AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY

RITZ-CARLTON WASHINGTON, D.C.
WASHINGTON, D.C.
SEPTEMBER 13 - 15, 2012
PROGRAM

of the

THIRTY-FIRST ANNUAL MEETING

of the

AMERICAN GYNECOLOGICAL

and

OBSTETRICAL SOCIETY
AGOS President
2011 - 2012
Mary E. D’Alton, MD
New York, New York
THE AMERICAN GYNECOLOGICAL
AND
OBSTETRICAL SOCIETY

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Mary D’Alton, MD
The Fellows of the American Gynecological and Obstetrical Society

Welcome All Spouses, Significant Others and Guests to the Thirty-First Annual Meeting
SOCIAL AND EDUCATIONAL EVENTS

THURSDAY, SEPTEMBER 13, 2012

*****

BREAKFAST SOCIAL
9:00 a.m. - 10:30 a.m. • The Plaza Ballroom
Welcoming Reception for Spouses and Significant Others of Members and Guests

CHARLES HUNTER PRIZE THESIS
8:00 a.m. - 8:45 a.m. • Salon I/II
N. Scott Adzick, MD
Philadelphia, Pennsylvania
“Fetal Surgery for Myelomenigocele: Trials and Tribulations”

JOSEPH PRICE ORATION
12:15 p.m. - 1:00 p.m. • Salon I/II
Diana Bianchi, MD
Boston, Massachusetts
“The “Up” Side of Down Syndrome: Safer Prenatal Screening and Novel Therapeutics for Affected Individuals”

WELCOME RECEPTION
6:00 p.m. - 7:30 p.m. • Plaza I, II, IIIA
FRIDAY, SEPTEMBER 14, 2012

*****

PRESIDENTIAL ADDRESS
12:00 p.m. - 1:00 p.m. • Salon I/II
Mary E. D’Alton, MD
“Putting the “M” Back into Maternal Fetal Medicine”

PRESIDENT’S RECEPTION
6:00 p.m. - 7:30 p.m.
Ritz Carlton Ballroom Foyer

SATURDAY, SEPTEMBER 15, 2012

*****

PRESIDENT’S SPECIAL GUEST LECTURER
9:00 a.m. - 10:00 a.m. • Salon I/II
Cecile Richards
President of Planned Parenthood Federation of America
and Planned Parenthood Action Fund

All Members, Spouse, Significant Others and Guests
are Invited to All Social Events
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Registration in the Salon I/II Foyer
6:30 a.m. – 1:00 p.m.

6:30 a.m.  CONTINENTAL BREAKFAST
Salon I/II Foyer

7:45 a.m.  ASSEMBLY AND WELCOME
Mary E. D’Alton, MD - AGOS President
   In Memoriam
   Welcome of New Fellows
   Welcome from the Secretary

FIRST SCIENTIFIC SESSION

8:00 a.m.  Charles A. Hunter Prize Thesis
“Fetal Surgery for Myelomenigocele: Trials and Tribulations”
   N. Scott Adzick, MD
   The Children’s Hospital of Philadelphia
   Philadelphia, PA

8:45 a.m.  AAOGF Career Speaker
“Personalized Genomic Cancer Medicine: Holy Grail or False Hope?”
   Andrew Berchuck, MD
   Duke University Medical Center
   Durham, NC

9:30 a.m.  “Update on Micro Array: The Times they are a Changin’”
   Ronald Wapner, MD
   Columbia University
   New York, NY

10:00 a.m.  Break
10:30 a.m.  Panel Presentation: “NICHD: Highlighting the 50th Anniversary”
    Alan E. Guttmacher, MD
    NICHD/NIH
    Bethesda, MD
    Catherine Spong, MD
    NICHD/NIH
    Bethesda, MD
    Alan DeCherney, MD
    NICHD/NIH
    Bethesda, MD
    James Segars, MD
    NICHD/NIH
    Bethesda, MD

12:15 p.m.  Joseph Price Oration
    “The “Up” Side of Down Syndrome: Safer Screening and Novel Therapeutics for Affected Prenatal Individuals”
    Diana Bianchi, MD
    Tufts University School of Medicine
    Boston, MA
FRIDAY, SEPTEMBER 14, 2012

Registration in the Salon I/II Foyer
6:30 a.m. – 1:00 p.m.

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<td>Salon I/II Foyer</td>
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<td>7:30 a.m.</td>
<td>AGOS Annual Business Meeting</td>
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<td>AAOGF Annual Business Meeting</td>
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<td><strong>SECOND SCIENTIFIC SESSION</strong></td>
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<td>“What’s New in Reproductive Endocrinology and Infertility”</td>
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<td>Rogerio Lobo, MD</td>
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<td>Columbia University</td>
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<td>New York, NY</td>
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<td>AAOGF/ABOG Endowment Scholar Lecture:</td>
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<td>“Excitotoxicity as a Mechanism of Fetal Cortical Brain Injury with Intrauterine Inflammation”</td>
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<td>Irina Bird, MD</td>
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<td>The Johns Hopkins Hospital</td>
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<td>Baltimore, MD</td>
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<td>9:30 a.m.</td>
<td>AAOGF/SMFM Endowment Scholar Lecture:</td>
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<td>“Soluble Toll-Like Receptor Extracellular Adaptor Proteins Actively Participate In Modulating the Bacterial Intra-Amniotic Inflammatory Response”</td>
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<td>Antonette Dulay, MD</td>
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<td>Yale Medical Group</td>
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<td>New Haven, CT</td>
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Ingrid Nygaard, MD
University Healthcare
Salt Lake City, UT

John DeLancey, MD
University of Michigan
Ann Arbor, MI

Matthew Barber, MD
Cleveland Clinic
Cleveland, OH

Charles Nager, MD
University of California, San Diego
La Jolla, CA

Holly Richter, MD
University of Alabama at Birmingham
Birmingham, AL

Deborah Myers, MD
Women and Infants’ Hospital of
Rhode Island
Providence, RI

Dee Fenner, MD
University of Michigan
Ann Arbor, MI

Linda Brubaker, MD
Loyola University Medical Center
Maywood, IL

12:00 p.m. Presidential Address: “Putting the “M” Back into Maternal Fetal Medicine”
Mary E. D’Alton, MD
New York, NY
PRESIDENTIAL ADDRESS

Friday, September 14, 2012
Salon I/II
12:00 p.m. - 1:00 p.m.

Mary E. D’Alton, MD
Columbia University
New York, NY

“Putting the “M” Back into Maternal Fetal Medicine”

All Members, Spouses, Significant Others and Guests are Invited to Attend
SATURDAY, SEPTEMBER 15, 2012

Registration in the Salon I/II Foyer
7:00 a.m. – 12:00 p.m.

7:00 a.m.  Continental Breakfast
           Salon I/II Foyer

THIRD SCIENTIFIC SESSION

8:00 a.m.  “Update on ABOG/ACOG”
           Larry Gilstrap, MD
           American Board of Obstetrics
           and Gynecology
           Dallas, TX

           Hal Lawrence, MD
           American College of Obstetrics
           and Gynecology
           Washington, DC

9:00 a.m.  President’s Invited Guest Lecturer
           Cecile Richards
           President of Planned Parenthood
           Federation of America and
           Planned Parenthood Action Fund
           New York, NY

10:00 a.m. Break

10:15 a.m. Panel Presentation: “Update on Robotics in
           Gynecologic Surgery; How are We to Train our
           Future Surgeons?”
           Jeffrey Fowler, MD
           The Ohio State University College of
           Medicine and Public Health
           Columbus, OH
Arnold Advincula, MD, FACOG, FACS
Center for Specialized Gynecology
Celebration, FL

Lee Learman, MD, PhD
Indiana University School of Medicine
Indianapolis, IN

John Lenihan, MD
MultiCare Tacoma Women’s Specialists
Tacoma, WA

11:45 a.m. Adjournment
Abstracts
Myelomeningocele (MMC), one of the most common congenital malformations, can result in severe lifelong disabilities, including paraplegia, hydrocephalus, Chiari II malformation, bowel and bladder dysfunction, skeletal deformations, and neurocognitive impairment. Experimental studies provide compelling evidence that the neurological deficits associated with MMC are not simply caused by incomplete neurulation but rather by the prolonged exposure of the vulnerable neural elements to the intrauterine environment. MMC is the first non-lethal anomaly considered for fetal surgical intervention, necessitating a careful analysis of risks and benefits. Retrospective studies and the NIH-sponsored prospective randomized Management of Myelomeningocele Study (MOMS) suggest that fetal surgery for MMC before 26 weeks gestation may preserve neuromotor function, reverse hindbrain herniation, and reduce the need for ventriculoperitoneal shunting. However, these studies also demonstrate that fetal surgery is associated with significant maternal and fetal risks. The facets of the MOMS trial and the follow up MOMS II study will be presented. Research is underway to further elucidate the pathophysiology of MMC, to define the ideal timing and technique of fetal repair, and to evaluate the long-term implications of prenatal intervention.
Genomic approaches enable dissection of ovarian cancer at a molecular level, and there is excitement about translating this knowledge into personalized approaches to prevention and treatment. However, genomic research has pitfalls as well as promise, including the potential for false-discovery and premature implementation.

The discovery of the BRCA1/2 susceptibility genes was the first major step towards personalized ovarian cancer prevention. Common low penetrance single nucleotide polymorphisms (SNPs) also may affect risk. The lack of robustness of associations with SNPs in candidate genes in the North Carolina Ovarian Cancer study and others led to the formation of the Ovarian Cancer Association Consortium (OCAC). Genome wide association studies performed by OCAC have identified a dozen SNPs that affect ovarian cancer risk by about 10-25% per risk allele. SNPs and epidemiological risk factors have the potential to further advance the utility of risk stratification and prevention.

Microarrays have been developed that can measure expression of thousands of genes in a cancer. Patterns of gene expression associated with clinical phenotypes have
been reported in ovarian and other cancers. However, these large data sets have proven fertile ground for false-discovery, both well intended and not so well intentioned.

Mutations that drive cancer growth have been targeted successfully in some types of cancers, but not in ovarian cancer. The Cancer Genome Atlas project has comprehensively catalogued the mutational spectrum of high grade serous ovarian cancer, and this may aid ongoing efforts to develop personalized therapies. Meanwhile, it is becoming increasingly affordable to sequence whole cancer genomes in search of targets, but the value of this strategy remains unproven.

Development of personalized ovarian cancer treatment and prevention remains the holy grail. Because genomics has led to both useful advances and false hopes, it is critical that new discoveries undergo extensive scrutiny and validation prior to clinical implementation.
New genetic technologies have quickly entered obstetrical care providing an ever-increasing amount of information about the fetus. Less than 5 years ago, karyotyping was the predominant tool for genetic evaluation of the fetus and was used predominately for aneuploidy detection and the identification of relatively large genomic changes of 7-10 million base pairs or larger. More recently, microarray technology has been introduced into prenatal evaluation and has the ability to identify much smaller genomic changes (microdeletions and duplications). With this increased resolution has come the knowledge that smaller findings also have significant clinical implications and are not infrequent in routine prenatal testing. In the near future sequencing of the fetus will be clinically available so that single base pair changes will be detectable. Already, we can screen couples for the carrier state of over 100 Mendelian Disorders and two recent publications have described non-invasive sequencing of the entire fetal genome from a maternal blood sample.

This genetic knowledge has allowed improved counseling for pregnancies identified with fetal structural anomalies in which approximately 6% of such cases with a normal karyotype will have a genomic cause identified by microarray testing. Approximately 1% or more of
structurally normal pregnancies also have clinically relevant genomic findings suggesting that all pregnant couples should consider invasive testing with microarray analysis.

This increasing ability to evaluate the fetal genome comes with significant responsibility for clinicians. These technologic advances have rapidly outpaced our ability to thoughtfully and appropriately use the information. Pretest and post-test counseling must be adapted so they are informative, prepare patients for the reproductive decisions they must make, and still be able to be accomplished within a feasible and timely period. How we use this information falls well within the realm of the obstetrical community and we need to be a vital part of the ongoing conversation.
Panel Presentation:
“NICHD: Highlighting the 50th Anniversary”

Alan E. Guttmacher, MD, Alan DeCherney, MD, James Segars, MD, Catherine Spong, MD
National Institute of Child Health & Human Development
Bethesda, Maryland

At the urging of his sister, Eunice Kennedy Shriver, President John F. Kennedy founded the National Institute of Child Health and Human Development in 1962, “to support the world’s best minds in investigating human development throughout the entire life process, focusing on understanding developmental disabilities, including intellectual and developmental disabilities, and illuminating important events that occur during pregnancy.” Over the ensuing 50 years, the Institute has supported numerous discoveries that enhance our understanding of health and disease throughout development. In this group of presentations we will provide an overview of the Institute’s accomplishments in the first 50 years and plans for the future. The NICHD’s mission, budget, funding mechanisms and opportunities in both its intramural and extramural components will be described. NICHD accomplishments will be highlighted across the spectrum of conditions of interest to AGOS membership, including research in contraception, reproductive endocrinology and infertility, urogynecology, gynecology, maternal fetal medicine, and obstetrics. This will include accomplishments that have changed practice and those fundamental to understanding disease mechanism in obstetrics and gynecology. Integral
to the NICHD mission, the development and success of NICHD training programs (BIRCH, WRHR, RSDP, LRP) and their importance to academic Ob/Gyn department will be described. The NICHD’s scientific visioning process of 2011 and plans for the future will be outlined, including scientific areas of interest, plans for training physician scientists, the culture of science, research networks, and the National Children’s Study. Following these presentations, a panel including NICHD staff who are AGOS members, will answer questions and provide additional insight into the NICHD and research funding.
Joseph Price Oration

“The “Up” Side of Down Syndrome: Safer Screening and Novel Therapeutics for Affected Prenatal Individuals”

Diana Bianchi, MD
Tufts University School of Medicine
Boston, Massachusetts

The American College of Obstetrics and Gynecology (ACOG) recommends offering prenatal diagnosis for Down syndrome to all pregnant women. Current screening algorithms involve measurement of maternal serum analytes and the fetal nuchal translucency by sonography. Screen positive results are then followed by invasive procedures to definitively determine the fetal karyotype. In October 2011 noninvasive prenatal testing (NIPT) using massively parallel sequencing of maternal plasma cell-free DNA was first offered on a clinical basis in the United States. Since then, over 10,000 tests have been performed domestically, and clinical experience is accruing with regard to the “real world” sensitivity and specificity of NIPT. It is currently under debate as to when and how to integrate this type of state-of-the-art genetic testing into clinical practice. Most providers, including genetic counselors, are offering NIPT as a secondary screen to high-risk women as an alternative to an invasive procedure. This has already resulted in a decrease in the number of such procedures, with a reduced incidence of procedure-related loss. In parallel, analyses of the gene expression profiles of second trimester fetuses that have Down syndrome compared with
euploid fetuses of the same gestational age have shown that oxidative stress is a prominent feature of the fetal phenotype. Our laboratory hypothesizes that it is possible to use the fetal transcriptome, derived from cell-free RNA in amniotic fluid, to develop novel therapeutics for affected fetuses. We are treating pregnant wild-type mice carrying pups with a model of Down syndrome with FDA-approved antioxidants to determine if antenatal treatment improves learning and memory. This work, if successful, will potentially lead to fetal personalized medicine for a variety of different conditions.
In 2012, data presented suggested that there have been 5 million births worldwide from IVF and ICSI, confirming the efficacy of this technology. While long-term safety issues remain a matter of debate, most recent data have been reassuring for both IVF and the use of ICSI. In IVF, recent data are beginning to suggest that PGS for aneuploidy using microarray technology rather than FISH may be able to increase the pregnancy rates and decrease the loss rate, particularly in older women. Becoming more routine in IVF cycles is the use of antagonists as well as the prospect of virtually eliminating all cases of severe Ovarian Hyperstimulation Syndrome by using a GnRH trigger.

Recent data have suggested the existence of stem cells in both testes and the ovary which may be able to replenish the population of sperm cells and oocytes respectively. While the issue of stem cells in the testis may be more established, the finding of stem cells which may lead to oocyte formation remains more controversial.

Now 10 years after the initial publication of WHI, a clearer and greater understanding of the use of hormones in women at the onset of the menopause has emerged and has been endorsed by major societies. This year also heralds the emergence of new prospective randomized data on the treatment of early menopausal women, namely KEEPS, ELITE and the Danish Osteoporosis Prevention study.
AAOGF/ABOG Endowment Scholar Lecture

“Excitotoxicity as a Mechanism of Fetal Cortical Brain Injury with Intrauterine Inflammation”

Irina Bird, MD
The Johns Hopkins Hospital
Baltimore, Maryland

Irina Burd, MD, PhD, 1, 2 Kirstin Leitner, MD, 3
Michael McLane, MS, 3 Wance Firdaus, PhD, 1
Michael Johnston, MD, 2 Michal Elovitz, MD 3

1Johns Hopkins Medicine, Department of Gynecology and Obstetrics, Baltimore, MD, 2Johns Hopkins Medicine, Department of Neurology, Baltimore, MD, 3Perelman School of Medicine, Department of Obstetrics and Gynecology, Philadelphia, PA

Introduction: Intrauterine inflammation has been linked to a spectrum of adverse neurological outcomes, including cerebral palsy. Using mouse model of inflammation-induced preterm birth (IIPTB), we have demonstrated that there is a marked elevation of IL1β in fetal brain and perturbations in neuronal morphology. The precise mechanisms by which perinatal brain injury occurs in IIPTB remain unknown. We sought to assess whether fetal neuronal damage in IIPTB occurs as a result of excitotoxicity; being initiated by increase in IL1β and propagated through activation of excitotoxic receptors (NMDA-R).
Methods: 1) To investigate pathways associated with excitotoxic injury: lipopolysaccharide (LPS) or normal saline (NS) were injected intrauterine; 2) To investigate if MK801 (MK), NMDA-R antagonist, could prevent injury, these groups were compared: a) NS+NS; b) NS+MK; c) LPS+NS; d) LPS+MK; 3) To investigate whether IL1–receptor antagonist (ILA) would prevent injury, these groups were compared: a) NS+NS; b) NS+LPS; c) ILA+LPS. Fetal brains (FB) were processed for whole brain analysis, or primary fetal neuronal cultures. Rates of PTB and growth were evaluated. Neuronal and neurobehavioral markers were assessed using QPCR, ELISA, Western blot and IHC.

Results: 1) In LPS-exposed FB, there was an increase in nNOS activity (p<0.05). In vitro, exposure to LPS resulted in increased glutamate (p<0.05) and NO (p<0.05), and delayed neurotoxicity (p<0.05). 2) In LPS+MK group, MK resulted in decreased NO (p<0.05) and delayed neurotoxicity was prevented (p<0.05). LPS+MK group did not result in altered cytokine response (p>0.05). 3) While ILA did not prevent IIPTB (p>0.05), postnatal levels of neuronal and neurobehavioral markers in cortex were similar to control (p>0.05). Cerebellar levels of neuronal and neurobehavioral markers remained elevated (p<0.05).

Conclusion: IIPTB activates fetal pathways known to be involved in excitotoxicity. Maternal administration of NMDA-R antagonist ameliorates these neurotoxic changes. Maternally administered IL1-receptor antagonist, prior to intrauterine inflammation, appears to prevent neonatal brain injury in a region specific manner but not preterm birth. These studies provide evidence that fetal brain injury and preterm birth, in response to intrauterine inflammation, may involve divergent pathways.
OBJECTIVE: Activation of innate immune pathways is a key defense mechanism in intra-amniotic infection. When properly controlled, the inflammatory response is beneficial to the host, but when deficient or exaggerated becomes detrimental, and associated with high perinatal morbidity. Toll-like receptors (TLRs), TLR-2 and TLR-4, are key operative innate immune response sensors against Gram-positive and Gram-negative organisms, respectively. Expression of TLR-2 and TLR-4 at the maternal-fetal interface is well-characterized in pregnancy. Yet, their expression level alone cannot account for the substantial diverse inflammatory response that follows microbial invasion. Both receptors have associated extracellular adaptor proteins that serve to modulate their activity following sensing of bacterial pathogens. For TLR-2, a critical role is played by soluble TLR-2 (sTLR2). Myeloid differentiation factor (MD)2, soluble MD2 (sMD2), LPS Binding Protein (LBP), and CD14, are vital adaptor proteins for TLR-4. We postulate that the extent to which TLR-2 and TLR-4 receptor activation generates an intra-amniotic immune response is highly dependent upon the presence, level of expression and molecular function of these proteins in human amniotic fluid (AF).
STUDY DESIGN: We conducted our research by investigating human AF retrieved from singleton gestations with normal outcomes (2nd trim. genetic karyotyping; 3rd trim. lung maturity). AF from women with preterm labor symptoms, who had an amniocentesis to rule-out infection and either delivered preterm or term, was analyzed based on microbial cultures, and Gram stain results. Tissue expression level of the TLR adaptor proteins was investigated using quantitative real-time PCR, Western-blotting and immunohistochemistry (IHC). The functional relevance of the adaptor proteins was demonstrated by employing placental villous, amniochorion explant, and HEK-293 Blue-4 cell line systems. Explant medium and AF cytokines (IL-6, IL-8, TNF-α) were quantified by ELISA. Incubation experiments were conducted in the presence of recombinant protein, specific synthetic ligand, and/or human AF. Specificity of the response was confirmed with neutralizing peptides. Synthesis and post-translational protein processing mechanisms were evaluated in the presence of specific inhibitors. Genetically engineered animals (C57B/6 WT +/+, TLR4 -/-, TLR2 -/-, MD2 -/-) were used to interrogate the functional relevance of TLRs and their adaptor proteins, in-vivo.

RESULTS: 1) TLR-2 and TLR-4 extracellular adaptor proteins are present in AF and exhibit gestational age and microbial type regulation; 2) Human AF displays various cytokine type responses that seem to be dependent on TLR2 and MD2 tissue expression level; 3) There are significant differences in the mRNA and IHC tissue expression pattern of TLR2 (syncytiotrophoblast) and MD2 (amniochorion); 4) In-vitro, sTLR2 displays a predominant inhibitory inflammatory response while sMD2 exhibits a stimulatory cytokine effect; 5) AF sTLR2 and sMD2 synthesis is post-translational regulated; 5) In-vivo, TLRs and MD2 deletion carries important preterm birth, fetal viability and end-organ status effects.
CONCLUSION: We provide evidence that TLR adaptor proteins are central components of an intra-amniotic inflammatory innate immune response to infection.
Panel Presentation:
“Where Have We Meshed Up?
Uro-Gynecological Panel”

1Ingrid Nygaard, MD, 2John DeLancey, MD,
3Matthew Barber, MD, 4Charles Nager, MD,
5Holly Richter, MD, 6Deborah Myers, MD,
2Dee Fenner, MD, 7Linda Brubaker, MD

1University Healthcare, Salt Lake City, UT, 2University of
Michigan, Ann Arbor, MI, 3Cleveland Clinic, Cleveland
OH, 4University of California, San Diego, La Jolla, CA,
5University of Alabama at Birmingham, Birmingham, AL,
6Women and Infants’ Hospital of Rhode Island, Providence,
RI, 7Loyola University Medical Center, Maywood IL

The FDA announcements in July and September 2011
regarding the use of trans-vaginal mesh in the surgical
treatment of pelvic organ prolapse and urinary incontinence
created a firestorm for gynecologic surgeons, urologic
surgeons, affected patients, lawyers and the public. This
series of events have highlighted gaps in our scientific
understanding, challenges to assessment of surgical
outcomes, and the flaws in the regulatory processes. In this
multi-faceted panel discussion, we will first set the stage
by reviewing new insights into pelvic floor biomechanics
concerning pelvic organ prolapse and how pelvic surgeries
attempt to address these conditions. We will summarize
traditional non-mesh POP surgeries and the continuum of
transvaginal mesh devices that have been introduced into
market. We will explore the difficulties inherent in how we
define success after POP surgeries. The evidence regarding
benefits and harms for using synthetic mesh to treat stress urinary incontinence and prolapse will be summarized. An overview of the FDA clearance for marketing of surgical devices will show that most devices reach the market with grossly inadequate clinical data to support their use. Based on personal involvement, we will explain the events of 2011, from the FDA statements to industry response to professional societies’ actions. Finally, we will consider whether informed consent is possible when dealing with new surgical technologies and will suggest a way forward to improve surgical innovation while maintaining ethical principles and medical standards. This discussion can be used as a model to consider any new innovation adapted before proven utility and thus should be relevant to members in all subspecialties.
“Update on ABOG/ACOG”

Larry Gilstrap, MD
American Board of Obstetrics & Gynecology
Dallas, Texas

Hal Lawrence, MD
American College of Obstetrics & Gynecology
Washington, DC
President’s Invited Guest Lecturer

Cecile Richards
President of Planned Parenthood Federation of America & Planned Parenthood Action Fund
New York, New York

Planned Parenthood will see one in five women in her lifetime in the United States, and is the nation’s most trusted provider for reproductive health care. Over the past two years, the organization has withstood unprecedented attacks on its ability to provide lifesaving cancer screenings and birth control to its nearly three million patients. Ms. Richards will discuss Planned Parenthood’s health care work in communities across the country, talk about the patients Planned Parenthood serves and their health care needs, and the organization’s plans to reach even more women in the coming years.

In this political climate—with state and federal politicians trying to interfere in providers’ work by passing restrictive legislation to limit access to safe and legal abortion, and even contraception—a strong partnership between OB/GYNs and Planned Parenthood is more important than ever. Ms. Richards will discuss the importance of protecting OB/GYNs’ ability to seamlessly provide lifesaving care to women.

Since joining Planned Parenthood in 2006, Ms. Richards has developed the organization’s advocacy strategy to protect and expand access to health care, leadership training for young people, and online programs to expand health
care information and services. Under her leadership, the number of Planned Parenthood's supporters has doubled, reaching a total of more than six million.
Panel Presentation:
“Update on Robotics in Gynecologic Surgery; How are We to Train our Future Surgeons?”

Jeffrey Fowler, MD
The Ohio State University College of Medicine and Public Health
Columbus, Ohio

Anrold Advincula, MD, FACOG, FACS
Center for Specialized Gynecology
Celebration, Florida

Lee Learman, MD, PhD
Indiana University School of Medicine
Indianapolis, Indiana

John Lenihan, MD
MultiCare Tacoma Women’s Specialists
Tacoma, Washington

Advanced minimally invasive surgical (MIS) technology has been available for over two decades. Incorporating laparoscopy (LS) into the comprehensive management of complicated gynecology and gynecologic oncology patients has only been moderately successful secondary to a difficult and long learning curve, variability in surgeon experience, longer operative times and patient factors such as surgical history and obesity. Technologic limitations to rapid implementation of complicated LS in gynecologic oncology include a limited 2-D field of vision, counterintuitive motions often required for the surgeon and assistant,
limited degrees of freedom of instruments, and ergonomic disadvantages for the surgeon. The robotic platform has been available for gynecologic surgery since 2006 and offers many technological advantages that afford the surgeon better vision, autonomy, surgical dexterity, precision and control of the surgical field.

Compared to LS, the robotic platform has become rapidly adapted especially by gynecologic oncologists. The published experience is growing end entirely retrospective. In gynecologic oncology, relatively large feasibility studies report improvements in many important peri-operative outcomes including length of stay, ability to perform surgical staging, shorter operative times and lower conversion rates to laparotomy compared to LS.

The technological advantages of the robotic platform have resulted in many major surgical cases that were routinely approached via laparotomy to be performed via MIS, which is likely to improve peri-operative outcomes for the patient. There are many critical issues that revolve around this revolutionary surgical advance. Overall cost, both initial capital investment and maintenance costs, is a major issue. Technology advances do not substitute for adequate training, surgeon experience and judgement, knowledge of disease and anatomy. In fact, MIS is likely to magnify any deficit in these areas leading to severe complications. Resident training and credentialing of attending physicians is a major challenge and yet to be standardized. Simulation training will likely aid this process.
## Invited Guests of Council

### 2012 Candidates

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<tr>
<td>Nadeem Abu-Rustum, MD</td>
<td>New York, NY</td>
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<tr>
<td>Ayman Al-Hendy, MD</td>
<td>Nashville, TN</td>
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<td>Hyagriv Simhan, MD</td>
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Cedars, Marcelle (Ivonne) ... San Francisco, CA
Chalas, Eva (Chris Westermann, MD) ... Mineola, NY
Chambers, Setsuko K. (Keith Joiner, MD) ... Tucson, AZ
Chan, John (Katherine Lok) ... San Francisco, CA
Chang, R. Jeffrey (Carol) ... La Jolla, CA
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Chi, Dennis (Hae-Young) ... New York, NY
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Cunningham, F. Gary ... Dallas, TX
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Darney, Philip D. (Uta Landy, PhD) ... San Francisco, CA
Davidson, Ezra C. (Joyce Montgomery) ... Los Angeles, CA
DeCherney, Alan H. (Dee Dee) ... Bethesda, MD
DeLancey, John O.L. (Barbara) ... Ann Arbor, MI
Devoe, Lawrence D. (Anne) ... Augusta, GA
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Evans, Mark I. ................................. New York, NY
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Granai, Cornelius (Cheryl Granai, RN, BSN, OCN) Providence, RI
Greene, Michael (Laurei) .......................... Boston, MA
Greer, Benjamin E. (Sheree Miller) .............. Seattle, WA
Gregory, Kimberly D. (Richard Casey, MD) ....... Los Angeles, CA
Guzick, David S. (Donne Giles, PhD) .............. Gainesville, FL
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Hankins, Gary D.V. (Barbara) ...................... Galveston, TX
Hatch, Kenneth D. (Rhea) ......................... Tucson, AZ
Hauth, John C. (Suzzon) ........................... Birmingham, AL
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Orr, James W. .................................. Fort Myers, FL
Parisi, Valerie M. (Gary Strong) .............. Detroit, MI
Patrizio, Pasquale (Vanessa) .................... New Haven, CT
Paulson, Richard J. (Lorraine) .................. Los Angeles, CA
Peaceman, Alan M. ................................ Chicago, IL
Pearlman, Mark (Susan) ......................... Ann Arbor, MI
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Plaxe, Steven (Angela Scioscia, MD) ........ La Jolla, CA
Quirk, James Gerald (Susan) .................... Stony Brook, NY
Raine-Bennett, Tina (Romina Kee) .......... Oakland, CA
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Resnik, Robert (Lauren) ....................... Solana Beach, CA
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Rock, John A. (Martha) ....................... Miami, FL
Romero, Roberto (Virginia Sabo) ............ Detroit, MI
Rosenn, Barak .................................. New York, NY
Rosenwaks, Zev (Stacy) ....................... New York, NY
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Rotmensch, Jacob (Nadine Foster) .......... Chicago, IL
Rouse, Dwight (Katherine) ................... Providence, RI
Rubin, Stephen C. (Anne) ..................... Philadelphia, PA
Runowicz, Carolyn D. (Sheldon Cherry, MD) .. Miami, FL
Saade, George R. (Yomna Monla, MD) ........ Galveston, TX
Sadovsky, Yoel (Elena) ....................... Pittsburgh, PA
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Van Voorhis, Bradley (Toni) .......................... Iowa City, IA
Wall, L. Lewis (Helen) ................................ St Louis, MO
Wapner, Ronald J. ................................. New York, NY
Weiner, Carl P. (Carol) ............................ Kansas City, KS
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Galask, Rudolph P. (Gloria) . . . . . . . . . . . . . . . Iowa City, IA
Gall, Stanley A. (Flo) . . . . . . . . . . . . . . . . . . . . Louisville, KY
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Goodlin, Robert C. (Velma) . . . . . . . . . . . . . . Cameron Park, CA
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Hammond, Charles B. (Peggy). . . . . . . . . . . . . Durham, NC
Haseltine, Florence P. (Alan Chodos, MD) . . . Bethesda, MD
Haskins, Arthur L. (Kathryn) . . . . . . . . . . . . . Charlotte, NC
Heinrichs, W. Leroy (Phyllis). . . . . . . . . . . . . Menlo Park, CA
Herbst, Arthur L. (Lee) . . . . . . . . . . . . . . . . . . Chicago, IL
Homesley, Howard D. (Jane) . . . . . . . . . . . . . Greenville, NC
Horger, Edgar O. (Polly) . . . . . . . . . . . . . . . . Columbia, SC
Jaffe, Robert B. (Evelyn). . . . . . . . . . . . . . . . . San Francisco, CA
Jewelewicz, Raphael (Roni) . . . . . . . . . . . . . . . Alpine, NJ
Jones, Howard W. . . . . . . . . . . . . . . . . . . . . . Norfolk, VA
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Wild, Robert A. (Judy) ............................. Oklahoma City, OK
Williams, Tiffany J. (Dohna) ....................... Englewood, FL
Wynn, Ralph M. .................................. New York, NY
Young, Bruce K. (Phyllis) .......................... New York, NY

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Van Niekerk, William A. (Magriet) ......... Capetown, South Africa
Widnell, Christopher (Anne) ............... Atlanta, GA
Wood, Alastair J. J. (Margaret) .............. New York, NY
In Memoriam
In Memoriam

Warren M. Crosby, MD
October 15, 2011

Born on March 19, 1931, and raised in Topeka, Kansas, Dr. Warren Crosby passed away on October 15, 2011 at the University of Oklahoma Medical Center. He attended Stanford University as an undergraduate for three years and finished his fourth year at Washburn University in Topeka. He obtained his medical degree from the Kansas University Medical School and served his internship in Kansas City at St. Luke’s Hospital. He then moved to San Francisco and completed a four year residency in Obstetrics & Gynecology at The University of California Hospitals, San Francisco.

In 1962, Dr. Crosby began his career at the Oklahoma University (OU) Health Sciences Center as an instructor.
in the Department of Obstetrics & Gynecology and served as Vice-Chair from 1969-1994. In the 1970’s he was a pioneer in researching the safety of seat belt restraints in pregnant women, which resulted in the recommendations for safety belt use in pregnant women that are still used today. He also conducted research in fetal treatment of Rh isoimmunization.

He was passionate about ensuring that women and infants in rural Oklahoma received safe, high quality perinatal care. He founded the Office of Perinatal Continuing Education in 1984 to provide education to all Oklahoma birthing hospitals. His vision and work provided the foundation for services to improve the quality of perinatal care in Oklahoma that are now offered through the Office of Perinatal Quality Improvement. The systems, procedures and programs he initiated in the 1980s to reduce the rate of infant mortality in Oklahoma continue to save lives today.

He was a member of this society, the American Board of Obstetrics and Gynecology, and a variety of other medical organizations throughout his career. At the time of his death, Dr. Crosby also served as the Honorary CME Chair of the Society for Humanism in Medicine. In January of 2011, he was honored with the OU Dean’s Award for Distinguished Medical Service. Although his research and clinical endeavors provided an immensely rewarding career, Dr. Crosby was most proud of his family. He is survived by his daughter Sarah and her husband Tad Cooper and his beloved wife Joanne Crosby, with whom he celebrated 58 years of marriage.

Submitted by Dr. Charles J. Lockwood and Dr. Robert Mannel
Dr. William (Bill) Ewart Easterling died at the age of 81 on December 28, 2011 of pancreatic cancer. Bill was born in Raleigh, North Carolina on October 8, 1930. He was educated in the Raleigh public schools. He served as President of his high school senior class. Dr. Easterling attended Duke University as an undergraduate on a prestigious Angier B. Duke scholarship. He then matriculated The University of North Carolina School of Medicine. This was the beginning of a life long career at UNC. After completion of medical school, he served his residency training in Ob-Gyn at UNC. Bill took a post-doctoral traineeship in reproductive endocrinology and infertility @ UCLA in 1964.
Dr. Easterling served many important roles for the UNC Medical School. He was an original member of the Division of Reproductive Endocrinology. He played an important role in the department’s research efforts, especially those utilizing urinary estriol levels to monitor the fetal health in pregnant women with diabetes. At the time, this was on the cutting edge of predicting fetal outcomes. He was a wonderful and very popular clinician as well.

Whenever he was called on to work for the good of the Institution he did and did well. His service included Associate Dean for Clinical Affairs and Chief of Staff of UNC Hospitals for 15 years, acting Dean of the Medical School for a year, and the Associate Dean for CME and Alumni Affairs for nine years.

Bill was very involved in community activities and his church. His passion was Penick Village Episcopal Home for the Aging in Southern Pines, North Carolina. He and his wife Ellyn were married nearly 60 years and raised five sons. He was so very proud and dedicated to all of them. Besides Ellyn, he is survived by William, III and wife Mary of State College, PA, David and wife Kimberly of Asheville, NC, Bryan and wife Carole, and Wyatt all of Nashville, TN, and Jeffrey and wife Melinda of Chapel Hill; and fourteen Easterling grandchildren: Hannah, Elise, Sara, Katie, Colton, Adam, Helen, Claire, Elizabeth, and Chelsea; step grandchildren: Joel, Arin, Cole, and William.

We have lost one of a kind in Bill Easterling. I have been a very lucky person to have known and worked with him for more than 45 years. He will be missed.

Submitted by Wesley C. “Butch” Fowler, Jr.
Robert Arthur Hugh Kinch
July 22, 2011

On the morning of July 22, 2011, Dr. Robert Arthur Hugh Kinch died at the Royal Victoria Hospital in Montreal. He was 91 years old, and his long life had a profound impact on those who loved him, those who worked with him, those he taught and those he healed.

Dr. Kinch was born in Kut-El-Amara, Iraq, the son of a British Royal Navy Captain. His early youth was spent in Mumbai, India, and he then matriculated at The Cranbrook School in Kent, England. He studied medicine during the WWII German “Blitz” of London at the Middlesex Hospital Medical School and Queen Charlotte’s Maternity Hospital.
He then enlisted and served as a Surgeon Lieutenant in the British Royal Navy. He saw action in the North Atlantic, South Pacific and on D-Day.

Dr. Kinch immigrated to Canada in 1949 and launched his medical career in Toronto as a practicing ob/gyn. In 1957, he and his family moved to London, Ontario, where he became the Head of the Department of Obstetrics and Gynecology at the University of Western Ontario. In 1968, Dr. Kinch moved to Montreal as a McGill University Professor of Obstetrics and Gynecology and ultimately became Chief of Obstetrics and Gynecology at the Montreal General Hospital and the Royal Victoria Hospital. In 1979, he was appointed Professor and Chairman of the Department of Obstetrics and Gynecology of McGill University. Dr. Kinch was recognized as an international leader in Obstetrics and Gynecology and as a true pioneer in women's health. He had 78 peer review publications delving into a range of clinical topics from premenstrual syndrome to preeclampsia. He also published in the area of family planning and studied translational endocrinology. He remained devoted to teaching until he was 86. He trained thousands of medical students, residents and fellows. Many of his students achieved success in academic medicine and among his graduates are the Chairs of the Departments of Obstetrics and Gynecology of eight Canadian universities.

Dr. Kinch was a wonderful human being. Everyone who met him could not fail to be engaged by his warmth, his energy, optimism, and compassion. Here are some excerpted quotes from former colleagues, students and patients that reflect his many qualities:
“From the time that he came to Western as the Head of Obstetrics and Gynecology at the age of 38, he inspired many students to go into the specialty, some of whom might not have done so if it were not for his leadership. In addition to his busy professional life, he was well-informed about painting and supported young Canadian artists such as Jack Chambers before they became national figures.”

“Dr. Kinch missed a delivery when I was a junior resident at the Montreal General Hospital. Instead of scolding me, he told the patient that he was my mentor and she was lucky to be delivered by his best student. He made me blush but I beamed with pride.”

”In the residency program, he was a wonderful mentor and role model. He taught with compassion and sensitivity, knowledge and humility and a deep love of Obstetrics and Gynaecology. He was often in my thoughts and I will never forget his kindness and encouragement. He made each and every one of us better doctors and better human beings. He will be greatly missed.”

“I was fortunate to have the experience of working as his assistant during his appointment for 5 years as Chairman of Obstetrics and Gynecology at the Royal Victoria Hospital in 1980. It was my first real employment after graduation from McGill. He was an exceptional person; a real gentleman and I have such fond memories of him. He taught me my first administrative skills, including impeccable English, which I have taken with me over the last 30 years. He was a boss, but a true friend. I feel lucky to have crossed his path and will never forget such a kind human being.”

“Dr. Kinch was my inspiration and my quiet guide.
He intuited all our needs as trainees, and met them: leading by his example of compassion, generosity, intelligence and kindness. When he offered me a staff position on finishing my studies when I was a mere second year resident, I knew immediately that he saw my insecurity, and that this was his treatment for my lack of self confidence! I know how exceptional it was to work in such an environment of respect and appreciation for women.”

“Embedded in Dr Kinch’s compassion and enthusiasm, was a vision. And he fulfilled that vision through his investment in his teaching and the creation of opportunities to learn firsthand. He launched many of us on a career that fulfilled his vision. A man easy to love but difficult to emulate, he was a great soul that lives on in my heart.”

“Dr. Kinch was my gynecologist during his last few years at the Royal Victoria Hospital. I truly loved him because he was so caring and sincere. After his heart attack, he called me personally to tell me that he could not be my doctor anymore because the hospital wouldn't let him practice anymore. Who among the doctors would do that? I would like to extend my deepest sympathy to his family and I would like to tell them how lucky they were to have him for 91 years and that I truly missed him as my doctor. What an exceptional human being. I will remember him forever.”

Dr. Kinch is survived by his loving wife Kathy Keefler and children: Martin (Miro), Richard (Anne), Cynthia, Jenepher (Larry), Shelagh (Marc), Robin (Greg), by his stepdaughters: the late Danielle (Kim), Nicole (Mark) and Michelle (Pete), by his grandchildren: Abigail, Jeffrey,
Shannon, Leigh, William, Elisabeth, David, Matthew, Juliana, Alexi, Natasha, Graeham, Amelia and Juliette and by his great-grandsons Hugo, Rainer, Michael and Nolan.

Submitted by Dr. Robert Casper, FRCS(C)
In Memoriam

Philip J. Krupp, Jr., MD
June 15, 2012

Philip J. Krupp, Jr., M.D. died on Friday, June 15, 2012, at age 88. He was born in New Orleans on January 11, 1924. His undergraduate education had been at Tulane University where he also received his medical degree in 1947. His residency was served at Charity Hospital at New Orleans and also received subspecialty training in the Air Force, culminating in certification by the American Board of Obstetrics and Gynecology and among the first to be certified by ABOG’s Division of Gynecologic Oncology in 1947. His military service included a stint on the Navy in the mid-40’s and service again during the Korean War in the Air Force. There he served as a First Lieutenant
with subsequent promotion to Captain in 1950. He was an Acting Base Surgeon directing a 150 bed hospital and served as chief obstetrics and gynecology until honorably discharged in 1953. He was appointed to the teaching faculty as assistant professor of the Tulane University Medical School in 1956 and rose to the rank of Professor and Chief of the Section of Gynecologic Oncology in 1970. He then left the university to devote himself to full time private practice in Gynecology and Gynecologic Oncology in New Orleans retaining title of Clinical Professor of Obstetrics and Gynecology at Tulane. He retired December 1994. Dr. Krupp was a member of this society as well as a founding member of Society of Gynecologic Oncology, and a member of Society of Pelvic Surgeons, Society of Gynecologic Surgeons, American College of Surgeons, and the Central Association OB-GYN. His peer reviewed publications spanned the breadth of the field with a particular focus on gynecological oncology. He was pre-deceased by his beloved wife, Patricia Anderson Krupp and is survived by his children Karen K. Pearson, Christen K. Miller, Robin P. Krupp and Philip J. Krupp III and grandchildren, James R. Sutterfield, Jr., Dana K. Sutterfield, Philip J. Krupp IV, Shane P. Krupp and Hailee B. Krupp.

Submitted by Dr. Charles. J. Lockwood
In Memoriam

A. Brian Little, MD
April 14, 2012

Alan Brian Little, MD died on April 14, 2012 after a long illness. He was born in Montreal, March 11, 1925, into a prominent family. His Grandfather was a successful businessman and benefactor of the community. His Father, an Obstetrician-Gynecologist, was instrumental in founding the women’s Pavilion at the Royal Victoria Hospital in Montreal. Unfortunately, he died prematurely at the age of 57 leaving his wife and three young sons. Dr Little’s mother became a writer for the Montreal Gazette and instilled a strong competence for the written word in Dr. Little. All of the boys served in the armed forces during WWII, but tragedy continued in the family as his
two brothers Patrick (1943) and Michael (1945) were killed in the war. After completing his Service as a flying officer (navigator) in the Royal Canadian Air Force, Dr. Little returned to Montreal and graduated from McGill Medical School. He subsequently completed residency in Obstetrics and Gynecology at Harvard Medical School, and joined the Harvard Medical School faculty.

His outstanding qualities were recognized early in his career and he was chosen to head Obstetrics and Gynecology at Boston City Hospital on the Harvard Service, where he did the first intrauterine transfusion for Rh sensitive fetuses. He was then recruited to become Chair at the Cleveland Metropolitan General Hospital and eventually he moved to become the Chair and Arthur H. Bill Professor of Obstetrics and Gynecology at Case Western Reserve Medical School. He was a “teacher of teachers” and a number of the faculty he recruited subsequently became chairs of other academic departments. Dr. Little returned to Montreal to become Professor and Chair of Obstetrics and Gynecology at the Medical School at McGill University where he continued his strong emphasis on research, teaching and excellent patient care. After retiring from McGill where he became Professor Emeritus, he continued his strong interest in teaching and mentoring students by accepting a Professorial appointment at UMDNJ - New Jersey Medical School in Newark, where he taught for 17 years.

Dr. Little had an extraordinarily successful academic career. He was an internationally recognized investigator in reproductive endocrinology studying the metabolism of steroid hormones and the neuroendocrinology of reproduction. Dr. Little maintained 28 years of continuous
NIH/MRCC [1959-1987] grant support as a principal investigator and was a leader in directing the research efforts of the National Institute of Child Health and Human Development (NICHD). He became chair of its Reproductive Biology Study Section and also served as chair of the steering committee of Reproductive Medical Centers. He served as a council member of the national advisory committee of NICHD, and was the chair of the National Heart, Lung, and Blood’s (NHLBI) policy monitoring panel for the clinical trial of antenatal steroid therapy. His studies contributed to our understanding of steroid hormone metabolism and human ovarian physiology, as well as the clinical implications of steroid therapy during pregnancy and other therapeutic advances. He authored some 110 original articles, books, and monographs. His academic accomplishments and leadership as an excellent clinician were recognized by his becoming a Director of the American Board of Obstetrics and Gynecology, and President of the prestigious American Gynecologic Society. He also served as President of the Perinatal Research Society and the Society for Gynecologic Investigation. He held membership in numerous academic medical societies.

Dr. Little was recognized by his peers and students as an intellectual leader with an ever-inquiring mind and for his mastery of the english language and the written word. He was a powerful and positive influence on his students, trainees, and faculty. Dr. Little was an exceptional role model, advisor, friend and confidant to faculty colleagues, medical students, residents, and fellows. His advice on career pathways and tailoring individual skills in appropriate directions was invaluable. His research mentorship allowed individuals to understand underlying
processes so they were able to better design and execute protocols. He stressed knowledge of the underlying physiology of biological processes and how these mechanisms were altered by pathology to understand the clinical manifestation of various disease entities and to be able to effectively explain these to patients and trainees. He taught in the clinics by example. Everyone who worked with him benefitted significantly by his presence, clinical skills, and sensitivity to individual patient needs. Dr. Little had an open door policy. He would frequently be cloistered with senior residents, fellows, and faculty, while he helped them maximize their strengths, establish paths of progress, and, thus, advance their careers. Suffice it to say that the individuals with which he had contact clearly benefitted from his help. He had a clear mind and a logical way of progressing thoughts, so that he could most effectively advise individuals and give them the tools to further their progress without external help. He was an especially good sounding board for plans and ideas of trainees and faculty.

An important and unique strength was Dr. Little’s highly developed sense of curiosity about all aspects of medicine and biomedical science. This well developed sense of curiosity made him the quintessential student, such that he always wanted to learn more and would never take anything at face value. “But what does that really mean?” was a phrase he frequently used, and by asking fostered his own and everyone else’s desire to think more deeply about a subject. This was also another way that he taught by example, expecting everyone to be as curious as he was and to never let anything get in the way of really understanding a new concept, technique or other advance in the field. His excellent sense of humor was frequently injected into his
piercing conversations. He was highly respected by all who came in contact with him for his honesty, dedication to excellence, and for being a true Gentleman.

Dr. Little married twice; first to Nancy Campbell in 1949 with whom he had six children. The oldest, Michael, died tragically in 1972 in a mountain accident in Austria at age 19. After his first marriage ended in divorce, Dr. Little married Dr. Bitten Stripp in 1984. She survives him along with his five daughters, Deborah Little (Tyler Miller, M.D.), Susan (Peter Hoagland), Catherine (Dr. Dan Reagan), Jane Little, M.D. (Tom Hostetter, M.D.), Lucinda Little (David Wells) and eight grandchildren: Catherine, Sam and William Miller-Little, Alexandra, Leah and Ian Hoagland, Andrew and Jane Reagan.

Submitted by Dr. Arthur L. Herbst & Dr. Gerson Weiss
Dr. Pentti “Finn” Siiteri, a distinguished steroid biochemist and reproductive endocrine scientist died on Friday, February 24, 2012 in Sonoma, CA. He was an Honorary Fellow of this society. During the course of his long and storied career he made influential discoveries in a wide range of fields. His analytical work led to purification of commercially available streptokinase, but he is best remembered for his seminal studies of placental steroidogenesis, and the role of steroids and steroid hormone receptors in the genesis of breast, endometrial and prostate cancer. He also explored the role of protein and steroid hormones in altering maternal immune responses. He helped describe the fetal zone of the fetal adrenal.
as the major source of dehydroepiandrosterone sulfate (DHAS) production. His work with Norman Gant and Paul MacDonald greatly advanced our understanding of placental dysfunction in eclampsia.

Dr. Siiteri obtained his PhD under the legendary steroid biochemist, Dr. Seymour Lieberman, in the Department of Biochemistry at the College of Physicians and Surgeons, Columbia University. It was in Lieberman’s lab that he met Paul MacDonald. By the end of his career he had amassed 124 peer review publications, many in high impact journals. He had a long record of NIH funding and served as chair of the Endocrine study section. Finn was a member and served leadership roles in the Endocrine Society, the Society for Gynecologic Investigation, and the Society for the Study of Reproduction. He was a recipient of the Order of the Lion of Finland, the highest civilian award granted by the President of Finland. He lived a long and accomplished life, and is survived by his wife of 62 years, Helen A. Siiteri, children Jon Everett (Rebecca), Eric Howard (Christine Luxen), Christian Martin (Darcie), Katherine Marie, and by 4 grandchildren; Jordan, Matthias, Parker and Leena Siiteri.

Dr. E. Aubrey Thompson, Professor of Cancer Biology at the Mayo Clinic Comprehensive Cancer Center was Finn Siiteri’s first graduate student, joining his laboratory in 1970, shortly after Finn and Paul MacDonald moved from Columbia to Southwestern Medical School. He was kind enough to share his reflections of his former mentor:

Perhaps the most telling tribute I can make to Finn Siiteri is the fact that I have told every graduate student with whom I have interacted, both in my laboratory
and otherwise, that if you choose the right mentor, then being a graduate student is the best job in the world. That was certainly my experience. When I joined Finn’s group, he and Paul MacDonald were collaborating on a series of very exciting studies designed to study steroid hormone metabolism during pregnancy. These studies exemplify one of Finn’s most prominent characteristics: although trained as a synthetic organic chemist, he was devoted to the concept that has subsequently come to be known as “translational research”, but to Finn it was simply physiology; and physiology was all that really mattered in the long run.

Working with Thompson, the pair studied the mechanism of human placental aromatase activity accounting for the conversion of androstenedione to estrone. Thompson noted that “Finn was at heart an organic chemist, and the tritiated water reaction that he personally created remains a standard tool in the study of aromatase to this day. The elucidation of the role of cytochrome P450 in aromatization represents another major contribution that derived from those studies…” Thompson reflected on Finn’s larger than life personality observing that “Many perceived Finn to be an iconoclast, an argumentative skeptic; and perhaps there is some basis for this perception. But I saw him otherwise, as a man who was unswervingly committed to rigorous, well-controlled experimentation and intolerant of over-interpretation or disinclination to consider alternative hypotheses.”

Thompson described Dr. Siiteri’s chief characteristics as loyalty and devotion to his family (both personal
and professional), experimental rigor, conservative interpretation of data, and consideration of alternative hypotheses. “He was a strong proponent of teamwork, particularly as it applied to collaboration between basic and clinical investigators. I have tried to adhere to these concepts and to teach them to my students and fellows, and I suppose that these precepts may be Finn’s most important legacy to me and my students. He was always a bit bigger than life to me, and many others. He had an indomitable love of life, and his passing does not sadden me; but there were few like him and his loss diminishes us all to a significant extent. Et lux aeterna lucient eis—Finn Siiteri, 2012.”

Submitted by Dr. Charles J. Lockwood

(My deepest thanks to Dr. E. Aubrey Thompson for sharing his reflections on Dr. Siiteri)
In Memoriam

George D. Wilbanks, Jr., MD
June 3, 2012

Born in Georgia in 1931, and raised on a cattle farm in Tampa, Dr. Wilbanks died of natural causes Sunday, June 3, 2012, in the Health & Wellness Center of The Forest at Duke in Durham, North Carolina. He was an internationally renowned cancer researcher, surgeon and professor of obstetrics and gynecology. He was a pioneer in establishing gynecologic oncology as a specialty and recognized for maintaining the balance between treating patients and research.

Dr. Wilbanks completed a 7 year combined BA/MD program at Duke University, served his internship at The
Pennsylvania Hospital, his Ob/Gyn residency at Duke, and a gynecological pathology training program at Boston’s Lying-In and Free Hospitals. He held an NIH grant for pathology training at Columbia Presbyterian Hospital and in 1965, he returned to Duke Medical School as Assistant Professor to establish its gynecologic pathology program. From 1970 to 1996, he was the John M. Simpson Professor and Chairman of Obstetrics and Gynecology at Rush Medical College in Chicago, Illinois. Their Board of Trustees established the George D Wilbanks Chair in Gynecological Oncology to support research in ovarian cancer when he left.

His early work identifying the human papillomavirus and its relation to cervical cancer contributed to development of the current vaccines. He had about 100 peer-reviewed publications, and held visiting professorships at Cambridge University, Cambridge, England, at St Thomas’s Hospital, London, UK and at the OB/GYN & Translational Oncology Lab at St. Bartholomew’s Hospital, London, UK. In addition, he was a Clinical Professor at the University of South Florida, Tampa, Florida.

Although happiest conducting research, caring for patients and sharing his expertise with doctors around the world, Dr. Wilbanks dedicated time to various professional organizations. He was a member of multiple professional organizations including this organization. He served as President of the American College of Obstetricians and Gynecologists (1995-1996), the Association of Professors of Gynecology & Obstetrics, the Council of University Chairs of Obstetrics/Gynecology, the International Federation of Cervical Pathology & Colposcopy, the
American Society of Colposcopy & Cervical Pathology, and the Chicago Gynecologic Society. He was Regent of the American College of Surgeons, and the medical adviser to Chicago and Illinois Planned Parenthood, Vice President and founding member of the Society of Gynecologic Oncologists, a member of the American Society of Clinical Oncology and the American Association for Cancer Research.

Dr. Wilbanks did research in ovarian cancer at the University of South Florida in Tampa, Florida, where he worked closely with the Ovarian Cancer Group. In addition to his scientific curiosity, he financially supported several small projects. His family sponsored the GD Wilbanks Lectureship in Gynecologic Oncology at the University of South Florida established in 1998 in his honor.

Although his cancer research and medical practice provided immense satisfaction to Dr. Wilbanks, his family was the true joy of his life. In the last few years, he and his wife split their time between Tampa, Florida and London and also kept a home in Durham. Dr. Wilbanks is survived by his wife of 58 years, Evelyn Rivers Wilbanks of Durham and his sons and daughters-in-law Wayne and Ashlin Wilbanks of Norfolk, Virginia, and George and Ann Wilbanks of Westport, Connecticut. He leaves four grandchildren: Margaret and Virginia Wilbanks of Norfolk, Virginia, and Elizabeth and George Alexander Wilbanks of Davis, California and New Delhi, India, respectively. Dr. Wilbanks was an avid tennis player and accomplished sailboat racer, passions he shared with his sons and grandchildren and many long-time friends. His son recalls much time on a ¾ ton racing boat during the 70s and 80s, racing 15+ Chicago
to Mackinaw races and sailing small dinghies in snow and 40 degree water in Belmont Harbor in Chicago!

Submitted by Dr. Jerome Yankowitz, MD
With help from Dr. Santo Nicosia, Mitch Hoffman and his wife and son Evelyn and Wayne Wilbanks.
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  Dr. Robert Resnik — 2010
Dr. Haywood L. Brown — 2011
  Dr. Mary E. D’Alton — 2012

* Deceased
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