# LSU School of Medicine
# Department of Obstetrics & Gynecology

# Resident Research Day
# Friday, May 8, 2026

**Center for Advanced Learning & Simulation**
**2021 Perdido Street, 1st Floor**
**New Orleans, LA**

**Keynote Speaker:**

***Ruben Alvero, MD***
*Clinical Professor of Obstetrics & Gynecology*
*Stanford University School of Medicine*

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***Dr. Ruben Alvero*** is Professor of Obstetrics and Gynecology at Stanford University and the former Division Director of Reproductive Endocrinology and Infertility at the Lucille Packard Children's Hospital. He graduated from Harvard College and received his MD from the Uniformed Services University of the Health Sciences in Bethesda, Maryland. He completed his residency at the Walter Reed Army Medical Center and fellowship in Reproductive Endocrinology and Infertility (REI) at the NIH. Dr. Alvero was previously Professor and Division Director at the University of Colorado and Brown University, Fellowship Director in REI at Brown, and Residency Program Director and Vice Chair of Education at the University of Colorado. He is and has been NIH funded. Dr. Alvero was formerly President of the Society for Reproductive Endocrinology and Infertility and is currently on the American Society for Reproductive Medicine Board of Directors. He is the Editor in Chief for Fertility and Sterility Reviews. A 27-year veteran of the United States Army, he retired as a Colonel. Service assignments included Germany, Mongolia, Kuwait, Iraq, DC, and Texas. A native Spanish speaker, Dr. Alvero is devoted to the care of underserved populations.

# LSU OBGYN Resident Research Day
# Friday, May 8, 2026

**8:00am-9:00am** **Welcome & Introduction of Guest Speaker**
Jaime Alleyn MD, FACOG
Chairperson, Department of Obstetrics and Gynecology

**Keynote Address** ***Highly Selective History of Medical Research***
Ruben Alvero MD
Clinical Professor of Obstetrics & Gynecology
Stanford University School of Medicine

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**SESSION 1**
Moderators: Jay Davis MD & Neelima Sukhavasi MD/MPH

**9:00-9:15am** ***Risk Factors for Surgical Site Infection following Cesarean Delivery***
Resident: Kayla Schwartzenburg MD, PGY 3 Baton Rouge
Advisor: Sarah Buzhardt MD

**9:15-9:30am** ***Maternal Anemia and Small for Gestational Age at Birth: Retrospective Delivery Cohort***
Resident: Aleah Singleton MD, PGY 4 New Orleans
Advisor: Tabitha Quebedeaux MD/PhD

**9:30-9:45am** ***Associations Between Hispanic Non-English-Speaking Status and Adverse Obstetrical Outcomes: A Retrospective Cohort Study***
Resident: Megan Molina MD, PGY 3 Baton Rouge
Advisor: Elizabeth Florence MD

**9:45-10:00am** **Break**

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**SESSION 2**
Moderators: La'Nasha Tanner MD & Sarah Buzhardt MD

**10:00-10:15am** ***Are Immunocompromised Patients Without HIV Being Screened According to ASCCP Guidelines?***
Resident: Saskya Etienne MD, PGY 4 New Orleans
Advisor: Amelia Jernigan MD

**10:15-10:30am** ***Human Papillomavirus Type Distribution Among Patients with High Grade Cervical Dysplasia in Lafayette, Louisiana***
Resident: Viktoria Taskov DO, PGY 4 New Orleans
Advisor: Holly Provost MD

**10:30-10:45am** ***Cytoreductive Surgery with Hyperthermic Intraperitoneal Chemotherapy for Recurrent Adult Granulosa Cell Tumor of the Ovary: A Retrospective Case Series***
Resident: Kristin Malone MD/MPH, PGY 3 New Orleans
Advisor: Amelia Jernigan MD

**10:45-11:00am** ***Probiotics in the Management of Endometriosis: A Meta-Analysis and Systematic Review***
Resident: Sean Backer-Meurke DO, PGY 2 New Orleans
Advisor: Antonia Traina MD

**11:00-11:15am** **Break**

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**SESSION 3**
Moderators: Andrew Jones MD & Elizabeth Florence MD

**11:15-11:30am** ***Relationship Between Co-occurring Fetal Growth Restriction and Preeclampsia***
Resident: Chaya Karunasiri MD, PGY 4 New Orleans
Advisor: Asha Heard MD/MPH

**11:30-11:45am** ***Elective Induction Rates and Outcomes in Low-Risk Nulliparous and Multiparous Patients Following the ARRIVE Trial: A Regional Cohort Study from South Central Louisiana***
Resident: Katherine Oliver MD, PGY 3 Baton Rouge
Advisor: Elizabeth Florence MD

**11:45am-12noon** ***Effects of Remote Blood Pressure Monitoring on Postpartum Readmission Rates***
Resident: Julia Hernandez MD, PGY 4 New Orleans
Advisor: Tabitha Quebedeaux MD/PhD

**12noon-12:15pm** ***Change in Anxiety and Depression Symptoms with Long-Term Hospital Admission in the Antepartum Period***
Resident: Jasmine Rogers MD, PGY 4 Baton Rouge
Advisor: Sarah Buzhardt MD

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**12:15-1:15pm** **Lunch**
**1:15pm-1:30pm** **Group Pictures**
**1:30pm-2:15pm** **POSTER SESSION**
**2:15pm** **Awards and Final Remarks**

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**Judges**
Jaime Alleyn MD - LSUHSC Department of Obstetrics & Gynecology
Ruben Alvero MD - Stanford School of Medicine
Jay Huber MD - LSUHSC Department of Obstetrics & Gynecology
Jay Mussell PhD - LSUHSC Department of Cell Biology & Anatomy

ABSTRACTS FOR ALL PRESENTATIONS ARE ON THE FOLLOWING PAGES.

A LIST OF POSTERS ARE AVAILABLE AT THE END OF THIS PROGRAM AND ARE NUMBERED FOR EASE OF VIEWING IN THE POSTER HALL.

# Risk Factors for Surgical Site Infection following Cesarean Delivery

*Kayla Schwartzenburg MD, Sarah Buzhardt MD, Dina Dinh MS,*
*J Hunter Collins PhD, and Elizabeth F Sutton PhD*

**Background:** Surgical site infections (SSIs) following Cesarean delivery (CD) are a significant cause of maternal morbidity, with global incidence estimates of 2–8%. Understanding modifiable and non-modifiable risk factors is essential for developing prevention strategies, particularly in high-risk populations in the southern United States. This study aims to identify predictors of SSI after CD at a high-volume obstetric center in South Louisiana with the overall goal of building upon existing evidence-based recommendations to remain proactive against a known cause of maternal morbidity.

**Methods:** We conducted a retrospective cohort study of 4,949 women who delivered via CD at Woman's Hospital from March 2024 to December 2025. Data were extracted from the Women and Infants Clinical (WINC) database. SSI was defined as infection at the surgical site within 30 postoperative days. Candidate predictors were assessed via univariable logistic regression, followed by multivariable logistic regression adjusted for relevant maternal demographic and clinical covariates.

**Results**: SSI occurred in 119 of 4,949 patients (2.4%). Univariable analysis identified BMI, gestational age, race, ASA classification, surgery duration, and hours of labor as significant candidates. Each 1-unit BMI increase was associated with a 6% increase in SSI odds (OR 1.06, 95% CI 1.04–1.08). Each additional operative minute increased SSI odds by 1% (OR 1.01, 95% CI 1.01–1.02), and each additional hour of labor increased odds by 2% (OR 1.02, 95% CI 1.00–1.03). On multivariable analysis, surgery duration (aOR 1.01, 95% CI 1.00–1.02), and hours of labor (aOR 1.02, 95% CI 1.00–1.03) were independent predictors of SSI. Remaining maternal, obstetric, and perioperative factors did not significantly contribute to SSI risk.

**Conclusions:** On multivariable analysis, operative duration, and hours of labor were independent predictors of SSI, with surgery duration standing out as a clinically modifiable target that underscores the importance of efficiency in the operating room. Laboring status did not significantly increase risk, which is a notable finding given common assumptions about this exposure. The null findings for diabetes and hypertension likely reflect the low prevalence of SSI in this cohort rather than a true absence of effect. Future directions include expanding the dataset and comparing risk factor profiles across regions to better characterize SSI risk in diverse obstetric populations. These findings provide a foundation for targeted prevention efforts aimed at reducing a known source of maternal morbidity.

# Maternal Anemia and Small for Gestational Age at Birth: Retrospective Delivery Cohort

*Aleah Singleton MD, La'Nasha Tanner MD, and Elizabeth F Sutton PhD, and Tabitha Quebedeaux MD/PhD*

**Introduction:** The World Health Organization estimates that 37% of pregnant women worldwide are affected by anemia. In pregnancy, anemia is defined as a hemoglobin <11 g/dL in the first and/or third trimesters and <10.5 g/dL in the second trimester. Previous studies have reported that moderate to severe maternal anemia appears to have an association with fetal growth, specifically with diagnoses of fetal growth restriction in utero and small for gestational age (SGA) at birth. The aim of our study was to evaluate the prevalence of SGA in pregnant patients diagnosed with and without anemia during pregnancy. We hypothesized that pregnant patients diagnosed with anemia will have higher prevalence of SGA than those without anemia diagnosis.

**Methods:** We performed a retrospective cohort analysis of 2,016 deliveries from 2018 to 2021. Admission anemia was defined by either hemoglobin <11 g/dL and/or hematocrit <33% measured at admission for hospital delivery. Small for gestational age (SGA) was defined by birthweight for gestational age percentile <10th. Crude associations were assessed with chi-square testing. Multivariable models adjusted for age, initial BMI, and race collapsed as Black vs Other/Unknown. A secondary analysis examined first-trimester anemia among records with non-missing initial anemia status.

**Results:** Overall, anemia at delivery admission was present in 989 of 2,016 patients (49.1%), and 291 of 2,016 infants born (14.4%) were considered SGA. The prevalence of SGA was 12.9% among patients with admission anemia versus 15.9% among those without admission anemia (p=0.071). The crude odds ratio for SGA with admission anemia was 0.79 (95% CI 0.61-1.01). After adjustment for maternal age and BMI, admission anemia was associated with lower odds of SGA (aOR 0.71, 95% CI 0.55–0.91; p=0.007). In the subset with first-trimester anemia data (n=1,789), initial anemia was not associated with SGA without and with adjustment (OR 1.05, 95% CI 0.77-1.44; aOR 1.01, 95% CI 0.74–1.38; p=0.95 respectively).

**Conclusions:** Admission anemia was not associated with a higher prevalence of SGA; the adjusted analysis showed a modest inverse association, while first-trimester anemia was not associated with SGA. These findings do not support the original hypothesis and suggest that anemia measured at delivery may not capture the antepartum exposure window most relevant to fetal growth.

# Associations Between Hispanic Non-English-Speaking Status and Adverse Obstetrical Outcomes: A Retrospective Cohort Study

*Megan Molina MD, Elizabeth Florence MD, Dina Dinh MS, and Elizabeth F Sutton PhD*

**Background:** Limited English proficiency has been associated with disparities in health status, access to preventive care, and adverse birth outcomes. Non-English-speaking patients have been shown to face elevated risks of obstetric trauma, emergency cesarean delivery, and small-for-gestational-age infants. However, evidence on the relationship between language, acculturation, and pregnancy outcomes is mixed, with some data suggesting that greater acculturation is paradoxically associated with increased risk of adverse outcomes among Hispanic patients. Given the growing diversity of the U.S. obstetric population and the limited data specific to Spanish-speaking Hispanic patients, we sought to evaluate the association between Hispanic non-English speaking status and adverse obstetrical outcomes at a women's specialty hospital in South Central Louisiana.

**Methods:** This retrospective cohort study included deliveries at Woman's Hospital in Baton Rouge, Louisiana from January 2022 through December 2025. The main data source was the Women and Infants Clinical (WINC) database. Patients were stratified into three groups: Non-Hispanic English-speaking (reference), Hispanic English-speaking, and Hispanic Spanish-speaking. Patients with missing outcome data were excluded. Examples of primary outcomes included hypertensive disorders of pregnancy (HDP), cesarean delivery, and neonatal intensive care unit (NICU) admission. A logistic regression analysis was used to calculate unadjusted odds ratios (OR) with 95% confidence intervals for each outcome.

**Results:** A total of 29,372 deliveries were analyzed: Non-Hispanic English-speaking (n=26,119), Hispanic English-speaking (n=857), and Hispanic Spanish-speaking (n=2,396). Relative to Non-Hispanic English-speaking patients, Hispanic Spanish-speaking patients had lower odds of HDP (16.0% vs. 26.8%; OR 1.92, 95% CI 1.68–2.20), cesarean delivery (31.5% vs. 36.6%; OR 1.26, 95% CI 1.13–1.40), and NICU admission (8.4% vs. 14.5%; OR 1.84, 95% CI 1.54–2.20; all $p<0.001$). Conversely, Hispanic Spanish-speaking patients had significantly higher odds of hemorrhage compared to the reference group (13.6% vs. 11.1%; OR 0.80, 95% CI 0.69–0.93, $p=0.001$). Hispanic English-speaking patients demonstrated intermediate rates across most primary outcomes. Other outcomes including shoulder dystocia, intrauterine fetal demise, and gestational diabetes showed no significant differences between groups.

**Conclusions:** Contrary to our initial hypothesis, Hispanic Spanish-speaking patients experienced lower rates of HDP, cesarean delivery, and NICU admission compared to Non-Hispanic English-speaking patients. However, elevated hemorrhage rates in this group represent a clinically meaningful disparity warranting further investigation. Future studies incorporating adjusted analyses and social determinants of health are needed to identify the mechanisms underlying these findings.

# Are Immunocompromised Patients Without HIV Being Screened According to ASCCP Guidelines?

*Saskya Etienne MD, Amelia Jernigan MD, Taylor Plaisance BS, Angella Chang BA, Ngan Tran BS, Jordan Richard BS, Tasnia Monir BS, and Elizabeth F Sutton PhD*

**Background:** Cervical cancer remains the fourth most common cancer among women worldwide. Immunocompromised patients without HIV have increased risk of cervical dysplasia and cervical cancer. ASCCP guidelines recommend more intensive screening in immunocompromised women, recommending three consecutive annual Pap tests before transitioning to screening every 3 years. However, adherence to these guidelines in the South Louisiana Health System remains unclear. The aim of this study was to evaluate if patients who are immunocompromised without HIV are screened according to ASCCP cervical cancer screening guidelines.

**Methods:** We conducted a retrospective cross-sectional study of immunocompromised female patients aged 21–65 years receiving gynecologic care within the South Louisiana Health System between January 1, 2019, and December 31, 2021. Patients were included if they had at least one preventive gynecologic visit within the LCMC system during the study period. Immunocompromised status was defined by diagnoses including systemic lupus erythematosus, inflammatory bowel disease, rheumatoid arthritis, solid organ transplantation, or hematopoietic stem cell transplantation. Patients with HIV infection, prior hysterectomy, or current cervical dysplasia were excluded. Data were obtained through electronic medical record review and included demographic, clinical, and cervical cancer screening history. The primary outcome was adherence to ASCCP cervical cancer screening guidelines for immunocompromised patients without HIV. Descriptive statistics were used to summarize patient characteristics. Associations between patient factors and screening adherence were assessed using Fisher's exact tests for categorical variables and Wilcoxon rank-sum tests for continuous variables, with statistical significance defined as $p<0.05$.

**Results:** A total of 177 immunocompromised patients without HIV met inclusion criteria. Overall, 76.3% (n=135) of patients received guideline-adherent follow-up according to ASCCP recommendations, while 23.7% (n=42) did not. Adherence to appropriate follow-up varied by select clinical factors. Patients with a history of cervical dysplasia were more likely to receive appropriate follow-up compared to those without prior dysplasia ($p = 0.049$). There was a trend toward differences in adherence by race ($p = 0.069$) and area deprivation index (local area deprivation index decile, $p = 0.099$), suggesting potential disparities, although these did not reach statistical significance. No significant differences in follow-up adherence were observed based on ethnicity ($p = 0.114$), marital status ($p = 0.186$), smoking status ($p = 0.624$), location ($p = 0.664$), immunosuppressive condition ($p = 0.207$), BMI ($p = 0.561$), or national area deprivation index percentile ($p = 0.115$).

**Conclusions:** In this cohort of immunocompromised patients without HIV, adherence to ASCCP-recommended cervical cancer screening follow-up was suboptimal, with nearly one-quarter of patients not receiving appropriate care. Patients with a prior history of cervical dysplasia were more likely to receive guideline-adherent follow-up, suggesting that recognized high-risk status may improve adherence. Trends toward disparities by race and neighborhood deprivation highlight potential inequities in care delivery that warrant further investigation. These findings underscore the need for improved systems-based interventions to ensure consistent adherence to cervical cancer screening guidelines in this high-risk population.

# Human Papillomavirus Type Distribution Among Patients with High Grade Cervical Dysplasia in Lafayette, Louisiana

*Viktoria Taskov DO, Anh Nguyen BS, Hinali Patel BS, and Holly Provost MD*

**Objective:** To evaluate the prevalence of high-grade cervical dysplasia- cervical intraepithelial neoplasia 2/3 (CIN 2/3)- and the associated presenting HPV genotypes. This study aims to determine what percentages of CIN 2/3 can be attributed to HPV 16, 18, and the Other high risk HPV group and assess potential associations with HPV vaccination status in a population from Lafayette, Louisiana.

**Methods:** A retrospective chart review was conducted for patients who underwent colposcopy between July 2019 and January 2025 at a single academic institution. Patients diagnosed with high-grade cervical dysplasia (CIN 2/3) were included. HPV genotype results and Gardasil vaccination status were extracted and analyzed. Chi-square tests and logistic regression were used to assess associations between HPV genotype, vaccination status, and severity of dysplasia. The primary outcome was the percentage of high-grade dysplasia associated with various HPV strains. The secondary outcome was to assess HPV vaccination rates.

**Results:** Among 257 patients reviewed, 137 (53.3%) had CIN 3. HPV 16 was the most common genotype (41.4%), followed by Other high-risk HPV types (35.6%) and HPV 18 (23.0%). Only 27.4% of CIN 3 patients were fully vaccinated, while 47.4% were never vaccinated. No significant associations were found between HPV genotype or vaccination status and dysplasia severity ($p > 0.05$). Age-stratified analysis revealed a non-significant trend toward increasing prevalence of non-16/18 genotypes with advancing age ($p = 0.097$).

**Conclusions:** HPV 16 remains the dominant genotype in high-grade dysplasia, but a substantial proportion of cases are due to non-16/18 types. Vaccination rates remain suboptimal in this population. No significant association was found between genotype or vaccination status and severity of dysplasia, though trends suggest evolving genotype patterns with age. These findings support continued emphasis on HPV vaccination and genotype surveillance.

# Cytoreductive Surgery with Hyperthermic Intraperitoneal Chemotherapy for Recurrent Adult Granulosa Cell Tumor of the Ovary: A Retrospective Case Series

*Kristin Malone MD/MPH, Elizabeth F Sutton PhD, Tara Castellano MD, Amma Agyemang MD/PhD, Sean Backer-Meurke DO, and Amelia Jernigan MD*

**Background:** Adult granulosa cell tumor (AGCT) of the ovary is a rare sex cord-stromal neoplasm characterized by an indolent but relapsing clinical course. While the initial prognosis is generally favorable, AGCT is associated with a high rate of late recurrence, which can sometimes occur decades after diagnosis. The standard management for recurrent AGCT consists primarily of repeat cytoreductive surgery (CRS), as systemic chemotherapy and hormonal therapy have shown limited efficacy in the salvage setting. Hyperthermic intraperitoneal chemotherapy (HIPEC) in combination with CRS has shown potential benefits in epithelial ovarian cancers and certain rare ovarian tumors. However, evidence supporting the use of HIPEC in recurrent AGCT is limited. This study reports the institutional experience with CRS and HIPEC in patients with recurrent AGCT.

**Methods:** A retrospective chart review was completed for patients with histologically confirmed AGCT of the ovary who underwent CRS and HIPEC at our institution between 2022 and 2024. HIPEC was performed after optimal or complete cytoreduction with cisplatin 100 mg/msq over 90 minutes. Descriptive statistics were applied.

**Results**: Four patients with recurrent AGCT were treated with CRS and HIPEC. Median age at the time of HIPEC was 45 years old, and the average number of recurrences before HIPEC was 1.5. All patients except one had received at least one prior line of adjuvant platinum-based chemotherapy as front-line before recurrence and HIPEC. At the time of HIPEC, all patients underwent complete cytoreduction to no visible disease. The procedure was well tolerated without perioperative mortality or complications. Median length of hospital stay was 4 days. After cytoreductive surgery and HIPEC, treatment included adjuvant platinum-based chemotherapy and maintenance hormonal therapy. Median progression-free survival was 22.5 months (range 10-36 months). The median overall survival from the time of HIPEC was 25.5 months, with 100% of patients alive at last follow-up.

**Conclusions:** This case series provides novel evidence that CRS and HIPEC is feasible and potentially effective in recurrent AGCT. The high rate of sustained progression-free survival in this cohort is notable, given the refractory nature of recurrent AGCT. Importantly, no grade II or higher adverse events attributable to HIPEC were observed, suggesting an acceptable safety profile. Larger multi-institutional studies are needed to further support HIPEC as a potential therapeutic option for recurrent AGCT.

# Probiotics in the Management of Endometriosis: A Meta-Analysis and Systematic Review

*Sean L. Backer-Meurke DO, Estefania Guthrie-Beckstrom MD, Kristin Malone MD/MPH, Siyi Chen PhD, Elizabeth F Sutton PhD, and Antonia Traina MD*

**Background:** Endometriosis affects 6-10% of women and is associated with pelvic pain and decreased quality of life. Frequently, outcomes from first-line medical therapy are limited and may warrant second-line agents or surgery which may introduce adverse effects, impact quality of life, and impose notable financial burden for patients and the healthcare system. As with other chronic inflammatory conditions, studies demonstrate a correlation between gut dysbiosis and endometriosis. Specifically, decreased lactobacilli concentration and increased firmicute to bacteriodetes ratio may impact inflammation and enteric estrogen metabolism, resulting in disease exacerbation.

**Objectives:** The goal was to examine whether probiotic supplementation to target gut dysbiosis may improve pelvic pain and quality of life among patients with endometriosis.

**Methods:** A systematic review and meta-analysis was performed to identify trials that evaluated pelvic pain with visual analog score (VAS), among patients with endometriosis, as an outcome of probiotic supplementation. Two randomized controlled trials were identified (n = 2 of 99) evaluating 8 and 12 week (respectively) daily probiotic (lactobacillus supplementation) compared to placebo. Quality of evidence and risk of bias was assessed using the Cochrane Risk of Bias in Randomized Trials (RoB 2.0) tool. No detectable between-study heterogeneity was identified. A fixed-effect model was utilized to analyze mean difference (MD) in pelvic pain (VAS) between probiotic intervention and placebo.

Main results: The Risk of Bias (RoB 2.0) tool was used to establish low publication bias for the two randomized control trials. A pooled MD of –1.28 (95% CI –1.44 to –1.12) was identified demonstrating significant reduction of pelvic pain in favor of probiotic supplementation intervention in relation to placebo after 8 weeks of intervention. One of the trials evaluated pelvic pain (VAS) after 8 weeks of intervention followed by 4 weeks without supplementation or placebo and identified a non-significant MD of –1.28 (95% CI –1.61 to –0.95). No adverse outcomes were identified.

**Conclusions:** Probiotic supplementation may be a promising low-risk intervention to reduce pelvic pain among patients with endometriosis, but future research is encouraged in the setting of limited data.

**PROSPERO registration: ID#: CRD420251108243; Date of registration: 19 July 2025**

# Relationship Between Co-occurring Fetal Growth Restriction and Preeclampsia

*Chaya Karunasiri MD, Rachel Denneny MD, Heather Duplessis MD, Sidney John MD, Emily Dubuisson MD, Carlee Myers MD, Mary Landry MD, Thomas Luke MD, Elizabeth F Sutton PhD, Tabitha Quebedeaux MD/PhD, and Asha Heard MD*

**Objective:** Preeclampsia (Pre-E) and fetal growth restriction (FGR) frequently coexist and may share underlying pathophysiology, though whether FGR should be included in Pre-E diagnostic criteria remains debated. While their combined presence is associated with worsened maternal cardiovascular markers and disease severity, the impact of the timing of each diagnosis on outcomes is unclear. This study aimed to evaluate whether the order of FGR and Pre-E diagnosis is associated with differences in maternal and fetal outcomes.

**Methods:** This retrospective cohort study included patients with both preeclampsia (Pre-E) and fetal growth restriction (FGR) at a single academic center (2017–2022), excluding multifetal gestations, fetal anomalies, and uncertain dating. Patients were grouped by diagnosis order (FGR-first vs Pre-E-first). Maternal outcomes included magnesium use, and unplanned cesarean delivery; fetal outcomes included gestational age at delivery, birthweight, and birth percentile. Comparisons were performed using Mann–Whitney U and Fisher's exact tests, with $p<0.05$ considered significant.

**Results:** A total of 27 patients met inclusion criteria, with 14 in the FGR-first group and 13 in the Pre-E-first group. Gestational age at initial diagnosis was earlier in the Pre-E-first group compared to the FGR-first group (25.2±6.3 vs 29.4±4.8 weeks, p=0.08). Patients diagnosed with Pre-E prior to FGR had a significantly longer interval from diagnosis to delivery compared to those with FGR first (10.0±7.2 vs 5.9±3.2 weeks, p=0.02). Gestational age at delivery was similar between groups (35±3 vs 35±4 weeks, p=0.92). Magnesium sulfate use was more frequent in the FGR-first group (53.8% vs 85.7%, p=0.09). No meaningful differences were observed in birthweight (2050±600 vs 1960±700 g, p=0.68), or delivery mode.

**Conclusions:** FGR diagnosed prior to preeclampsia was associated with a shorter interval from diagnosis to delivery, and increased magnesium use suggesting a more rapidly progressive disease course compared to cases in which preeclampsia occurs first. Larger prospective studies are needed to confirm these findings and to better characterize how the timing of these diagnoses should inform monitoring and delivery planning.

# Elective Induction Rates and Outcomes in Low-Risk Nulliparous and Multiparous Patients Following the ARRIVE Trial: A Regional Cohort Study from South Central Louisiana

*Katherine Oliver MD, Elizabeth Florence MD, Elizabeth F Sutton PhD, Dina Dinh MS, and J Hunter Collins PhD*

**Background:** The ARRIVE trial was a landmark study published in 2018 that investigated elective inductions of labor between 39 0/7 – 39 4/7 weeks gestational age compared to expectant management. This study found that elective inductions at 39 weeks were associated with a decreased cesarean delivery rate and no adverse neonatal outcomes. However, data on real-world adoption and outcomes following the publication of ARRIVE, particularly in more diverse regions compared to the trial setting, remain limited. This study aims to determine the changes in elective induction rates and outcomes at our institution after the ARRIVE trial publication.

**Methods:** A retrospective cohort study utilizing Woman's Hospital's Women and Infants Clinical (WINC) database was performed spanning 2016 to 2021. Our analysis included data divided into pre- and post-ARRIVE. Pre-ARRIVE data spanned January 1, 2016, through July 31, 2018, prior to publication of the ARRIVE trial. We excluded August 2018 to allow for adoption of practice changes based on the ARRIVE results. Post-ARRIVE data included September 1st, 2018, to March 31st, 2021. Each period had an equal number of calendar days (n = 943) to facilitate comparison. Inclusion and exclusion criteria were similar to the ARRIVE trial. We identified low-risk nulliparous, term, vertex and singleton pregnancies that had an elective induction between 39 0/7 and 39 4/7 weeks gestational age. We also identified low-risk multiparous individuals with similar gestational age range, no prior cesarean, vertex, and singleton. Individuals with contraindications to vaginal delivery, PROM, multiple gestation, fetal growth restriction, fetal anomaly, or any medical indication for induction were excluded.

**Results**: Our study included a total of 6518 low risk nulliparous and multiparous patients divided into pre-ARRIVE (N=3273) and post-ARRIVE (N=3245). Odds of elective induction increased significantly in the post-ARRIVE period (OR 1.26, 95% CI 1.14–1.39, $p<0.001$). We did not see a significant decrease in the odds of a cesarean delivery when comparing pre- and post-ARRIVE groups (OR 1.00, 95% CI 0.86-1.15, $p=0.96$). Other variables, including the odds of gestational hypertension diagnosis, pre-eclampsia diagnosis, and NICU admissions were not significantly different between pre- and post-ARRIVE groups. The odds of hemorrhage were approximately twice as high in the post-ARRIVE group compared to the pre-ARRIVE group (OR 2.1, 95% CI 1.62-2.73, $p<0.001$).

**Conclusions:** We observed a statistically significant increase in the odds of elective inductions after publication of the ARRIVE trial, suggesting a shift in clinical practice. However, unlike the ARRIVE trial, we did not find a significant reduction in the odds of cesarean delivery or hypertensive disorders of pregnancy. Differences in study design, patient population, and the transitional nature of the post-ARRIVE period may account for the differences in findings between our study and the original trial. Interestingly, the odds of hemorrhage were significantly higher in the post-ARRIVE group. This may be due to practice changes in blood loss documentation in deliveries (estimated to quantitative) that were adopted during the study period. Future work will examine a longer post-ARRIVE period to determine whether elective induction rates and associated outcomes continue to evolve as practice patterns mature.

# Effects of Remote Blood Pressure Monitoring on Postpartum Readmission Rates

*Julia Hernandez MD, Sidney John MD, Elizabeth F Sutton PhD, Stacey Holman MD, Asha Heard MD/MPH, and Tabitha Quebedeaux MD/PhD*

**Background:** Maternal mortality and morbidity are on the rise in the United States, especially in Louisiana. Hypertensive disorders of pregnancy/chronic hypertension significantly contribute to these trends, especially in the postpartum (PP) period. Remote blood pressure (BP) monitoring during the PP period presents an opportunity to more efficiently identify patients at risk of significant PP complications. The purpose of this study is to evaluate the effect of remote BP monitoring on the rate of PP readmission for hypertension.

**Methods:** Beginning in 2022, remote BP monitoring was prescribed to PP patients discharged from Touro Infirmary with either a diagnosis of chronic hypertension or a hypertensive disorder of pregnancy. An observational study was completed to compare readmission rates for hypertension before and after initiation of remote BP monitoring. Data was collected from patients delivering from January 1, 2019, to December 31, 2025. Deliveries between January 1, 2022, to December 31, 2022, were omitted as remote BP monitoring was initiated approximately halfway through this year. A comparison of rates of PP readmission pre– and post–intervention was completed.

**Results:** A total of 24,053 PP patients were identified for this observational study. 13,857 patients delivered between January 1, 2019, and December 31, 2021, with a total of 219 readmissions, and 160 of those readmissions being for a hypertensive disorder of pregnancy. Post-intervention, 10, 196 patients delivered between January 1, 2023, and December 31, 2025, with a total of 232 readmissions, and 169 of those being for a hypertensive disorder of pregnancy. We observed a slightly increased rate of HTN readmission after the intervention of PP remote BP monitoring (1.15 vs. 1.66%, respectively).

**Conclusions:** This data collection noted that there was a slight increase in readmission rates following initiation of remote PP BP monitoring. Further directions for this research would include identifying severity of disease for all readmissions and understanding if remote BP monitoring captures PP patients earlier in the course of their disease. It would also be beneficial to identify how social determinants of health may impact a patient's ability to seek in person evaluation in the PP period. There is concern for possible delays in presentation in this population given socioeconomic status and possibility of presenting to care from cities outside of New Orleans.

# Change in Anxiety and Depression Symptoms with Long-Term Hospital Admission in the Antepartum Period

*Jasmine Rogers MD, Briasha Jones MPH, Ashley Edwards PhD, Kristian Phillips BS, Bryn Daneshfar BS, Sarah Buzhardt MD, and Elizabeth F Sutton PhD*

**Background:** Depression and anxiety during pregnancy are associated with adverse maternal and neonatal outcomes, such as increased risk of preterm birth, low birth weight, and both elective and emergency cesarean sections. Antepartum hospitalization presents a unique stressor due to factors such as separation from family, loss of autonomy, and concern for the pregnancy. The objective of this study was to characterize the prevalence and change in symptoms of anxiety and depression among hospitalized pregnant patients. We hypothesized that as length of hospitalization increased, both GAD-7 and PHQ-9 scores would be associated with higher scores.

**Methods:** This is a prospective observational study conducted at Woman's Hospital's High-Risk Unit in Baton Rouge, Louisiana from December 2024 through February 2026. Patients admitted to the HRU were eligible to enroll with a viable intrauterine pregnancy, gestational age greater than or equal to 24 weeks, and English proficiency. Patients less than 18 years of age and those unable to provide informed consent were excluded. After informed consent was obtained, participants completed anxiety and depression symptom assessments using the GAD-7 and PHQ-9 respectively. Surveys were then repeated twice weekly for the duration of the hospital stay until delivery or discharge from the HRU. Baseline PHQ-9 and GAD-7 scores were compared across groups using ANOVA. Changes from baseline to final assessment were analyzed using one-sample t-tests and compared across groups using ANOVA.

**Results:** Among the 106 patients approached, 59 patients were enrolled in the study and 188 surveys completed (range 1-17 survey encounters). At admission to HRU, participants were on average 31.0±5.7 years old, with gravidity 2.6± 2.0 and parity 0.9±1.0, and 28.3± 3.4 weeks pregnant. All participants identified as non-Hispanic, and 53% of participants self-reported White race and 48% Black race. First PHQ-9 scores were on average 3.8±3.9, and first mean GAD-7 score was 5.4±4.7. First PHQ-9 and GAD-7 scores did not differ by indication for HRU admission (PPROM vs. HDP vs. Other: PHQ-9 $p=0.96$; GAD-7 $p=0.98$). Among 37 patients with repeated assessments, mean PHQ-9 scores remained stable over time (mean change +0.08, $p>0.05$), while GAD-7 scores significantly decreased (mean change −2.00, $p<0.001$). While GAD7 scores decreased across all indication groups, PPROM had the largest drop, though not statistically significant.

**Conclusions:** Symptoms of depression and anxiety were common among hospitalized antepartum patients but did not differ by admission indication. While depressive symptoms remained stable throughout hospitalization, anxiety symptoms significantly improved over time. These findings suggest that distress may be greatest at the time of admission, supporting early screening and targeted mental health interventions.

# POSTERS

**Posters are numbered 1- 9 for ease of viewing in the observation hall.**

## OBSTETRICS

**1 – Effects of Misoprostol Controlled Substance Classification in Pregnant and Birthing Individuals in Louisiana**
Estefania Guthrie MD and Nicole Freehill MD

**2 – Timing of Chronic Hypertension in Pregnancy and Perinatal Outcomes: A Comparative Cohort Study**
Sidney John MD, Keiko Long MD/MPH, and Tabitha Quebedeaux MD/PhD

**3 - Interrater Reliability of Fetal Heart Rate Tracing Interpretation Among Providers: A Pilot Study**
Mia McFadden MD, Sarah Buzhardt MD, and J Hunter Collins PhD

**4 - Pregnant Patients' Knowledge, Attitudes, and Counseling Experiences Related to Diastasis Recti Abdominis (DRA)**
Kyla Smith-Thomas MD, Sarah Buzhardt MD, J Hunter Collins PhD, and Elizabeth F Sutton PhD

**5 - Concordance Between Universal Drug Screening and Self-Reported Substance Use in Pregnant OB/GYN Patients**
Leigh Sumner MD, Neelima Sukhavasi MD/MPH, and J Hunter Collins PhD

## GYNECOLOGY

**6 - Impact of Pelvic Radiotherapy on Mesh-Bashed Urogynecologic Surgery in Gynecologic Oncology Patients**
Claire Mersereau MD, Tara Castellano MD, Amelia Jernigan MD, and Ryan Krlin MD

**7 - Predictors of Severe Anemia in Adolescents and Young Adults with Abnormal Uterine Bleeding**
Adelaide Schultz MD, J Hunter Collins PhD, and Neelima Sukhavasi MD/MPH

**8 – Excisional Managements vs Surveillance in Persistent HPV-Positive NILM: Cytology Detection of CIN2+ After Negative or Low-Grade Colposcopy**
Eliza Schneider MD, Antonia Traina MD, and Holly Provost MD

**9 – Post-Operative Examination After Cold Knife Conization**
Judi Stephens MD, Holly Provost MD, and Andrew Jones MD