

Shee-Uan Chen
(P1)



CURRICULUM VITAE

Shee-Uan Chen

President, Taiwan Association of Obstetrics and Gynecology.

Professor and Director, Department of Obstetrics and Gynecology, National Taiwan University Hospital

Education

College of Medicine, National Taiwan University.

Employment/Leadership Positions

Dr. Shee-Uan Chen was a graduate of College of Medicine, National Taiwan University. He completed the residency training of Obstetrics and Gynecology and research fellow of reproductive medicine in National Taiwan University Hospital. His major research interests include clinical and basic reproductive medicine, cryopreservation of oocytes, embryos and ovarian tissue and preimplantation genetic diagnosis. He has many research papers in reproductive medicine, such as Human Reproduction, Fertility and Sterility, and Journal of Clinical Endocrinology and Metabolism, and gets lots of research awards. He is also the reviewer of these well-known journals and the member of editorial board of the Journal of Formosan Medical Association. He had been the president of Taiwanese Society of Reproductive Medicine. Now he is professor and director of National Taiwan University Hospital and the president of Taiwan Association of Obstetrics and Gynecology.

Elective oocyte freezing for non-medical reasons

Shee-Uan Chen, MD

President, Taiwan Association of Obstetrics and Gynecology

Professor, Department of Obstetrics and Gynecology, National Taiwan University Hospital, Taiwan

Lack of a suitable partner and incomplete self-accomplishment are the most frequent reasons prompting reproductive-aged women to defer childbearing. Pregnancy potential declines significantly in women after 35 years of age. An increased rate of aneuploidy of oocytes and diminished ovarian reserve are two significant risk factors. Social/elective oocyte freezing is a strategy for women who wish to preserve their oocytes from age-related fertility loss.

Therefore, we started the oocyte cryopreservation program for unmarried healthy women with non-medical reasons. A total of 645 women with 840 cycles from our center (2002-2020) were reported in the recent literature. The mean age of oocyte freezing was 37 years. The median number of oocytes frozen was 12. Fifty-four women thawed their oocytes at our hospital. The usage rate in Taiwan was 8.4%. Fifteen women (2.3%) transported their frozen oocytes abroad. The median storage duration was 3.0 years for those who thawed oocytes. The median age of thawing was 42 years. The survival rate was 76.8% and fertilization rate was 66.3%. There were 18 live births with 21 babies. The live birth rate for age less than 35 years was 63.6%, 36-39 years, 30.8%, and \geq 40 years 17.6%. The cumulative live birth per thawed case was 33%.

In Taiwan, the practice of IVF is restricted between a licensed married heterosexual couple. Sperm donation is not available for single women. That may partly explain the lower usage rate. However, the use of transported oocytes abroad may underestimate the actual usage rate. Nevertheless, the oocyte freezing of single woman with non-medical reasons provides an important opportunity to own biological children. Oocyte cryopreservation in the age before 35 years old is more effective. The ask for oocyte cryopreservation in women is increasing in the recent years.

Jeanne Conry
(P2)



CURRICULUM VITAE

Jeanne Ann Conry, MD, PhD

President, The International Federation of Gynecology and Obstetrics
Past-President, American College of Obstetricians and Gynecologists

Employment/Leadership Positions

2017-present President, CEO and founder Environmental Health Leadership
2021-2024 The Partnership for Maternal, Newborn and Child Health (PMNCH) ,WHO
2016-2026 Chair, Women' s Preventive Services Initiative
2013-2014 Past-President of the American College of Obstetricians and Gynecologists (ACOG).

Education

1982-1986 Medical Degree, University of California, Davis

Awards and Fellowships

2018-present Honorary Fellow, Taiwan Association of Obstetrics and Gynecology

Leadership, Collaboration and Advocacy

Jeanne A Conry, MD PhD

President The International Federation of Gynecology and Obstetrics

The International Federation of Gynecology and Obstetrics is the global voice for Women's Health. We are comprised of over 135 Member Societies, divided into five major regions of the world. We collaborate and work closely with the Asia Oceania Federation of Obstetrics and Gynecology, and count Taiwan as an important member society. Taiwan is a leader in obstetrics and gynecology care. FIGO relies on four pillars as we describe our strong foundation of leadership: Research Interpretation and Implementation, Education of our Colleagues, our Patients and our Health Leaders, Advocacy to improve women's health and Capacity Building to provide the work force our world needs. I will provide an overview of leadership opportunities in our lives and describe four of the steps I believe are essential. The most important and first step is to recognize yourself as a leader right now, in your current stage in life. Leaders change, leaders evolve, but it is that first step in recognition that you are a leader is most critical. Second, we must say Yes to all opportunities that arise before us, because quite often we do not appreciate where our work will take us. By saying YES to opportunities, we broaden our horizons and achieve much more. Third, we must follow our passions. If we have an innate interest in one area of medicine, we should follow that path. We then engage our energy and our interests more fully. And, we will accomplish much more personally and professionally. Finally, we must appreciate that leadership paths are not linear, and each time we take a path to the side or on a different direction it contributes to our growth. Leaders must be flexible and help those around them grow. I will discuss FIGO and its strategic plan, that relies on Member Societies and Regional Federations to guide global health. I will close my remarks with what it means for FIGO and TAOG to be global leaders in women's health. This role will require more than just a diverse perspective, it will require partnerships, it will require focus, and it will require collaboration around the world.

Pisake Lumbiganon
(P3)



CURRICULUM VITAE

Pisake Lumbiganon

Pisake Lumbiganon is a Professor of Obstetrics and Gynecology, Convenor of Cochrane Thailand and Director of the WHO Collaborating Centre on Research Synthesis in Reproductive Health based at Faculty of Medicine, Khon Kaen University, Thailand. He is currently the President of the Asia Ocenia Federation of Obstetrics and Gynecology. He has received research grants from many international organizations including IDRC, WHO, Wellcome Trust, European Comission, Thailand Research Fund. He has published more than 150 papers in various international journals including many Cochrane reviews. He was a dean of the Faculty of Medicine at Khon Kaen University from 2009 to 2013 and the President of the Royal Thai College of Obstetricians and Gynecologists from 2016 to 2018. In 2019 he received Fellow ad eundum from the Royal College of Obstetricians and Gynaecologists. His main areas of interest include maternal and perinatal health, evidence based practices, systematic review and meta-analysis.

WHO recommendations Intrapartum care for a positive childbirth experience

*Pisake Lumbiganon, MD, MS(Penn), FRCOG (ad eundem)
President, Asia Oceania Federation of Obstetrics and Gynecology*

This guideline addresses these issues by identifying the most common practices used throughout labour and delivery to establish norms of good practice for the conduct of uncomplicated labour and childbirth. The guideline recognizes a “positive childbirth experience” as a significant end point for all women undergoing labour. The WHO technical consultations led to 56 recommendations on intrapartum care: 26 of these are newly developed recommendations and 30 are recommendations integrated from existing WHO guidelines.

Recommended cares throughout labour and delivery include:

- 1) Respectful maternity care,
- 2) Effective communication,
- 3) Companionship during labour and childbirth.

For the first stage of labour, the following definitions and interventions are recommended:

- 1) The latent first stage is a period of time characterized by painful uterine contractions and variable changes of the cervix, including some degree of effacement and slower progression of dilatation up to 5 cm for first and subsequent labours,
- 2) The active first stage is a period characterized by regular painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation from 5 cm until full dilatation.
- 3) Women should be informed that a standard duration of the latent first stage has not been established and can vary widely from one woman to another. However, the duration of active first stage (from 5 cm until full cervical dilatation) usually does not extend beyond 12 hours in first labours, and usually does not extend beyond 10 hours in subsequent labours.
- 4) Digital vaginal examination at intervals of four hours is recommended for routine assessment of active first stage of labour in low-risk women.
- 5) Parenteral opioids, such as fentanyl, diamorphine and pethidine, are recommended options for healthy pregnant women requesting pain relief during labour, depending on a woman’s preferences.
- 6) For women at low risk, oral fluid and food intake during labour is recommended.
- 7) Encouraging the adoption of mobility and an upright position during labour in women at low risk is recommended.

For the second stage of labour, the following definitions and interventions are recommended:

- 1) The second stage is the period of time between full cervical dilatation and birth of the baby, during which the woman has an involuntary urge to bear down, as a result of expulsive uterine contractions.
- 2) Women should be informed that the duration of the second stage varies from one woman to another. In first labours, birth is usually completed within 3 hours whereas in subsequent labours, birth is usually completed within 2 hours.
- 3) For women without epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.
- 4) Routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth.

For the third stage of labour, the following interventions are recommended:

- 1) The use of uterotonics for the prevention of postpartum haemorrhage (PPH) during the third stage of labour is recommended for all births.
- 2) Oxytocin (10 IU, IM/IV) is the recommended uterotonic drug for the prevention of postpartum haemorrhage (PPH).
- 3) In settings where oxytocin is unavailable, the use of other injectable uterotonics (if appropriate, ergometrine/ methylergometrine, or the fixed drug combination of oxytocin and ergometrine) or oral misoprostol (600 µg) is recommended.
- 4) Delayed umbilical cord clamping (not earlier than 1 minute after birth) is recommended for improved maternal and infant health and nutrition outcomes.

For newborns the following interventions are recommended:

- 1) Newborns without complications should be kept in skin-to-skin contact (SSC) with their mothers during the first hour after birth to prevent hypothermia and promote breastfeeding.
- 2) All newborns, including low-birth-weight (LBW) babies who are able to breastfeed, should be put to the breast as soon as possible after birth when they are clinically stable, and the mother and baby are ready.
- 3) All newborns should be given 1 mg of vitamin K intramuscularly after birth (i.e. after the first hour by which the infant should be in skin-to-skin contact with the mother and breastfeeding should be initiated).

Tadashi Kimura
(P4)



CURRICULUM VITAE

Tadashi KIMURA MD,PhD.

Qualifications

1985	M.D. Osaka University Faculty of Medicine
1990	Specialist of the Board, Japan Society of Obstetrics and Gynecology
1993	Ph.D., Osaka University Graduate School of Medicine,
2005	Specialist of the Board, Japan Society of Reproductive Medicine
2007	Specialist of the Board, Japan Society of Gynecologic Oncology

Academic and Professional posts (held since graduation)

2023-	Auditor, JSOG
2019-2023	Chairperson of the Executive Board, JSOG (Japan Society of Obstetrics and Gynecology)
2020-present	Assistant to the hospital director, Osaka University Hospital
2018-2020	Director, Osaka University Hospital
2014-2018	Vice Director, Osaka University Hospital
2011-2017	Executive Board Member, FIGO (International Federation of Obstetrics and Gynecology)
2011-2017	Council member, AOFOG (Asia-Oceania Federation of Obstetrics and Gynecology)
2009-2023	Executive Board Member, JSOG
2006-present	Professor and Chairperson, Department of Obstetrics and Gynecology, Osaka University Graduate School of Medicine
2005-2006	Lecturer, Department of Obstetrics and Gynecology, Osaka University Graduate School of Medicine
1991-2006	Assistant Professor, Department of Obstetrics and Gynecology, Osaka University Graduate School of Medicine (1995-1997 Visiting Scientist, University of Hamburg)

How we could transfer our fruit from bench to bedside

Tadashi Kimura M.D., Ph.D.

Auditor/Immediate Past Chairperson, Japan Society of Obstetrics and Gynecology

Professor and Chairperson

Department of Obstetrics and Gynecology, Osaka University Graduate School of Medicine

Among Japanese MDs, we often get trained in basic research works at the age of late 20' s and early 30' s. I believe a research which appears to connect directly to clinics is easy to be fade into oblivion. I deeply considered how we could get a fruit from my bench works (basic science) to improve our clinical practice.

My first theme was about the onset of labor because I wondered when I induced labor at term, effectiveness of oxytocin so varied among women and even among date. In 1979, Soloff et al., had already revealed H³-oxytocin binding was drastically increased at the time of labor in rat myometrium. However, molecular background of this regulation was totally unknown. In order to elucidate the mechanism of the oxytocin receptor (OTR) induction in term myometrium, we cloned human OTR cDNA (Nature 1992), and its' gene (JBC 1994). We also established its monoclonal antibody and revealed its temporal and special expression in decidua (JCI 1994) and myometrium at term (Endocrinology 1996). We tested the existence of DNA binding protein on OTR gene upstream region in term myometrium (Mol Cell Endocrinol 1999) and cloned one cDNA encoding human *maff* cDNA (BBRC 1999). However, this protein lacks transactivation activity and the mechanism of upregulation of this gene is still not clear. We cloned murine OTR gene (Mol Cell Endocrinol 1996) and established OTR knockout mouse (PNAS 2005). However, female OTR (-/-) mice revealed no phenotype on their parturition. I expect this cDNA, as well as crystal structure should help to develop novel selective antagonist/agonist, however until now no clinically effective ligand had developed.

My second theme was about implantation. We established *in vivo*/transient gene transfer system with HVJ (Haemagglutinating virus of Japan)-E vector to mouse endometrium at opening of implantation window (Mol Hum Reprod 2003) and revealed stat-3 was the critical factor to open the window (FEBS let 2006). With these mice as implantation failure model, we applied physiological analysis (intrauterine oxidation-reduction potential (ORP; Reprod Fertil Dev 2017) and vaginal impedance (VZ; Hum Reprod 2018)). These two parameters clearly discriminate "implantable" (control) and "unimplantable" (stat-3 disturbed) mice, so that we applied these parameters to human. Recently Japanese authority (PMDA) approved our system to measure intrauterine impedance (not for diagnosis). I sincerely expect our collaborative clinical trial between Taiwan and Japan will be successful.

Our team is now dealing with labor with multichannel flexible dermal electrodes system to monitor uterine activity and fetal ECG. I believe when we get stuck in wet science such as molecular biology, it should be the time when "physiological method strikes back" .

Joong-Shin Park

(P5)



CURRICULUM VITAE

Joong Shin Park, MD, PhD

Vice President, Seoul National University Hospital,
Professor, Department of Obstetrics and Gynecology, Seoul National University College of Medicine
Chairman of the Board, Korean Society of Obstetrics and Gynecology

Education

Seoul National University College of Medicine (M.D.)
Seoul National University Graduate School (M.S.)
Seoul National University Graduate School (Ph.D.)
Residency, Dept. of Obstetrics and Gynecology, Seoul National University Hospital
Fellowship, Dept. of Obstetrics and Gynecology, Seoul National University Hospital

Postgraduate position

2012~2014 Director, Dept. of Education and Training, Seoul National University Hospital
2014~2016 Associate Dean for Public Relations, Seoul National University College of Medicine
2014~2016 Director of Medical Library, Seoul National University
2015~2018 Director of Graduate Medical Education, Korean Academy of Medical Sciences
2015~2017 President, Korean Society of Ultrasound in Obstetrics and Gynecology
2016~2017 Associate Dean for Academic Affairs, Seoul National University College of Medicine
2018~2021 Director of Specialty Examination, Korean Academy of Medical Sciences
2018~2020 Chair of Scientific Committee, Korean Society of Maternal Fetal Medicine
2018~2021 Chair of Scientific Committee, Korean Society of Obstetrics & Gynecology
2018~2023 Chairman, Department of Obstetrics & Gynecology, Seoul National University College of Medicine & Seoul National University Hospital
2019~2023 Director of Medical Museum, Seoul National University Hospital
2020~2023 Director of Headquarters of Research Administration & Coordination, Seoul National University Hospital
2020~2022 Vice President, The Korean Society of Medical Education
2021~2022 Chairman, Council for Graduate Medical Training, Ministry of Health & Welfare, Korea

Current position

1998~Present Assistant Professor, Associate Professor, Professor, Department of Obstetrics & Gynecology, Seoul National University College of Medicine & Seoul National University Hospital
2020~Present Vice President, Korean Society of Maternal Fetal Medicine
2021~Present Vice President, Korean Academy of Medical Sciences
2021~Present Chairman of the Board, Korean Society of Obstetrics & Gynecology
2022~Present Treasurer, Asia & Oceania Federation of Obstetrics & Gynecology
2022~Present President, The Korean Society of Medical Education
2023~Present Vice President, Seoul National University Hospital

Early prediction of gestational diabetes mellitus

Joong Shin Park, MD, PhD

*Department of Obstetrics and Gynecology
Seoul National University College of Medicine*

Gestational diabetes mellitus (GDM) is a common complication of pregnancy characterized by glucose intolerances diagnosed for the first time during pregnancy. Its prevalence among Korean pregnant women is reported to range from 5.7% to 9.5%. GDM not only affects pregnant women but also has adverse outcomes for fetuses and newborns. With the increasing global incidence of obesity and metabolic complications, the prevalence of GDM is also rising. Therefore, it is crucial to accurately diagnose GDM early in pregnancy to minimize associated complications.

To achieve an accurate diagnosis of GDM, we compared the predictive performance between old criteria (based on five historical/demographic factors) and new criteria (consisting of 11 factors) defined by American College of Obstetricians and Gynecologists (ACOG). According to the old criteria, approximately 30% of women were classified as high-risk, while the new criteria classified around 16% as high-risk. Among women diagnosed with GDM, about 45% were incorrectly classified as not high-risk using the old criteria, and approximately 50% were incorrectly classified as not high-risk using the new criteria. Among women without GDM, about 28% were classified as high-risk by the old criteria, and approximately 14% were classified as high-risk by the new criteria. We concluded that the use of new criteria reduces the need for early GDM screening by reducing the number of cases identified as high-risk compared to the use of old criteria.

Additionally, a machine learning-based model was developed to predict GDM in early pregnancy and we evaluated whether prediction model including NAFLD-related factors showed improved performance. Ultrasound was performed on pregnant women at 10-14 weeks to evaluate NAFLD, and GDM was evaluated at 24-28 weeks. Clinical variables collected before 14 weeks were used to develop prediction models for GDM. Various machine learning methods, including logistic regression, random forests, support vector machines, and deep neural networks were utilized and the model that incorporated both clinical variables and NAFLD-related factors demonstrated the highest predictability.

Lastly, we conducted a study that compared the intestinal microbiota between pregnant women with GDM and those without GDM. The analysis revealed that pregnant women with GDM had lower levels of bacteria such as *Agathobacter rectalis*, *Bifidobacterium longum* group and *Bacteroids plebeius* compared to healthy non-GDM women. On the other hand, bacteria such as Firmicutes and *Blautia* were more abundant in women with GDM. These differences in the intestine microbiome suggest the possibility of developing a model for early detection of GDM.

In summary, we employed various approaches to predict GDM earlier such as comparing old and new criteria, developing predictive models using machine learning and analyzing the intestinal microbiome in pregnant women. By early prediction of GDM, we expect to reduce the complications related with GDM through early and proper management.

Verda J. Hicks
(P6)



CURRICULUM VITAE

Verda J. Hicks

President ACOG

Clinical Associate Professor, University of Missouri, Kansas City

Education

Medical School: University of Illinois, James Scholar

Residency: The Union Memorial Hospital, Baltimore, MD

Fellowship: a. Duke University, Gyn Oncology

b. Medical Education Research Fellowship, CGEA

Practice-related Activities

Site: Locum Tenens, Jersey Shore University Medical Center

a. Director Gyn Oncology

b. Sope: Full service Gyn-Oncology Division across a 7 hospital system providing medical, surgical, and oncologic care.

ACOG Activities

Prologue Advisory Committee, Gyn Oncology and Critical Care

ACOG Distinguished Service Award *

President-elect ACOG

President ACOG

The Obstetrician-Gynecologist as Leader

*Verda Hicks, MD FACOG FACS
President, ACOG*

As an Obstetrician-Gynecologist we are taught to use evidence-based medicine as foundation of the care that we provide our patients. Even though we may not consider ourselves as a leader, to our patients, their families, and their communities-- **We Are Leaders.** But, we are not trained in evidence-based leadership.

In addition, we must lead our profession to address the many challenges that are shared by us across the world that we practice in—maternal mortality, staffing shortages, challenges to reproductive rights, mental health, systemic racism and social determinants of health, equitable reimbursement, violence against providers, sexual assault/misogyny, and resultant burnout—as examples.

In this lecture we will address some examples of evidence-based leadership practice. The information and resources provided will be a starting point to accept the challenge to lead—**To Lead From Where You Are.**

We must lead in our practices, in our communities, and within our specialty or subspecialty. We can all lead around personal privacy protection and support evidence-based medicine. We can lead by calling out biases when we see them and recognize our own implicit biases. We can reach out to each other, communicate understanding of each other, help each other elevate each other, be kinder to each other—realizing that we are all living similar shared experiences in stressful times. We must respect and value those things that seem to apparently divide us, so that they do not permanently divide us.

No matter where we are on our career journey, we can lift up the mission of our profession as a first step in recognizing the leader in us.