.
- If you speak to your legislator and you know the topic is difficult or you know your opinions differ, be courteous and explain the reasons for your point of view. One of three things could happen: they may agree with you, disagree with you, or pivot and change the subject. No matter, you want them to know your perspective. You may not always get the vote you would like however the legislative process is a long journey and over time you may be surprised how influential your engagement can be. Don't forget there are always issues where their vote can be important and more in line with your perspective. Developing a credible, respectful relationship with your legislator is invaluable.

It is important to get involved and stay involved. We should always remember: we are representing our patients and our profession. If you are not willing to offer your time, your personal experience and share your opinion, you can't complain about the outcomes. No one can represent you better than you and the organizations you support.

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Maternal Mortality Reduction and Prevention Network Resolution

(continued from page 1)

optimize reach and access to care for pregnant persons with cardiovascular complications. Extension of Medicaid for one year postpartum should help our Medicaid patients get the care they need with some reimbursement for the providers. This is important, especially for our postpartum patients, since most of our maternal deaths occur in the post-partum period.

Forming the Maternal Mortality Reduction and Prevention Network is the first step in addressing a huge issue. Part of the purpose of our resolution to MAG was to gain support as we undertake this process to connect Cardiologists to rural communities where the payor system is primarily Medicaid. There is a call to action from DPH Commissioner Kathleen Toomey, MD, for cardiologists who provide care to women during pregnancy and postpartum to engage in GaPQC's new Cardiac Conditions in Obstetric Care initiative and to become part of a cardiology referral network to ensure timely and appropriate referrals to care. The purpose is to generate a statewide OB cardiology referral list to support providers and hospitals with timely and appropriate consultations and referrals for pregnant and post-partum patients with, or at risk for, cardiac conditions.

- To view the letter from Kathleen Toomey, MD, to Georgia cardiologists, see highlighted letter or pdf link
- Cardiologists may enter their practice information **HERE** or through the following link: **https://www.surveymonkey.com/r/CardiacReferralNetworks**

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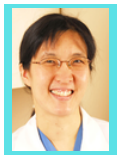

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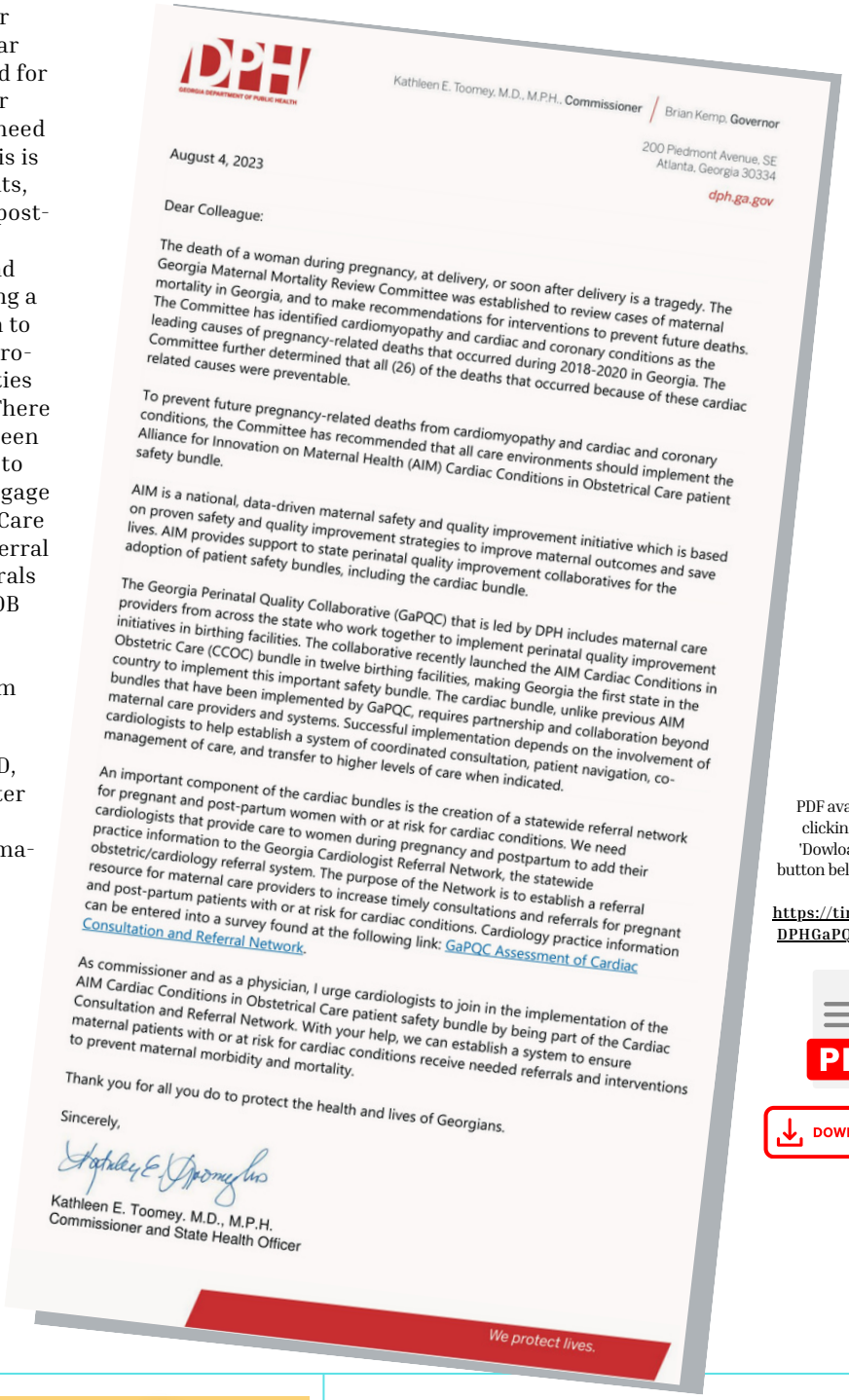

DPH
GEORGIA DEPARTMENT OF PUBLIC HEALTH

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

200 Piedmont Avenue, SE
Atlanta, Georgia 30334
dph.ga.gov

August 4, 2023

Dear Colleague:

The death of a woman during pregnancy, at delivery, or soon after delivery is a tragedy. The Georgia Maternal Mortality Review Committee was established to review cases of maternal mortality in Georgia, and to make recommendations for interventions to prevent future deaths. The Committee has identified cardiomyopathy and cardiac and coronary conditions as the leading causes of pregnancy-related deaths that occurred during 2018-2020 in Georgia. The Committee further determined that all (26) of the deaths that occurred because of these cardiac related causes were preventable.

To prevent future pregnancy-related deaths from cardiomyopathy and cardiac and coronary conditions, the Committee has recommended that all care environments should implement the Alliance for Innovation on Maternal Health (AIM) Cardiac Conditions in Obstetrical Care patient safety bundle.

AIM is a national, data-driven maternal safety and quality improvement initiative which is based on proven safety and quality improvement strategies to improve maternal outcomes and save lives. AIM provides support to state perinatal quality improvement collaboratives for the adoption of patient safety bundles, including the cardiac bundle.

The Georgia Perinatal Quality Collaborative (GaPQC) that is led by DPH includes maternal care providers from across the state who work together to implement perinatal quality improvement initiatives in birthing facilities. The collaborative recently launched the AIM Cardiac Conditions in Obstetric Care (CCOC) bundle in twelve birthing facilities, making Georgia the first state in the country to implement this important safety bundle. The cardiac bundle, unlike previous AIM bundles that have been implemented by GaPQC, requires partnership and collaboration beyond maternal care providers and systems. Successful implementation depends on the involvement of cardiologists to help establish a system of coordinated consultation, patient navigation, co-management of care, and transfer to higher levels of care when indicated.

An important component of the cardiac bundles is the creation of a statewide referral network for pregnant and post-partum women with or at risk for cardiac conditions. We need cardiologists that provide care to women during pregnancy and postpartum to add their practice information to the Georgia Cardiologist Referral Network, the statewide obstetric/cardiology referral system. The purpose of the Network is to establish a referral resource for maternal care providers to increase timely consultations and referrals for pregnant and post-partum patients with or at risk for cardiac conditions. Cardiology practice information can be entered into a survey found at the following link: GaPQC Assessment of Cardiac Consultation and Referral Network.

As commissioner and as a physician, I urge cardiologists to join in the implementation of the AIM Cardiac Conditions in Obstetrical Care patient safety bundle by being part of the Cardiac Consultation and Referral Network. With your help, we can establish a system to ensure maternal patients with or at risk for cardiac conditions receive needed referrals and interventions to prevent maternal morbidity and mortality.

Thank you for all you do to protect the health and lives of Georgians.

Sincerely,

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

We protect lives.

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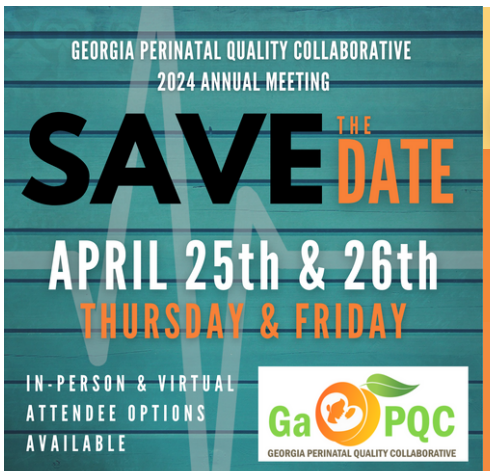


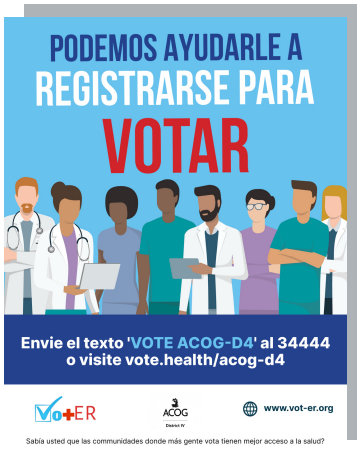
Vot-ER: Make a Difference in Your Community and Help Register Patients to Vote

Register Patients to Vote with ACOG District IV and Vot-ER!

The ACOG District IV Legislative Advocacy Committee is excited to announce a partnership with **Vot-ER**, a nonpartisan organization that strives to increase health care-based voter registration. Through this partnership, we will make a lasting impact on our District's civic health by registering people to vote in the course of our day-to-day work. We serve as trusted messengers in our communities and treat people from communities that historically vote in low numbers, such as young people and those who are uninsured or underinsured, putting us in a great position to reach these populations. With lawmakers making decisions about health care now more than ever, it's vital that we equip our patients with the tools to make their vote count.

The Vot-ER program was created by a doctor who understood that voter engagement work is critical—but also that such work must coexist with the demands of caring for patients. Vot-ER's tools are designed to work independently of health care staff involvement, and the voter registration itself is done exclusively through the patient's personal device. When patients scan the QR code or text message the number provided, they can navigate to a nonpartisan voter registration platform and register to vote, request a mail-in ballot, or learn about upcoming elections. How to get involved:

- Download the District IV QR code materials to share at your institution in print or digital form. Consider displaying the posters in patient exam rooms or including the digital materials in your inpatient and outpatient after-visit summaries. Materials are available **HERE**. Just a few examples that are available are shown below:



These and other materials are available online at:
https://tinyurl.com/ACOGD4Vote24Materials

- Use Vot-ER's **unique QR code** for District IV members to register patients to vote so that we can track our progress. We encourage all District IV members to **order a free physical badge from Vot-ER** that includes this code and will easily connect patients to Vot-ER's voter registration platform. Make sure to select "ACOG District IV" as your organization when ordering. You can also keep the QR code stored in your phone for easy access during patient encounters.
- Learn more about how to start the conversation about voting with your patients by visiting the **Vot-ER** website
- Spread the word about District IV and Vot-ER's voter registration campaign.

Join us in this partnership to ensure that patients throughout District IV are equipped with the tools and information they need to make their voices heard at the polls!

*Please reach out to Dr. Adrienne Zertuche at **zertuchemd@gmail.com** if you have any questions*

Preparing your Practice and Providers for the Fall and Winter RSV Season

Haben Debessai, MD; Elisha Hall, PhD, RD; and
Dana Meaney-Delman, MD, MPH, FACOG

Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Respiratory syncytial virus (RSV) is a leading cause of hospitalization among infants globally and one study showed an overall RSV-associated hospitalization rate of 678 per 100,000 children under 2 years old in the United States in 2014-2015.[1] RSV can lead to lower respiratory tract infections (LRTI) such as bronchiolitis and pneumonia and is stressful for parents and families of children afflicted with severe disease.[3, 4] Two options for prevention of RSV-associated LRTIs in infants are approved by the Food and Drug Administration (FDA) and recommended by the Centers Beyfortus; both products are not needed for most infants.[6]

The maternal vaccine, Abrysvo, is a recombinant protein vaccine recommended indicated for pregnant people from 32-0/7 through 36-6/7 weeks' gestation, at least 14 days prior to delivery, to reduce the risk of RSV-associated LRTI in infants up to age 6 months.[6, 7] Only Abrysvo is approved for use in pregnant people.[7] An additional RSV vaccine (Arexvy, manufactured by GSK) is not approved or recommended for use in pregnant people.[8] In most of the continental United States, Abrysvo is recommended for administration from September through January. In jurisdictions that have differing seasonality than most of the continental US, it is recommended to follow local guidance on timing or administration.[6] In clinical trials, when the vaccine was given between 24 and 36 weeks' gestation, vaccine efficacy was 56.8% (99.17% CI: 10.1 to 80.7) in preventing RSV-associated hospitalization in infants within 6 months of birth.[6] The clinical trial identified a small increase in the number of preterm births and hypertensive disorders of pregnancy in those who received the vaccine compared to placebo, however these differences were not statistically significant, and thus it is unclear if this is a true safety problem Fattributable to the vaccine or if this occurred for reasons unrelated to vaccination.[6, 9] Administration during 32–36 weeks gestation reduces the potential risk of preterm birth.[6] Advantages of Abrysvo include immediate protection at birth, and potentially higher resistance to viral mutations. Disadvantages include potentially reduced protection in some situations, for example, if the pregnant person's immunity is compromised.[6]

Beyfortus is a monoclonal antibody that can be given to all infants younger than 8 months of age born shortly before or entering their first RSV season and those aged 8–19 months who are at increased risk of severe RSV disease and entering their second RSV season.[5] In clinical trials, Beyfortus was found to be 80.6% (95% CI: 62.3 to 90.1) efficacious in preventing RSV-associated LRTI hospitalizations when compared to placebo.[5] Advantages of Beyfortus include potentially longer protection due to decreased waning of immunity, direct receipt of antibodies without reliance on maternal transplacental transfer, and avoiding any potential risks to pregnancy as mentioned previously. Disadvantages include potentially limited availability during this RSV season and it requires infant injection.[5]

Providers should be aware of key implementation considerations for the 2023-2024 season. First, the supply of Beyfortus is limited for 2023-2024. The CDC has a health advisory through the Health Alert Network (HAN) with updated recommendations on Beyfortus administration given the current limited availability.[10] Prenatal and infant providers will need to collaborate to adequately counsel pa-tients on availability of these options in their own healthcare network. Although the maternal vaccine is covered for nearly all full-adult beneficiaries of Medicaid, coverage for other types of Medicaid (e.g. emergency Medicaid) varies by state.[11] Furthermore, most private insurance plans are required to cover the vaccine, but have one year to do so.

It is important for prenatal providers to counsel their patients on these options taking into account patient preferences, the advantages and disadvantages of either option, and local availability of Beyfortus. Documentation of receipt of Abrysvo is important for accuracy in determining the need for Beyfortus. It is recommended that providers give patients a record of their vaccination either physically or electronically and document in the electronic health record and Immunization Information System. The CDC website, **Healthcare Provider Toolkit** has additional information. Additionally, V-safe, a CDC program that allows vaccinated persons to share how they feel after vaccination, will be available later this month and providers can help CDC promote V-safe by directing patients to vsafe.cdc.gov or sharing printed materials.

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REFERENCES:

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GOGS Connections: GOGS Members Making Connections

GEORGIA OBGYN SOCIETY connections

Dr. Keisha Callins and GOGS Exec Director, Kate Boyenga

GA Rep Debbie Buckner, GA Sen. Kay Kirkpatrick, GA Rep. Teri Anulewicz, GA Sen. Sally Harrell, and GA Rep Kim Alexander

Drs. Sandra Reed and Keisha Callins

Recently, Drs. Sandra Reed, Keisha Callins, and GOGS Executive Director, Kate Boyenga attended the Georgia Women's Legislative Caucus Fall Conference, held in Savannah, GA, in early October.

Founded in 1990, the formal bipartisan, bicameral Georgia Legislative Women's Caucus brings women members of the Georgia House and Senate together to work on issues important to Georgian women and families.

In mid October, Drs. Keisha Callins, Winnie Soufi, Jane Ellis, and GOGS Executive Director, Kate Boyenga attended the 2023 Medical Association of Georgia's House of Delegates (HOD) meeting, held in Savannah, GA.

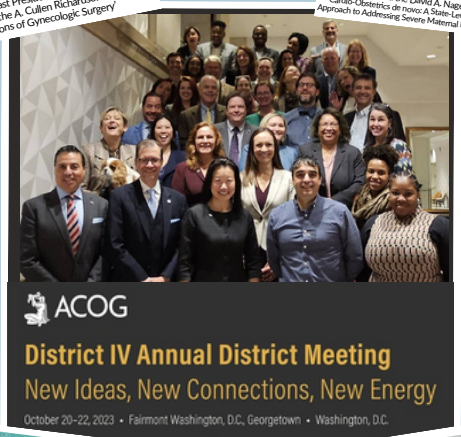
The HOD is the primary policy-making body of MAG. Its purpose is to give a means to express ideas and an opportunity to implement those ideas into action by creating policy regarding the practice of medicine in Georgia. For more details on this event, see the *Maternal Mortality Reduction and Prevention Network Resolution* article on page 1.

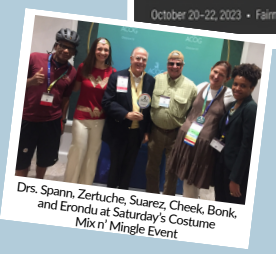
Dr. Keisha Callins, GA Senator Kay Kirkpatrick, Dr. Winnie Soufi, GA Representative Michelle Au, and Dr. Jane Ellis

Dr. Keisha Callins, Kate Boyenga, Dr. Jane Ellis, GA Representative Sharon Cooper, and Dale Matthews enjoying a cool treat

GOGS Past President, Dr. Cyril Spann presented the A. Cullen Richardson lecture, 'Incisions of Gynecologic Surgery'

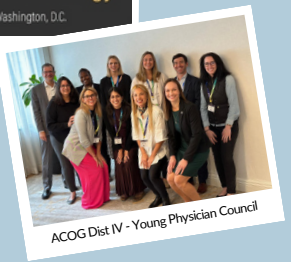
GOGS Past President, Dr. Chad Ray presented the David A. Nagey lecturer, 'Cardio-Obstetrics de novo: A State-Level Evidence-Based Approach to Addressing Severe Maternal Morbidity & Mortality'





Drs. Spann, Zertuche, Suarez, Cheek, Bonk, and Erondu at Saturday's Costume Mix n' Mingle Event

Georgia Section ACOG Jr. Fellow Chair and Vice Chair Drs. Sehar and Holt



ACOG Dist IV - Young Physician Council

GOGS Past Presidents, Drs. Spann and Ray were part of the many lectures presented at the recent ACOG District IV Annual District Meeting. Other fellow GOGS members present at this event were Drs. Bonk, Cheek, Erondu, Green, Reed, Suarez, Verma, and Zertuche; as well as our GA Section ACOG Jr. Fellow members, Drs. Ali and Holt.

Do you have a recent " connections " idea you would like to share? Please submit by clicking or using the following link:

https://forms.gle/LPKRkrsfB45Ku7mBA

Thank you for making "connections"on behalf of the society and members!

Check out GOGS YouTube Channel

Lectures from the GOGS 2023 Annual Meeting are Now Available

Georgia OBGyn Society | On Demand Videos

All lectures from the GOGS 2023 Annual Educational Meeting, held last August, are now available on our YouTube channel. Check out what's new:

- *Incision Decisions for Gynecologic Surgery*
- *Iron Deficiency Anemia in Pregnancy: Can We Do Better?*
- *Navigating Legal Battles in the Medical World - A Guide to Medical Malpractice Claims*
- *One Year Post-Dobbs, Where Are We Now?*
- *The Evolution of Periviability and its Impact on Extremely Premature Infants*
- *AI and Medicine*
- *Intrauterine Postpartum Hemorrhage Control Devices*
- *ASCCP Risk-Based Management Guidelines and its Clinical Application*
- *Managing Chronic Vulvovaginal Diseases: Lessons Learned from a Tertiary Care Center*
- *An Update on Georgia Medical Malpractice Environment*
- *A Proactive Strategy for Reducing Cardiac Related Maternal Deaths*

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