The Department of Obstetrics, Gynecology and Reproductive Medicine acknowledges with gratitude the educational grants which have made this program possible:

Abbott Laboratories
Duramed
Matria Healthcare
Merck & Co., Inc.
Proctor & Gamble Pharmaceuticals
Roche Laboratories, Inc.
Warner Chilcot
Wyeth Pharmaceuticals

Department of Obstetrics, Gynecology and Reproductive Medicine

TWENTY-NINTH ANNUAL RESIDENTS RESEARCH DAY

June 17, 2009

STATE UNIVERSITY OF NEW YORK
STONY BROOK
HEALTH SCIENCES CENTER

Stony Brook University Medical Center
Stony Brook, New York

Notes:

Department of Obstetrics, Gynecology and Reproductive Medicine
School of Medicine
Stony Brook University Medical Center
Twenty-Eighth Annual Residents Research Day
June 18, 2008

Chairman: J. Gerald Quirk, M.D., Ph.D.

Residency Director: Todd Griffin, M.D.

Associate Residency Director: Adam P. Buckley, M.D.

RRD Program Director: Richard Bronson, M.D.

RRD Program Committee:
Deborah Duttge
Terry Leonbruno
Adrianne Lo Bue
Darlene Swords

Departmental Faculty:

Susan Altman, C.N.M.
Cecilia Avila, M.D.
David Baker, M.D.
Richard Bronson, M.D.
Adam Buckley, M.D.
Lauri Budnick, M.D.
Ann Buhl, M.D.
Eva Chalas, M.D.
Kent Chan, M.D.
Karen Coburn, N.P.
Christine Conway, M.D.
Reinaldo Figueroa, M.D.
Heather Findletar, C.N.M.
Marie Frey, C.N.M.
Jennifer Griffin, N.P.
Todd Griffin, M.D.
Jessica Hilsenroth, C.N.M.
Jennifer Johnson, M.D.
Daniel Kiefer, M.D.
Christina Kocis, C.N.M.
Laura Lesch, N.P.
Michael Lydic, M.D.
Goldie McBride, C.M.
Careen Mauro, C.N.M.
Alan Monheit, M.D.
Paul L. Ogburn, Jr., M.D.
Michael Pearl, M.D.
Natalie Semenyuk, M.D.
Eva Swoboda, M.D.
Siamak Tabibzadeh, M.D.
Linda Tseng, Ph.D.
Jeannine Villella, D.O.
Ann Visser, C.N.M.

Martin L. Stone, M.D.
Professor Emeritus

LECTURER AND JUDGES

TWENTIETH ANNUAL
MARTIN L. STONE, M.D. LECTURER AND JUDGE

Anthony Vintzileos, M.D.
Chairman and Residency Program Director
Department of Obstetrics and Gynecology
Winthrop University Hospital
Professor of Obstetrics, Gynecology
and Reproductive Medicine
Stony Brook University Medical Center

JUDGES

Martin L. Stone M.D.
Founding Chairman
Professor Emeritus
Department of Obstetrics, Gynecology
and Reproductive Medicine
Stony Brook University Medical Center

Eva Chalas, M.D.
Professor of Obstetrics, Gynecology
and Reproductive Medicine
Stony Brook University Medical Center
Vice Chairman of Obs/Gyn
Chief, Division of Gyn Oncology
Winthrop University Hospital

DEPARTMENTAL RESIDENTS

CHIEFS
Rupinder Bhangoo, M.D.
Kristen Patzkowsky, M.D.
Kelly van den Heuvel, M.D.
Dympna Weil, M.D. (Administrative Chief)

PGY-3
Kirthi Katkuri, M.D.
Nikole Ostrov, M.D.
Erin Stevens, M.D.

PGY-2
Jerasimos Ballas, M.D.
Shelly-Ann James, M.D.
Lan Na Lee, M.D.
Randi Turkewitz, M.D.

PGY-1
Elizabeth Buescher, M.D.
Joseph Chappelle, M.D.
Donald Phillibert, M.D.
Chandra Reese, M.D.
Elizabeth Garduno, M.D.

Notes:

Notes:

PROGRAM

8:30 - 8:35	*Welcome* **J. Gerald Quirk, M.D., Ph.D.** Chairman
8:35 - 8:45	*Introduction* **Richard Bronson, M.D.**
8:45 - 8:55	*The Effect of Hyperoxia on Inflammatory Cytokines in Rat Pups* **Elizabeth Buescher, M.D.** Faculty Sponsor: Shetal Shah, M.D.
8:55 - 9:05	Open Discussion Discussant: Cecilia Avila, M.D.
9:05 - 9:20	Preterm Labor Risk Scoring **Jerasimos Ballas, M.D**. Faculty Sponsor: Paul Ogburn, M.D.
9:20 - 9:35	Discussion and Questions Discussant: Winfred Tovar, M.D.
9:35 - 9:45	*Estimating Fetal Weight in Obese Patients Using Three Methods* **Chanda Reese, M.D.** Faculty Sponsor: Reinaldo Figueroa, M.D.
9:45 - 9:55	Open Discussion **Jerasimos Ballas, M.D.** Discussant: Adam P. Buckley, M.D.
9:45 - 10:25	Coffee Break
10:25—10:40	*Quality of Life Postpartum—Comparison of Cesarean and Vaginal Delivery* **Lan Na Lee, M.D.** Faculty Sponsor: Daniel Kiefer, M.D.
10:40 - 10:55	Discussion and Questions Discussant: Lauri Budnick, M.D.
10:55 - 11:55	*Seamless Healthcare for Women* **Frederick Naftolin, M.D.**

PROGRAM (Continued)

11:15—12:15	*Evidence Based Medical Practice* **Anthony Vintzileos, M.D.**
12:15 - 12:30	*Patient Perception of Pain during a Medical Abortion Based on Their Support System* **Erin Stevens, M.D.** Faculty Sponsors: Deborah Davenport, M.D. Adam P. Buckley, M.D.
12:30—12:45	Discussion and Questions Discussant: Natalie Semenyuk, M.D.
12:45 - 1:45	Lunch
1:45— 2:00	*Chorioamniotis: A Clinical Diagnosis?* **Randi Turkewitz, M.D.** Faculty Sponsor: Reinaldo Figueroa, M.D.
2:00 - 2:15	Discussion and Questions Discussant: Paul L. Ogburn, M.D.
2:15 - 2:30	*Is the Code Noelle Protocol Effective in Decreasing or Preventing Complications Associated with Cesarean Hysterectomy?* **Shelly-Ann James, M.D.** Faculty Sponsor: Todd Griffin, M.D.
2:30 - 2:45	Discussion and Questions Discussant: J. Gerald Quirk, M.D., Ph.D.

PROGRAM OBJECTIVES

The purpose of this program is to provide a forum for discussion of original research findings and for the introduction, development, and review of new and most accepted approaches to the discipline of Obstetrics and Gynecology. Upon completion of the program, participants should be able to apply medical problem-solving skills, practice new approaches to manual and surgical skills, and utilize skills in evaluating new information.

CREDITS

The School of Medicine, State University of New York at Stony Brook, is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The School of Medicine, State University of New York at Stony Brook, designates this educational activity for up to 3.5 hours in Category 1 towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

The American College of Obstetricians and Gynecologists has assigned 4 cognate credits to this program.

ALUMNI RESIDENTS (CONTINUED)

2002-2003
Karen Chu, M.D., Private Practice, San Francisco, California
JoAnna Paolilli, M.D., Private Practice, Mineola, New York
Hera Sambaziotis, M.D., M.P.H., Albert Einstein Medical Center, Bronx, New York
Julie Welischar, M.D., Private Practice, Setauket, New York

2003-2004
Patricia Ardise, M.D., Private Practice, New Jersey
Anne Hunter, M.D.
Sara Petruska, M.D., Private Practice, Kentucky
Alejandra Turmero, M.D., Private Practice, Rhode Island

2004-2005
Heather McGehean, M.D., Urogynecology Fellowship, Pennsylvania
Timothy Hale, M.D., Private Practice, Massachusetts
Joyce Rubin, M.D., Private Practice, Smithtown, New York
Vanessa Soviero, M.D., Private Practice, East Setauket, New York
Eva Swoboda, M.D., Stony Brook University Hospital, Stony Brook, New York

2005-2006
Lynda Gioia, M.D., Private Practice, Tennessee
Olga Glushets, M.D., Urogynecology Fellowship, Brooklyn, New York
Meredith McDowell, M.D., Private Practice, Norwich, New York

2006-2007
Patricia Dramitinos, M.D., Urogynecology Fellowship, Cambridge, Massachusetts
Megan Lochner, M.D., Private Practice, Setauket
Christopher Paoloni, M.D., Private Practice, Virginia
Anita Patibandla, M.D., Private Practice, Ohio

Obstetric Hemorrhage Screening Tool: Can We Predict Outcomes?

Kirthi Katkuri, MD and Todd Griffin, MD

Objective: The purpose of this study is to evaluate the proper use and accuracy of the Risk Assessment Form established for obstetric hemorrhage.

Study Design: A retrospective study of admissions between February and May 2007 to Labor and Delivery was performed. Obstetric hemorrhage was defined as blood loss more than five hundred milliliters in vaginal deliveries and more than thousand milliliters in cesarean deliveries. We reviewed 804 admissions and analyzed whether the risk assessment form was being used for all admissions. The charts were reviewed for demographic data, hemorrhage risk assessment score, risk factors, need for transfusions, and other interventions. Statistical Analysis was performed using Excel 2007 and SPSS 16.

Results: Of 804 admissions, 94 patients hemorrhaged; 59.6% among vaginal deliveries and 32.2% among cesarean deliveries at term. The risk assessment form was being utilized for 90% of admissions. We noted that half of those not scored were due to non-compliance during transfer of admits from Antepartum unit to Labor and Delivery Unit. Percent of low, moderate and high risk scores are 64.30% (517), 24.50% (197) and 1.99% (16) respectively. High risk scores correlate with hemorrhage with odds ratio of 4.109 (95% CI 1.392 - 12.127, $P<0.003$).

Conclusions: We report approximately 90% compliance with the risk assessment form. High risk scores are predictive of obstetric hemorrhage. Our tool does predict hemorrhage and can be used to identify these patients to improve outcomes.

Maternal Determinants of Glucagon-like Peptide-1: A Pilot Study

Nikole Ostrov MD; Andrew Lane MD, Thomas Wilson MD and Lourdes Aguayo MD

Objective: To determine to what extent a gravid mother's genes or her own blood sugar concentration influences Glucagon-like Peptide-1 (GLP-1) in the fetus. GLP-1 is an intestinal incretin hormone known to play an important role in controlling postprandial hyperglycemia in normal individuals. We hypothesize that cord blood levels of GLP-1 are lower in infants born to mothers with type 2 diabetes when compared to infants born to healthy controls. By measuring cord blood GLP-1 levels in newborns of mothers with type 2 diabetes and comparing the values to those from infants of non-diabetic mothers we will test this hypothesis. Since studies to date have not attempted to isolate GLP-1 in cord blood we first started with a pilot study of 10 cord blood samples to test if this protein could be isolated and quantified in cord blood.

Methods: Upon admission to labor and delivery, pregnant females were consented to partake in this study. Immediately after delivery, 3 ml of cord blood was collected to which 30 uL of DPP-IV (dipeptidyl peptidase-4) inhibitor was immediately added. The sample was centrifuged for 5 minutes after which the plasma was separated from the whole blood. The samples were stored at -70° C. ELISA was used for the quantitative determination of GLP-1.

Results: Our pilot study of ten patients demonstrates that GLP-1 can be reliably detected and measured in fetal cord blood. GLP-1 levels in fetal cord blood ranged from 2.030-8.541 pM, averaging 4.260 pM.

Conclusion: For the first time GLP-1 has been isolated from fetal cord blood, this study will therefore be expanded to 125 patients, with both control and affected arms. Additionally, further data including hemoglobin A1C will be obtained to investigate potential relationships between GLP-1 in fetuses from poorly controlled versus well controlled diabetic

Alumni Residents (Continued)

1993-1994
Ira Chan, M.D., Instructor, Beth Israel Hospital, Harvard Medical School, Boston, MA
Pui Chun Cheng, M.D., Gynecologic Oncology, New Orleans, Louisiana
Lawrence Weinstein, M.D., Private Practice, Kingston, New York

1994-1995
Ira Bachman, M.D., Private Practice, Cedarhurst, New York
Petra Belady, M.D., Private Practice, Bloomington, Indiana
Gloria Escamilla, M.D., Private Practice, Smithtown, New York
Lisa Farkouh, M.D., Private Practice, Denver, Colorado

1995-1996
Felicia Callan, M.D., Private Practice, Huntington, New York
Charles Mirabile, M.D., Private Practice, West Islip, New York
Karen Morris, M.D., Private Practice, Huntington, New York
James Stelling, M.D., Private Practice, Stony Brook, New York

1996-1997
Jacqueline Ammirata, M.D., Private Practice, West Islip, New York
Todd Griffin, M.D., Stony Brook University Hospital, Stony Brook, New York
Hitesh Narain, M.D., Private Practice, Patchogue, New York
Florence Rolston, M.D., Private Practice, Southampton, New York

1997-1998
Salil Bakshi, M.D., Private Practice, Oakdale, New York
Wei Chu, M.D., Private Practice, East Islip, New York
David Reavis, M.D., Private Practice, Patchogue, New York
Marian Zinnante, M.D., Private Practice, Arlington, Texas

1998-1999
Robert Duck, M.D., Private Practice, Winchester, Virginia
Christopher Fabricant, M.D., Univ. of Texas, Southwestern Medical Center, Dallas, Texas
Anne Hardart, M.D., University of Southern California, Los Angeles, California
Lynne Macco, M.D., Private Practice, West Islip, New York

1999-2000
Vito Alamia, M.D., Private Practice, Southampton, New York
Terry Allen, M.D., Private Practice, Fairfax, Virginia
Mari Inagami, M.D., Private Practice, Westport, Connecticut
Jill Thompson, M.D., Private Practice, Northport, New York

2000-2001
Martina Frandina, M.D., New York Downtown Hospital, New York, New York
Dennis McGroary, M.D. Private Practice, Mt. Kisco, New York
Antonia Pinney, M.D., Private Practice, New Jersey

2001-2002
Siobhan Hayden, M.D., Mary Imogene Barrett Hospital, Cooperstown, New York
Antoun Khabbaz, M.D., Appalachian Regional Healthcare, Harlan, Kentucky
Dennis Strittmatter, M.D., Private Practice, Port Jefferson, New York

Alumni Residents

1981-1982
Richard Scotti, M.D., Dir., Female Pelvic Med. & Reconstructive Surgery , Los Angeles, CA
W. Robert Lockridge, M.D., New York

1982-1983
Deborah Davenport, M.D., Private Practice, East Setauket, New York
William Shuell, M.D., Private Practice, Southampton, New York

1983-1984
Robert O'Keefe, M.D., Private Practice, Setauket, New York
Alexandra Taylor, M.D.

1984-1985
Eva Chalas, M.D., Private Practice, Smithtown, New York
Professor of OB/GYN, Stony Brook University, Stony Brook, New York
David Kreiner, M.D., Private Practice, Woodbury, New York

1985-1986
Jeffrey Porte, M.D., Private Practice, Setauket, New York
Gae Rodke, M.D., Private Practice, New York, New York

1986-1987
Lance Edwards, M.D., Private Practice, Port Jefferson, New York
Mindy Shaffran, M.D., Private Practice, Port Jefferson, New York
Christian Westermann, M.D., Private Practice, Stony Brook, New York

1987-1988
Timothy Bonney, M.D., Private Practice, West Islip, New York
Arlene Kaelber, M.D., Private Practice, Setauket, New York

1988-1989
Michael Arato, M.D., Private Practice, Stony Brook, New York
Miriam Sivkin, M.D., Private Practice, Milford, Connecticut

1989-1990
Michael Klotz, M.D., Private Practice, Seattle, Washington
Paul Meyers, M.D., Riverside Hospital, Newport News, Virginia
Gustavo San Roman, M.D., Private Practice, Port Jefferson Station, New York

1990-1991
Cheri Coyle, M.D., Private Practice, Hampton, Virginia
Syau-fu Ma, M.D., Private Practice, Ridgewood, New Jersey
John Wagner, M.D., Private Practice, East Northport, New York

1991-1992
Brian McKenna, M.D., Private Practice, Smithtown, New York
Gerald Siegel, M.D., Private Practice, Commack, New York
Marie Welshinger, M.D., Women's Cancer Center, Morristown Memorial, Morristown, NJ

1992-1993
Theodore Goldman, M.D., Private Practice, East Northport, New York
Stephanie Mann, M.D., Private Practice, Los Angeles, California
Robert Scanlon, M.D., Private Practice, Kingston, New York

Preterm Labor Risk Score Assessment: A Pilot Study

Jerasimos Ballas MD, MPH, Paul L. Ogburn MD, Daniel Kiefer MD and Lillian Meek, RN

Objective: To develop a prenatal scoring system to assess our patients' risks of delivering prematurely.

Hypothesis: By using a system of risk scoring early in pregnancy, it is possible to select a subset of patients who are at increased risk for preterm birth.

Background: Despite decades worth of research and interventions, preterm labor and preterm delivery remain among the most significant problems faced by obstetricians. Detection of preterm labor for the purpose of postponing delivery and improving outcomes remains one of the most heavily researched areas in the current literature. Identifying women at risk early in their pregnancy, however, is still an evolving area. While certain risk factors have been shown to be associated with an increased risk at delivering early, quantifying a woman's risk given one or more risk factors at the time of initiating prenatal care and adjusting a woman's treatment accordingly continues to be explored. Work by Creasy and colleagues in the early 1980's and subsequent research by others has shown promise, but a reliable risk scoring system has yet to gain acceptance. Ultimately, such stratification schemes, along with the development of prenatal therapies aimed at preventing preterm labor in the asymptomatic patient, could lead to delay of delivery and improved neonatal outcomes.

Methods and Materials: This study consisted of a chart review that that retrospectively applied a risk score derived from patient responses to 12 questions asked during their initial intake interview in order to assess whether any combination of these responses correlate with gestational age at delivery. Standard prenatal data and demographics were also collected for statistical purposes.

Results: A total of ninety patient records were reviewed and scored for the purpose of the study. Of those patients, thirty-seven (41.1%) were either lost to follow-up or had another pregnancy outcome such as a termination of pregnancy or spontaneous abortion. Nine of the remaining 53 patients delivered prior to 37 weeks (16.9%). None of the investigational risk factors were found to be significantly associated with preterm delivery when compared independently. When the factors were appropriately scored and summed for each patient, a significant association was found between a patient's risk score and whether she delivered prematurely ($p=0.024$). A patient was considered "low risk" with a risk score less than 3, "moderate risk" between 3 and 6, and "high risk" with a score greater than 6. Both moderate and high-risk groups were found to be significantly associated with risk of delivering prematurely ($p=0.01$) when compared to the low risk population.

Conclusions: The risk scoring system developed and used in this pilot study seemed to be effective in identifying a subpopulation of our patients with increased risk of Preterm delivery. Currently, treatment with weekly 17-alpha hydroxyprogesterone caproate is the only prenatal regimen endorsed by the American College of Obstetricians and Gynecologists for prevention of preterm delivery in high-risk populations, namely those with a history of premature deliveries. As more prenatal treatments for preventing premature delivery become part of standard care, such scoring may prove to be a standardized and inexpensive way of screening all women presenting for prenatal care. This study serves and a preliminary investigation for a prospective study that is currently under consideration. Particular issues that will hopefully be addressed in future prospective studies are: lack of power for many of the factor comparisons, the high loss to follow up rate, and the ability to develop a relative risk rather than an estimated odds ratio.

Evaluating the Impact of Route of Delivery on Health-related Quality of Life

Lan Na Lee, MD and Daniel Kiefer, MD

Objective: It has been well established that there are significant differences in morbidity and mortality following cesarean delivery when compared to vaginal delivery. The national delivery rate has been reported as high as 30%. Few studies have evaluated the impact of route of delivery on health related quality of life (HRQoL). HRQoL is a multidimensional concept with physical, psychological and social domains. The assessment of HRQoL has become increasingly important in clinical research. The Euroqol5D and Euroqol VAS (visual analog scale) surveys have been established as valid and reliable measurements of HR-QOL in the obstetric setting.

Methods: Prospective cohort study involving patients receiving prenatal care at participating institutions. Information regarding baseline demographics, route of delivery and perinatal factors were obtained from enrolled patients during the immediate postpartum period. The EQ-5D and EQ-VAS surveys were used to assess HRQoL for each patient. Patients are encountered at 4 survey points (immediate postpartum period; 6wk, 6mos, and 1yr postpartum). Using Fisher's exact test for categorical variables and the Wilcoxon sum test for continuous variables, the differences between the cesarean-delivery group and vaginal-delivery group were calculated.

Results: There were no differences in baseline demographics, except the cesarean-delivery group delivered on average one week earlier than the vaginal-delivery group (p-value 0.04). Patients who delivered via cesarean reported significantly more difficulty with self care, and mobility than those who underwent vaginal delivery (p-value 0.0001, 0.005 respectively). No significant difference was found between the two groups in terms of pain and discomfort (p=0.18), anxiety and depression (p=0.48) as well as state of health (p=0.81) using the EQVAS.

Conclusions: There are no significant differences in baseline characteristics between vaginal and cesarean deliveries, except for gestational age. Cesarean delivery patients had significantly lower mobility, self-care, and usual activity scores. Pain and anxiety/depression scores were similar. Overall health ratings on VAS were similar.

AWARDS-PAST RECIPIENTS

The William J. Mann, M.D. Pathology Award

1982	Deborah Davenport, M.D.
1983	Deborah Davenport, M.D.
1984	Eva Chalas, M.D.
1985	Eva Chalas, M.D.
1986	Mindy Shaffran, M.D.
1987	Christian Westermann, M.D.
1988	Michael Arato, M.D.
1989	Paul Meyers, M.D.
1990	Syau-fu Ma, M.D.
1991	Cheri Coyle, M.D.
1992	Robert Scanlon, M.D.
1993	Robert Scanlon, M.D.
1994	Petra Belady, M.D.
1995	Charles Mirabile, M.D.
1996	James Stelling, M.D..
1997	Todd Griffin, M.D.
1998	Robert Duck, M.D.
1999	Jill Thompson, M.D.
2000	Jill Thompson, M.D.
	Terry Allen, M.D.
2001	Hera Sambaziotis, M.D., .M.P.H
2002	JoAnna Paolilli, M.D.
2003	Timothy Hale, M.D.
2004	Vanessa Soviero, M.D.
2005	Megan Lochner, M.D.
2006	Olga Glushets, M.D.
2007	Patricia Dramitinos, M.D.

Faculty Teaching Award

In Recognition and Appreciation for Outstanding Teaching and Service to the Residency Program

1982	Alan Monheit, M.D.
1983	Mark Funt, M.D.
1984	William Mann, M.D.
	John Chumas, M.D.
1985	Burton Rochelson, M.D.
1986	Carolyn Trunca, Ph.D.
	Abraham Halfen, M.D.
	Lawrence Minei, M.D.
1987	William Mann, M.D.
1988	Alan Monheit, M.D.
1989	James Droesch, M.D.
1990	John Chumas, M.D.
1991	Adrienne Thomas, M.D.
1992	Daniel Saltzman, M.D.
1993	Fidel Valea, M.D.
1994	James Droesch, M.D.
1995	Bruce Meyer, M.D.
1996	Joseph Schaffer, M.D.
1997	Michael Pearl, M.D.
1998	Anthony Royek, M.D.
1999	Stephen Salmieri, M.D.
2000	Alan Monheit, M.D.
2001	Anthony Royek, M.D.
2002	Andrew Elimian, M.D.
2003	David Garry, D.O.

AWARDS—PAST RECIPIENTS

The Robert L. Barbieri, M.D. Research Award

(Formerly the Resident Research Award)

1981	Deborah Davenport, M.D.	**1996**	Todd Griffin, M.D.
1982	Alexandra Taylor, M.D.		Marian Zinnante, M.D.
1983	Deborah Davenport, M.D.	**1997**	Ann Hardart, M.D.
1984	Robert O'Keefe, M.D.		Marian Zinnante, M.D.
1985	Gae Rodke, M.D.	**1998**	Ann Hardart, M.D.
1986	Christian Westermann, M.D.		Jill Thompson, M.D.
1987	Mindy Shaffran, M.D.	**1999**	Vito Alamia, M.D.
1988	Michael Arato, M.D.	**2000**	Mari Inagami, M.D.
1989	Syau-fu Ma, M.D.	**2001**	Dennis Strittmatter, M.D.
1990	John Wagner, M.D.	**2002**	JoAnna Paolilli, M.D.
1991	John Wagner, M.D.	**2003**	Sara Petruska, M.D.
1992	Robert Scanlon, M.D.	**2004**	Anne Hunter, M.D.
1993	Robert Scanlon, M.D.	**2005**	Lynda Gioia, M.D.
1994	Ira Bachman, M.D.	**2006**	Kristin Patkowsky, M.D.
1995	Felicia Callan, M.D.	**2007**	Kelly van den Heuvel, M.D.

The Golden Scalpel Award

In Recognition of Demonstrating Excellence in Technical Skills

2001	Martina Frandina, M.D.
2002	Antoun Khabbaz, M.D.
2003	Julie Welischar, M.D.
2004	Joyce Rubin, M.D.
2005	Eva Swoboda, M.D.
2006	Megan Lochner, M.D.
2007	Megan Lochner, M.D.

Patient Perception of Pain During a Medical Abortion Based On Their Support System

Erin E. Stevens, MD, Adam Buckley, MD and Deborah Davenport, MD

Objective: 48% of all pregnancies each year in the United States are unintended and more than one-fifth of all pregnancies, planned or unplanned, end in abortion. Patients have two options when considering termination, and may choose a medical over surgical abortion because it is thought to be more natural and more private. Previous studies show that lower maternal age, lower parity, and anxiety were found to be predictors of severe pain during a medical termination. Currently, there have been no investigations into whether a patient's support system plays in the amount of pain a patient reports. The purpose of this study is to determine whether patients will report experiencing less pain if they have a support system during the abortion.

Materials and Methods: This is a prospective, descriptive study. A survey was administered to all patients who elected to undergo a medical termination at Planned Parenthood locations in the Hudson-Peconic area. The survey was administered at their follow-up appointment and collected demographic information, evaluated the amount of pain and bleeding patients perceived during the termination and their level of psychosocial support.

Results: 118 completed surveys were used. The average age of the subjects was 25.9. It was the first pregnancy for 35.5% of the patients, and 50.8% had never had a live birth. 76.2% were either in a serious relationship, engaged or married. 40.6% had completed college or had a more advanced degree. Average gestational age was 6.2 weeks. Subjects who were of a more advanced gestational age reported significantly more bleeding and pain during and after the abortion. Those who were more anxious or had more bleeding than expected also reported significantly more pain during the abortion. Every subject told someone about the abortion. 10% of subjects had no one with them during the administration of misoprostol. No significant difference was found for pain scores of subjects who had no one with them compared to those with a support system. Subjects were significantly more anxious if their significant other was not with them at the time of misoprostol. Subjects were more satisfied with the procedure if their mother was not with them at the time of misoprostol administration.

Still to be investigated at this time is the role of friend support at the time of termination.

Conclusion: A support system during a medical termination of pregnancy plays a role in the reported amount of pain, anxiety, and satisfaction.

Chorioamnionitis: A Clinical Diagnosis?

Randi Turkewitz, MD and Reinaldo Figueroa, MD

Objective: To test the hypothesis that premature neonates born to mothers with clinical chorioamnionitis (CCA) plus histological chorioamnionitis (HCA) have worse outcomes than those born to mothers with histological chorioamnionitis only.

Study Design: A retrospective chart review was conducted from January 1, 1995 until January 1, 2007 of mothers who delivered neonates prematurely at Stony Brook University Medical Center. Pregnancies delivered between 23 weeks and 32 6/7 weeks gestation with a pathological diagnosis of HCA were eligible for this study. 363 deliveries met these criteria. However, after excluding neonates with known structural malformations, chromosomal abnormalities and multiple gestations, a total of 255 deliveries were examined. Patient groupings were created based on the presence (n=130) or absence (n=125) of CCA. Neonatal complications, including respiratory distress syndrome, necrotizing enterocolitis, bronchopulmonary dysplasia, patent ductus arteriosis, intraventricular hemorrhage, early sepsis and periventricular leukomalacia, were compared between the two groups using the Fischer exact test. Average maternal age, gestational age, birth weight, mode of delivery and gender were also examined. Finally, mortality was compared between the two groups.

Results: Average gestational age at the time of delivery was the only statistically significant variable between the HCA+CCA group and the HCA-CCA group (26.74 vs. 27.48, p=0.0333). Multivariable logistic regression models indicated a significant relationship between gestational age at time of delivery and survival. The diagnosis of CCA did not significantly impact neonatal mortality when controlling for gestational age, gender and mode of delivery.

Conclusion: The diagnosis of clinical chorioamnionitis in prematurely delivered neonates with histological chorioamnionitis does not impact neonatal complications or mortality.

AWARDS-PAST RECIPIENTS

The David Marzouk, M.D. Humanism in Medicine Award

In Recognition of Warmth, Compassion, and Devotion to the Profession of Medicine

1985	Eva Chalas, M.D.
1986	Timothy Bonney, M.D.
1987	Michael Arato, M.D.
1988	Michael Arato, M.D.
1989	Syau-fu Ma, M.D.
1990	Brian McKenna, M.D.
1991	Robert Scanlon, M.D.
1992	Stephanie Mann, M.D.
1993	Petra Belady, M.D.
1994	Felicia Callan, M.D.
1995	Elizabeth Folland, M.D.
1996	Florence Rolston, M.D.
1997	David Reavis, M.D.
1998	Vito Alamia, M.D.
1999	Lynne Macco, M.D.
2000	Siobhan Hayden, M.D.
2001	Anne Hunter, M.D.
2002	JoAnna Paolilli, M.D.
2003	Sara Petruska, M.D.
2004	Vanessa Soviero, M.D.
2005	Megan Lochner, M.D.
2006	Meredith McDowell, M.D.
2007	Dympna Weil, M.D.

Resident Teaching Award

In Recognition of Commitment, Dedication, and Enthusiasm in the Teaching and Nurturing of Medical Students

1990	Brian McKenna, M.D. John Wagner, M.D.
1991	Pui Chun Cheng, M.D.
1992	Pui Chun Cheng, M.D.
1993	Lawrence Weinstein, M.D.
1994	Todd Griffin, M.D.
1995	David Reavis, M.D.
1996	David Reavis, M.D.
1997	David Reavis, M.D.
1998	David Reavis, M.D.
1999	Vito Alamia, M.D.
2000	JoAnna Paolilli, M.D.
2001	JoAnna Paolilli, M.D. Hera Sambaziotis, M.D.
2002	Joyce Rubin, M.D.
2003	JoAnna Paolilli, M.D.
2004	Heather McGehean, M.D.
2005	Anita Patibandla, M.D.
2006	Anita Patibandla, M.D.
2007	Anita Patibandla, M.D.

AWARDS-PAST RECIPIENTS

The Martin L. Stone, M.D. Award

The Outstanding Resident in Recognition of Dedication, Commitment, and Service
(Formerly Resident of the Year Award)

1982	Robert O'Keefe, M.D.	**1995**	Ira Bachman, M.D.
1983	Eva Chalas, M.D.	**1996**	James Stelling, M.D.
1984	Jeffrey Porte, M.D	**1997**	Todd Griffin, M.D.
1985	Eva Chalas, M.D.	**1998**	David Reavis, M.D.
1986	Jeffrey Porte, M.D.	**1999**	Lynn Macco, M.D.
1987	Christian Westermann, M.D.	**2000**	Siobhan Hayden, M.D.
1988	Timothy Bonney, M.D.	**2001**	Martina Frandina, M.D.
1989	Michael Arato, M.D.	**2002**	Siobhan Hayden, M.D.
1990	Marie Welshinger, M.D.	**2003**	JoAnna Paolilli, M.D.
1991	John Wagner, M.D.	**2004**	Patricia Ardise, M.D.
1992	Pui Chun Cheng, M.D.	**2005**	Heather McGehean, M.D.
1993	Lawrence Weinstein, M.D.	**2006**	Lynda Gioia, M.D.
1994	Ira Bachman, M.D.	**2007**	Megan Lochner, M.D.

The Voluntary Clinical Faculty Award

In Recognition of and Appreciation for Outstanding Teaching and Service to the Residency Program

1995	Richard Halpert, M.D.		
1996	Christian Westermann, M.D.	**2002**	Todd Griffin, M.D.
1997	James Droesch, M.D.	**2003**	Philip Schoenfeld, M.D.
1998	Deborah Davenport, M.D.	**2004**	James Stelling M.D.
1999	Christian Westermann, M.D.	**2005**	James Droesch, M.D.
2000	Abraham Halfen, M.D.	**2006**	James Droesch, M.D.
2001	Abraham Halfen, M.D.	**2007**	Jeffrey Porte, M.D.

Is the Code Noelle Protocol Effective in Decreasing and Preventing Complications Associated with Cesarean Hysterectomy?

Shelly-Ann James, MD and Todd Griffin, MD

Objective: The purpose of this study is to evaluate the effectiveness of the Code Noelle protocol to decrease and/or prevent complications associated with Cesarean Hysterectomy.

Background: Cesarean Hysterectomy may be performed as a planned procedure or emergently as a last resort for a woman with persistent bleeding. The most common indication for cesarean hysterectomy is severe uterine hemorrhage that cannot be controlled by conservative measures. Such hemorrhage may be due to coagulopathy, laceration of pelvic vessels, uterine rupture, uterine atony, or an abnormally implanted placenta. In late 2005 Stony Brook Obstetrical Department introduced the Code Noelle protocol. Initially proposed as an interdisciplinary task force, it was charged with mobilizing resources such as blood products and personnel, in order to facilitate rapid response to patient care. The ultimate goal being to improve outcomes associated with obstetrical hemorrhage, which is the most important cause of maternal mortality and morbidity.

Methods: A retrospective review of all the Cesarean Hysterectomies performed prior to the initiation of Code Noelle between 2004-2005 were compared to those that occurred following implementation of this protocol on labor and delivery. Inclusion criteria were all the Code Noelle admissions to Labor & Delivery unit during these years. Cesarean Hysterectomy was defined as the complete removal of the uterus at the time of delivery whether emergently or planned. Endpoints were blood transfusions, length of stay in hospital, ICU admission, time to transfusion, number of transfusion, post operative complications, and evidence of DIC.

Initial Results: Patients undergoing peripartum hysterectomy post Code Noelle had decreased estimated blood loss, decreased intensive care unit length of stay and decreased time to transfusion. These results were statistically significant p value < 0.05. There was no difference in length of stay in the hospital, number of transfusion, complications or evidence of DIC.

Conclusion: Our results suggest that the implementation of Code Noelle has been effective in improving outcomes for patients undergoing peripartum hysterectomy for life-threatening hemorrhage.

APPENDIX

PAST AWARD WINNERS

AND

ALUMNI

10:30 - 10:45	*HSV Seroprevalence and Acceptance of Serotologic Testing Amongst Pregnant Women* **Patricia Dramitinos, M.D.** Faculty Sponsor: **David Baker, M.D.**
10:45-10:50	Discussant: Lynda Gioia, M.D.
10:50-10:55	Questions