NINETY-FIFTH ANNIVERSARY
PACIFIC COAST
OBSTETRICAL AND
GYNECOLOGICAL
SOCIETY

Ninety-Third Annual Meeting
September 23-27, 2026
The Fairmont Chateau Whistler, Whistler, BC

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Continuing Medical Education credit is provided through joint providership with The American College of Obstetricians and Gynecologists.

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Las Vegas, NV

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2026 CAUCUS ARRANGEMENTS CHAIR

Kristy Roloff

2026 PROGRAM COMMITTEE

Kathleen Bradley Chair
Paula Bednarek
Deirdre Lyell
Linda Eckert
Maria Manriquez

SOCIETY ADMINISTRATOR

Daniella Esquivias

ROSTER OF MEETINGS AND PRESIDENTS

November 19-20, 1931 – San Francisco
Organization Meeting
Albert Mathieu, Chairman
December 8-10, 1932 – Los Angeles
Frank W. Lynch
October 19-21, 1933 – Portland
Albert Mathieu
November 21-24, 1934 – Del Monte
Lyle G. McNeile
November 6-9, 1935 – Los Angeles
J. Morris Slemons
November 11-14, 1936 – Seattle
Clarence A. DePuy
November 3-6, 1937 – San Francisco
Ludwig A. Emge
November 30-December 3, 1938 – Los Angeles
Raymond E. Watkins
November 1-4, 1939 – Portland
Edmund M. Lazard
November 6-9, 1940 – San Francisco
Alice F. Maxwell
November 5-8, 1941 – Pasadena
John Vruwink
November 5-7, 1942 – Oakland
T. Floyd Bell
November 3-5, 1943 – San Francisco
C. Frederic Fluhmann
November 6-9, 1946 – San Francisco
Goodrich C. Schauffler
October 1-4, 1947 – Seattle
Henry N. Shaw
November 10-13, 1948 – Los Angeles
Phillip H. Arnot
November 9-12, 1949 – San Francisco
William Benbow Thompson
November 4-19, 1950 – Timberline Lodge
Albert W. Holman
December 5-8, 1951 – Coronado
Roy E. Fallas
October 15-18, 1952 – Del Monte
Karl L. Schaupp
October 21-24, 1953 – Victoria, B.C.
Theodore W. Adams
October 27-30, 1954 – Santa Barbara
Emil J. Krahulik

October 6-9, 1955 – Sun Valley
Henry A. Stephenson
October 31 – November 3, 1956 – San Francisco
Donald G. Tollefson
October 30 – November 2, 1957 – Palm Springs
Bernard J. Hanley
October 15-18, 1958 – Seattle
Donald J. Thorp
October 21-24, 1959 – San Francisco
Donald A. Dallas
September 28 – October 1, 1960 – Yosemite
George E. Judd
September 20-23, 1961 – Yosemite
Donald W. de Carle
October 3-6, 1962 – Portland
Daniel G. Morton
September 18-21, 1963 – Yosemite
Howard C. Stearns
November 4-7, 1964 – Santa Barbara
Charles T. Hayden
September 29 – October 2, 1965 – Vancouver, B.C.
Alfred M. McCausland
November 2-5, 1966 – Santa Barbara
Robert K. Plant
November 29 – December 2, 1967 – Phoenix
L. Grant Baldwin
October 2-5, 1968 – Shalishan
Keith P. Russell
October 1-4, 1969 – Yosemite
Robert D. Dunn
November 9-14, 1970 – Kauai
Ralph C. Benson
October 5-10, 1971 – La Costa
Ernest W. Page
October 3-7, 1972 – Harrison Hot Springs
Purvis L. Martin
October 29 – November 4, 1973 – The Wigwam
Charles F. McLennan
October 6-10, 1974 – Sun River
Paul G. Peterson
October 6-11, 1975 – Del Monte
Ralph H. Walker
November 7-13, 1976 – Kona
Carl Goetsch
October 4-8, 1977 – Santa Barbara
Melvin W. Breese
September 26-30, 1978 – Salishan
William J. Dignam

September 26-30, 1979 – Palm Springs
Leon J. Shulman
October 6-11, 1980 – Monterey
Leon P. Fox
September 27 – October 3, 1981 – Kauai
Colin C. McCorriston
September 26-30, 1982 – Pebble Beach
Ivan I. Langley
September 6-10, 1983 – Vancouver, B.C. Canada
George A. Macer
October 21-27, 1984 – Tucson
Jesse A. Rust, Jr.
September 29 – October 4, 1985 – Napa
Edward C. Hill
September 21-25, 1986 – Salishan
Charles D. Kimball
September 27 – October 2, 1987 – Pebble Beach
Charles F. Langmade
November 12-19, 1988 SS Independence
Eugene C. Sandberg
September 17-21, 1989 – Coronado
David C. Figge
September 9-14, 1990 – Sun Valley
James M. Maharry
September 9-12, 1991 – Ashland
Richard N. Bolton
October 11-16, 1992 – Ojai
Walter S. Keifer
September 7-12, 1993 – Bellingham
Gilbert A. Webb
October 24-29, 1994 – Scottsdale
David Pent
September 16-21, 1995 – Squaw Valley
E. Forrest Boyd, Jr.
October 2-6, 1996 – Sunriver
Theodore W. Loring
September 17-21, 1997 – Coeur d'Alene
James C. Caillouette
September 16-20, 1998 – Whistler
E. Paul Kirk
October 20-24, 1999 – Cancun
Michael R. Smith
November 14-19, 2000 – Hawaii
S. Gainer Pillsbury, Jr.
October 3-7, 2001 – Ashland
W. Gordon Peacock

October 22-27, 2002 – Rancho Mirage
Robert Israel
September 16-21, 2003 – Anchorage
Emmet J. Lamb
October 19-24, 2004 – Phoenix
Russell K. Laros, Jr.
September 28-October 2, 2005 – Kauai
P. Ronald Millard
October 4-8, 2006—Sun Valley, Idaho
Kenneth A. Burry
October 10-14, 2007—Henderson, Nevada
Frank R. Gamberdella
October 15-19-2008—Victoria, B. C., Canada
Jerry M. Shefren
September 30-October 4, 2009—La Jolla, California
Lyman A. Rust
September 29-October 3, 2010—Kohala Coast, Hawaii
J. T. (Bill) Parer
September 14-18, 2011—Sunriver, Oregon
Robert Prins
October 3-7, 2012—Newport Beach, California
John A. Enbom
October 2-6, 2013—Walla Walla, Washington
Marilyn K. Laughead
October 22-26, 2014 - Marana, Arizona
Donald Barford
September 2-6, 2015 - Kahuku, Hawaii
Phillip E. Patton
September 28-October 2, 2016, Sun Valley, Idaho
Thomas W. Powers
November 1-5, 2017, Palm Desert, California
Patricia A. Robertson
September 26-30, 2018, Coeur d'Alene, Idaho
David C. Lagrew, Jr.
October 23-27, 2019, San Diego, California
James A. Macer
September 5th & September 12th, 2020, Virtual Meeting
President Elect Dale Reisner Presiding
September 6th, 2021, Virtual Meeting
Fung Lam
August 30-September 4th, 2022 - Wailea Maui, Hawaii
Dale Reisner
September 8-12, 2023 - Sunriver, Oregon
Glenn Huerta-Enochian

September 11-15, 2024- Victoria, B.C
Richard Paulson
October 8-12, 2025- Carlsbad, CA
Lorna Marshall

RECIPIENTS OF
PCOGS FRANK LECOCQ
LIFETIME ACHIEVEMENT AWARD

Frank LeCocq - November 18, 2000

Robert C. Goodlin - October 6, 2001

William Dignam - October 20, 2002

Robert (Bob) Israel - October 3, 2009

Jerry M. Shefren - September 29, 2010

Linda G. Hinrichsen - October 6, 2012

James C. Caillouette - October 23, 2014

John A. Enbom - September 29, 2016

Martha Goetsch- September 5, 2021

RECIPIENTS OF
THE BOB ISRAEL EMERITUS AWARD

Malcolm Munro- 2024
Adam Crosland- 2025

In Memory Of our Recently Passed Fellows

Donald Smith, Seattle Caucus
Robert Resnik, SD/AZ Caucus
Edward (Ted) Quilligan, Los Angeles Caucus

Active Fellows

Adams
Aghajanian
Ahsan
Ali
Al-Marayati
Atamdede
Barkley
Bayer
Bednarek
Behera
Bennet
Benoit, M
Benoit, R
Bradley
Broberg
Brown
Buchanan
Burlingame
Bush
Busse
Cabrera
Card
Caughey
Chandler
Colwill
Coonrod
Crosland
Dimer
Dunsmoor-Su
Duong
Durinzi
Eastwood
El-Sayed
Esakoff
Fassett
Finburg
Fisher
Foley
Friedman
Fuller
Furukawa
Garcia
Garrett
Gonzalez-Velez
Gorman
Gregory
Gregory
Hicks
Houston
Illangeske
Incerpi
Israel
Iriye
Jaque
Kavipurapu
Keith
Khieu
Kilpatrick
Kim
Kopp
Lager
Lagrew
Lamb
Larsen
Leslie
Lyell
Macaulay
Macdonald
McNulty
Melville
Mercer
Miksovsky
Mukul
Naqvi
Oliver
O'Reilly-Green
Ouzounian
Ozimek
Pandipati
Pare
Patel
Paulson
Peterson
Phillips
Powers
Press
Ramzan
Rangel
Roloff
Romero
Schlaerth
Shaffer, B
Shaffer, L
Smith
Sodhi
Thomas
Valenzuela
Vasquez
Veljovich
Venkat
Wentross
Wickman
Wiggins
Williams, III
Winch, Jr
Winter, M
Winter, W
Wittenberg
Wohlmuth
Wollan-Francis
Wu
Zhou

Semi-Retired Fellows

Bates
Coleman
Combs
Eckert
Grady
Hassan
Huerta-Enochian
Israel
Lofquist
Macer
Manriquez
Marshall
Munro
A. Nelson
H. Nelson
L. Nelson
Ogasawara
Robertson
Segal
Vasilev

Retired Fellows

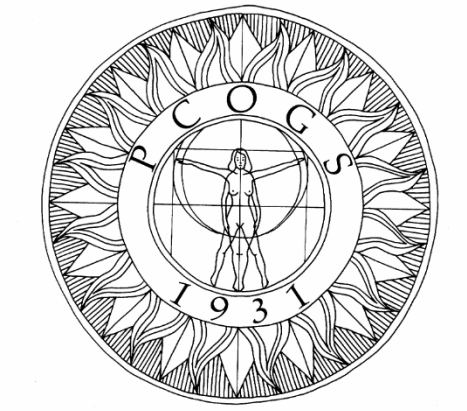
Adamson
Allen
Ambrose
Autry
Barbis
Barford
Berek
Boyle
Cain
Cohen
Cole
Collins
Corlett
Davis
Deasy
Deasy
deCastro
Dotters
Druzin
Ellsworth
Enbom
Fearl
Forsythe
Freeman
Garite
Gaylord
Giudice
Goetsch
Goldberg
Golditch
Goodwin
Graham
Gravett
Greenberg
Hanson
Hanss
Hartman
Hedriana
Hickok, D
Hickok, L
Hoffman
Jacobson
Jensen
Johnson
Kaplan
Katz
Kettel
Kim
Kirk
Korman
Lam
Lamb
Lanouette
Laughead
Lenihan
Lentz
Lowensohn
Luthy
Main, D
Main, E
Margolin
Maples
Mayo
McCausland
Miller
Moran
Morcos
Mouer
Mutch
Nageotte
Nakayama
Neilson
Nelson, R
Nichols
Norton
Novy
Paek
Palmer
Partoll
Patterson
Patton
Paul
Peacock
Peters
Pitkin
Platt
Plaut
Price
Reed
Reinsch, C
Reinsch, R
Robboy
Roberts
Rowles
Schlaerth
Schlesinger
Schrinsky
Schwartz
Shefren
Shields
Simpson
Shy
Smith
Snell
Soderstrom
Steinke
Stucky
Tache
Tamimi
Tarr
Tomlinson
Towers
Towner
Unzelman
Veltman
Walker
Wallace
Watson
Welch
Wesol
Whitelaw
Woods
Yee

Honorary Fellows

Felix
Jensen
Smith-Sehdev

Non- Resident Fellows

Ballon
Blanchette
Brewster
Futoran
Haesslein
Hale
Lanouette
Learman
Martin-Cadieux
Towers



A LOGO
TO IDENTIFY A
FIFTY-YEAR TRADITION

A logo is a symbol of identity and, as such, should be filled with symbolism and, in fact, tell a story. With this in mind the Logo Committee, seeking symbols, researched the name of the Society-first the region, Pacific Coast; second our specialty, obstetrics and gynecology; and third our birth, a Society founded in 1931, three elements suggesting a Trinity or three-part logo.

The first effort was to derive symbols from the Pacific Coast which would relate to our region and specialty: sun, energy, birth, life. The most common symbol in the Pacific is the sun. Pacific is, of course, from the Latin word Pacificus, meaning "more peaceful"-sunny and more peaceful. It was Magellan who named the Pacific Ocean in 1520 and appropriately so. Since the sun gives life and is symbolic of our region, it was chosen for the outer protective circle of our logo. The middle circle contains essential information providing the initials for Pacific Coast Obstetrical and Gynecological Society and the founding date, 1931.

The third part, and the heart of the logo, required difficult decisions. Once again, symbols began to flow: feminine, dynamic, classic, historic, anatomic, scientific, timeless, cyclic, lunar. It seemed appropriate to draw from the work of one of the three great artists of all time, one who was also an anatomist, engineer, inventor-a true Renaissance man, a person to emulate-Leonardo de Vinci. The artist, Dorothy Koll, adapted Leonardo's work "Canon of Proportions" from his anatomy notebook "Quarderni di Anatomia," volume VI, folio 8r. This drawing was sketched at approximately the same time that Magellan was naming the Pacific Ocean. What a fitting coincidence for our logo. The central figure is appropriately female rather than Leonardo's male. The anatomy is clear. The figure illustrates structure and movement, depicting the dynamic, cyclic, and ever-changing life of the female.

James C. Caillouette
Chairman, Logo Committee
Kauai 1981
50th Anniversary Meeting

HISTORIAN'S CORNER

LEARN ABOUT PCOGS HISTORY!

On our PCOGS web site (www.pcogs.org) under Society Info you can find the drop down called "Historian's Corner." Visit it to find many offerings. You'll find accounts of the founding years, biographies of some members including members honored by memorial funds. Many of the early presidential addresses are there, giving a flavor of the times and perspectives of members on challenging societal and medical issues. These offerings will transport you back in time to earlier years of our profession, as will selected scientific papers presented at meetings over the years. Interviews with members describe important Ob/Gyn history, offer fond recollections, and a few wild stories.

PCOGS MEMBERSHIP PROCESS

The Pacific Coast Ob Gyn Society (PCOGS) was founded in 1931 and has a long tradition of excellent annual scientific meetings that offer presentations from all areas of the specialty. The Society is composed of five regional caucuses representing the geographic organizations of the PCOGS structure. Members (Fellows) reside in seven western states stretching from Arizona to Alaska, including Hawaii. Membership in the society has always been by invitation, and presentation of a scientific paper is the steppingstone to membership. It is hoped that new members will come to value the society, regularly attend meetings, and contribute with subsequent presentations, formal discussions, and/or in the informal discussions from the floor.

In order to evaluate the Society and decide whether guests wish to pursue membership, interested physicians can come to an annual meeting as a member's personal guest. The formal process to join begins in the applicant's geographic caucus where a member sponsors a guest physician's application. Caucus members then vote to invite applicants to be a guest of the Caucus at the following annual scientific meeting. This provides an official introduction to the larger group, allows more exposure to the process, and starts the timeline for presentation of a paper two years later. Guests committed to membership can come in the intervening year as a guest of the Board of Directors if they wish. In years past the candidate always waited out a year before presenting, but prospective members can be welcomed each year. Meeting registration and expenses are the responsibility of invited guests for each meeting.
Two years after becoming a Caucus Guest, and following caucus and board approval, candidates will be invited as a Society Guest to present a scientific paper. Following each annual scientific meeting, the PCOGS members vote on the Society guests, and the board sends its confirmation of membership.

Society guests always present their papers in an oral format for admission to the society. The scientific program also includes presentations by Fellows. Posters are a second presentation format, and every year ObGyn residents and fellows from pacific coast medical centers are invited to exhibit posters as guests of the society. Resident fellows submitting manuscripts compete for an oral presentation, the Frank Lynch Memorial Essay, which includes an honorarium. The best poster is awarded an honorarium, The Charles Kimball Award, at the meeting. Poster presenters give an oral 5-minute summary from the podium at the meeting so that they can be formally introduced to the membership.

A mentoring process for PCOGS Society guests is in place to facilitate the best project possible with the least distress for the candidate. Each caucus matches the candidate with a suitable mentor. This person will be able to help guests understand the process and find those knowledgeable in their area of research. Some projects require assistance from several mentors to facilitate the planning process, IRB approval,

and data analysis. As IRB approval can take time, it is important to factor this in. Your caucus chair should assist in arranging a mentor who suits you. Please ask for more assistance if this does not seem to be working.

Society has always prided itself on the quality of papers presented. Presentations have historically been the culmination of a process of collecting original data, analyzing it, drafting a manuscript suitable for publication, and presenting it orally at the annual meeting. Formal presentation of the manuscript at the meeting is followed by a formal discussion from a member of the society. That member has volunteered to critique the manuscript and therefore needs to have received the completed manuscript before the meeting. They provide several questions to the presenter. After the formal discussion, audience members have the opportunity to ask further questions which the presenter then answers from the podium.

Historically, the various regional ObGyn societies in the country, such as PCOGS, have had a relationship with the American Journal of ObGyn, and papers were first submitted there. As of 2018, there is no longer a prioritized journal to which papers are to be sent. Presenters are expected to submit their paper for publication, but the choice of journal is left to the author and mentor. In order to bolster manuscript quality, the Society offers candidates the expert critique of the society's editor of scientific proceedings in a non-mandatory pre-submission review, or "pre-review."

PCOGS is a member-run organization. Many members devote time to making the organization work. There is only one employee, a masterful administrative assistant, who manages correspondence and organizational details. Guests attending a meeting will soon realize that member-volunteers and spouses manage all of the arrangements, the registration and the entire agenda. Attention to provided information and instructions, coupled with timely responses, will help the efforts and efficiency of the hard-working PCOGS Fellows who make these meetings so successful.

Society blends those in community practice and those in academic practice, essentially academic clinicians and clinical academicians, and welcomes their families to meetings. Members take pride in the social aspects of the society, which open opportunities to develop lasting friendships with members geographically distant from their own communities. The addition of enthusiastic new members is vital to the continuation of the Society. We hope our guests will be interested in learning more and pursuing membership.

Martha F. Goetsch & John A. Enbom

RECENT PCOGS PRESENTATIONS
PUBLISHED

Association of checklist usage with adherence to recommended prophylactic low-dose aspirin for prevention of preeclampsia.

Ming Zhou, MD- The American Journal of Obstetrics and Gynecology

How Medical Societies Can Collaborate with Vendors to Improve EHR Utilization

Brian Iriye, MD- NEJM Catalyst

Frank Lynch Essay (2024)
Introduction of advanced maternal age based on mortality-specific severe morbidity.
Masjedi AD, Anderson ZS, Pon FF, Matsuzaki S, Mandelbaum RS, Ouzounian JG, Matsuo K.
Int J Gynaecol Obstet. 2025 Mar;168(3):1328-1331

Shorey-Kendrick LE*, Crosland BA*, Schabel MC, Messaoudi I, Guo M, Drake MG, Nie Z, Edenfield RC, Cinco I, Davies M, Graham JA, Hagen OL, McCarty OJT, McEvoy CT, Spindel ER, Lo JO. **Effects of maternal edible THC consumption on offspring lung growth and function in a rhesus macaque model.** Am J Physiol Lung Cell Mol Physiol. 2025 Feb 4. doi: 10.1152/ajplung.00360.2024. Epub ahead of print. PMID: 39903192. *Both authors contributed equally

Frank Lynch Essay (2025)
Boller MJ, Garg B, Baker HA, Rodriguez MI, Marshall NE, Caughey AB. **Racial and Ethnic Disparities in Cesarean Birth Trends in the United States**. JAMA Netw Open. 2025 Nov 3;8(11):e2544078.

Cirillo AA, Zeme M, Morales A, Rahseparian N, Cortez C, Gaw SL, Blauvelt CA. **Regional variation in maternal RSV vaccine access and attitudes across two California cohorts**. Prev Med Rep. 2026 Feb 11;63:103408.

Frank Lynch Essay (2024)
Introduction of advanced maternal age based on mortality-specific severe morbidity.
Masjedi AD, Anderson ZS, Pon FF, Matsuzaki S, Mandelbaum RS, Ouzounian JG, Matsuo K. Int J Gynaecol Obstet. 2025 Mar;168(3):1328-1331

Qiao, Erica; Burns, Haley; Rodriguez, Maria I.; Cichowski, Sara B. **Urinary Incontinence and Menopausal Symptom Burden.** Obstetrics & Gynecology 146(3):p 402-404, September 2025.
Shorey-Kendrick LE*, Crosland BA*, Schabel MC, Messaoudi I, Guo M, Drake MG, Nie Z, Edenfield RC, Cinco I, Davies M, Graham JA, Hagen OL, McCarty OJT, McEvoy CT, Spindel ER, Lo JO. Effects of maternal edible THC consumption on offspring lung growth and function in a rhesus macaque model. Am J Physiol Lung Cell Mol Physiol. 2025 Feb 4. doi: 10.1152/ajplung.00360.2024. Epub ahead of print. PMID: 39903192. *both authors contributed equally

2026 Society Guests

First Name	Last Name	Caucus	Sponsor	Companion
Stephanie	Lin	Los Angeles	Larry Shield	
Claire	Gould	Portland	Abby Furukawa	
Jil	Johnson	Portland	Aaron Caughey	
Eva	Patil	Portland	Lisa Bayer	
Carolyn	Piszczek	Portland	Abby Furukawa	
Jessica	Reid	Portland	Lisa Bayer	
Simone	van Swam	Portland	Abby Furukawa	
Adrienne	Bonham	Portland	Aaron Caughey	
Michael	Ruma	San Diego/Arizona	Maria Manriquez	
Stephanie	Gaw	San Francisco	Meg Autry	
Suha	Patel	San Francisco	Keith Ogasawara	
Rebecca	Taub	San Francisco	Angelyn Thomas	Joe Perrone
Darcy	Broughton	Seattle	Lori Marshall	Debbie Broughton & Bill Mirand

2026 Caucus Guests

First Name	Last Name	Caucus	Sponsor	Companion
Leena	Nathan	Los Angeles	Paola Aghajanian	Ramesh Nathan
Vivienne	Meljen	Portland	Brandi Vasquez	Brad Olson
Leo	Pereira	Portland	Aaron Caughey	Natasha Pereira
Danielle	Prentice	Portland	Adam Crosland	Caleb Prentice
Jorge	Alvarado	San Diego/AZ	Katherine Macaulay	
Josh	Benham	San Francisco	Donna Wiggins	
Isabelle	Cohen	San Francisco	Pavithra Venkat	
Veronica	Gonzalez	San Francisco	Patty Robertson	Eduardo Jaime
Steven	Minaglia	San Francisco	Susan Gorman	Madeleine Young
Wendy	Lorentz	Seattle	Suzanne Peterson	
Emily	Norland	Seattle	Adrianne Wesol	Craig Hetherington
Ana	Torvie	Seattle	Dan Veljovich	
Diana	Xiaojie Zhou	Seattle	Julie Lamb	Peter Forsberg

2026 Personal Guests

First Name	Last Name	Caucus	Sponsor	Companion
Gabriela	Dellapiana	Los Angeles	John Williams	Quy Nguyen
Lisa	Galbraith	Seattle	Kristy Roloff	
Anne	Kennard	Los Angeles	Kiran Kavi	Lemay Henderson
Victor	Long	Los Angeles	Cinna Wohlmuth	
Begum	Ozel	Los Angeles	Bob Israel	
Amie	Hollard	Seattle	Barbra Fisher	
Julia	Ritchie	San Diego/AZ	Laura Greenberg	
Hannele	Laine	Portland	Barbra Fisher	Marcus Fenton
Amanda	Shepherd-Littlejohn	San Francisco	Jill Foley	Tereasa Shepherd
Audrey	Toda	San Francisco	A Nelson/D. Lyell	Jacques Wilson
Michelle	Nguyen	San Diego/AZ	Laura Mercer	
Onouwem	Nseyo	San Francisco	Angelyn Thomas	
Karen	Bar-Joseph	Seattle	Jennifer Melville	
Zach	Pollack	Seattle	Linda Eckert	Connie Wang
Alicia	Scribner	Seattle	Linda Eckert	Ken Scribner
Joy	Zia	Seattle	Dan Veljovich	Matt Alexander

2026 Guests of the Board of Directors

First Name	Last Name	Caucus	Sponsor	Guest Type	Companion
Ariel	Lee	Portland	Glenn Huerta-Enochian	2027 Society Guest	
Christopher	Downer	San Francisco	Meg Autry	2027 Society Guest	Amy Downer
Ashley	Fuller	Seattle	Rebecca Dunsmoor-Su	2027 Society Guest	Albert Delgado
Chrissy	Rodriguez	Seattle	Bettina Paek	2027 Society Guest	Carlos Rodriguez
Melissa	Tondre	Seattle	Dan Veljovich	2027 Society Guest	
Amanda	Black			Caillouette Lecturer	
Michael	McHale			Presidential Lecturer	
Evgenya	Shkolnik			Luncheon Lecturer	
Alexandra	Calderon			Frank Lynch Award	Aydin Mehrage
Megha	Arora			Ted Adams Award	Karthik Ravichandram
Carolyn	Green			Ted Adams Award	
Emily	Modlin			Ted Adams Award	
Neha	Mishra			Ted Adams Award	
Jallanie	Negussie			Ted Adams Award	
Clarice	Hopman			Ted Adams Award	Carlos Moncayo
Sophia	Han			Ted Adams Award	Sook Hankim
Daisy	Miller			Ted Adams Award	
Miranda	Prints			Ted Adams Award	

2026 Attendees & Companions

127 registered attendees and 61 adult companions, from registrations as of September 21, 2026. Children are not listed.

Attendee	Caucus	Companion(s)
Paola Aghajanian	Los Angeles	
Jorge Alvarado	San Diego/AZ	
Megha Arora	Portland	Karthik Ravichandram
Karen Bar-Joseph	Seattle	
Donald Barford	Portland	Klara Barford
Paula Bednarek	Portland	
Millie Behera	San Diego/AZ	Sanjiv Behera
Joshua Benham	San Francisco	
Sylvana Bennett	Portland	
Amanda Black		
Adrienne Bonham	Portland	
Jodell Boyle	Portland	
Kathleen Bradley	Los Angeles	Richard Kahanowitch
Darcy Broughton	Seattle	Debbie Broughton & Bill Mirand
Dennis Buchanan	Los Angeles	
Melissa Bush	Los Angeles	
Raydeen Busse	San Francisco	Candy Busse
Alexandra Calderon	San Francisco	Aydin Mehrage
Amy Card	Portland	
Aaron Caughey	Portland	
Isabelle Cohen	San Francisco	
Joel Cohen	San Francisco	Hope Cohen
Fred Coleman	Portland	Cece Coleman & Jessica Coleman
Alyssa Colwill	Portland	
Adam Crosland	Portland	Joshua Maisner
Gabriela Dellapiana	Los Angeles	Quy Nguyen
Jane Ann Dimer	Seattle	
Christopher Downer	San Francisco	Amy Downer
Rebecca Dunsmoor-Su	Seattle	Leonard Su
Katherine Eastwood	Seattle	
Linda Eckert	Seattle	Buckley Eckert
Daniella Esquivias		
Barbra Fisher	Portland	
Jill Foley	San Francisco	
Ashley Fuller	Seattle	Albert Delgado
Abby Furukawa	Portland	
Lisa Galbraith	Seattle	
Audrey Garrett	Portland	
Stephanie Gaw	San Francisco	
Thomas Gaylord	San Diego/AZ	Erin Garcia & Rigo Garcia
Veronica Gonzalez	San Francisco	Eduardo Jaime
Claire Gould	Portland	
Shaun Grady	Los Angeles	Audrey Grady

Attendee	Caucus	Companion(s)
Carolyn Green	Portland	
Laura Greenberg	Portland	
Sophia Han	San Francisco	Sook Hankim
Rosetta Hassan	Los Angeles	
Amie Hollard	Seattle	
Clarice Hopman	Los Angeles	Carlos Moncayo
Jennifer Israel	Los Angeles	
Robert Israel	Los Angeles	
Jil Johnson	Portland	
Anne Kennard	Los Angeles	Lemay Henderson
Dawn Kopp	Seattle	
Laura Korman	Portland	
David Lagrew	Los Angeles	Karen Lagrew
Hannele Laine	Portland	Marcus Fenton
Julie Lamb	Seattle	Andrew Lamb
Ariel Lee	Portland	
Stephanie Lin	Los Angeles	
Victor Long	Los Angeles	
Wendy Lorentz	Seattle	
Kathryn Macaulay	San Diego/AZ	Frank Macaulay
James Macer	Los Angeles	Cindy Macer
Lorna Marshall	Seattle	
Michael McHale		
Vivienne Meljen	Portland	Brad Olson
Jennifer Melville	Seattle	Brian Todd
Laura Mercer	San Diego/AZ	Levi Roemer
Daisy Miller	Los Angeles	
Steven Minaglia	San Francisco	Madeleine Young
Neha Mishra	Portland	
Emily W. Modlin	Portland	
Malcolm Munro	Los Angeles	Sandra Munro
Leena Nathan	Los Angeles	Ramesh Nathan
Jallanie Negussie	Portland	
Anita Nelson	Los Angeles	Diane Kessler
Michelle Nguyen	San Diego/AZ	
Emily Norland	Seattle	Craig Hetherington
Onouwem Nseyo	San Francisco	
Keith Ogasawara	San Francisco	
Begum Ozel	Los Angeles	
Jasmine Patel	San Francisco	Eddie Wardwell
Suha Patel	San Francisco	
Eva Patil	Portland	
Richard Paulson	Los Angeles	Lorraine Paulson
Leo Pereira	Portland	Natasha Pereira
Suzanne Peterson	Seattle	
Albert Phillips	Los Angeles	Sue Phillips

Attendee	Caucus	Companion(s)
Carolyn Piszczek	Portland	
Zachary Pollack	Seattle	Connie Wang
Thomas Powers	Los Angeles	Meredith Powers
Danielle Prentice	Portland	Caleb Prentice
Joshua Press	Seattle	
Kerry Price	San Francisco	
Miranda Prints	San Francisco	
Emily Rangel	Portland	
Jessica Reid	Portland	
Julia Ritchie	San Diego/AZ	
Chrissy Rodriguez	Seattle	Carlos Rodriguez
Kristy Roloff	Los Angeles	Jason Roloff & Karen Skaret
Michael Ruma	San Diego/AZ	
Alicia Scribner	Seattle	Ken Scribner
Amanda Shepherd-Littlejohn	San Francisco	Tereasa Shepherd
Evgenya Shkolnik		
Neetu Sodhi	Los Angeles	Rishi Sodhi
Jody Steinauer	San Francisco	
Roydon Steinke	Los Angeles	Elizabeth Steinke
Simone van Swam	Portland	
Rebecca Taub	San Francisco	Joe Perrone
Angelyn Thomas	San Francisco	
Audrey Toda	San Francisco	Jacques Wilson
Melissa Tondre	Seattle	
Ana Torvie	Seattle	
Dena Towner	San Francisco	Robert Greer
Brandi Vasquez	Portland	
Dan Veljovich	Seattle	
Sally Wentross	Portland	Sean Rose
Donna Wiggins	San Francisco	John Orofino
John Williams III	Los Angeles	Marilyn Smith-Williams
Marc Winter	Los Angeles	Ellen Winter
William Winter	Portland	
Cinna Wohlmuth	Los Angeles	Joe Wohlmuth
Melissa Wollan-Francis	Portland	
Alison Wu	San Francisco	
Diana Xiaojie Zhou	Seattle	Peter Forsberg
Joy Zia	Seattle	Matt Alexander

General Information

Meeting registration starts at 3:00pm on Wednesday in Macdonald Foyer

The registration fee includes:
Wednesday: Welcoming and Honoring Adams and Lynch Recipients Reception & Dinner
Award Winner Reception Following Wednesday Reception/Dinner
New Members' Gathering, following reception/dinner Wednesday evening - Casual.
Full Breakfast for attendees and companions on Thursday, Friday and Saturday
Thursday Luncheon Lecture- *Business*
Thursday- Cultural Center and Dinner
Saturday Evening Presidential Address/Reception and Dinner/Dance – *Elegant Attire*
Breaks for scientific sessions (Thurs. Fri., Sat.)
Sunday- Farewell in the Hospitality suite

PLEASE WEAR YOUR IDENTIFICATION BADGE TO ALL FUNCTIONS

Attire for scientific sessions - business casual

Presentation Guidelines

- 12 minutes presentation, 3-minute distillation, 3-5 minutes response, 8-10 minutes general Q&A
- **Lynch Essay** is 18-20 minutes presentation, 10-12 minutes general Q&A

Formal Discussion/Review Guidelines

Formal Discussant - assigned to 30-minute presentations - Formal discussants will present their discussion orally. Three (3) minutes is allowed for formal discussion.

ACCME Accreditation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of The American College of Obstetricians and Gynecologists and Pacific Coast Ob/Gyn Society. The American College of Obstetricians and Gynecologists is accredited by the ACCME to provide continuing medical education for physicians.
AMA PRA Category 1 Credit(s)™
The American College of Obstetricians and Gynecologists designates this live activity for a maximum of 15 AMA PRA Category 1 Credits™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.
College Cognate Credit(s)
The American College of Obstetricians and Gynecologists designates this live activity for a maximum of 15 Category 1 College Cognate Credits. The College has a reciprocity agreement with the AMA that allows AMA PRA Category 1

Credits™ to be equivalent to College Cognate Credits.

LEARNING OBJECTIVES

1) To learn about specific research projects and their application to clinical practice in obstetrics and gynecology, through oral presentations and poster sessions by different members of the Pacific Coast Obstetrical and Gynecological Society and their invited guests.
2) To review a controversial topic in the field of obstetrics and gynecology, by inviting a national expert to present and review data.
3) To network professionally with leaders in the field of obstetrics and gynecology as regards the future of the specialty, residencies, and medical students.

TARGET AUDIENCE

This educational activity is designed for Women's Health physicians.

DISCLOSURE POLICY

The faculty, committee members, and staff who are in position to control the content of this activity is required to disclose to ACOG and Pacific Coast Ob/Gyn Society and to learners any financial relationship(s) of the individual that have occurred within the last 24 months with any ineligible entities whose products are related to the continuing education content. Financial relationships are defined by remuneration in any amount from the ineligible entities in the form of grants; research support; consulting fees; salary; ownership interest (e.g., stocks, stocks, stocks, stocks, stocks, stocks
options, or ownership interest excluding diversified mutual funds); honoraria or other payments for participation in speakers' bureaus, advisory boards, or boards of directors; or other financial benefits. The intent of this disclosure is not to prevent planners with relevant financial relationships from planning or delivering content, but rather to provide learners with information that allows them to make their own judgments of whether these financial relationships may have influenced the educational activity with regard to exposition or conclusion. ACOG and Pacific Coast Ob/Gyn Society has reviewed all disclosures and resolved or managed all identified conflicts of interest, as applicable.

The following activity planning members reported no financial relationships:
Linda Eckert, MD Maria Manriquez, MD Paula Bednarek, MD
Deirdre Lyell, MD Kathleen Bradley, MD
Daniella Esquivias
All staff reported no relevant financial relationships.

CONTENT VALIDITY

All recommendations involving clinical medicine are based on evidence accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients; AND/OR all scientific research referred to or reported in support or justification of a patient care recommendation conforms to generally accepted standards of experimental design, data collection, and analysis.

ELIGIBILITY TO EARN CONTINUING EDUCATION CREDIT

CME certificates are provided to registered participants based on the successful completion of the activity, in its entirety, including the activity evaluation.

Mission Statement

The Pacific Coast Obstetrical and Gynecological Society is composed of physicians who are dedicated to excellence in the field of obstetrical and gynecological health care. These physicians will:

- Be of honorable character and reputation,
- Promote cooperative efforts and unity between private practitioners and those in the academic sector,
- Advance scientific knowledge related to the specialty of Obstetrics and Gynecology,
- Provide Continuing Medical Education for its participating Fellows and Guests
- Support physicians in training so as to encourage careers in Obstetrics and Gynecology, and
- Address issues which impact health care delivery including social issues, disparities that affect practitioners and patients, as well as the education of patients in regard to their health.

Frank Lynch Memorial Essayists

2001-2025

Vance McCausland	USC	2001
Jennifer Dizon-Israel	USC	2002
Arus Zograbyan	USC	2003
Iris Colon	Stanford	2004
Chad Hamilton	Stanford	2005
Katherine Gabriel-Cox	Kaiser SF	2006
Anjali Kaimal	UCSF	2007
Brian L. Shaffer	UCSF	2008
Tania F. Esakoff	UCSF	2009
Christine Hiebert	USC	2010
Pavithra Venkat	UCSF	2011
Not awarded	n/a	2012
Jessica Atrio	USC	2013
Marc Gualtieri	USC	2014
Jonas J. Swartz	OHSU	2015
Alexandra Rzepka	Univ of AZ	2016
Nicole B. Kurata	Univ of HI	2017
Whitney Wellenstein	Kaiser Oakland	2018
Meghan Smith	USC	2019
Brian A. Crosland	UCI	2020
Alyssa Hersh	OHSU	2021
Ravi Agarwal	USC	2022
Brianna Byers	OHSU	2023
Aaron Masjedi	USC	2024
Marie Boller	OHSU	2025

Charles Kimball Award

2008-2025

Tania Esakoff	UCSF	2008
Tevy Tith	UCLA	2009
Clara Ward	UCSF	2010
Manijeh Torki	USC	2011
Uyen Huynh	Kaiser-Santa Clara	2012
Melissa Rosenstein	UCSF	2013
Sigita Cahoon	USC	2014
Kristl Tomlin	PIROG	2015
Neetu K. Sodhi	UCLA	2016
James A. Sargent	OHSU	2017
Martha Tesfalul	UCSF	2018
Melody Besharati	Santa Clara Med	2019
Christina Buchanan	Univ of HI	2020
Inessa Dombrovsky		2021
Eleanor Schmidt	OHSU	2022
Michelle Nugyen	USC	2023
Darean Hunt	Creighton	2024
Kristina Nalbandyan	Western	2025

Anti-Harassment Policies

Non-Discrimination Policy

The Pacific Coast Obstetrical and Gynecological Society does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations. These activities include, but are not limited to, hiring and firing of staff, selection of members and vendors, and provision of services. We are committed to providing an inclusive and welcoming environment for all members of our staff, members, candidates, guest speakers, scholarship candidates and recipients. The Society's nondiscrimination policy also extends to the industry supporters of the Society, whether by education grants or by exhibits.

The Pacific Coast Obstetrical and Gynecological Society is an equal opportunity employer. We will not discriminate and will take affirmative action measures to ensure against discrimination in employment, recruitment, advertisements for employment, compensation, termination, upgrading, promotions, and other conditions of employment against any employee or job applicant on the bases of race, color, gender, national origin, age, religion, creed, disability, veteran's status, sexual orientation, gender identity or gender expression.

Sexual Harassment Policies

It is the policy of the Pacific Coast Obstetrical and Gynecological Society that the workplace, meetings, and society activities are conducted in an environment free from sexual harassment. This policy applies to all attendees at Society activities, including members, speakers, students, guests, staff, contractors, exhibitors, and volunteers. The Pacific Coast Obstetrical and Gynecological Society strongly disapproves of offensive or inappropriate sexual behavior and participants must avoid any action or conduct which could be viewed as sexual harassment. Sexual harassment is defined by the Equal Employment Opportunity Commission (EEOC) as any unwelcome sexual advance, request for sexual favors, or other verbal or physical conduct of a sexual nature, when: (1) submission to the harassment is made either explicitly or implicitly a term or condition of employment or membership ; (2) submission to or rejection of the harassment is used as the basis for employment or membership decisions affecting the individual; or (3) the harassment has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Any employee or Society participant who has a complaint of sexual harassment by anyone, should first clearly inform the harasser that his/her behavior is offensive or unwelcome and request that the behavior stop. Society strongly urges reporting of all incidents of harassment, regardless of the offender's identity or position by contacting the Caucus Chair and/or a member of the Board of Directors, who can be reached at (contact members only site at www.pcogs.com). If deemed necessary by those experiencing harassment, the Board of Directors/Caucus chair will assist in contacting convention center/hotel/venue security or local law enforcement. He or she is not required or expected to discuss the concern with the alleged offender. All complaints will be treated seriously and be investigated promptly. Confidentiality will be honored to the extent permitted as long as the rights of others are not compromised.

If the Caucus Chair and or Board Member knows of an incident of sexual harassment, they shall take appropriate remedial action immediately. If the alleged harassment involves any type of threats of physical harm to the victim, the alleged harasser may be immediately suspended or expelled from Society. All complaints will be investigated by the Pacific Coast Obstetrical and Gynecological Society Board of Directors. The Board of Directors will name an impartial investigator, usually a Society Officer or Caucus member. Any named investigator who believes they have a conflict of interest should not serve as an investigator. In most cases, the complainant will be interviewed first and the written complaint reviewed.

If the complainant has not already filed a formal complaint, he or she should be asked to do so. The details of the complaint should be explained to the alleged offender by the investigator. The alleged offender should be given a reasonable chance to respond to the evidence of the complainant and to bring his or her own evidence. If the facts are in dispute, further investigatory steps may include interviewing those named as witnesses. If, for any reason, the investigator is in doubt about whether or how to continue, he or she will seek appropriate counsel. When the investigation is complete, the investigator should report the findings to the Board of Directors. If the investigation supports charges of sexual harassment by the Board of Directors, disciplinary action against the alleged harasser will take place and may include suspension, expulsion, or other disciplinary actions. If the investigation reveals that the charges were brought falsely and with malicious intent, the charging party may be subject to disciplinary action, including termination or expulsion by the Board of Directors.

2026 Arrangements Program Summary

Tuesday, September 22

5:00 PM – 9:00 PM Pub Crawl — Whistler Village
7:45 PM – 9:45 PM Vallea Lumina Night walk — Vallea Lumina

Wednesday, September 23

10:30 AM – 11:30 AM Downhill Mountain Biking — Whistler Blackcomb Mountain
11:00 AM – 2:30 PM Fishing Adventure
12:30 PM – 3:00 PM Lunch: 4-Restaurant Progressive Guided Tour — Whistler Village
1:00 PM – 3:00 PM Hiking — Whistler Blackcomb Mountain- Fairmont Lobby
1:00 PM – 3:00 PM Pickleball — Fairmont Chateau Whistler
2:00 PM – 5:00 PM Registration Desk — Macdonald Ballroom Foyer
2:30 PM – 5:30 PM Zip trek Bear Zipline Adventure — Carleton Lodge
4:30 PM – 5:30 PM Board of Directors Gathering — Hospitality Suite
5:30 PM – 8:30 PM Welcoming and Honoring Adams and Lynch Recipients Reception & Dinner — Woodlands Terrace
8:00 PM – 9:00 PM Ted Adams Scholarship Recipient Reception — Hospitality Suite
8:30 PM – 11:00 PM Hospitality Suite
9:00 PM – 10:00 PM New Fellow Reception — Mallard Room

Thursday, September 24

6:00 AM-7:00 AM Yoga- Fairmont Yoga Studio
7:00 AM – 8:30 AM Attendee & Companion Breakfast — Woodlands Terrace
7:50 AM – 8:00 AM Opening Remarks: President Gaylord — Macdonald Ballroom
8:00 AM – 8:30 AM Ted Adams Scholarship Award Synopses — Macdonald Ballroom
8:30 AM – 9:00 AM Society Guest Presentation: Darcy Broughton — Macdonald Ballroom
9:00 AM – 9:30 AM Society Guest Presentation: Claire Gould — Macdonald Ballroom
9:30 AM – 10:00 AM Fellow Presentation: Linda Eckert — Macdonald Ballroom
10:00 AM – 10:45 AM Poster Presentations / Industry Exhibits / Morning Break — Macdonald Ballroom
10:45 AM – 11:15 AM Society Guest Presentation: Stephanie Gaw — Macdonald Ballroom
11:15 AM – 11:45 AM Society Guest Presentation: Suha Patel — Macdonald Ballroom
11:45 AM – 12:15 PM Society Guest Presentation: Eva Patil — Macdonald Ballroom
12:15 PM – 1:30 PM Luncheon Lecture: Worlds Beyond — Macdonald Ballroom
12:45 PM – 1:00 PM Group Photo: Ted Adams Scholars – Lower Garden Lawn
1:30 PM – 1:45 PM Group Photo: PCOGS Guests – Lower Garden Lawn
1:30 PM – 2:00 PM First Business Meeting (Fellows Only) — Macdonald Ballroom

2:00 PM – 2:15 PM Group Photo: PCOGS Fellows – Lower Garden Lawn
2:15 PM – 2:45 PM Society Guest Presentation: Carolyn Piszczek — Macdonald Ballroom
2:45 PM – 3:15 PM Society Guest Presentation: Jessica Reid — Macdonald Ballroom
3:15 PM – 4:00 PM Break: Industry Exhibits / Poster Presentations / Informal Discussion — Ballroom & Foyer
4:00 PM – 4:30 PM Society Guest Presentation: Rebecca Taub — Macdonald Ballroom
5:30 PM – 6:00 PM Processional to Squamish Lil'wat Cultural Centre
6:00 PM – 10:00 PM Squamish Lil'wat Cultural Centre Event and Dinner
9:00 PM – 11:00 PM Hospitality Suite

Friday, September 25

7:00 AM – 8:30 AM Guest and Companion Breakfast Buffets — Macdonald Foyer/Empress Foyer- Eating in Empress BC
7:00 AM – 7:50 AM Caucus Breakfasts Meetings for PCOGS Fellows- Macdonald Foyer

Los Angeles- Macdonald E **Portland**- Macdonald F **San Diego/AZ**- Empress BC
San Francisco- Beausejour **Seattle-** Montebello

8:00 AM – 8:30 AM Frank Lynch Memorial Essay: Alexandra Calderon — Macdonald Ballroom
8:30 AM – 9:00 AM Society Guest Presentation: Simone van Swam — Macdonald Ballroom
9:00 AM – 10:00 AM James C. & Joan Caillouette Lecture: Amanda Black — Macdonald Ballroom
10:00 AM – 11:00 AM Break: Industry Exhibits / Poster Presentations / Informal Discussion — Ballroom & Foyer
10:00 AM – 11:00 AM Book Club: Rule Number Two — Hospitality Suite
11:00 AM – 11:30 AM Society Guest Presentation: Adrienne Bonham — Macdonald Ballroom
11:30 AM – 12:00 PM Society Guest Presentation: Jil Johnson — Macdonald Ballroom
1:00 PM – 4:00 PM Jeep (Bear) Photo Safari — Whistler Olympic Park
1:30 PM – 4:00 PM Recreational Bike Ride — Whistler Valley Trails
1:30 PM – 4:30 PM Scandinave Thermal Spa
1:30 PM -4:30 PM Hiking- Lost Lake Loop- Fairmont Lobby
2:00 PM – 3:30 PM Audain Art Museum
2:00 PM – 3:30 PM Whistler Distillery Tour — Montis Distillery
6:30 PM – 8:30 PM Caucus Dinners

Los Angeles- Fairmont Whistler- Woodlands Terrace
Portland- Forged Axe Throwing **San Francisco-** Caramba Restaurant (6:00pm)
San Diego/Arizona- 21 Steps Kitchen **Seattle-** Earl's

9:00 PM – 11:00 PM Hospitality Suite

Saturday, September 26

6:00 AM-7:00 AM Yoga- Fairmont Yoga Studio
7:00 AM – 8:30 AM Attendee & Companion Breakfast- Woodlands Terrace
7:00 AM – 7:50 AM Membership Track Breakfast- Macdonald E
8:00 AM – 8:30 AM Society Guest Presentation: Michael Ruma — Macdonald Ballroom
8:30 AM – 9:00 AM Society Guest Presentation: Stephanie Lin — Macdonald Ballroom
9:00 AM – 9:30 AM Fellow Presentation: Dawn Kopp — Macdonald Ballroom
9:30 AM – 10:00 AM Fellow Presentation: Malcolm Munro — Macdonald Ballroom
10:00 AM – 10:45 AM Break: Industry Exhibits / Poster Presentations / Informal Discussion — Ballroom & Foyer
10:45 AM – 11:45 AM Presidential Choice Lecture: Michael McHale — Macdonald Ballroom
11:45 AM – 12:15 PM Second Business Meeting — Macdonald Ballroom
12:30 PM – 3:00 PM Second Annual Board of Directors Meeting- Macdonald F
5:00 PM – 6:00 PM Presidential Address — Macdonald Ballroom B
6:00 PM – 6:30 PM Presidential Toast — Macdonald Foyer
6:30 PM – 10:00 PM Presidential Dinner Dance — Macdonald Ballroom CD
9:00 PM – 11:00 PM Hospitality Suite

Sunday, September 27

8:00 AM – 10:00 AM Farewell Breakfast & Auld Lang Syne - Hospitality Suite

Location of Functions
Academic/Social

Function	Day(s)	Location
Registration	W, Th, F	Macdonald Foyer
Board Gathering	W	Hospitality Suite
Wednesday Reception	W	Woodlands Terrace
New Member's Gathering	W	Mallard Room
Ted Adam's Recipient Reception	W	Hospitality Suite
Breakfast Buffet	Th, S	Woodlands Terrace
Breakfast Buffet	F	Empress Foyer
Yoga	Th, S	Fairmont Yoga Studio
Hospitality Suite	W, Th, F, S, Su	4910 Spearhead Place
Membership Track Breakfast	S	Macdonald E
Scientific Sessions	Th, F, S	Macdonald CD Ballroom
Poster Presentations	Th, F, S	Macdonald Foyer
Exhibits & Coffee	Th, F, S	Macdonald AB Ballroom
Combined Luncheon Lecture	Th	Macdonald CD Ballroom
LA Caucus Dinner	F	Woodlands Terrace
Portland Caucus Dinner	F	Forged Axe Throwing
San Francisco Caucus Dinner	F	Caramba
Seattle Caucus Dinner	F	Earl's
San Diego/AZ Caucus Dinner	F	21 Steps Kitchen
Book Club	F	Hospitality Suite
LA Caucus Breakfast	F	Macdonald E
Portland Caucus Breakfast	F	Macdonald F
San Francisco Caucus Breakfast	F	Beausejour
Seattle Caucus Breakfast	F	Montebello
San Diego Breakfast	F	Empress BC
Presidential Address	S	Macdonald Ballroom B
Presidential Dinner & Dance	S	Macdonald Ballroom CD
Group Photos	Th	Lower Garden Lawn
Offsite Event	Th	Squamish Lil'wat CC
Sunday Farewell	Su	Hospitality Suite
Pub Crawl	T	Meet in Lobby
Vallea Lumina Night walk	T	Gateway Loop
Hiking	W & F	Meet in Lobby
Biking	W & F	Meet in Lobby
Lunch Tour	W	Meet in Lobby
Fishing Adventure	W	Meet in Lobby
Pickleball	W	Fairmont Courts
Thermal Spa	F	Scandinave Spa
Zip trek Zipline	W	Carleton Lodge
Jeep Bear Safari	F	Meet in Lobby
Audain Art Museum	F	Audain Art Museum
Whistler Distillery Tour	F	Montis Distillery

History of the Designated Funds

FRANK LYNCH MEMORIAL ESSAY
Frank W. Lynch was the first PCOGS President and was honored after death by initiation of a prize and lecture at each meeting; these now go to the best manuscript submitted by a resident/fellow.

TED ADAMS SCHOLARSHIP AWARD
Ted Adams was a charter member from Portland. His wife gifted the society with seed money to start a fund supporting scholarships for resident presenters.

CHARLES KIMBALL MEMORIAL FUND
Charlie Kimball was a member from Seattle who gifted money to the Society. The Board approved utilizing these funds for an award for the "best poster presentation" at each annual meeting.

JAMES C. & JOAN CAILLOUETTE GUEST LECTURESHIP
James "Jim" and Joan Caillouette funded an annual meeting lecture on the topic of population & family planning.

MEMBERSHIP DEVELOPMENT FUND
The newly formed "Membership Development Fund" honors many of our recently passed members (Bill Parer, Russ Laros and others*). When fully vested, it will help defray the registration costs for Caucus guests and support PCOGS membership.
*gifts designated "In Memory of... at time of donations

PCOGS 2026 ANNUAL MEETING
Scientific Sessions

Thursday September 24th, 2026

7:50 am Welcoming remarks President Thomas Gaylord- Macdonald Ballroom

8:00-8:30am- Oral Synopsis of Ted Adams Scholarship Award Poster Presentations

P- 01 Clarice Hopman, MD *(By Invitation)*
Examining the Value of Urine Protein for the Diagnosis of Hypertensive Disorders of Pregnancy

Objective
We examine the utility of the 24-hour urine protein (24UP) and the urine protein-creatinine ratio (PCR) in predicting progression of gestational hypertension (gHTN) or preeclampsia without severe features (PreE w/o SF) to preeclampsia with severe features (PreE w/SF).

Study Design
We completed a retrospective cohort study of 1,687 patients who delivered a live-born neonate at our urban, academic hospital between September 2011 and September 2021. All patients had an initial diagnosis of either gHTN or PreE w/o SF. Patients with chronic hypertension or an initial diagnosis of PreE w/SF were excluded. Analysis was completed using chi-square and ANOVA. Post-hoc Bonferroni-corrected p-values of < 0.05 were considered significant. Of the patients who progressed to PreE w/SF, we evaluated the rate of progression, severe features, and mode of delivery.

Results
Our sample was primarily Black race (57.7%, n=972) and non-Hispanic ethnicity (67.0%, n=1,130). A total of 910 (54%) and 777 (46%) patients were initially diagnosed with gHTN and PreE w/o SF, respectively. The rate of progression to PreE w/SF did not significantly differ across the initial diagnoses of either gHTN (n=147 (16%)) or PreE w/o SF (n=153 (19%)) ($X2$ (1) = 3.548, p=0.060).

Conclusion
Proteinuria status does not demonstrate value in predicting progression to preeclampsia with severe features. Performing a 24UP or PCR takes healthcare dollars and patients' time, which has economic and social effects. Given the similar clinical monitoring and management of gHTN and PreE w/o SF, our findings support consideration for elimination of the 24UP/PCR as a diagnostic criterion.

P- 02 Carolyn Green, MD *(By Invitation)*
Neonatal outcomes by gestational age among pregnancies complicated by vasa previa

Objective:
Vasa previa is a rare condition, affecting 1/2500 pregnancies. However, it is a diagnosis associated with severely adverse neonatal outcomes. Due to this high concern for morbidity in the setting of fetal vascular rupture, practices around the ideal timing of delivery for vasa previa vary. The objective of this study is to examine the association between gestational age at the time of delivery with neonatal outcomes for a contemporary cohort of patients with vasa previa.

Study design:
This is a retrospective cohort study using California's linked vital statistics-hospital discharge data between 2008 – 2023. We included singleton births with gestational age of 32-37 weeks, among individuals with a diagnosis of vasa previa who were hospitalized before delivery. Vasa previa was identified using *ICD-9* and *ICD-10* diagnostic codes. Maternal and neonatal outcomes were compared between two consecutive weeks of gestational age using chi-square tests and multivariate Poisson regression.

Results:
A total of 1,152 cases met inclusion criteria. Rates of adverse neonatal outcomes were observed to decline with increasing gestational age. For example, the rate of respiratory distress syndrome (RDS) decreased from 52.5% at 32 weeks to 6.3% at 36 weeks. Rates of severe neonatal morbidity (including intraventricular hemorrhage, necrotizing enterocolitis, hypoxic-ischemic encephalopathy, and death) decreased from 3.4% at 32 weeks to 0.5% at 35 weeks. After adjusting for confounders, delivery at 35 vs. 34 weeks was associated with lower risk of RDS (aRR 0.57, 95% CI 0.45 – 0.73) and jaundice (aRR 0.76, 95% CI 0.69 – 0.86). Delivery at 36 weeks vs 35 weeks also showed significant differences in rates of RDS and NICU admission.

Conclusion:
Among patients hospitalized due to vasa previa before delivery, neonatal outcomes improved incrementally as gestational age advanced up to 36 weeks, with significant differences noted in rates of RDS, NICU admission, Apgar score, and jaundice. These findings highlight the importance of balancing risks of prematurity with potential neonatal morbidity when determining optimal timing for delivery.

P- 03 Emily Modlin, MD *(By Invitation)*
Adverse Perinatal Outcomes Among Pregnant People with Prior Placental Abruption

Objective: Placental abruption is associated with significant adverse maternal and neonatal outcomes. Roughly half of abruptions occur at preterm gestations in the United States. Recurrence risk is estimated to be as high as 10-fold but less is known about degree of risk based on gestational timing of abruption. The objective of this study is to examine the association between prior abruption (term and preterm) and perinatal outcomes.

Study Design: This is a retrospective cohort study using California's linked birth certificate and hospital discharge data from 2008-2023. Two consecutive deliveries of singleton, non-anomalous gestations who delivered between 23 and 42 weeks were included. Prior placental abruptions (term (≥37 weeks) and preterm (23-36 weeks)) were identified using vital statistics, ICD-9 and ICD-10 codes. Chi-square tests and multivariable Poisson regression models were used to examine association of prior placental abruption with adverse maternal and neonatal outcomes in subsequent delivery, when compared to no prior abruption (Table 1).

Results: A total of 1,318,636 pregnant patients with two consecutive deliveries were included, of which 0.47% had prior preterm, 0.70% term, and 98.83% no prior abruption. As expected, prior abruption was associated with increased risk for abruption, with greater risk for those with prior abruption at preterm (aRR= 7.22, 99% CI 6.34-8.22) versus term (aRR = 4.41, 99% CI 3.84-5.05) gestations. Neonates of patients with prior preterm abruption had significantly increased risk for respiratory distress syndrome (aRR=7.45, 99% CI 6.72-8.28), infant death (aRR =7.25, 99% CI 5.65-9.31), and preterm birth <32 weeks (aRR= 6.29, 99% CI 5.42-7.29). While neonates of those with prior term abruption also had increased risk for neonatal morbidity and mortality, the strength of association was notably reduced or not statistically significant.

Conclusion: Preterm placental abruption is associated with increased risk for both maternal and neonatal complications in subsequent pregnancy. The most significant risks include abruption recurrence, respiratory distress syndrome, early preterm birth, and infant death. These findings support careful considerations for family planning, pre-conception and prenatal counseling, and fetal surveillance for patients with history of preterm abruption.

P- 04 Megha Arora, MD *(By Invitation)*
Perinatal Outcomes Among Patients with History of Migraine Headache

Objective:
To examine maternal and neonatal outcomes among pregnant patients with and without a history of migraine headaches.

Study design:
We conducted a retrospective cohort study of births in the state of California from 2008 to 2023 to compare perinatal outcomes between those with and without a history of migraine headaches. Patients with singleton, non-anomalous pregnancies delivered between 23-42 weeks of gestation were included. Outcomes included gestational hypertension/preeclampsia without severe features, preeclampsia with severe features, severe maternal morbidity (SMM), preterm birth <37 weeks, preterm birth <34 weeks, NICU admission, and respiratory distress syndrome (RDS). Multivariable Poisson regression analyses were performed to control for maternal age, race/ethnicity, level of education, pre-pregnancy BMI, parity, insurance type, chronic hypertension, and pre-gestational diabetes.

Results:
Of the total 5,894,954 pregnant individuals in the cohort, 1.2% had a history of migraines. Patients with a migraine history had higher rates of gestational hypertension/preeclampsia (11.2% vs. 5.7%, p<0.001) and preeclampsia with severe features (4.0% vs. 1.6%) as well as SMM and several neonatal complications. When controlling for potential confounding variables, those with migraines had higher risk of gestational hypertension or preeclampsia without severe features (aRR 1.55, CI 1.52-1.59), preeclampsia with severe features (aRR 2.15, CI 2.07-2.23), SMM (aRR 1.71, CI 1.64-1.88), preterm birth <37 weeks (aRR 1.24, CI 1.21-1.28), preterm birth <34 weeks (aRR 1.27, CI 1.20-1.35) and RDS (aRR 1.39, CI 1.31-1.47).

Conclusion:
In this large cohort of pregnant patients, those with a history of migraines had greater risk of adverse perinatal outcomes compared to those without migraine history. Of note, there was a higher rate of preeclampsia with severe features and preterm birth <37 weeks and <34 weeks among the migraine cohort, which may signal a predisposition towards placental, vascular, or neurologic complications of pregnancy requiring preterm delivery. Individuals with migraine headaches require further characterization and risk stratification with regards to hypertensive disorders of pregnancy and preterm birth as well as consideration for prevention in future studies.

P- 05 Jallanie Negussie, MD *(By Invitation)*
Pre-Pregnancy BMI and Perinatal Outcomes in Emergency Cesarean Delivery

Objective: Obese pregnant patients have higher rates of complications in pregnancy and after surgical deliveries. Emergent cesarean delivery presents several unique challenges including airway concerns, obtaining rapid regional anesthesia, as well as surgical decision making, all of which may lead to delays in rapid fetal delivery. This study aims to examine relationships between obesity and neonatal outcomes in the setting of an emergency cesarean delivery.

Study Design: This is a retrospective cohort study of patients that underwent an emergent cesarean delivery in California from 2008 to 2023. The data were stratified into three groups (BMI < 30, 30-39.9, and BMI ≥ 40) and associations with neonatal outcomes were examined. The studied population included term patients who underwent emergency cesareans. An emergency cesarean was defined as those who experienced a uterine rupture or had a placental abruption in conjunction with fetal heart rate abnormalities. A multivariable Poisson regression was utilized to control for potential confounding variables.

Results: When evaluating neonatal outcomes, infants born to those with morbid obesity (BMI ≥ 40) were noted to be at increased risk for APGAR < 7 at 5 minutes (IRR 1.4 , 95% CI 1.1-1.8). Following similar Poisson analysis, this relationship between morbid obesity and worsened APGAR scores persisted.

Conclusion: In this cohort of patients undergoing emergency cesarean delivery, BMI ≥ 40 was associated with higher rates of low 5-minute Apgar scores. This difference may have led to higher rates of downstream neonatal neurologic sequalae but was underpowered among this data. Consideration of surgical challenges and barriers to rapid delivery in this population should be noted when managing these patients in labor and delivery.

P- 06 Neha Mishra, MD *(By Invitation)*
Title: Maternal and Neonatal Outcomes by Pre-pregnancy BMI Among Patients with Type 2 Diabetes Mellitus

Objective: Pre-existing obesity and type 2 diabetes mellitus (T2DM) are increasingly prevalent and associated with adverse perinatal outcomes. In 2022, 55% of pregnancies complicated by pregestational diabetes were due to T2DM, compared with 27% in 2003. However, less is known about the impact of increasing BMI among patients with T2DM. The objective of this study was to evaluate maternal and neonatal outcomes across pre-pregnancy BMI categories among patients with T2DM.

Methods: This is a retrospective cohort study of California's linked vital statistics and hospital discharge data (2008-2023). We included singleton, non-anomalous births among people with T2DM between 23 and 42 weeks. We excluded patients who were underweight (BMI < 18.5), had Type 1 diabetes, gestational diabetes, or chronic hypertension. Chi-square tests and multivariable Poisson regression models were used to estimate adjusted risk ratios (aRRs) and 95% confidence intervals for adverse maternal and neonatal outcomes across BMI categories.

Results: We included 12,874 pregnant patients with pre-existing T2DM. Compared with patients with normal BMI (BMI 18.5-24.9 kg/m^2), those with severe obesity (BMI $\geq$40 kg/m^2) had increased risk of gestational hypertension (aRR 2.33, 95% CI 1.85-2.93), preeclampsia (aRR 1.24, 95% CI 1.07-1.45), and large-for-gestational-age birth (aRR 1.63, 95% CI 1.45-1.84). Increasing BMI was associated with lower risk of small-for-gestational-age birth (aRR 0.40, 95% CI 0.30-0.53). Severe maternal morbidity, preterm birth, NICU admission, and respiratory distress syndrome were highest among patients with normal BMI.

8:30-9:00 am
Darcy Broughton, MD *(By Invitation)*
Society Guest

Improving the Tolerability of Hysterosalpingography using Nitrous Oxide, a Quality Improvement Project

Broughton DE, Chen E, Mayberry PL, Lamb JD, Rothenberg SS

Objective: To integrate the use of procedural nitrous oxide (N_20) into the outpatient clinic setting and subsequently evaluate whether its use during hysterosalpingography (HSG) decreases procedural pain and anxiety.
Design: This was a quality improvement (QI) project evaluated using a prospective patient survey after introduction of N_20 as an option for pain relief during HSG in our outpatient fertility clinic. In March 2024 the clinic purchased portable N_20 units and trained all appropriate providers and staff on their use. All patients presenting for HSG began to be offered the use of N_20 during the procedure upon check-in for an additional fee. If they opt-in they are screened with a medical questionnaire to ensure no contraindications to use. During the QI study period from January 2026 - April 2026 all patients undergoing HSG were invited to participate in the project and provided verbal consent. A pre-procedural questionnaire was administered evaluating level of anxiety related to the upcoming HSG and expected level of pain during the procedure using a 100 mm visual analog scale (VAS; anchors 0 = no pain or anxiety and 100 = worst pain or anxiety possible). They were also queried about baseline pelvic pain and any use of pre-procedure oral analgesics. A post-procedural questionnaire was completed immediately after the HSG evaluating anxiety and pain levels during the procedure, as well as any observed adverse effects of the N_20. Results were then compared between patients that used N_20 and those that did not.
Results: A total of 108 patients participated in the survey study. Of those, 46/108 (42.6%) opted to use N_20 during the HSG. There was no significant difference in the level of baseline pelvic pain before the procedure between the groups. In the group using N_20 there were significantly higher levels of anxiety pre-procedure (59.0 v 42.9, p=0.003) and higher anticipated pain (60.0 v 51.3, p=0.037). There were no significant differences between level of anxiety (33.9 v 37.6, p=0.47) and pain during the procedure (36.1 v 41.4, p=0.24). In the group using N_20, they experienced significantly less anxiety during the procedure than pre-procedure (33.9 v 59.0, $p<0.001$). In addition, their pain during the procedure was significantly less than anticipated pain (36.1 v 60.0, $p<0.001$). In the group not using N_20, there was no significant difference between anxiety before and during the procedure (42.9 v 37.6, p=0.06), but experienced pain was lower than anticipated pain (41.4 v 51.3, p=0.005). The incidence of negative side effects was low (2/46, 4.3%), with one patient reporting dizziness and another lightheadedness. An additional three patients reported not feeling any effect of the nitrous (3/46, 6.5%).
Conclusion: Implementing the use of N_20 into the outpatient setting was reasonable in terms of cost and training requirements. We observed higher uptake of N_20 use than expected despite additional out-of-pocket cost, identifying it as an attractive option for patients. Evaluation of the effectiveness of N_20 as an analgesic in our study is limited by selection bias. Patients who chose to use N_20 had higher baseline levels of anxiety and anticipated pain. However, it is encouraging that levels of anxiety and pain were not higher during the procedure in the nitrous group, and that these levels were significantly less than pre-procedure anxiety and anticipated pain. N_20 was well tolerated; the incidence of perceived negative side effects was low. Future evaluation of N_20 during HSG would ideally be randomized and placebo controlled with use of oxygen alone in the non-nitrous study arm. Our results indicate that N_20 has the potential to be implemented more broadly for gynecologic procedures in the outpatient setting.
Formal Discussant Brandi Vasquez, MD

9:00 – 9:30 am
Claire Gould, MD (*By Invitation*)
Society Guest
Beyond the Route: Prioritizing Surgical Expertise in Gynecologic Surgery

Background: Over the past 25 years, the use of minimally invasive surgery in gynecology has expanded substantially. Once limited to a small group of specialized surgeons, laparoscopic and robot-assisted laparoscopic techniques have become the standard of care for many gynecologic procedures. Minimally invasive approaches have consistently been associated with lower complication rates, reduced perioperative morbidity, shorter hospital stays, and faster return to normal activities. Historically, research in this field has focused primarily on the choice of surgical route—open, vaginal, or laparoscopic—particularly in the context of hysterectomy. In contrast, far less attention has been given to the complexity of benign gynecologic pathology and surgeon experience to determine which surgeons are best equipped to perform these procedures.
Objective: The primary objective of this study is to compare the number, type, and surgical route of gynecologic procedures performed by fellowship trained surgeons versus general (non-fellowship-trained) gynecologists.
Secondary objectives were to compare the following between the two groups: uterine weight among hysterectomy cases, documented stage of endometriosis and number of surgical specimens removed, type and size of ovarian cysts managed.

Methods: This study is a retrospective chart review of gynecologic surgical procedures performed by eight surgeons within the Legacy Health system between April 1, 2025, and September 30, 2025. Using the EPIC electronic health record system, cases were first identified by querying all procedures in which each surgeon was listed as the primary surgeon. To ensure no data was missed, a secondary search of all gynecologic surgeries performed during the study period was conducted and cross-referenced with the initial report. Because this study focused specifically on gynecologic procedures, Cesarean deliveries were not included in this review.

For each surgical case, the patient's chart was reviewed including the operative report, demographic information, and pathology reports when applicable. Surgical characteristics collected included the procedure(s) performed, surgical route (laparoscopic, vaginal, abdominal, robotic, hysteroscopic, or cystoscopic), primary surgeon, and secondary surgeon (if a second service line was involved). Patient demographic data (age, BMI) and relevant pathology details (uterine weight, documented stage of endometriosis, number of endometriosis specimens removed, and pathology classification of ovarian cysts) were also recorded.

Results: All hysterectomies performed during the study period were completed laparoscopically with no open gynecologic procedures performed. One hysterectomy in the generalist group required a larger incision for specimen removal only.

Formal Discussant Kerry Price, MD

9:30-10:00 am
Linda Eckert, MD
PCOGS Fellow

Vaccine Messaging: Separating the Wheat from the Chaff

10:00-10:45am **Break Poster Presentations & Informal Discussion**
Exhibits/Industry Representatives

10:45 – 11:15am
Stephanie Gaw, MD (*By Invitation*)
Society Guest

Inflammatory correlates of pregnancy outcomes differ by fetal sex and are disrupted by maternal COVID-19

Background
COVID-19 infection is linked to increased adverse outcomes and mortality in pregnant women. Imbalances in cytokines are associated with detrimental outcomes in mother and baby. While our understanding of humoral and cellular immunity against SARS-CoV-2 during pregnancy has advanced significantly, the role of cytokines—key mediators of immune responses—remains underexplored, particularly in cord blood and placental tissues.

Methods
Matched maternal blood, cord blood, and placental samples were collected at delivery from pregnant women with (n = 80) and without (n = 30) SARS-CoV-2 infection during pregnancy. COVID-19 patients were stratified as asymptomatic (n = 30), mild (n = 30), or severe (n = 20). Cytokine (n=22) levels were quantified using Luminex multiplex assays.

Results
In general, cytokines exhibited distinct profiles in maternal blood, cord blood, and placental tissues independent of COVID-19 infection in terms of mean levels, detectability, and correlation patterns. Maternal SARS-CoV-2 infection was associated with distinct cytokine changes across the three compartments, and these differences were persistent, lasting until delivery. In maternal blood, COVID-19 was associated with elevated levels of CCL2, CXCL10, and IL-6, and decreased CCL17. While, in cord blood, infection was associated with increased levels of CCL2, CCL4, IL-2, and TNF-α, and decreases in IL-10 and IL-23, suggesting a pro-inflammatory state in both mother and baby. In contrast, the placenta exhibited global cytokine suppression in COVID-19 infection, with significant decreased levels of CXCL8, IL-7, IL-17, IFN-γ, TNF-R1, IL-6, and IFN-β compared to the controls. Notably, a significant Th1/Th2 and Th1/Th17 imbalance skewed towards Th1 dominance was observed in cord blood but not in maternal blood or placenta. Stratification by fetal sex revealed sex-specific correlations between cytokine levels and clinical outcomes, which was dysregulated after maternal COVID-19.

Conclusion
Maternal SARS-CoV-2 infection induces a pro-inflammatory state in both maternal and cord blood, with uncontrolled systemic inflammation in cord blood. In contrast, the placenta exhibits global immune suppression, highlighting distinct immune responses across maternal, fetal, and placental compartments. Maternal COVID-19 was associated with sex-specific dysregulation of cytokine expression and clinical outcomes.

Formal Discussant: Suzanne Peterson, MD

11:15-11:45 am
Suha Patel, MD (*By Invitation*)
Society Guest

Evaluation of a CMQCC-based intervention to reduce NTSV cesarean rates in a Hawai‘i hospital with high Native Hawaiian and Pacific Islander representation

Suha J Patel MD MPH, Nami Ono CNM, Lariza Bush RN, BSN, Linda Chong-Tim CNM, Alexandra Sueda, MD

Objective:
While cesarean delivery can be life-saving, it can also increase the risk of severe maternal morbidity (SMM). Prevention of primary cesarean delivery can reduce the risk of SMM related to cesarean delivery. In this study, we evaluate a hospital intervention to reduce NTSV cesarean rates in a primarily Asian and NHPI population in Hawai'i.

Study Design:
A physician and midwife intervention was implemented as part of a hospital initiative to reduce the NTSV cesarean rate below 23.6% recommended by the Joint Commission and Healthy People 2020. The intervention consisted of introduction of standardized algorithms to guide labor management, provider orientation to protocols, and primary NTSV case log on our Labor and Delivery unit. Midwives received formal training on positions to facilitate movement in labor. Additionally, a quality dashboard with NTSV cesarean rates was shared with all providers on a bi-monthly basis. New providers who joined the group received orientation to the intervention. To evaluate the intervention, a retrospective chart review was conducted of all NTSV deliveries that occurred at our facility for 1 year before and 1 year after orientation of the provider group to the intervention (Jun 2023).

Results:
The median gestational age at delivery was 39 weeks in both groups. The median age was 29 and 28 in the pre and post-implementation groups respectively. 316 (71.5%) and 346 (73.3%) of the pre and post-implementation groups identified as Asian or NHPI. 95 (21.4%) and 120 (25.4%) of the pre and post-implementation groups had any hypertensive disease in pregnancy ($p=0.16$). 56 (12.6%) and 52 (11%) of the pre and post implementation groups had gestational or pregestational diabetes ($p=0.44$). 229 (51.7%) and 242 (51.2%) of the pre and post implementation groups had induction of labor.
The NTSV cesarean rate was 26.64% in the pre-implementation group vs 19.87% in the post-implementation group ($p<0.02$).

Conclusion:
Significant reduction in the NTSV cesarean rate to below the 2030 Healthy People target was achieved in a primarily Asian and NHPI population at one year following a CMQCC-based intervention.

Formal Discussant: Keith Ogasawara, MD

11:45-12:15 pm
Eva Patil, MD, MPH (*By Invitation*)
Society Guest

Potential Abortifacient Exposures Reported to United States Poison Centers Before and After Dobbs

Background: In June 2022, the US Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision ended the federal right to abortion, increasing geographic variation in abortion access. Some individuals may seek self-managed abortion using medications, herbs, or other substances, but the frequency of these practices is difficult to measure. We sought to evaluate trends in calls to US poison centers after exposures to potential abortifacient substances, comparing data before and after *Dobbs* and between restrictive versus nonrestrictive states.

Design: We queried the National Poison Data System (NPDS) for reports of potential abortifacient exposures among females aged 15-44 years during the three years before and after the June 2022 *Dobbs* decision. Additional characteristics were gathered including pregnancy status and state location of exposure. For the primary analysis and a subgroup of pregnant individuals, we calculated annual state-level abortifacient exposure report rates per 100,000 women aged 15 to 44 years using state population estimates as denominators. We used a difference-in-differences design to compare changes before and after the *Dobbs* decision between states with restrictive and non-restrictive abortion policies. State-year panel models incorporated state and year fixed effects to estimate the association between abortion policy environment and post-*Dobbs* changes in abortifacient exposure report rates.

Results: Among 1,271 potential intentional abortifacient exposures reported to poison centers, restrictive-state status was not associated with a significant differential post-*Dobbs* change in exposure reporting rates in difference-in-differences models with state and year fixed effects (β=0.05 exposures per 100,000 women aged 15-44 years, SE=0.07, p=0.45). Exposure reporting rates declined in both policy environments, decreasing from 0.52 to 0.27 per 100,000 women aged 15-44 years in nonrestrictive states and from 0.41 to 0.33 per 100,000 in restrictive states. Only five queried abortifacient categories generated identifiable exposure reports: oral contraceptives, laxatives, ethanol, pennyroyal oil, and plant hormones. Among 29 pregnant cases (18 pre-*Dobbs* and 11 post-*Dobbs*), there was no statistical difference in age, living in a state with restrictive laws, exposure characteristics or medical outcomes.

Conclusion: Reports of potential abortifacient exposures to poison centers declined after *Dobbs* in both restrictive and non-restrictive states. We found no evidence that abortion policy restrictiveness was associated with a differential change in exposure reporting rates overall or among pregnant individuals. The limited number and lack of specificity of identified exposures suggest poison center data may have limited utility for studying self-managed abortion.

Formal Discussant: Jody Steinauer, MD

12:15 pm Pick up lunch- Macdonald Foyer

12:30-1:30pm Luncheon Lecture
Evgenya Shkolnik, Ph.D.

Worlds Beyond: The Hunt for Habitable Planets and Alien Life (Professor of Astrophysics School of Earth and Space Exploration Arizona State University Principal Investigator, SPARCS)

1:30-2:00 pm First Business Meeting, guests dismissed- Macdonald Ballroom
Guest Photos - Garden Lawn
2:00 pm Fellow Photos- Garden Lawn

2:15-2:45 pm
Carolyn Piszczek, MD (*By Invitation*)
Society Guest
Spontaneous resolution of an incarcerated gravid fibroid uterus at 25 weeks gestation: conservatively managed in a subsequent pregnancy with term delivery

Introduction: Uterine incarceration in pregnancy is typically managed expectantly after 20 weeks gestation, often with poor neonatal and maternal outcome. The weight and mechanics of a large uterine fibroid can be the precipitating factor that prevents the rise of a retroverted uterus to the anterior ventral position, leading to persistent retroversion and entrapment of the uterus below the sacral promontory, resulting in incarceration. Incarceration in the setting of a precipitating uterine fibroid isn't well described in the current body of literature, and, therefore, little is known about maternal and fetal outcomes in this clinical setting.

Case description: A 34 yo G1 at 21w1d gestation underwent a laparoscopy for a planned ovarian cystectomy of a 12 cm complex adnexal mass. Intraoperatively, a large 24 week size uterus with normal appearing serosa was noted and bilateral ovaries appeared normal. An intraoperative ultrasound showed that the presumed adnexal mass was in fact a 12.4 x 10.1 x 12.2 cm cystic uterine mass occupying the most cephalad aspect of the gravid uterus. Clinical exam a week later was suspicious for incarceration of a retroverted uterus, with the true fundus palpated vaginally as a posterior fullness and the cystic mass noted in the anterior uterine wall. An MRI confirmed this suspicion, and the mass was most consistent with a degenerating Type 5 anterior uterine fibroid. After reviewing options for manual and surgical reduction, the uterine incarceration was managed expectantly. The patient's symptoms resolved suddenly at 25 weeks gestation and the incarceration was found to have spontaneously reduced. The patient went on to PPROM at 34w4d gestation and deliver via spontaneous vaginal delivery at 35w1d. The uterine fibroid persisted at 8.8 x 8.6 x 7.8 cm three months postpartum. The patient was asymptomatic and wanted to conceive in the next year. Myomectomy was recommended to prevent incarceration in a subsequent pregnancy and gain a definitive diagnosis. The patient declined. Fifteen months after her prior delivery, the patient was again pregnant. The mass was smaller, 4.7 x 3.8 x 4.7 cm, at 12 weeks gestation. At 14w3d gestation, the uterus was noted to be retroverted. Given the concern that the anterior fibroid would lead to incarceration, the patient elected for uterine reduction by clinical exam and ultrasound manipulation, which was successful. At 16w3d, the uterus was once again noted to be retroverted, and uterine reduction was again performed and successful. The uterus persisted in the neutral position at 18w4d and remained in this position throughout pregnancy. The patient went on to deliver a normally grown newborn at 38w1d via an uncomplicated spontaneous vaginal delivery.

Discussion: This case illustrates the natural course of an incarcerated uterus greater than 20 weeks in the setting of an anterior Type 5 fibroid, as well as successful active conservative management in a subsequent pregnancy. It demonstrates a potential management strategy for this particular and rare case that can end in good fetal and maternal outcomes for the index and subsequent pregnancies.

Formal Discussant: Fred Coleman, MD
2:45-3:15 pm
Jessica Reid, MD (*By Invitation*)
Society Guest

Menstrual cup use as an adjuvant tool for IUD self-removal: a feasibility study

Abigail Liberty, Megan Cohen, Jessica Reid

Objectives: Concurrent menstrual cup and intrauterine device (IUD) use is associated with increased risk of inadvertent IUD removal. It is unknown whether purposefully using a menstrual cup as an adjuvant tool is a feasible IUD self-removal strategy.

Study Design: We undertook a feasibility study of 30 participants presenting for IUD removal in a clinical setting. Participants were offered a menstrual cup alongside an IUD self-removal guide. Participants completed surveys before and after the removal attempt. If a participant was unsuccessful with self-removal, a provider removed the IUD. We measured duration of self removal attempt and total IUD string length. Providers also completed a survey after the removal.

Results: A third of individuals (n=10) successfully self-removed their IUD, only one reported use of the menstrual cup. Of the participants who were unsuccessful (n=20), 50% could feel the strings and 67% attempted self-removal with a menstrual cup. Two participants reported inability to feel the strings prior to cup use, but identified strings after cup use even though they could not grasp them. The average duration of successful self-removals was shorter than the duration of attempt among those who were unsuccessful (2.6 minutes compared to 10.0 minutes). There was no difference between the total string length of IUDs by successful self-removal (63 ± 7mm versus 64 ± 14mm). There were no adverse events. A third of successful participants and a quarter of unsuccessful participants reported preferring the option for self-removal attempt in a clinical setting in the future.

Conclusions: Menstrual cup use to facilitate IUD self-removal did not increase success nor complications. Offering IUD self-removal in a clinical setting was feasible and acceptable to participants.

Formal Discussant: Anita Nelson, MD

3:15-4:00 pm Break Poster Presentations & Informal Discussion
Exhibits/Industry Representatives

4:00-4:30 pm
Rebecca Taub, MD (*By Invitation*)
Society Guest

Fertility-Sparing Management of Subinvolution of the Placental Site after Dilation and Evacuation: A Case Report

Objective: Sub-involution of the placental site (SIPS) is an underrecognized cause of delayed hemorrhage after delivery or abortion. Though well-documented in the histopathologic literature, clinical guidance is lacking, particularly for those desiring fertility-sparing options or presenting with non-emergent bleeding.

Case: The patient is a 36 year old G3P2012 who presented with abnormal uterine bleeding (AUB) 6 weeks after a second-trimester dilation and evacuation (D&E). Ultrasound showed concern for possible retained products of conception (RPOC). Hysteroscopic biopsy confirmed the diagnosis of SIPS. After counseling the patient opted for medical management with combined oral contraceptives (COCs), which she self-discontinued after one month. Following withdrawal bleed she returned to normal menses. Repeat imaging and endometrial sampling was normal.

Conclusion: SIPS is a rare cause of hemorrhage or AUB after a delivery or abortion. Though classically presenting with emergent bleeding, SIPS should be included in the differential diagnosis for AUB after a pregnancy ends, particularly in cases of second-trimester pregnancy loss or abortion when bleeding may be lighter. In these cases, medical or expectant management may be reasonable treatment options.

Formal Discussant: Jasmine Patel, MD

7:50 am Opening Remarks – Macdonald Ballroom

8:00 – 8:30 am Frank Lynch Memorial Essay
Alexandra Calderon, MD (*by Invitation)*

Multiple Balloon Catheter Use During Cervical Ripening Is Associated with Increased Cesarean Delivery in Nulliparous Term Patients

Objective: To evaluate obstetric and neonatal outcomes associated with one versus two or more balloon catheters during cervical ripening among nulliparous, term, singleton, vertex patients undergoing labor induction.

Methods: We conducted a retrospective cohort study of nulliparous, term, singleton, vertex patients undergoing induction of labor at a single integrated healthcare system. Patients were grouped by receipt of one versus two or more balloon catheters during cervical ripening. The primary outcome was cesarean delivery. Secondary outcomes included mode of delivery, labor duration, and maternal and neonatal morbidity. Multivariable logistic regression was used to estimate adjusted odds ratios (aORs) and 95% confidence intervals (CIs) for cesarean delivery.

Results: Among 3,558 patients, 187 (5.3%) required two or more balloon catheters. Patients requiring multiple balloons had significantly higher rates of cesarean delivery compared to those requiring one balloon (57% vs 35%; aOR 2.32, 95% CI 1.71–3.15). Vacuum-assisted delivery was less common in the multiple balloon group (7.5% vs 11%). Labor duration did not differ significantly in the primary analysis (median 19.1 vs 21.9 hours, $p>0.9$); however, in a sensitivity analysis restricted to the 2,427 patients with complete and standardized documentation of labor onset, those requiring two or more balloons experienced substantially longer labor duration (median 47.1 vs 27.6 hours, $p<0.001$). Rates of postpartum hemorrhage trended higher in the multiple balloon group but did not reach statistical significance. Neonates in the multiple balloon group had lower 1-minute Apgar scores (median 8 [IQR 7.5–8] vs 8 [IQR 8–9], $p=0.013$) and higher rates of 1-minute Apgar less than 7 (14% vs 8.2%, $p=0.042$); NICU admission rates were similar between groups.

Conclusion: Requirement of two or more balloon catheters during cervical ripening is associated with increased odds of cesarean delivery and longer labor duration on sensitivity analysis. These findings suggest that repeated mechanical ripening may serve as an early clinical marker of a complex induction course, with important implications for patient counseling and labor management.

8:30-9:00 am
Simone van Swam, MD (*by Invitation)*
Society Guest

An Atypical Presentation of Retained Placenta Following Vaginal Delivery: A Case Report

Objective Active management of the third stage of labor following vaginal delivery is routine; however, retained placenta occurs in approximately 2% of deliveries and may necessitate additional intervention. Initial management typically involves bedside manual extraction, with escalation to operative management when unsuccessful. We describe a case in which standard bedside and operative approaches were unsuccessful, yet the patient remained hemodynamically stable, allowing for further diagnostic evaluation and consideration of alternative management strategies.

Methods This case report describes a non-surgical approach to the management of a retained placenta that was inaccessible to both manual extraction and surgical instrumentation immediately postpartum. Ultrasonography was utilized to further characterize placental position and to inform the suspected etiology of placental retention. Imaging demonstrated an intrauterine placenta predominantly located in the left fundal region, without sonographic evidence of placenta accreta spectrum or uterine structural anomalies. Such presentations are rare and have historically been described in association with “angular pregnancies”, a term used to denote eccentric implantation within the uterine cavity near the uterine cornua. Consistent with contemporary nomenclature, this case is more accurately characterized as an intrauterine pregnancy with eccentric placental implantation, without evidence of interstitial ectopic pregnancy. Through intraoperative multidisciplinary care planning, nitroglycerin was administered to facilitate uterine relaxation and improve access to the uterine cavity, ultimately allowing for successful placental removal without the need for hysterotomy.

Results Medical management resulted in sufficient uterine relaxation to permit manual extraction of the placenta. The placenta was removed intact without maternal complications whilst avoiding increasingly invasive surgical techniques. No evidence of placenta accreta spectrum was identified on histopathologic examination.

Conclusion Atypical presentations of the third stage of labor require individualized management to ensure maternal safety. In clinically stable patients, adjunctive diagnostic evaluation, including ultrasonography, may provide critical information to guide management. This case contributes to the limited body of literature on non-surgical management of intrauterine pregnancies with eccentric placentation and highlights the need for further research to define optimal management strategies in these rare scenarios.

Formal Discussant: Adam Crosland, MD

9:00 – 10:00 am James C. & Joan Caillouette Lecture
Dr. Amanda Black (*By Invitation*)

Contraception Beyond the Prescription: Advancing Reproductive Autonomy through Clinical Care, Systems Change, and Advocacy

10:00 – 11:00 am
Break Poster Presentations & Informal Discussion-
Exhibits/Industry Representatives

11:00-11:30 am
Adrienne Bonham, MD, MS (*By Invitation*)
Society Guest
Vulvar Lichen Sclerosus in Pregnancy: A retrospective review

Background: Vulvar lichen sclerosus (VLS) in pregnancy is a poorly understood phenomenon, however up to 46% of patients with this condition are reproductive aged. Patients with VLS frequently report concerns about whether their condition will worsen during pregnancy, whether they are at a greater risk of obstetrical lacerations, whether they are candidates for vaginal delivery and whether topical corticosteroids are safe in pregnancy. Few studies focusing on these outcomes are currently available.

Objectives: This study seeks to characterize the course of VLS in pregnancy, including patient concerns, treatment compliance, provider recommendations, rate of elective cesarean section and frequency of obstetrical lacerations.

Methods: This is a retrospective chart review of individuals who were 18 years or older, assigned female at birth, who delivered between the dates of 1/1/2015 and 6/1/2026 at the OHSU Marquam Hill location and in whose chart documentation of pregnancy outcome and lichen sclerosus management was considered sufficient for the study aims. Collected data included the following: demographic characteristics; age at diagnosis; age at delivery; mode of delivery; baseline treatment recommendations; changes in treatment recommendations; changes in symptom severity; documented patient concerns; documented provider counseling; and obstetrical lacerations during delivery. Descriptive statistics were used to characterize the results.

Results: Forty-four patients with forty-nine deliveries meeting inclusion criteria were identified. Documentation of patient concerns about obstetrical lacerations was seen in 25% of patients, steroid safety in 9% and appropriateness of vaginal delivery in 14%. In all but 2 pregnancies, providers recommended continuation of topical corticosteroids during pregnancy. 95% of patients were initially managed with ultra-high potency or medium potency steroids, the most common regimen being 2-3 times weekly dosing. Of those patients who were advised to continue corticosteroid use, 22% self-discontinued use during the pregnancy, and in 18%, the potency or frequency of treatment was decreased by the provider. Fifteen patients underwent cesarean section, 13 of which were performed for obstetrical indications, and 4 patients had assisted vaginal deliveries. Among the 30 spontaneous vaginal deliveries, the rate of obstetrical laceration rate was 76.7%. 22% of patients reported that their symptoms improved or resolved during pregnancy, and no patient reported worsening of the condition.

Conclusions: The majority of providers in this study prescribed VLS treatment protocols consistent with established recommendations. Patient concerns demonstrated in this study were largely consistent with those previously described, and while no patient reported concerns about symptom worsening, this may reflect preemptive counseling by their providers. In this study, VLS symptoms remained stable or improved during the pregnancy, and no patient reported worsening of their symptoms overall. Rates of obstetrical lacerations are consistent with described rates seen in patients without VLS, and vaginal delivery remains the recommended mode of delivery if obstetrically indicated.

Formal Discussant: Rebecca Dunsmoor-Su, MD

11:30-12:00 pm
Jil Johnson, MD (*By Invitation*)

Reexamining the Myth of Surgical Invincibility: Professional Identity and Health-Related Functional Transition in OB/GYN Surgeons

Physicians experience chronic health conditions at meaningful rates, and studies consistently show that many continue working despite illness or reduced physical capacity. At the same time, a significant portion of practicing OB/GYNs are mid- to late career, increasing the likelihood of health-related change before traditional retirement. Long-term disability risk among physicians is measurable, yet open conversation about health vulnerability remains limited within surgical culture.

For many surgeons, being in the operating room is more than a job - it is central to professional identity. When physical capacity changes, even subtly, the impact may extend beyond scheduling or workload. It can affect confidence, career planning and sense of self. Despite this predictable reality, few structured discussions address how surgeons can prepare for or navigate this transition.

This presentation reviews workforce data and physician disability risk and examines the connection between operative performance and professional identity. It outlines practical steps for proactive planning, including financial protection, thoughtful career design and development of roles beyond procedural volume.

Health-related change is part of human biology. Preparing for it is part of professional responsibility.

Formal Discussant: Adam Crosland, MD

7: 50 am Opening Remarks Macdonald Ballroom

8:00 – 8:30 am
Michael Ruma (*By Invitation*)
Society Guest
Improving obstetric ultrasound using a checklist-based protocol

Objective: Ultrasound in obstetrics is used worldwide for maternal and fetal evaluation. Obstetric ultrasound offers the ability to evaluate for fetal anomalies, abnormal fetal growth, and the impact of medications and infections during pregnancy. Obstetric ultrasound requires the acquisition of a standard set of maternal and fetal images recommended by such organizations as the American Institute of Ultrasound in Medicine. We evaluated the impact of implementation of a checklist-based protocol on the duration of obstetric ultrasound exams, extent of exam completion, accuracy of documentation, and the effect on individual obstetric sonographer performance in a large perinatal population within a statewide maternal-fetal medicine practice.

Design: We conducted a case-cohort study reviewing obstetric ultrasounds performed in all trimesters before and after the implementation of a checklist-based protocol. The duration of the ultrasound, number of missing required exam images, and documentation of missing images were abstracted. To account for clustering by sonographer, mixed effects models with sonographer-specific intercepts and protocol effects were used to evaluate the effect on total time of exam, number of missing images, and whether missing images were documented.

Results: A total of 1000 ultrasound examinations were compared, 500 prior to and 500 following the implementation of the checklist-based protocol. The mean gestational ages for the obstetric ultrasound exams were 22.7 weeks pre- and 23.73 weeks post-protocol implementation. Statistically significant differences before and after implementation of the protocol were observed for all outcomes. The pre-protocol median elapsed time for obstetric ultrasounds was reduced from 27.55 minutes to 20.30 post-protocol, a 26.3% reduction (95%CI 19.2, 32.8).
Across 22 individual sonographers, the estimated sonographer-specific reduction in ultrasound exam time ranged from 17.2% to 40.6%, with a median reduction of 24.9%. The median proportion of missing required images decreased from 17.2% in the pre-protocol group to 8.5% post-protocol, corresponding to a 55.3% reduction in the odds of a required image being missing (OR 0.45; 95% CI 0.39, 0.51; $P < 0.001$). This effect corresponds to a reduction of 8.7 missing images for a 100-image protocol. Similarly, the estimated sonographer-specific odds a required image was missing during an exam ranged from 0.30 to 0.67, with a median of 0.45.
The proportion of proper documentation of missing images increased from 49.9% pre-protocol to 87.4% post-protocol (OR 6.98; 95% CI 3.36, 14.52; $P < 0.001$). The estimated sonographer-specific odds ratio a missing required image was properly documented in the post-protocol group ranged from 1.05 to 21.39, with a median of 7.60 compared to the pre-protocol group.

Conclusion: Implementation of a checklist-based protocol significantly reduced the time of obstetric ultrasound exams, improved the proportion of complete examinations, and enhanced the accuracy of documentation on final ultrasound reports. The use of a checklist-based protocol incorporating professional society practice parameters amplified the individual sonographer's performance in all outcomes evaluated in this study. The findings of this study should be leveraged and incorporated

throughout practices in the United States to improve access, throughput, and performance of obstetric ultrasound care for mothers and their unborn infants.

Formal Discussant, David Lagrew, MD

8:30 – 9:00 am
Stephanie Lin, MD (*By Invitation*)
Society Guest
Oxytocin infusion rates >20 mu/min have significantly higher adverse maternal and neonatal outcomes

Objective: While a maximum oxytocin dose has not been determined, many hospitals have protocols that limit the maximum rate of oxytocin infusion for augmentation or induction of labor due to concerns about the safety and efficacy of higher infusion rates. The objective of this study is to compare maternal and neonatal outcomes with maximum oxytocin doses of 1-20 milliunits/minute (mu/min) vs. >20 mu/min during labor.

Study Design: This is a retrospective cohort study in a large healthcare system of term, singleton deliveries from 1/1/2020 to 12/31/2023 that received oxytocin for induction or augmentation of labor. Patients were excluded if they were 42 weeks gestation, postpartum dose was charted as having been given antepartum or if the total time on oxytocin was >72 hours. Chi-square test was used to compare categorical variables.

Results: A total of 100,315 deliveries met inclusion criteria. 94,514 patients (94.2%) had a maximum oxytocin infusion rate of 1-20 mu/min and 5,801(4.8%) had a maximum rate of >20 mu/min. Of those that had a vaginal delivery, 95.1% had an oxytocin dose between 1-20 mu/min and 4.9% had a maximal dose that was >20mu/min. Although the vaginal delivery rate in those receiving >20 mu/min was 72.1%, the maternal and neonatal outcomes were significantly worse with an 83% increase in NICU admissions (9.7% vs. 5.3% p20 mu/min are at significantly higher risk of meaningful adverse maternal and neonatal outcomes with a relative low effect on overall mode of delivery. Based on this review, oxytocin dosing above 20 mu/min should be used with caution.

Formal Discussant, Alison Wu, MD

9:00 – 9:30 am
Dawn Kopp, MD MPH
PCOGS Fellow

Understanding Infertility and Fertility Care Decision-Making Among Female Veterans and Active-Duty Service Members: A Qualitative Study

Objective: To explore the lived experiences of female veterans and active-duty service members struggling with fertility challenges, with particular attention to how military service influences perceptions of fertility, decisions to seek care, and perceived barriers and facilitators to fertility treatment.

Study Design: This is a qualitative study utilizing semi-structured, in-depth interviews conducted via videoconferencing. Eligible female veterans and active-duty service members were recruited through flyers, social media, and community outreach. Interviews were audio-recorded, transcribed verbatim, de-identified, and analyzed using thematic analysis to identify recurrent patterns and themes across participant narratives.

Results: Analysis revealed several central themes, including how military service and deployment experiences shaped fertility intentions and timing; the systemic and logistical barriers patients faced when seeking fertility evaluation and treatment; and the complex factors influencing decisions to engage in or decline fertility care.

Conclusion: This study seeks to center the voices of female veterans and active-duty service members to address a critical gap in understanding infertility within military-affiliated populations. By examining personal experiences and fertility-related decision-making, this study aims to inform patient-centered clinical care, enhance healthcare professional awareness of options for fertility care, and support policy and system-level efforts to improve equitable access to fertility services for those who serve or have served.

Formal Discussant: Anita Nelson, MD

9:30 – 10:00 am
Malcolm Munro, MD, FACOG, FRCSC, FRCOG ad eundem
PCOGS Fellow

R U MOVVING SOMEe? Seeing past your specialty for Chronic Pelvic Pain (A Classification System)

Formal Discussant: Linda Eckert, MD

10:00-10:45 am
Break Poster Presentations & Informal Discussion-
Exhibits/Industry Representatives

10:45-11:45 am
Michael McHale, MD
Presidential Choice Lecture

Presidential Choice Lecture- Enhancing Surgical Quality Through High Performing Teams: The Power of Collaboration and Communication

11:45 – 12:15 pm
PCOGS Fellows Second Business Meeting, guests dismissed

12:30 -3:00 pm
PCOGS Second Annual Board Meeting
Macdonald F

5:00-6:00PM
Presidential Address – Macdonald Ballroom
PCOGS President Thomas Gaylord

There is More to a Military OB/GYN than you Learn in Residency

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