



Obstetrics & Gynecology Institute

9TH ANNUAL

Research Day

May 15, 2024

Bunts Auditorium
or via Webex





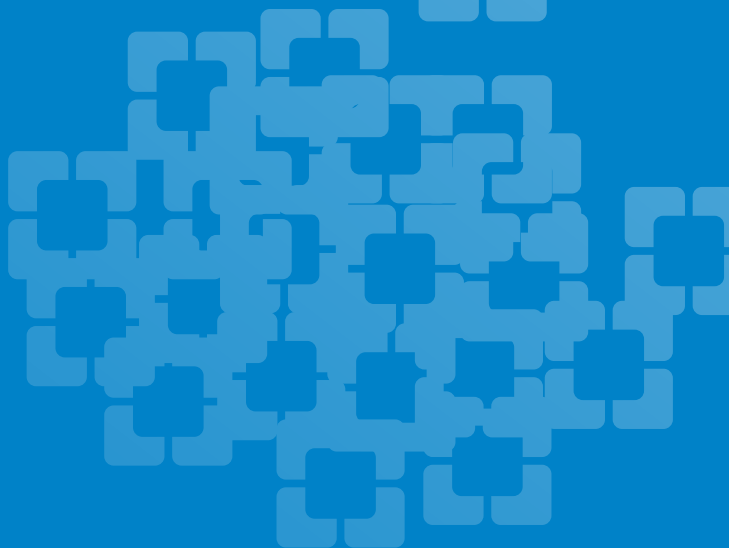
9TH ANNUAL

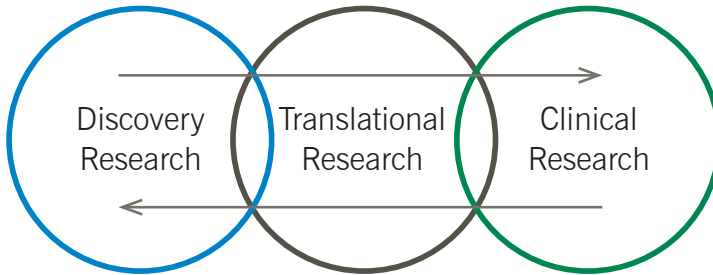
Obstetrics & Gynecology
Institute

RESEARCH DAY

May 15, 2024







Key Note Address & Lecture

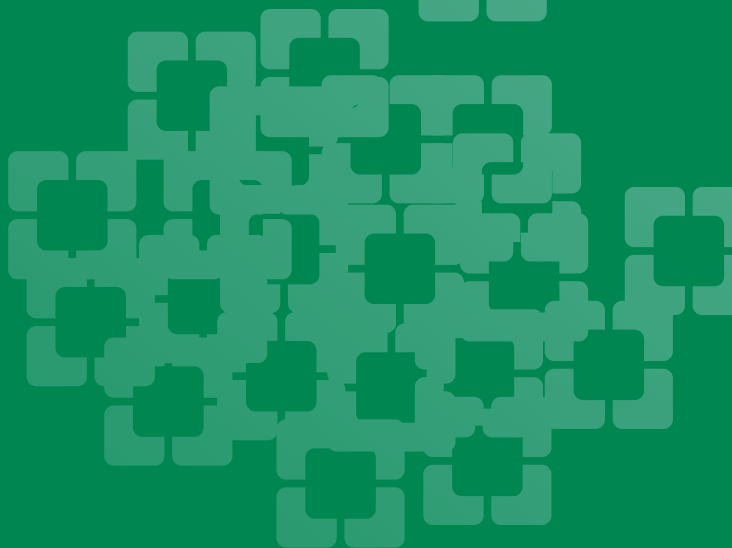
Emily S. Miller, MD, MPH
Associate Professor in Obstetrics & Gynecology
Warren Alpert Medical School of Brown University
Division Director of Maternal Fetal Medicine
Women & Infants Hospital of Rhode Island

Judges (Oral Presentations)

Mariam Alhilli, MD
Linda Bradley, MD
Adina R. Kern-Goldberger, MD, MPH
Justin Lappen, MD
Emily Miller, MD, MPH
Marie Fidela Paraiso, MD
Amy Park, MD
Mitchell Reider, MD
Steven Waggoner, MD

Judges (Poster Presentations)

Cara D Dolin, MD
Ashley Gubbels, MD
Swapna Kollikonda, MD
Shannon L Wallace, MD



Agenda

- 6:45 am** **Participants, Presenter & Judges Registration**
- 7:00–7:05 am** **Introduction & Welcome**
Ruth Farrell, MD, MA
Vice Chair, Research, Obstetrics and Gynecology Institute
- 7:05–7:55 am** **Key Note Address**
Listening to the Living: Innovative Approaches to Perinatal Mental Health Care
Emily S. Miller, MD MPH
Associate Professor in Obstetrics & Gynecology
Warren Alpert Medical School of Brown University
Division Director of Maternal Fetal Medicine
Women & Infants Hospital of Rhode Island
- 7:55–8:05 am** **Q&A**
- 8:05–8:15 am** **Break**

8:15–10:00 am **PGY3 Resident Oral Presentations**

- 8:15 am *Use of Simulation in Obstetrics and Gynecology Residency Curricula*
Emily Armstrong, MD
- 8:25 am Q&A
- 8:30 am *Immediate Postpartum Levonorgestrel (Mirena) IUD Insertion: Analysis of Insertion Technique and Expulsion Rates*
Riva Desai, MD
- 8:40 am Q&A
- 8:45 am *Breaking Bad News: A Simulation-Based Training Program for Ob/Gyn Residents*
Katarina Fleckenstein, MD
- 8:55 am Q&A

- 9:00 am *Artificial Intelligence for Fetal Sex Determination*
Emily Frisch, MD
- 9:10 am Q&A
- 9:15 am *Access to Ergonomic Equipment and Instruments Among
Obstetric and Gynecologic Surgeons*
Olivia Neumann, MD
- 9:25 am Q&A
- 9:30 am *Impact of Highly Restrictive Abortion Bans on the
Management of Pregnancies with Known Trisomy 13/18:
A Cost-effective Analysis*
Kirat Sandhu, MD
- 9:40 am Q&A
- 9:45 am *Implementation and Impact of the Early Pregnancy
Assessment Clinic at Cleveland Clinic*
Dominic Sandler, MD
- 9:55 am Q&A
- 10:00 am Refreshment Break & PGY2 Resident Poster Viewing**

**10:15 am–
12:00 pm**

Graduating Fellows Oral Presentation

- 10:15 am *Divergent Evolutionary Response to Multiple Fractions
of Radiation (MF2) Therapy in Cervical Cancer Cell Lines
(CCCL)*
Johanna Kelley, MD
Fellow, Gynecologic Oncology
- 10:25 am Q&A
- 10:30 am *Effect of Surgical Specialty on Management of
Endometriomas in Reproductive-Aged Women:
A Single Center Review*
Jensara Clay, MD
Clinical Fellow, Minimally Invasive Gynecologic Surgery
- 10:40 am Q&A

- 10:45 am ***Patient-Reported Outcome Measures Used in Randomized Controlled Trials Following Surgical Intervention for Endometriosis***
Thomas Gallant, MD
Clinical Fellow, Minimally Invasive Gynecologic Surgery
- 10:55 am Q&A
- 11:00 am ***The Experience of Intended Parents During the Egg Donor-Recipient Matching Process***
Bailey McGuinness, MD
Fellow, Reproductive Endocrinology & Infertility
- 11:10 am Q&A
- 11:15 am ***Factors Influencing Surgical Approach in Women with Stress Urinary Incontinence***
Amy Gee, MD
Fellow, Female Pelvic Medicine and Reconstructive Surgery
- 11:25 am Q&A
- 11:30 pm ***Are Virtual Visits for Delivery of Postoperative Care Following Urogynecologic Surgery Equal to Office Visits? The VIDEO Randomized Trial***
Lannah Lua-Mailland, MD
Fellow, Female Pelvic Medicine and Reconstructive Surgery
- 11:40 pm Q&A
- 11:45 am ***HSD3B1 Polymorphisms and Spontaneous Preterm Birth***
Justin Moore, MD
Fellow, Maternal Fetal Medicine
- 11:55 am Q&A
- 12:00 pm **Grab and Go Lunch & View Posters**

12:15 pm–
1:15 pm

Innovations in Ob/Gyn Lecture

- 12:15 pm *Breaking Boundaries and Bridging the Gaps:
A Holistic Approach to Addressing Maternal Morbidity
and Mortality, and Eliminating Health Disparities*
Monique Katsuki, MD, FACOG
Obstetrics & Gynecology Hospitalist
Assistant Professor, OB/Gyn & Reproductive Biology
CCLCM
Co-Chair, OGI Council on Diversity, Equity & Inclusion
Program Director, Center for Infant and Maternal Health
Cleveland Clinic
- 1:05 pm Q&A
- 1:15 pm **Group picture of all presenters, speakers &
Institute Leadership**

Past Research Day Award Winners

Resident Poster Presentation – 1st Place

- 2023 Emily Frisch, MD
- 2022 Erika Lampert, MD
- 2021 Rachel Shin, MD, MPH
- 2020 Carrie Bennett, MD
- 2019 Jessica Son, MD
- 2018 Sarah Hershman, MD
- 2017 Caitlin Carr, MD
- 2016 Laura Moulton, DO, MS

Resident Oral Presentation – 1st Place

- 2023 Erika Lampert, MD
- 2022 Rachel Shin, MD, MPH
- 2021 Jonathan Hunt, MD, MBA
- 2020 Anna Chichura, MD
- Alyssa Herrmann, MD
- 2019 Emily Holthaus, MD
- 2018 Caitlin Carr, MD
- Julian Gingold, MD, PhD
- 2017 Laura Moulton, DO, MS
- 2016 Jamie Stanhiser, MD
- 2016 Lisa Caronia Hickman, MD

Fellow Oral Presentation – 1st Place

- 2023 Danielle Chau, MD
- 2022 Michelle Kuznicki, MD, MA
- 2021 Laura Chambers, DO, MS
- 2020 Katie Crean-Tate, MD
- 2019 Elizabeth Conner, MD
- 2018 Tonya Nikki Thomas, MD
- 2017 Kathryn Maurer, MD
- 2016 Linnea Goodman, MD



Keynote Address & Lecture

Emily S. Miller, MD, MPH

Associate Professor in Obstetrics & Gynecology
Warren Alpert Medical School of Brown University
Division Director of Maternal Fetal Medicine
Women & Infants Hospital of Rhode Island



Dr. Miller is an Associate Professor in Obstetrics & Gynecology at the Alpert Medical School of Brown University. She is the Division Director of Maternal Fetal Medicine at Women & Infants Hospital of Rhode Island. She is committed to improving mental health care for pregnant and postpartum people, with the overarching goal of equitable access to holistic wellness for all new families.

She was nominated to the American College of Obstetricians and Gynecologists (ACOG's) "Maternal Mental Health Expert Work Group" and has led the development of multiple national consensus statements to guide care provision for perinatal mental health. By bringing attention to gaps in health services for perinatal mental health care, she has challenged the paradigm of our current obstetric model of perinatal mental health care and transformed care delivery.

She is currently PI of three NIH-funded studies focused on dissemination of the collaborative care model as a health services intervention to equitably and sustainably integrate mental health care into obstetric settings. Her work focuses around digital health tools to scale postpartum collaborative care, implementation strategies to optimize collaborative care workflow, and prevention of perinatal depression programs with the collaborative care model for individuals with childhood adversity.

Judges (Oral Presentations)



Mariam Alhilli, MD
Associate Professor
Cleveland Clinic
Obstetrics & Gynecology Institute
Subspecialty Care for Women's Health
Faculty, Gynecologic Oncology



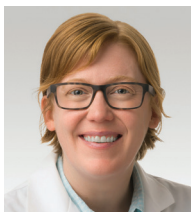
Linda Bradley, MD
Vice Chairman
Cleveland Clinic
Obstetrics & Gynecology Institute
Subspecialty Care for Women's Health
Faculty, Benign Gynecology



Adina Kern-Goldberger, MD, MPH
Staff
Cleveland Clinic
Obstetrics & Gynecology Institute
Obstetrics and Gynecology
Faculty, Maternal Fetal Medicine



Justin Lappen, MD
Section Head
Cleveland Clinic
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Faculty, Maternal Fetal Medicine



Emily S. Miller, MD, MPH
Associate Professor in Obstetrics & Gynecology
Warren Alpert Medical School of
Brown University
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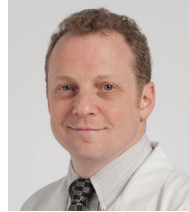


Marie Fidela Paraiso, MD
Staff
Cleveland Clinic
Obstetrics & Gynecology Institute
Subspecialty Care for Women's Health
Faculty, Urogynecology

Judges (Oral Presentations)



Amy Park, MD
Section Head
Cleveland Clinic
Obstetrics & Gynecology Institute
Subspecialty Care for Women's Health
Faculty, Urogynecology



Mitchell Reider, MD
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Faculty, Obstetrics and Gynecology



Steven Waggoner, MD
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Subspecialty Care for Women's Health
Faculty, Gynecologic Oncology

Judges (Poster Presentation)



Cara Dolin, MD
Staff
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Obstetrics & Gynecology Institute
Obstetrics and Gynecology
Faculty, Maternal Fetal Medicine



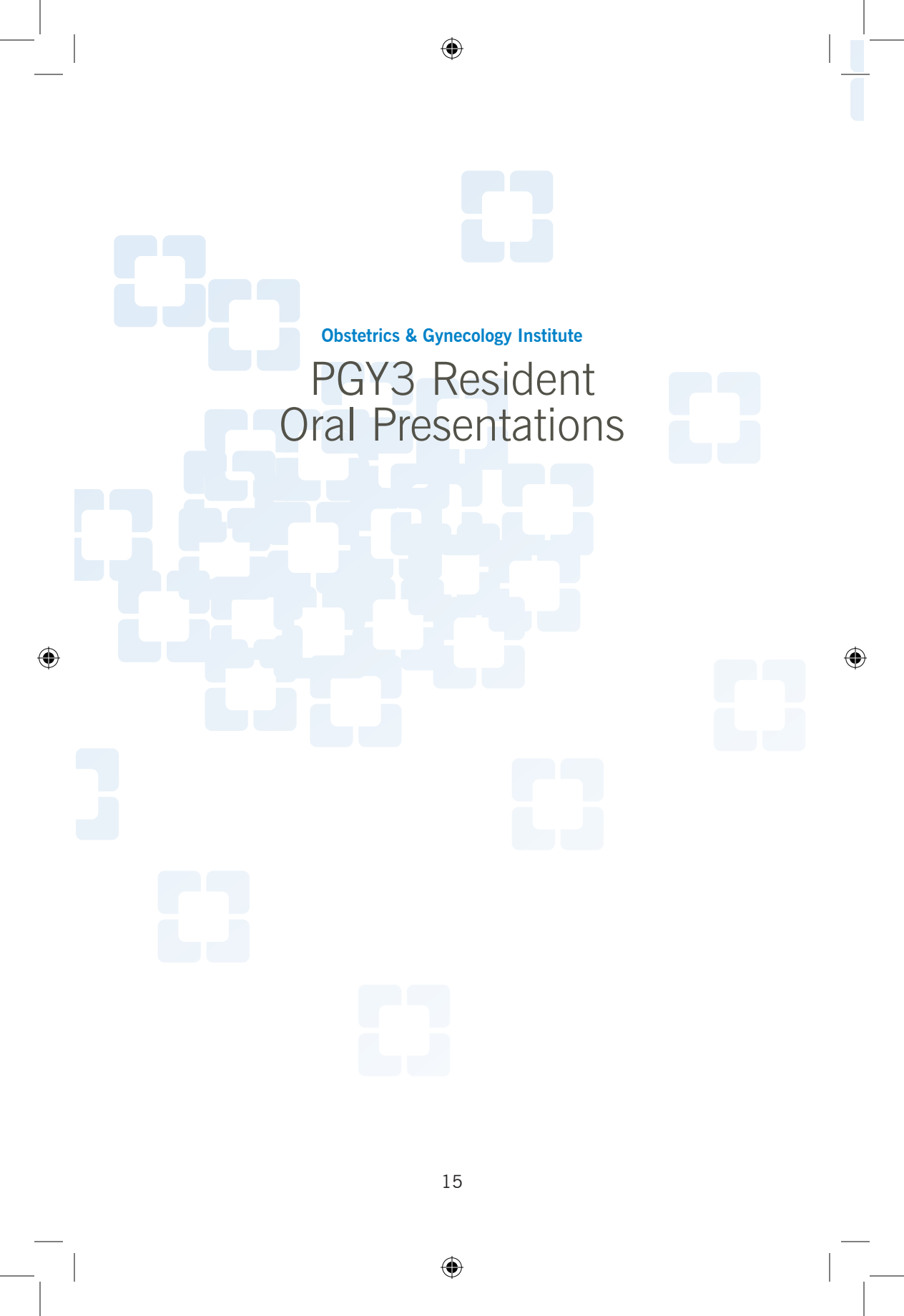
Ashley Gubbels, MD
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Faculty, Minimally Invasive Gynecologic Surgery



Swapna Kollikonda, MD
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Obstetrics and Gynecology
Faculty, Obstetrics and Gynecology



Shannon Wallace, MD
Associate Program Director
Cleveland Clinic
Obstetrics & Gynecology Institute
Subspecialty Care for Women's Health
Faculty, Urogynecology



Obstetrics & Gynecology Institute
PGY3 Resident
Oral Presentations

Use of Simulation in Obstetrics and Gynecology Residency Curricula – IRB 23-1239



Emily Armstrong, MD

Objective: Simulation is an important cornerstone in residency education. There is currently no standardized national simulation curriculum for Obstetrics and Gynecology residencies, and there are few studies investigating the attitudes of residents and program directors towards simulation and its utility. The goal of this study was to describe use of simulation in Ob/Gyn residencies, evaluate resident and program director attitudes toward simulation, and identify barriers to implementation of simulation in residency education.

Methods: A REDCap survey was sent to Ob/Gyn residents and program directors through the use of email databases. Statistical analysis was conducted using SPSS. Chi squared and student's t-test were used to identify differences between groups, and Spearman correlation was used to assess the strength of relationship between ordinal variables. Significance was determined by a p value ≤ 0.05 .

Results: A total of 134 residents and 95 program directors completed the survey. Resident answers indicated that 96% of respondents had some form of dedicated simulation space, and most residents participated in 4-9 dedicated simulations annually. The most cited motivation for self-led simulation was practice before a particular surgical case (64.9%). The largest barriers residents faced for seeking more simulation opportunities were lack of time (82.0%) and not built into clinical rotation (50.0%). The most common barriers for faculty were lack of protected time for faculty (71.6%) and cost (57.9%). Rating of quality of simulation did not differ in type of residency program (academic vs. non-academic), and attitudes toward applicability or value did not differ based on post-graduation plans. Residents who rated their program's sim quality higher were more likely to rate the value and applicability of simulation higher. Residents who participated in more than 10 simulations annually were more likely to rate simulation value higher but not applicability. Rating of value and applicability of simulation in education did not differ based on PGY year or use of feedback.

Conclusions: Simulation is a valuable tool for Ob/Gyn residency education. Improvements to allow residents and faculty more dedicated time toward simulation, as well as improving funds for simulation, may improve overall quality and satisfaction with simulation.

Funding Source: None

Faculty Mentor: Erin Higgins, MD

Immediate Postpartum Levonorgestrel (Mirena) IUD insertion: Analysis of Insertion Technique and Expulsion Rates – IRB 22-1130



Riva Desai, MD

Objective: To assess whether the method of immediate postpartum (IPP) Mirena IUD insertion after vaginal delivery (manual versus device applicator versus ring forceps) is associated with IPP IUD expulsion by 6 months postpartum.

Methods: We conducted a retrospective cohort study using electronic medical data to identify patients who delivered vaginally in a multihospital healthcare system and received an IPP Mirena IUD from 2019–2022. We identified eligible patients using ICD-10 codes and MAR administration. We manually extracted confounding variables and outcomes: obstetrical characteristics, use of ultrasound, expulsion, and composite IUD complications (malposition, perforation, or discontinuation). The primary outcome was the rate of IUD expulsion within 6 months of delivery. The secondary outcomes were the rate of composite IUD complications, use of ultrasound at time of IPP IUD insertion, and association of patient characteristics. With a power of .80 and p value threshold of 0.05 with equal group size, approximately 184 patients were required in each arm to detect a 15% absolute difference in expulsion rate.

Results: Of the 647 patients that met inclusion criteria, 311 IPP IUDs were placed via manual insertion (47.9%); 247 were placed via device applicator (38.1%); and 89 were placed via ring forceps (13.7%). Data analysis is still in process and will be presented.

Conclusions: This is one of the first reviews of IPP Mirena IUD insertion based on method of insertion. While the data analysis is still pending, we hypothesize a 15% lower absolute difference in expulsion rate for ring forceps compared to both manual and device applicator insertion methods. The results of this study will guide future practice and offer providers a data-driven approach to improve immediate postpartum contraceptive efficacy.

Funding source: None

Faculty Mentor: Ashley Brant, DO

Breaking Bad News: A Simulation-Based Training Program for Ob/Gyn Residents – IRB 23-405



Katarina Fleckenstein, MD

Objective: Delivering bad news has moral and medico-legal obligations for physicians. Studies have shown that the way news is delivered directly affects a patient's understanding of and satisfaction with their medical care (Konstantis et al, 2015). Additionally, poor communication skills involved in breaking bad news contribute to patient dissatisfaction and provider stress (Brown et al, 2008). Ob/Gyn residents are often responsible for delivering bad news, but there are few formal training programs focused on there are few formal training programs focused on developing this skill.

Methods: To address this need, we developed a simulation-based Breaking Bad News curriculum for Ob/Gyn residents. The 3-hour curriculum consisted of a didactic on palliative medicine, case-based standardized patient interactions, and a panel discussion. Case topics included previable PPROM, surgical complication, cancer diagnosis, and intrauterine fetal demise. Participants were asked to complete a questionnaire focused on their ability to deliver bad news before and after training (Oliveira et al, 2020). Responses were compared pre- and post-training.

Results: 15 residents ranging from PGY-1 to PGY-4 participated in the training; 13 completed both the pre- and post-training questionnaire. Comparing pre- and post-survey results, residents felt more prepared when breaking bad news (46% vs 85%). Specifically, residents felt more comfortable delivering bad news related to IUFD (61% vs. 84%), cancer diagnosis (38% vs. 69%), and previable PPROM (46% vs. 77%). 100% of participants stated that they felt this training helped in their clinical practice.

Conclusions: This pilot study demonstrates that this simulation-based curriculum was effective in improving a resident's ability to deliver bad news. We plan to offer this training on a regular basis as part of our educational programming and hope to share this curriculum with other Ob/Gyn residencies. Additionally, we believe it could be adapted for other specialties to address this educational need while improving patient quality and satisfaction outcomes.

Funding source: None

Faculty Mentor: Erin Higgins, MD

Artificial Intelligence for Fetal Sex Determination – IRB 23-770



Emily Frisch, MD

Objective: Determination of fetal sex is one of the cardinal requirements of an anatomic ultrasound. It provides important clinical information that could profoundly affect both fetal and neonatal care and, in addition, is one of the most requested questions providers are asked during an ultrasound visit. Recognizing the different genders requires an element of skill and training which is not always available in more rural areas. A viable artificial intelligence (AI) model for fetal sex determination could be of significant value to providers in these settings. Our novel study assessed how confidently a prediction model can determine the sex of a fetus from an ultrasound image.

Methods: Analysis was performed using 25,000 ultrasound image slices from a high-volume fetal sex determination practice. This dataset was then split into a training set (17,500) and holdout test set (7,500). A computer vision model was trained using a transfer learning approach with EfficientNetB4 architecture as base. The performance of the computer vision model was evaluated on the holdout test set. Accuracy, Cohen's Kappa and Multiclass Receiver Operating Characteristic AUC were used to evaluate the performance of the model.

Results: The AI model achieved an Accuracy of 88.27% on the holdout test set and a Quadratic Cohen's Kappa score 0.843. The Multiclass ROC AUC score for Male was calculated to be 0.896, for Female a score of 0.897, Unable to Assess a score of 0.916 and for Text Added score of 0.981 was achieved.

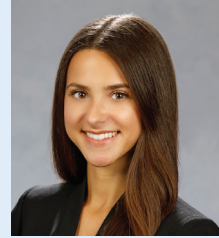
Conclusions: This novel AI/ML model proved to have a high rate of fetal sex capture that could be of significant use in areas where ultrasound expertise is not readily available.

Funding source: None

Faculty Mentor: Elliott Richards, MD

Primary Investigator: Amol Malshe, MD

Access to Ergonomic Equipment and Instruments among Obstetric and Gynecologic Surgeons – IRB 23-562



Olivia Neumann, MD

Objective: Ergonomics is the science of humans' interactions with their working environment, particularly associated with comfort and efficiency. Current data shows surgeons' concern for musculoskeletal strain due to ergonomic challenges in the operating room (OR). However, there is little research on the accessibility of ergonomic instruments for cohorts of primarily female surgeons. This study aims to evaluate access to ergonomic equipment among obstetric and gynecologic (OB/Gyn) surgeons, identifying areas for improvement in the promotion of inclusivity within the OR.

Methods: This is a cross-sectional survey study among members of OB/Gyn societies (AAGL, SMFM, SGO, and SGS). The survey assesses demographic information and the need for and access to ergonomic instruments. Respondents were grouped by glove size (Small: ≤ 6 , Medium: 6.5-7, and Large: ≥ 7.5) and height based on CDC data (Female: below average $\leq 5'3''$ and average and above: $\geq 5'4''$; Male: below average $\leq 5'8''$ and average and above $\geq 5'9''$). Unpaired t-test and one-way ANOVA with post-hoc Tukey HSD were used for statistical analysis, with $p \leq .05$ as significant.

Results: There were 328 responses (243 female and 83 male), primarily gynecologic oncologists (155) and minimally invasive gynecologic surgeons (115). Women with below average height reported higher rates of discomfort with laparoscopic instruments ($p = .0105$) and were more likely to have requested specialized ergonomic instruments ($p = .0103$). This group also reported greater difficulty accessing OR lights ($p < .0001$), correct glove size ($p = .0107$), and OR tables adjusted to their preferred height ($p < .0001$). While not statistically significant, females of below average height reported more concern about both patient ($p = .0871$) and physician ($p = .0732$) safety associated with ergonomics. Surgeons with small glove sizes reported more discomfort with laparoscopic instruments ($p < .0000$), more difficulty accessing correct glove size ($p < .0000$), and more often noted ergonomics impacted their career satisfaction ($p = .0034$).

Conclusions: Surgeons with smaller glove size and shorter stature had increased discomfort with laparoscopic instruments and difficulty accessing ergonomic

equipment. Additionally, surgeons with smaller glove sizes reported the impact of ergonomics on career satisfaction. To promote inclusivity and safety within the OR and to support career longevity, efforts should be placed on developing and distributing surgical instruments focused on the ergonomics of these surgeons.

Funding: None

Faculty Mentor: Cara King, DO

Impact of Highly Restrictive Abortion Bans on the Management of Pregnancies with known Trisomy 13/18: A Cost-effective Analysis – IRB 23-690



Kirat Sandhu, MD

Objective: To assess institutional data regarding T13 and T18 including probability of pregnancy termination, stillbirth, livebirth and utilization of neonatal ICU care prior to and after the Dobbs decision at Cleveland Clinic. To assess the cost in healthcare expenditure of restrictive abortion bans on pregnancies with known trisomy 13 compared to states with legal access to abortion for fetal anomalies.

Methods: The estimated prevalence of outcomes and costs were obtained through the medical literature and Cleveland Clinic institutional data. Decision analytic model using TreeAge Software (Williamstown, MA) compared pregnancies affected by Trisomy 13 in two different hypothetical regions, one with no access to pregnancy termination and another with access to pregnancy termination. Important assumptions in the model include base-case maternal age 35, neonatal intensive care provided for all neonates not planning for palliative care. Strategies compared using a primary outcome of incremental cost/livebirth and cost/stillbirth prevented.

Results: In the base case, access to termination was less costly (\$20,216 vs \$63,103) and resulted in fewer stillbirths than restricted abortion access and was the choice strategy. The model was most sensitive to cost of stillbirth and probability of livebirth. Abortion restriction costs \$116,998 per case of stillbirth avoided. In sensitivity analysis, there was no threshold for stillbirth risk at which restricting access becomes cost saving. With the assumed T13 prevalence and national birth rate, access to termination would result in 222 fewer stillbirths annually and \$9,520,914 lower costs.

Conclusions: For pregnancies impacted by Trisomy 13 diagnosis in the first or



early second trimester, access to termination as a treatment option would result in fewer stillbirths and less costs.

Funding: None

Faculty Mentor: Maeve Hopkins, MD

Implementation and Impact of the Early Pregnancy Assessment Clinic at Cleveland Clinic – IRB 23-662




Dominic Sandler, MD

Objective: We aimed to evaluate selected implementation outcomes of the Pregnancy Early Assessment Clinic (PEAC) at OGI using the validated REAIM and PRISM Frameworks in order to understand and describe PEAC implementation at CCF.

Methods: We retrospectively queried the electronic medical record (EMR) to identify characteristics of PEAC participants and to assess the reach of PEAC in 2022. All patients with emergency department encounters with ICD10 codes for early pregnancy complications from CCF northeast Ohio locations were identified. Patients were classified as PEAC participants vs non-participants. Variables queried included age, race, insurance provider, diagnosis, and management, including misoprostol, mifepristone, methotrexate, uterine aspiration, dilation and curettage, and laparoscopy. We also queried location of intervention for surgical treatments. A separate cohort of all PEAC participants and PEAC encounters were identified to examine follow-up timing, ultrasound frequency, referral diagnosis, and billing.

Results: We identified 2196 patients meeting the ED inclusion criteria. 23% received a PEAC referral, and 12% would ultimately follow with PEAC. Of the 2196, 22% received intervention: 48% medical intervention, 52% surgical intervention. Within medical interventions, 20% received methotrexate, and 80% received misoprostol. Of those receiving misoprostol, 10% received mifepristone in combination. Within surgical interventions, 91% received uterine evacuation (MVA, D&C), while 9% required laparoscopy. We plan to compare demographic characteristics, frequency of treatment strategies implemented, time to treatment from diagnosis, and frequency of ambulatory vs. hospital management for PEAC vs non-PEAC to describe the reach and impact of PEAC. We plan to assess whether





there are demographic disparities in treatment strategies for PEAC vs non-PEAC participants.

Conclusions: We anticipate that we will find that EPAC results in more frequent medical and ambulatory management. The results of this study will provide important evidence from a leading health system that can be used across the country to implement EPACs and to improve the quality of early pregnancy care. The results will also allow us to critically evaluate the performance of our EPAC, develop recommendations for the future, and to assess improvements in the quality of early pregnancy care compared to traditional care at Cleveland Clinic.

Funding: CCF Healthcare Delivery and Implementation Science Center (HDISC) grant

Faculty Mentor: Ashley Brant, DO



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Obstetrics & Gynecology Institute

PGY2 Resident Poster Presentations



IRB 21-1064

Administration of Betamethasone in the Late Preterm Period: Outcomes for Small For Gestational Age (SGA) Infants

Faculty Mentor: Amol Malshe, MD



Megan Ansbro, MD, PhD

IRB 24-272

Rates of Aneuploidy Amongst Patients With Recurrent Pregnancy Loss (RPL) vs Patients without RPL Undergoing *In-Vitro* Fertilization

Faculty Mentor: Jenna Rehmer, MD



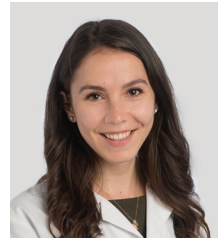
Dana Baraki, MD



IRB 23-775

Response to Immunotherapy with Pembrolizumab and Lenvatinib for Recurrent Endometrial Cancer Stratified by Platinum Free Interval

Faculty Mentor: Lisa Rauh-Benoit MD



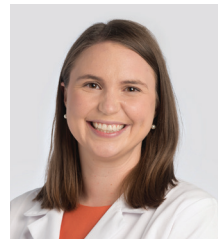
Andreea Dinicu, MD



IRB 22-820

Carbon Footprint of Gynecologic Surgery: How Do We Reduce Our Waste In The Operating Room?

Faculty Mentor: Elliott Richards, MD



Emma Gargus, MD, PhD



IRB 23-498

Obstetric Outcomes Following Previabre Prelabor Rupture of Membranes and The Impact on Subsequent Pregnancies

Faculty Mentor: Amol Malshe, MD

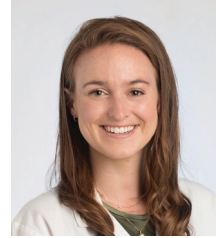


Marissa Hand, MD

IRB 20-273

Assessment of the Five Factor Modified Frailty Index in Predicting Postoperative Complications and Non-Home Discharge in Patients Undergoing Interval Cytoreductive Surgery for Ovarian Cancer

Faculty Mentor: Mariam AlHilli, MD

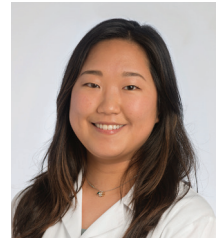


Jennifer Hansen, MD

IRB 21-612

Evaluation of Comprehensive Documentation Following Repair of Obstetric Anal Sphincter Injury

Faculty Mentor: Cecile Ferrando, MD MPH



Sunny Lee, MD



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Obstetrics & Gynecology Institute

Graduating Fellow Oral Presentations

Effect of Surgical Specialty on Management of Endometriomas in Reproductive-Aged Women: A Single Center Review – IRB 23-679



Jensara Clay, MD

Objective: Surgical innovation and trends towards minimally invasive approaches have increased the complexity of gynecologic surgeries, which has impacted gynecologic surgical training. Patients with endometriomas undergo surgical treatment by general OB/GYNS, MIGS fellowship trained surgeons, Reproductive Endocrinology and Infertility specialists, Urogynecologists and Gynecologic Oncologists. The objective of this study was to evaluate the effect of gynecologic surgical training and subspecialty on the surgical route and procedure performed in endometrioma management.

Methods: This is a retrospective cohort review of patients between ages 18-50 who underwent surgical management of a histologically confirmed endometrioma from 2012-2022 at a tertiary care center. ICD and CPT codes were used to identify patients. Surgeon characteristics, patient characteristics, surgical route, procedures performed, and outcomes were reviewed from an electronic medical record system. The results were summarized and compared using two-sample t-tests, Wilcoxon rank sum tests, Pearson chi-square and Fischer's Exact tests, when appropriate.

Results: A total of 194 surgeries were performed. Patients were divided into cystectomy or oophorectomy groups; 142 (73.2 %) patients had a cystectomy and 46 (23.7%) had an oophorectomy. Six patients had both. General OBGYN, MIGS, Gyn Oncology, REI, and Urogynecology performed 18 (9.3%), 94 (48.5%), 19 (9.8%), 92 (32%), and 1 (0.5%) of the procedures, respectively. When Gyn Oncologists performed the procedure, oophorectomy was more likely (74% vs 0-44%) ($p < 0.001$). Between the cystectomy and oophorectomy groups, there was no difference in route of surgery with 90.7% of all procedures performed laparoscopically. Patients who had an oophorectomy were more likely to be older (32.0 ± 6.3 vs 40.3 ± 5.4 years, $p < 0.001$), have had a child and have a concomitant hysterectomy (38.7 vs 63.1%, $p < 0.001$). Complexity of the procedure (defined as moderately complex: excision of endometriosis, ureterolysis, lysis of adhesions; or very complex: bowel resection) did not differ between the groups.

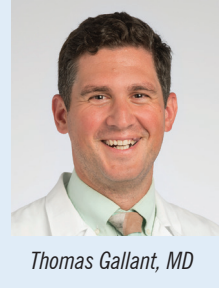


Conclusions: Overall, patients undergoing surgical management of an endometrioma were more likely to undergo a cystectomy. When considering surgeon training, Gynecologic Oncologists were more likely to perform an oophorectomy. Further studies are needed to evaluate the factors that influence the decision to proceed with oophorectomy or cystectomy in the surgical management of endometriomas.

Funding: None

Faculty Mentor: Megan Billow, DO

Patient-Reported Outcome Measures Used in Randomized Controlled Trials Following Surgical Intervention for Endometriosis



Thomas Gallant, MD

Objective: No consensus currently exists regarding patient-reported outcome measure (PROM) instruments. This structured review was conducted to identify the PROMs used by randomized controlled trials (RCTs) that evaluated surgical treatment in patients with endometriosis.

Methods: During the title and abstract screening and reference check, 600 results were identified on PROMs relating to QoL and 465 studies on PROMs relating to pain and sexual, bowel, and/or bladder function and an evaluation of 17 and 12 studies conducted, respectively. The inclusion criteria involved selecting RCTs that focused on surgical intervention and assessing QoL, pain, and sexual, bowel, and/or bladder function using PROMs.

Results: A total of 19 studies were identified involving 2089 participants and a total of 16 PROMs used across the studies; 9 of 19 studies (47%) were rated as having a low risk of bias. There were no high-risk studies identified in this review. This study identified a large number of RCTs in surgical treatment of endometriosis that used various PROMs to assess QoL, pain, and bladder, bowel, and sexual function.

Conclusions: The PROMs used by high-quality RCTs for QoL include Endometriosis Health Profile-30, Endometriosis Health Profile-5, Short-Form 36, Short-Form 12, and EQ-5D; for bowel-related symptoms Knowles-Eccersley-Scott-Symptom Questionnaire, Gastrointestinal Quality of Life Index, and Cleveland Clinic Fecal Incontinence Severity Scoring System/Wexner; for bladder-related function Bristol Female Lower Urinary Tract Symptoms, International Prostate Symptom Score, Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire, and



Urinary Symptom Profile; and finally for sexual function Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire and Sexual Activity Questionnaire. Unlike other domains, only one tool (visual analog scale) was the dominant PROM used for the assessment of pain. In addition, the use of more than one PROM in each study to assess different aspects of patient's health and pain symptoms did not become prevalent until after 2015.

Funding: None

Faculty Mentor: Miguel Luna-Russo, MD

Factors Influencing Surgical Approach in Women with Stress Urinary Incontinence – IRB 23-408



Amy Gee, MD

Objective: To determine procedure-specific factors that influence patient decision-making when choosing treatment for stress urinary incontinence (SUI).

Methods: This is a cross-sectional survey study evaluating factors that affect a patient's decision to proceed with either midurethral sling (MUS) or urethral bulking (UB) for treatment of SUI. Patients were invited to complete an anonymous survey if they reported bothersome SUI on routine screening questionnaire. A convenience sample of 100 patients from an academic urogynecology clinic completed a structured survey assessing various factors related to undergoing a procedure for SUI.

Results: 100 surveys were analyzed. Patients had a mean age of 57.1 [±] 13.6 years. 85 patients were white, 47 were employed full-time, and 50 patients had received a bachelor's degree or higher. A total of 33 and 9 patients were familiar with MUS and UB, respectively. Of the 33 patients familiar with MUS, 25 (75.8%) had either negative or unsure feelings about the procedure. In contrast, 4 patients out of 9 (44.4%) reported similar feelings for UB. The top three influential factors were procedure success rate (72%), amount of research available on procedure (52%), and chance of needing retreatment for SUI (34%). UB was favored in almost every procedure-specific category (wait time, pain medications, days off work, need for anesthesia, chance of catheter, and risk of abnormal voiding and/or mesh exposure); however, MUS was favored in the categories of amount of research performed on the intervention and known research outcomes. At the end of the survey, 51 patients responded that they were more likely to choose a MUS

as their intervention of choice, while 39 were more likely to undergo UB, and 10 were equally as likely to undergo either procedure. Patients in all three response groups did not differ in age, race, employment status or education. In patients that preferred MUS, the top three influential factors were amount of research on procedure (66.7%), chance of needing retreatment for SUI (35.3%), and procedure location (such as operating room or clinic) (21.6%).

Conclusions: Understanding patient factors when addressing treatment for SUI is essential for effective shared decision-making and overall patient outcomes and satisfaction.

Funding: None

Faculty Mentor: Cecile Ferrando, MD, MPH

Divergent Evolutionary Response to Multiple Fractions of Radiation (MF2) Therapy in Cervical Cancer Cell Lines (CCCL)



Johannah Kelley, MD

Objective: To explore the potential for differential evolutionary trajectories of radiation (RT) resistance throughout treatment using two in vitro models.

Methods: Sixteen CCCL were exposed to 1.8 Gy fractions of RT for five sequential days and the surviving fraction (MF2) calculated. Differential gene expression (DGE) was performed on pre treatment samples. Partial least squares (PLS) regression was completed with MF2 as the endpoint. Protein-protein interaction (PPI) network and overrepresentation analysis of genes was also performed. Four CCCL (BOKU, SKG II SF, ME180, and HeLa) were serially exposed to 50 Gy of gamma RT given in 2Gy fractions. Five evolutionary replicates and three passage-controls were maintained. The mean integral survival as a function of dose (AUC) was calculated and ANOVA analysis performed.

Results: MF2 as the phenotypic endpoint identified 19 DE genes. PLS identified histones (H4C8, H2BC18, H2BC4) as positively associated and transcriptional regulators (NR2F1, KALRN) as negatively associated with MF2 (1A). PPI and Reactome Pathways also highlighted histone deacetylase pathways, nucleosome assembly and regulation of membrane potentials (1B). Longitudinal RT identified differential evolutionary trajectories between CCCL replicates. Two BOKU ($p =$

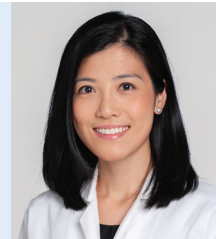
0.005 and 0.0090), one SKG II SF ($p = 0.0146$), and one ME180 ($p = 0.0384$) replicates became resistant. Four SKG II SF ($p < 0.0001$), and two HeLa ($p = 0.0005$ and $p = 0.0068$) became more sensitive to RT (1C).

Conclusions: Divergent evolutionary trajectories under therapeutic stress can be elicited using in vitro evolutionary experimentation with CCCL. Genomic correlation with divergent evolutionary trajectories may allow for the identification of real-time markers of resistance or sensitivity and allow for true RT personalization.

Funding source: Velosano Dream Trainee Grant

Faculty Mentor: Roberto Vargas, MD

Are Virtual Visits for Delivery of Postoperative Care Following Urogynecologic Surgery Equal to Office Visits? The VIDEO Randomized Trial – IRB 22-1269



Lannah Lua-Mailland, MD

Objective: To compare patient satisfaction, healthcare resource utilization, and adverse events among patients receiving a virtual-video versus in-office postoperative visit following urogynecologic surgery. We hypothesized that virtual-video visits would be noninferior to in-office visits.

Methods: This was a single-center randomized noninferiority clinical trial of patients undergoing surgery for pelvic organ prolapse and/or urinary incontinence from January 2023 to November 2023. Participants were randomized to receive either a virtual-video postoperative visit or standard in-office postoperative visit. The primary outcome was patient satisfaction, which was measured using the validated Patient Satisfaction Questionnaire-18 (PSQ-18). This questionnaire was completed at the scheduled 6-week postoperative visit. The noninferiority margin was 5 points for PSQ-18 total score and 0.5 points for PSQ-18 domain scores for general satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with doctor, and accessibility and convenience. Secondary outcomes included composite rates of healthcare utilization and adverse events after the 6-week postoperative visit up to 12 weeks after surgery, with a noninferiority margin of 10% absolute.



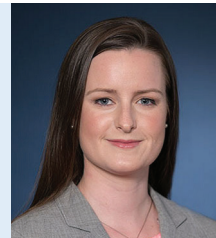
Results: Of the 265 patients approached, 104 were randomized and 100 (50 per arm) completed the study. The mean (SD) age was 57.0 (13.2) years. The mean (SD) PSQ-18 total score was 75.18 (8.15) in the virtual group vs 75.14 (8.7) in the in-office group. The mean PSQ-18 total score was 0.04 points higher (i.e., greater degree of satisfaction) in the virtual group, with 95% CI -2.75 to 2.83, which met criterion for noninferiority ($P=.002$). Between-group differences for all PSQ-18 domain scores likewise met criterion for noninferiority ($P<.05$ for all). The composite healthcare utilization rate was 14% lower in the virtual group than the in-office group (20% vs 34%, 95% CI -28% to 1%, $P=.004$). For composite adverse event rates, the between-group difference was 2% (2% in virtual vs 0% in in-office, 95% CI -3% to 8%, $P=.03$). There were no Clavien-Dindo grade ≥ 3 complications during the follow-up period.

Conclusions: This trial validates telehealth use in the postoperative setting. Clinicians can use these findings to provide evidence-based recommendations about the safety and feasibility of virtual-video visits for follow-up after urogynecologic surgery while ensuring that surgical quality of care is maintained.

Funding: Research Program Committees Grant (RPC 6265)

Faculty Mentor: Cecile Ferrando, MD MPH

The Experience of Intended Parents During the Egg Donor-Recipient Matching Process – IRB 23-550



Bailey McGuinness, MD

Objective: To provide evidence that egg donor recipients' preferred donor race, ethnicity, and religion at the Cleveland Clinic Fertility Center (CCFC) are indicators of barriers to obtaining donor eggs and that such barriers impact patient satisfaction.

Methods: A survey study of recipients of donor eggs at CCFC was created and pilot tested. The survey was then modified as needed for field testing. Participants must have created embryos using donor eggs at CCFC between January 2015 and July 2022, speak English, be at least 18 years of age, and consent to participate in the study. Patients who adopted embryos previously created with donor eggs were excluded. Two groups were examined: 1.) patients who sought a non-white or Jewish donor and 2.) patients who sought a white or non-Jewish donor or who had no preference. Patients were compensated for their participation. All analyses



were done using SAS and $p < 0.05$ was considered statistically significant.

Results: 0=287 patients were identified as potentially eligible for the field study. 108 patients (37.6%) completed the survey. 16 patients were in Group 1, and 92 patients were in Group 2. Patients in Group 1 were more likely to:

- describe egg donor agencies/banks as not have candidates with the preferred characteristics ($p < 0.001$).
- match with a donor without the preferred characteristics ($p < 0.001$).
- be unsatisfied by the final characteristics of their chosen donor ($p = 0.008$).
- describe feeling pressured to compromise their preferences for donor race, ethnicity, or religion in order to obtain donor eggs to achieve pregnancy ($p = 0.044$).

Conclusions: Barriers may result in certain groups of intended parents compromising their preferences for donor characteristics in order to obtain donor eggs to achieve pregnancy. Barriers to obtaining donor eggs may be evidenced by 1.) the availability of donor candidates with preferred racial, ethnic, and religious characteristics, 2.) the inability to match with a donor of the recipient's preferred race, ethnicity, or religion, and 3.) the perceived pressure on recipients to compromise their stated preferred donor characteristics to obtain donor eggs. Obtaining donor eggs without, rather than with, the preferred racial, ethnic, or religious characteristic results in lower patient satisfaction.

Funding: The Falcone Fund

Faculty Mentor: Ruth Farrell, MD, MA


HSD3B1 Polymorphisms and Spontaneous Preterm Birth – IRB 22-778



Justin Moore, MD

Objective: To evaluate placental expression of HSD3B1 variant 1245C and its associated with protection from preterm birth that is suspected to be from increased production of progesterone.

Methods: A Retrospective cohort study was performed with DNA extracted from 166 paraffin embedded placental cord segments from patients that had spontaneous preterm birth (<37 weeks). This group was compared to DNA from 186 fresh cord segments collected from term (>37 weeks) deliveries. These patients



met strict inclusion criteria: Age 18-35, Nulliparity, BMI 18.5 – 39.9, Anatomical survey without major anomalies, and pregnancy dating prior to 28 weeks. The exclusion criteria was extensive and briefly summarized as medically indicated induction or for maternal or fetal indication or any substantial maternal medical history. A list of some criteria follows; cardiopulmonary, hepatorenal, significant endocrine disorders, autoimmune, connective tissue disorders, uterine anomalies, IUFD, drug or tobacco use during pregnancy, multiple gestation, IVF, COVID-19, severe FGR, and recent trauma. This would help distinguish a true phenotypic influence that the 1245C allele has on preterm birth. The group was further divided into self-reported race; black or white and the spontaneous preterm group was further divided in 50% late preterm birth (34 week to 36 weeks and 6 days) as well as 50% before 34 weeks. Genotyping was then performed on all available samples within the two groups and compared against preterm birth and neonatal outcomes.

Results: Results are still being analyzed.

Conclusions: We hypothesize that women with the 1245C allele which creates a gain of function mutation in 3BHSD1 enzyme found within the placental trophoblastic cells will lead to an increase in downstream hormones which include progesterone. This increase in progesterone is suspected to be protective of preterm birth and therefore those with the expressed allele 1245C will have a longer gestational period than those without.



Funding: None



Faculty Mentor: Edward Chien, MD, MBA





2023

Resident, Fellow and Faculty Publications

Obstetrics and Gynecology

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