2025
Subspecialty Certifying Examination Bulletin

Including:

Complex Family Planning (CFP) – ACGME-Trained Candidates

Gynecologic Oncology (GYN ONC)

Maternal-Fetal Medicine (MFM)

Reproductive Endocrinology and Infertility (REI)

Urogynecology and Reconstructive Pelvic Surgery (URPS)*

ABOG

American Board of Obstetrics & Gynecology

First in Women's Health®

This *Bulletin*, issued in January of 2024, represents the official statement of the requirements for the Subspecialty Certifying Examinations to be given in April 2025.

Revised January 16, 2024

***Formerly known as Female Pelvic Medicine and Reconstructive Surgery (FPMRS)**

A list of the ABOG Division Committee for each subspecialty can be found on the ABOG website.

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GENERAL INFORMATION FOR ALL CANDIDATES

Gender Language Disclaimer

The American Board of Obstetrics and Gynecology (ABOG) recognizes that patients have diverse gender identities and is striving to use gender-inclusive language in its publications, literature, and other printed and digital materials. In some instances, ABOG uses the word "woman" (and the pronouns "she" and "her") to describe patients or individuals whose sex assigned at birth was female, whether they identify as female, male, or non-binary. As gender language continues to evolve in the scientific and medical communities, ABOG will periodically reassess this usage and will make appropriate adjustments as necessary. When describing or referencing study populations used in research, ABOG will use the gender terminology reported by the study investigators.

Non-Discrimination and Fairness Disclaimer

The American Board of Obstetrics and Gynecology does not discriminate on the basis of race, color, creed, age, gender, national origin, religion, disability, marital status, parental status, ancestry, sexual orientation, or any other status protected by law. All candidates for certification will be treated in an equitable manner throughout the certification process and judged solely on the criteria determined by the American Board of Obstetrics and Gynecology.

Candidate Responsibility

The process of certification in any of the subspecialties by the American Board of Obstetrics and Gynecology is voluntary. ABOG does not assume responsibility to contact potential candidates. Each candidate is responsible for initiating the process, completing all applications, submitting required materials by the deadlines, and paying the appropriate fees.

ABOG annually reviews policies and procedures for determining applicant and candidate certification requirements, as well as compliance with these requirements based on industry standards. Candidates must meet the eligibility requirements published in the *Bulletin* dated for the year in which they are to take the Certifying Examination as requirements may change from year to year. The *Bulletin* is available online at www.abog.org under the "Subspecialty Certification" tab. It is the candidate's responsibility to become familiar with all the material contained in the *Bulleti*n, including the information in the Appendices. Each candidate is also responsible for reading all the policies included in the Policies section under the "About ABOG" tab on the ABOG home page.

After applying, it is the responsibility of each candidate to update their personal email and mailing addresses in the profile section of their ABOG portal. Because hospital and university email addresses are often closed after the completion of training, candidates should list a personal email address.

Physicians who have completed an ACGME-accredited fellowship in Complex Family Planning, Gynecologic Oncology, Maternal-Fetal Medicine, Reproductive Endocrinology and Infertility, or Urogynecology and Reconstructive Pelvic Surgery/Female Pelvic Medicine and Reconstructive Surgery must achieve ABOG subspecialty certification within 8 years of completion of training. If certification is not achieved within 8 years, the physician will no longer be eligible to apply for the Qualifying and Certifying Subspecialty Examination unless an additional 6 months of

supervised subspecialty practice is completed. For additional information on regaining eligibility, please see the Policy on Regaining Eligibility for Subspecialty Certification at www.abog.org. For any questions on the policy, please contact the ABOG Certification Standards department at applications@abog.org. Please note that the term “Board Eligible” is not used or recognized by ABOG.

Please note that Appendices C-G have specific information about each subspecialty’s case lists minimums and examination topics.

2025 CERTIFYING EXAMINATION

Introduction

The process of certification by ABOG is voluntary. ABOG has a two-step certification process for each subspecialty: (a) a multiple-choice, computer-based Qualifying Examination, and (b) an oral, face-to-face Certifying Examination. The ABOG Certifying Examination is the last step in the certification process for all ABOG subspecialties. The Certifying Examination will evaluate the candidate’s approach to and rationale for the clinical care of various patient management problems in the subspecialty. A combination of standardized structured cases and candidates’ own case lists will be used by the examiners during the exam to assess candidates.

Candidates will be expected to demonstrate a level of knowledge that allows them to serve as consultants to physicians in their community who are obstetrician-gynecologists and to provide knowledgeable and clinically capable care to women.

Overview of Deadlines and Fees

The following table lists the deadlines and fees for the Certifying Examination. Deadlines cannot be extended. Case lists, thesis, and all fees must be submitted on the candidate’s ABOG portal prior to midnight Central time on their due date. The system will prevent submission once the deadline has passed. If you fail to submit by the deadline, please email the Certification Standards Department at applications@abog.org. The application fee must be paid by credit card through the candidate’s ABOG portal at the time of application. The examination fee must be paid by credit card through the candidate’s ABOG portal at the time of notification of acceptance to the examination.

Certifying Examination: Deadlines

January 1, 2024 – December 31, 2024	Case list collection period
May 22, 2024	Applications available online
July 22, 2024	No applications accepted after this date
September 2024	Candidates will be notified to submit case lists, thesis, and a photograph and to pay the examination fee
September 30, 2024	Last day for receipt of thesis, photograph, and examination fee

February 3, 2025	Last day for receipt of case lists
April 7-10, 2025	Certifying Exam

Certifying Examination: Application Fees

May 22, 2024 – July 5, 2024	$1180
July 6-22, 2024	$1180 + $400 late fee = $1580

Certifying Examination: Examination Fees

September 30, 2024	$1425

Application Deadline and Fee

The final deadline to complete the online application and pay the application fee is July 22, 2024. Application fees are not refundable.

Examination Deadline and Fee

If the candidate's application is accepted, a notice of acceptance will be emailed to the candidate in September 2024. The email will explain the process of submitting the thesis and case lists. The examination fee must be paid on or before September 30, 2024.

Thesis Deadline

The final deadline for uploading a PDF copy of the thesis and current Thesis Affidavit in the candidate's ABOG portal is September 30, 2024. See the Thesis Submission section for the preparation and submission information.

Case List Deadline

The final deadline for receipt of the case lists is February 3, 2025. Case lists must be submitted electronically using the ABOG case list program located on the candidate's ABOG portal. The completed Case List Affidavit must first be uploaded in the case list program in order to submit the case list. Candidates must submit the case lists in the proper format and include the appropriate number of cases.

Eligibility Requirements

Each candidate must meet the following requirements:

1. **Must be a Diplomate** of ABOG and hold an Active Certificate in Obstetrics and Gynecology.
2. **Must have passed the Qualifying Examination in their subspecialty on their most recent attempt.**
3. **Hold an unrestricted license to practice medicine** in all states or territories of the United States or Canada in which the candidate holds a medical license. Licenses that have been revoked, suspended, or are on probation, or are subject to conditions of any type, are considered to be restricted.
4. **Have privileges at one or more acute care hospitals.** While full, unrestricted privileges to perform all procedures associated with their subspecialty are preferred, at a minimum, these

privileges must allow the candidate to perform an in-hospital consultation on patients who have been admitted. The latest date a candidate can have privileges in effect is June 19, 2024. If a candidate holds hospital privileges in more than one hospital, they can give up privileges voluntarily as long as they still hold unrestricted hospital privileges in another hospital. Privileges that are resigned or dropped in lieu of an investigation or adverse action are not considered to be given up voluntarily and must be reported. The candidate's privileges must remain in effect at the time of the Certifying Examination and may not be suspended or revoked, and the candidate must not be under investigation for patient care issues.

5. **Be of good moral and ethical character** and have shown appropriate professionalism in all interactions with patients, peers, and other medical personnel. A felony conviction, even if unrelated to the practice of medicine, will be considered evidence of failure to meet this standard.
6. **Have not resigned hospital privileges or membership in any medical organization** (e.g., ACOG) while under investigation. If the candidate is under investigation or on probation, the application will not be approved. The candidate must reapply and pay a new application fee once the probation and/or restrictions have been resolved. However, resolution of these matters does not guarantee that the candidate's application will be approved.
7. **Have had an independent practice as a subspecialist** in their subspecialty field and have privileges in a center or centers providing or having ready access to the essential diagnostic and therapeutic facilities for the practice in their subspecialty field, and to retain such practice until the date of the candidate's examination. Practice may include locum tenens work.
8. **Submit electronic case lists** that document a practice that demonstrates sufficient depth and breadth of practice in their subspecialty field to permit the evaluation of the candidate's ability to function in the subspecialty. The case lists must be appropriately de-identified.
9. **Submit a thesis** that meets the standards of their subspecialties' requirements, as noted in this bulletin. Each submitted thesis will be reviewed for acceptability. Prior publication in a peer-reviewed journal does not guarantee acceptance.
10. **Have not failed to disclose any adverse action**. If a non-disclosed falsification or adverse action is identified by ABOG, it will result in a deferral of a candidate's eligibility to sit for the Certifying Examination for a period of at least 3 years. If the candidate is allowed to sit for the examination at the end of the deferral period, the candidate must meet all requirements in effect at that time.
11. **A candidate who practices outside of the United States, its territories, or Canada** must submit, with the application, a letter(s) from a senior responsible officer in the hospital(s) where the candidate practices, verifying the candidate's responsibility for independent, unsupervised care of patients.

Application Process

1. Applications will be available online beginning May 22, 2024, on the candidate's ABOG portal. The application fee must be paid online by credit card at the time of application. No other form of payment will be accepted. All fees are quoted and payable in US dollars. The

application fee for the Certifying Examination will not be refunded. The final day applications will be accepted is July 22, 2024.

2. During the application process, a completed Verification of Hospital Privileges Form will be required. This form must be printed from the candidate's ABOG portal and must be signed and uploaded using the task on the candidate's ABOG portal dashboard.
3. If the candidate's application is approved, an email will be sent with instructions for submitting the case lists and thesis. The examination fee must be paid at this time. The case lists will not be accepted unless the examination fee is paid in full by credit card on the candidate's ABOG portal by the deadline.
4. Prior to approval of application, all inquiries and correspondence about applications must be in English and sent to applications@abog.org.
5. If full payment of the examination fee has not been received by September 30, 2024, for the 2025 examination, the candidate will not be scheduled, and no fees will be refunded.
6. Once all materials have been received by ABOG and the appropriate fees paid, the candidate will receive an Examination Date Notification posted on the candidate's ABOG portal at least one month prior to the date of the examination.
7. Each year ABOG notifies the American College of Obstetricians and Gynecologists (ACOG), the American Board of Medical Specialties (ABMS), the American Medical Association (AMA), the American Journal of Obstetrics and Gynecology (AJOG), American Society for Reproductive Medicine (ASRM), American Urogynecologic Society (AUGS), Society for Gynecologic Oncology (SGO), Society for Maternal-Fetal Medicine (SMFM) and the Society for Family Planning (SFP) of the names and addresses of the Diplomates who have been certified in the course of that year. ABOG also provides de-identified data to fellowship programs and to the ACGME about fellowship program pass rates to be used as a criterion to evaluate the effectiveness of program training. ABOG, ACOG, AMA, ABMS, ASRM, AUGS, SGO, SMFM, and SFP on request, also make this information available to the public, including, but not limited to, hospitals, agencies of government, insurers, and laypersons. ABOG may use the results of certification examinations for research purposes and may publish the results of the research.
8. As a condition for acceptance as a candidate for certification as a Subspecialty Diplomate, each candidate, at the time of the Certifying Examination, is required to sign an irrevocable waiver authorizing the dissemination of the candidate's certification status without limitation or condition.

Thesis

A thesis is required by all subspecialties and must be submitted by the date listed in the bulletin and according to the guidelines for preparation listed below. The subspecialty's division will review the thesis and decide acceptability. Prior publication of a thesis by a refereed journal does not guarantee acceptance of the thesis for the Certifying Examination. It is not necessary for the thesis to have been published.

Thesis Preparation Instructions

1. Format: The format of the thesis must comply with the instructions for authors for a major peer-reviewed journal in a field related to the subspecialty except as noted below. The name

of the journal must be identified clearly on the cover page of the manuscript. Theses that are not in the proper journal format will not be accepted.

The cover page of the thesis should only show the:

a. thesis title,
b. name of the candidate,
c. hypothesis (or purpose for research not testing a hypothesis),
d. name of the journal format.

Electronic copies or reprints of published manuscripts are acceptable.

2. Hypothesis or Purpose: The thesis must clearly state the hypothesis to be tested in the form of a simple declarative sentence. The hypothesis must be included on the cover page and in the body of the paper, not just in the Abstract.

   Whenever possible, the hypothesis should include a statement such as, “Our hypothesis is that XXX is statistically significantly different from YYY.” It may be useful to follow PICOT criteria (population, intervention [for intervention studies], comparison group, outcome of interest, and time) in composing the hypothesis. Conversely, the null hypothesis may be stated.

   If the research does not involve hypothesis testing, the thesis must clearly state a purpose in the form of a simple declarative sentence. The purpose statement should convey the goal or overall aim of the inquiry. The purpose statement must be included on the cover page and in the body of the document, not just in the Abstract.

3. Authorship: The cover page should only list the title of the thesis, the candidate’s name, the hypothesis or purpose, and the name of the journal format. You do not need to list the co-authors on the cover page if submitting a published copy.

   Acknowledgments are not allowed.

4. Subject Matter: The subject matter must be clearly related to the area of the subspecialty and be important to the field.
5. Research: The thesis must be based on clinical or laboratory research performed during the fellowship period. A review of work performed by others is not acceptable.
6. IRB Approval: All research must be reviewed and approved by the human or animal institutional review boards (IRBs) of the sponsoring institution. If the institutional IRB does not review studies that do not include humans and/or animals, there must be a statement from the IRB to that effect.
7. Unacceptable Papers: The following are not acceptable for a fellow’s thesis:
   a. Book chapters
   b. Case reports
   c. Case series
8. Potentially Acceptable Theses: Any thesis submitted must be the product of a significantly thoughtful and robust research effort and will be reviewed by the subspecialty division for acceptability. Reports of the results of treatment of patients from a practice or department are not acceptable as these are considered to be a case series.

The research must be important to the field of the subspecialty. The following types of research conducted during a fellowship may qualify as an acceptable thesis for examination for certification:

a. Laboratory, Translational, and Animal research.
b. Randomized Controlled Trial: The study must adhere to the CONSORT standards.
c. Meta-Analysis and Systemic Review: The report must adhere to the PRISMA or MOOSE guidelines.
d. Cost-Effective Analysis: The report must conform to the recommendations of the Second Panel on Cost-Effectiveness in Health and Medicine for reporting CEA results.
e. Case-Control Study: The study must conform to the STROBE guidelines for observational studies.
f. Cohort Study: The candidate must have developed the cohort. The study must conform to the STROBE guidelines for observational studies.
g. Survey Research: The candidate must have developed the questionnaire or used a previously validated questionnaire, and there should be a 50% return and completion of the questionnaire. The thesis must conform to the STROBE guidelines for observational studies and CHERRIEs guidelines for Web-based surveys.
h. Epidemiology Research: The study must conform to the STROBE guidelines for Epidemiological Studies.
i. Mechanistic Trials: The study should meet NIH criteria for a clinical trial.
j. Modeling and Simulation-based Research (SBR): A prediction model thesis must follow the TRIPOD statement. An SBR thesis must adhere to the SBR extensions to the CONSORT and STROBE statements.
k. Quality Improvement: The thesis must adhere to the SQUIRE 2.0 guidelines.
l. Qualitative Research: The thesis must adhere to the COREQ or SRQR guidelines.
m. Artificial Intelligence and Machine Learning Research: The thesis must adhere to the SPIRIT-AI Extension or the CONSORT-AI Extension statements.
n. Implementation Science: The thesis must conform to the StaRI guidelines.

Thesis Submission Instructions

A copy of the completed thesis and 2025 Thesis Affidavit Form in PDF format must be uploaded on the candidate's ABOG portal under the assigned tasks that will be made available upon approval of application for the certifying examination.

The thesis file must be saved as a PDF with the appropriate following naming convention:

ABOG ID #-last name-REI-thesis ABOG ID #-last name-MFM-thesis

ABOG ID #-last name-GO-thesis ABOG ID #-last name-URPS-thesis

ABOG ID #-last name-CFP-thesis

Example: 9999999-Smith-REI-thesis

The 2025 Thesis Affidavit Form must be saved as a PDF with the appropriate following naming convention:

ABOG ID #-last name-REI-TA ABOG ID #-last name-MFM-TA

ABOG ID #-last name-GO-TA ABOG ID #-last name-URPS-TA

ABOG ID #-last name-CFP-TA

Example: 9999999-Smith-REI-TA

Candidates must submit a thesis that adheres to the requirements listed in Thesis Submission Section of this Bulletin.

Candidates who have previously submitted a thesis and were unsuccessful in passing the examination must upload a PDF copy of the thesis using the naming convention above. Candidates may submit a previously submitted thesis or another work that was completed during fellowship. However, thesis requirements change frequently. The thesis must fulfill the requirements for the year of the exam. Prior acceptance of a thesis does not assure re-acceptance. The thesis affidavit for a previously submitted thesis does not need to be resubmitted.

For questions about the thesis, please email applications@abog.org.

Case List

Case List Entry

All information for the case lists for the 2025 Subspecialty Certifying Examination must be entered online within the ABOG Case List Entry system. To enter a case, a candidate must access their ABOG portal and click on Case List Entry. The Case List Entry system will become available to candidates in February of the year the candidate begins collecting cases. The entry process is simple, and common abbreviations are acceptable (see Approved Abbreviations). If a problem is encountered, there is a frequently asked questions (FAQ) button where most questions will be answered. However, if the problem is not resolved, the candidate should call the ABOG Assessment Department or email exams@abog.org.

The case list information can be entered through any device with an internet connection, including smartphones, laptops, tablets, and desktop computers.

Candidates will be asked to enter patient-identifying information in the Case List Entry System (i.e., Hospital, Patient Initial, and Patient ID fields). This patient identification will only be used on the patient lists for verification by hospital medical records staff. The electronic copy of the case list that is submitted to ABOG will be electronically de-identified and will not contain the patient-identifying information. The case description fields in the Case List Entry System should not contain any patient identifying information.

Case List Preparation and Submission

The candidate must:

1. Collect cases between January 1 and December 31, 2024.
2. Meet the category requirements as listed in the Case Lists Content section for their subspecialty. If enough cases cannot be collected in a one-year period of time, the collection of cases may be extended to 18 months or 2 years. However, it may not include cases collected during fellowship.
3. Not include any case previously used on a prior case list for a Specialty or Subspecialty Certifying Examination.
4. Have the case lists certified by the appropriate personnel of the institution(s) in which the care was given.
5. De-identify the case lists in accordance with the requirements of Section 164.514(a)(b) and (b)(2)(i)&(ii) of the Final Privacy Rule. (See De-Identification of Case Lists in this Bulletin).

6. Use standard English language nomenclature. The list of acceptable abbreviations can be found under ABOG Approved Abbreviations (Appendix A).
7. **List the patient only once.** If the patient is admitted more than once, provide information regarding the additional admissions in the appropriate boxes. (If a patient has several admissions or is seen in the outpatient setting and subsequently becomes a surgical patient, that patient may only be listed once.)

For physicians who are in a group practice where responsibility for patients is shared, the decision of whether to list a particular patient should be based on which physician had primary responsibility for the inpatient care. However, when asked to perform a consult on an inpatient on another physician's service, that patient may be listed.

The case lists must include sufficient numbers as well as sufficient breadth and depth of clinical difficulty to demonstrate that the candidate is practicing the full spectrum of their subspecialty.

De-Identification of Case Lists

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Secretary of the DHHS issued a Final Privacy Rule (HIPAA Privacy Rule) governing the terms and conditions by which health care providers can make available individually identifiable health information. The HIPAA Privacy Rule permits the release of patient information if the information does not permit the patient to be individually identified. Therefore, candidates must exclude from the case lists submitted to the Board such information as could permit the identification of an individual patient.

The HIPAA Privacy Rule specifically enumerates the categories of information that must be removed from patient case lists in order for such case lists to be de-identified and thereby become available for submission to the Board.

Section 164.514(b) provides that a physician/candidate may determine that health information is not individually identifiable health information only if the following identifiers are removed:

1. Names
2. Geographic subdivisions smaller than a state
3. Date of birth, admission date, discharge date, date of death; and all ages over 89 except that such ages and elements may be aggregated into a single category of age 90 or older
4. Telephone numbers, fax numbers, email addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate and/or license numbers
5. Biometric identifiers, including finger and voiceprints
6. Full face photographic images and any comparable images
7. Any other unique identifying number, characteristic, or codes

The submission of any patient information in the case description fields of the Case Lists is strictly prohibited and can result in disapproval for the Certifying Examination. The de-identification of patient case lists does not allow the omission of any cases involving patients under the candidate's care that are otherwise required to be reported. Any effort to use the HIPAA rule to avoid listing patients will disqualify the candidate from the examination and additional disciplinary action as appropriate. The completeness of the candidate's case lists is subject to audit by the Board.

Case List Verification and Audit

Any case list that fails to provide the required information, includes an insufficient number of patients, is inadequately or incompletely prepared, is not appropriately de-identified, or fails to provide sufficient breadth and depth of clinical problems may disqualify the candidate from admission to the Certifying Examination. The candidate is personally responsible for the proper preparation, de-identified accuracy, and completeness of their case list.

The completeness and accuracy of all submitted case lists are subject to audit by ABOG. All audits will be conducted in accordance with the provisions of the HIPAA Privacy Rule. Permission to conduct on-site audits will be required of each candidate prior to final approval to take the Certifying Examination. Falsification of information in the case list may result in ineligibility to apply for the Certifying Examination for a minimum of three years. The candidate must then meet all requirements in effect at the end of the deferred period. If the falsification is discovered after the candidate has successfully completed the Certifying Examination, the results of the test will be voided, and the candidate's certification will be revoked.

Applicants Ruled Not Admissible

If a decision is made by ABOG that a candidate has not met the requirements for admission to the Certifying Examination, the candidate may appeal the decision by writing to the ABOG Chief of Assessments at exams@abog.org. Such appeals may be forwarded to the appropriate ABOG Committee for reconsideration. If the appeal is successful, no late fees will apply. If the successful decision occurs after the date of the Certifying Examination, the candidate will be scheduled for the next available Certifying Examination in the subspecialty, and no additional application fee will apply. However, the examination fee must be paid before the deadline.

If the candidate's appeal is not successful, or the candidate does not appeal the inadmissibility decision, the candidate may reapply by submitting a new application, paying the application fee, and meeting the requirements applicable at the time of the reapplication. Documentation that the cause for the initial disapproval has been cleared must be submitted with the application.

Accommodations

Candidates with documented disabilities should review the Examination Accommodation Requests Section (Appendix B). Candidates in need of special testing circumstances must notify ABOG in writing of their request at the time of application. This deadline is necessary in order to allow the Board to request the required documentation, to review the records, and verify the disability, if necessary.

Candidates who will be lactating at the time of the examination should notify ABOG as soon as possible. Lactation rooms will be scheduled on a first-come, first-served basis. If all the lactation rooms are full, the candidate will be given an alternate location at the ABOG Testing Center. See Examination Accommodation Requests Section for additional information on lactation accommodations.

Test Security

A week before the Certifying Examination, a task will be added to each candidate's portal to sign the following Terms of Agreement. If a candidate refuses to sign the agreement, they will not be allowed to take the Certifying Examination.

1. I agree and understand that all of the test materials used in ABOG examinations are copyrighted intellectual property of ABOG and will, at all times, remain confidential.
2. I agree and understand that I may not provide any information before, during, or after the examination concerning the content of the examination including, but not limited to, test items and cases, to anyone, for any reason, including, but not limited to, (i) anyone who is scheduled to take the examination or may be eligible to take the examination, (ii) any formal or informal test preparation group, service, or company, or (iii) any person representing a company or other entity that provides courses, practice tests, or other study material for the examination.
3. I agree and understand that I may not reproduce, transmit, publish, disclose, and/or distribute any examination materials by any means, including memorization, recording, internet, or other methods that would allow any other individual, company, or organization to recreate, in whole or in part, any test questions or material.
4. I agree and understand that during any ABOG examination, I will not have in my possession any notes, papers, study materials, formulas, pens, pencils, cellular telephones, smartwatches, photographic equipment, recording devices, or other similar contraband. I will not have any type of electronic device that could provide information that could be used to answer questions on the examination. I further agree that if I am discovered to have any such device in my possession during the examination, the test will be halted immediately, and I will not receive a grade for the examination.
5. I agree and understand that if anyone observes any action of mine that may be interpreted as violating or potentially violating test administration rules, the test will be halted immediately, and I will receive no grade for the examination.
6. I agree and understand that if I violate any part of this agreement, (i) my test results will be canceled, (ii) I may be subject to further sanctions and/or legal action, and (iii) I will not be allowed to reapply for the examination for a minimum of three years.
7. I agree and understand that if ABOG discovers I have violated any terms or conditions of this agreement after I have been awarded Diplomate status, such status will be revoked.
8. I agree and understand that, if requested by ABOG, I will fully participate in the investigation of any suspected violation of the terms and conditions of this agreement by any candidate.
9. I attest that since the date of my application and to the day of my examination, I have had no (i) limitation or suspension of hospital privileges, (ii) substance abuse offenses, or (iii) suspension, revocation, or restriction placed on my license to practice medicine in any state or country.
10. I agree and understand ABOG is authorized to make my name and business address available on request to the public, including, but not limited to, hospitals, insurers, agencies of government, specialty societies, laypersons, my Program Director(s), and/or the Accreditation Council of Graduate Medical Education (ACGME).
11. I agree and understand that de-identified results of my examination may be used for research purposes by ABOG or other parties requesting the same.
12. I agree and understand that my results may be released to my Program Director(s) by name.
13. I agree and understand that if I am certified as a Diplomate, ABOG is authorized to provide my professional personal identifiable information to other entities for a proper purpose. Some of these professional medical organizations include Obstetrics & Gynecology, The American

Journal of Obstetrics and Gynecology, the American Board of Medical Specialties (ABMS), American College of Obstetricians and Gynecologists (ACOG), American Medical Association (AMA), American Society for Reproductive Medicine (ASRM), American Urogynecologic Society (AUGS), Society for Gynecologic Oncology (SGO), Society for Maternal-Fetal Medicine (SMFM), and the Society for Family Planning (SFP).

14. I agree and understand that I may not appeal the results of the examination based on the format of the examination, the sufficiency or accuracy of the answers to examination questions, the scoring of the examination, or the cut score used to determine the passing grade for the examination.
15. I agree to indemnify, defend, and hold ABOG harmless against any losses, liabilities, damages, claims, and expenses (including attorneys' fees and court costs) arising out of any claims or suits, whatever their nature and however arising, in whole or in part, which may be brought or made against ABOG in connection with: (i) any claims which are caused, directly or indirectly by any negligent act, omission, illegal or willful misconduct by me; (ii) my misuse of certification; or (iii) my use or misuse of ABOG's proprietary and/or confidential information.
16. Under no circumstances will ABOG be liable for any consequential, special, incidental, exemplary, or indirect damages arising from or relating to this agreement, even if ABOG has been advised of the possibility of such damages.
17. The failure to enforce or the waiver by ABOG of a default or breach of this agreement shall not be considered a waiver of any subsequent default or breach.
18. This agreement is governed by the laws of the State of Texas. The exclusive jurisdiction of any suit arising out of, relating to, or in any way connected with this agreement shall be in the state or federal courts, as applicable, located in Dallas, Texas.
19. Provisions that survive termination or expiration of this agreement include those pertaining to limitation of liability, indemnification, nondisclosure, and others that by their nature are intended to survive.

Administration of the Certifying Examination

The Certifying Examination is three hours in length. Each hour will be divided into two sections of approximately 30 minutes, with the first comprising structured cases and the last comprising the candidates' personal case lists. The three hours are equally divided into the following areas for each subspecialty:

Subspecialty	Hour 1	Hour 2	Hour 3
Complex Family Planning	Structured Cases Contraception Case List	Structured Cases Early Pregnancy Evaluation and Management Case List	Structured Cases Abortion and Pregnancy Termination Case List

Gynecologic Oncology	Structured Cases Ovarian, Peritoneal, and Fallopian Tube Cancer (include chemotherapy cases) Case List	Structured Cases Uterine Malignancies: Endometrial Cancer, Sarcoma, GTD, Other Case List	Structured Cases Cervical, Vulvar, and Vaginal Cancer and Radiation Therapy Case List
Maternal-Fetal Medicine	Structured Cases Medical Complications of Pregnancy Case List	Structured Cases Genetics/Fetal Disorders/Fetal Anomalies Case List	Structured Cases Obstetrical and Surgical Complications Case List
Reproductive Endocrinology and Infertility	Structured Cases Infertility/IVF Case List	Structured Cases Reproductive Endocrinology Case List	Structured Cases Reproductive Surgery Case List
Urogynecology and Reconstructive Pelvic Surgery	Structured Cases Office Case List	Structured Cases Prolapse & Reconstructive Surgical Cases Case List	Structured Cases Urinary & Fecal Incontinence Surgical Cases Case List

Communication, ethics, and patient safety questions may be included within the structured cases or case lists. The structured cases are used to elicit the candidate's responses to specific clinical situations. A list of the topics that may be covered in the examination can be found in the Examination Topics Section for each subspecialty in Appendices C-G.

The candidates for the examination will be informed of the time and place of the registration process when they receive information concerning their assigned examination date. Candidates who are late for registration may not be allowed to sit for the examination. Following registration, the candidates will be provided an orientation. After the orientation, candidates will be escorted to their testing room. All examinations will be conducted in English and will be administered by two examiners per section. Each candidate will be informed of the names of the six examiners who will conduct their examination. If the candidate believes that one or more examiners would be unable to provide them with an unbiased exam, this will be discussed with an ABOG executive physician. If the decision is made that a conflict exists, an alternate examiner will be provided.

Candidates may not take any electronic devices into the examination. This includes, but is not limited to, cellular phones and all devices that can record, including smartwatches and similar

devices. If a candidate is found to have an electronic device in an examination room, the test will be halted immediately, and the candidate will receive no grade for the examination. In addition, all fees will be forfeited. Candidates will also not be permitted to bring their thesis or case lists into the examination room.

Each examiner will score the candidate on all the topics covered within each section. The final grade will be determined analytically following the examination and will be released no later than six weeks following the examination.

Results and Scoring

The results of the Certifying Examination will be reported online to each candidate no later than six weeks following their examination week. We recognize waiting for up to six weeks for these important results is difficult. Please be assured during this post-examination period, extensive quality assurance checks take place to ensure test results are fair and accurate. The Many Facet Rasch Model used in calculating a candidate's score accounts for examiner severity and case difficulty, and that score is determined during these weeks of statistical analysis.

As part of the application process, the candidate will be required to irrevocably agree that the results of the candidate's examination may be made available to the Program Director(s) of any fellowship program(s) in which the candidate may have participated or in which the candidate is currently involved, and/or the American Council of Graduate Medical Education (ACGME) for any and all purposes. Furthermore, the candidate will be required to release and agree to indemnify and hold ABOG and its officers, directors, and employees harmless of and from any and all claims the candidate may have with regard to the effect or impact upon the candidate of the release of the candidate's examination results to the candidate's Program Director(s) or the ACGME and waive any rights the applicant may have, if any, to have the examination results maintained in confidence.

Rescores and Appeals

If at the completion of the Certifying Examination, a candidate believes the test has not been conducted in a fair and unprejudiced manner, a second examination may be requested. The request must be made within 24 hours of the completion of the Certifying Examination via email to exams@abog.org.

If the request is granted:

1. No final grade will be assigned, and all grades will be discarded;
2. The candidate must reapply for the Certifying Examination the next year (i.e., cannot delay beyond the next year) and meet all of the requirements applicable at that time;
3. If the candidate meets the requirements, a second examination will be scheduled at the next regularly scheduled annual Certifying Examinations at no additional charge;
4. The candidate must prepare a new case list for the repeat examination and the case list for the repeat examination may not include any patient listed on the first examination case list;
5. The repeat examination will be conducted by a different team of examiners, who will not be informed that the examination is being conducted as a result of an appeal;
6. Neither the questions nor the candidate's answers on the first examination will be known to or considered by the second group of examiners; and

7. The decision of the examiners conducting the second examination will be used by the Board to determine the results of the candidate's Certifying Examination.

Appeals based on the composition of the Certifying Examination team shall not be considered if the candidate was informed before the Certifying Examination of the identity of each member of the team and did not object to the participation of any member in time for an acceptable substitute to be provided.

Appeals based on the content of the examination, the sufficiency or accuracy of the answers given, or the final grade will not be considered.

Requests for Re-Examination

Candidates who are disapproved for the Certifying Examination, scheduled to take the Certifying Examination but do not do so, as well as candidates who do not pass the examination and who wish to repeat the examination, must complete a new application on the ABOG website and pay a new fee. It is necessary for each applicant to meet the requirements in effect the year the application is submitted. These requirements can be found in the *Bulletin* for the year the application is submitted. The re-applicant must complete the application process before the applicable deadline. Following notification of approval to retake the Certifying Examination, the candidate must submit a new case list, submit their thesis, and pay the examination fee on or before the established deadlines. Candidates may submit a previously submitted thesis or another work that was completed during fellowship.

NEW SUBSPECIALTY DIPLOMATES

Length of Certification

All certificates issued by ABOG in 1986 and thereafter are time-limited and remain in effect only if the Diplomate participates in and successfully completes the Maintenance of Certification (MOC) process each year. All Diplomates taking the 2025 Subspecialty Certifying Examination are required to participate in and successfully complete the Maintenance of Certification process in 2025. Applications for the 2025 MOC process will be available online beginning in January 2025. Please reference the 2025 Continuing Certification Bulletin for details on requirements.

List of Certified Diplomates

Each year ABOG notifies the American College of Obstetricians and Gynecologists of the names and addresses of the Diplomates certified in that year. A list of the names is also sent to the American Board of Medical Specialties (ABMS) with the request that they be included in the ABMS Database that includes displays in Certification Matters™ and ABMS Solutions products that are used for primary source verification (PSV) of certification by various stakeholders. Diplomate status may also be provided to other organizations, government agencies, and the lay public. Candidates must sign a statement acknowledging this fact at the time of the Certifying Examination.

After this effort to ensure initial listings of the newly certified Diplomates, the Board assumes no responsibility for a Diplomate's listing in subsequent issues of any directory.

The results of the Certifying Examination will be forwarded to the candidate's residency program and/or the American College of Graduate Medical Education (ACGME). De-identified results of the Certifying Examination may be used by ABOG or other parties for research purposes.

APPENDICES

Appendix A: ABOG Approved Abbreviations

2D	2-dimensional
3D	3-dimensional
17-OHP	17-hydroxyprogesterone
aCGH	Array comparative genomic hybridization
ACTH	Adrenocorticotropic hormone
AFI	Amniotic fluid index
AFP	Alpha-fetoprotein
AGC	Atypical glandular cells
AIS	Adenocarcinoma in situ
ALT	Alanine aminotransaminase
AMA	Advanced maternal age
AMH	Antimullerian hormone
ANC	Absolute neutrophil count
APS	Antiphospholipid antibody syndrome
ARDS	Acute respiratory distress syndrome
AROM	Artificial rupture of membranes
ART	Antiretroviral therapy or Assisted reproductive technology
ASA score	American Society of Anesthesiologists score
ASC	Abdominal sacrocolpopexy
ASCUS	Atypical cells of undetermined significance
ASRM	American Society for Reproductive Medicine
AST	Aspartate aminotransaminase
ATFP	Arcus tendineus fascia pelvis
AUB	Abnormal uterine bleeding
AZF	Azoospermia factor
BEP	Bleomycin, etoposide, cisplatin
BSO	Bilateral salpingo-oophorectomy
BTL	Bilateral tubal ligation
BMI	Body mass index
BUN	Blood urea nitrogen
Cm	Centimeter
CA125	Cancer antigen 125
CBAVD	Congenital bilateral absence of the vas deferens
CBC	Complete blood count
CD4	Cluster of differentiation 4
CEA	Carcinoembryonic antigen
CI	Confidence interval
CIN	Cervical intraepithelial neoplasia
CMV	Cytomegalovirus
CNS	Central nervous system
COC	Combined oral contraceptive
CPR	Cardiopulmonary resuscitation
CT	Computerized tomography
CTA	Computerized tomography angiography
CTLA-4	Cytotoxic T lymphocyte-associated antigen 4
CVS	Chorionic villus sampling
dMMR	Deficient mismatch repair
D & C	Dilatation and curettage
D & E	Dilatation and evacuation

DEXA	Dual-energy x-ray absorptiometry
DHEA	Dehydroepiandrosterone
DHEAS	Dehydroepiandrosterone sulfate
DIC	Disseminated intravascular coagulopathy
DKA	Diabetic ketoacidosis
DM	Diabetes mellitus
DMSO	Dimethyl sulfoxide
DNA	Deoxyribonucleic acid
DSD	Differences of sexual development
DVP	Deepest vertical pocket
DVT	Deep vein thrombosis
EAS	External anal sphincter
EBL	Estimated blood loss
ECC	Endocervical curettage
ECMO	Extracorporeal membrane oxygenation
EGA	Estimated gestational age
EIN	Endometrial intraepithelial neoplasia
ELISA	Enzyme-linked immunosorbent assay
EKG/ECG	Electrocardiogram
EMA-CO	Etoposide, methotrexate, actinomycin D-cyclophosphamide, Oncovin®
EMB	Endometrial biopsy
EFW	Estimated fetal weight
ER	Estrogen receptor
ERAS	Enhanced recovery after surgery
ESHRE	European Society of Human Reproduction and Embryology
FDA	Food and Drug Administration
FENa	Fractional excretion of sodium
FFP	Fresh frozen plasma
FGR	Fetal growth restriction
FHR	Fetal heart rate
FHT	Fetal heart tones
FIGO	International Federation of Gynecology and Obstetrics
FISH	Fluorescence in situ hybridization
FSH	Follicle-stimulating hormone
g	Gram
GBS	Group B streptococcus
G-CSF	Granulocyte colony-stimulating factor
GDM	Gestational diabetes mellitus
GIFT	Gamete intrafallopian transfer
GnRH	Gonadotropin-releasing hormone
GOG	Gynecologic Oncology Group
GTD	Gestational trophoblastic disease
GTN	Gestational trophoblastic neoplasia
HbA1c	Hemoglobin A1c
HELLP	Hemolysis, elevated liver function tests, low platelet count
HCG	Human chorionic gonadotropin
HIV	Human immunodeficiency virus
hMG	Human menopausal gonadotropin
HNPCC	Hereditary nonpolyposis colorectal cancer
HPO	Hypothalamic-pituitary-ovarian
HPV	Human papillomavirus
HRT	Hormone replacement therapy
HSG	Hysterosalpingogram

HSIL	High-grade squamous intraepithelial lesion
HSV	Herpes simplex virus
IAS	Internal anal sphincter
IC/BPS	Interstitial cystitis/Bladder pain syndrome
ICSI	Intracytoplasmic sperm injection
ICU	Intensive care unit
IgG	Immunoglobulin G
IgM	Immunoglobulin M
IM	Intramuscular
INR	International normalized ratio
IPG	Implantable pulse generator
IUD	Intrauterine device
IUFD	Intrauterine fetal death
IUI	Intrauterine insemination
IUP	Intrauterine pregnancy
IV	Intravenous
IVF	In vitro fertilization
IVIG	Intravenous immunoglobulin
kg	Kilogram
KUB	Kidney, ureter, bladder
L & D	Labor and delivery
LARC	Long-acting reversible contraception
LAVH	Laparoscopic-assisted vaginal hysterectomy
LDH	Lactate dehydrogenase
LEEP	Loop electrosurgical excision procedure
LGA	Large for gestational age
LGBTQIA	Lesbian gay bisexual transgender queer intersex asexual
LFT	Liver function test
LH	Luteinizing hormone
LMP	Last menstrual period
LMWH	Low-molecular-weight heparin
LSIL	Low-grade squamous intraepithelial lesion
LVSI	Lymphovascular space invasion
mL	Milliliter
mTOR	Mammalian target of rapamycin
MCA	Middle cerebral artery
MESA	Microsurgical epididymal sperm aspiration
MIS	Minimally invasive surgery
MRI	Magnetic resonance imaging
MRKH	Mayer-Rokitansky-Küster-Hauser
MSAFP	Maternal serum alpha-fetoprotein
MSI-H, -L	Microsatellite instability-high, -low
MTP	Massive transfusion protocol
MURCS	Müllerian duct aplasia, renal aplasia, cervicothoracic somite dysplasia
NAAT	Nucleic-acid amplification test
NGS	Next-generation sequencing
NICU	Neonatal intensive care unit
NIPT	Noninvasive prenatal testing
NPO	Nil per os
NSAID	Nonsteroidal anti-inflammatory drug
OAB	Overactive bladder
OASIS	Obstetric anal sphincter injuries
OHSS	Ovarian hyperstimulation syndrome

OHVIRA	Obstructed hemivagina ipsilateral renal agenesis
PACU	Postanesthesia care unit
PALND	Para-aortic lymph node dissection
PAP	Papanicolaou smear
PARP	Poly adenosine diphosphate-ribose polymerase
PCOS	Polycystic ovarian syndrome
PCR	Polymerase chain reaction
PD-1	Programmed cell death protein 1
PD-L1	Programmed cell death ligand 1
PESA	Percutaneous epididymal sperm aspiration
PET	Positron emission tomography
PFMT	Pelvic floor muscle therapy
PFPT	Pelvic floor physical therapy
PGT-A	Preimplantation genetic testing for aneuploidy
PGT-M	Preimplantation genetic testing for monogenic disorder
PGT-SR	Preimplantation genetic testing for structural rearrangements
PLND	Pelvic lymph node dissection
PNE	Peripheral nerve evaluation
POP	Pelvic organ prolapse
POP-Q	Pelvic organ prolapse quantification system
PPH	Postpartum hemorrhage
PR	Progesterone receptor
PROM	Premature rupture of membranes
PT	Prothrombin time
PTT	Partial thromboplastin time
PPROM	Preterm premature rupture of membranes
PTNS	Posterior tibial nerve stimulation
PUBS	Percutaneous umbilical blood sampling
PUPPP	Pruritic urticarial papules and plaques of pregnancy
PVR	Postvoid residual
RAIR	Rectoanal inhibitory reflex
RBC	Red blood cell
RCT	Randomized controlled trial
RNA	Ribonucleic acid
RPL	Recurrent pregnancy loss
RPR	Rapid plasma reagin
SBO	Small bowel obstruction
S/D (ratio)	Systolic/diastolic ratio
SGA	Small for gestational age
SHBG	Sex hormone-binding globulin
SLND	Sentinel lymph node dissection
SNM	Sacral neuromodulation
SNP	Single-nucleotide polymorphism
SO	Salpingo-oophorectomy: preceded by R (right) or L (left) or unilateral (U)
SROM	Spontaneous rupture of membranes
SSLF	Sacrospinous ligament fixation
STI	Sexually transmitted infection
SUI	Stress urinary incontinence
SS-A	Sjogren syndrome A
SS-B	Sjogren syndrome B
SVD	Spontaneous vaginal delivery
T1DM	Type I diabetes mellitus
T2DM	Type II diabetes mellitus

TAH	Total abdominal hysterectomy
TCGA	The Cancer Genome Atlas
TESA	Testicular sperm aspiration
TESE	Testicular sperm extraction
TLH	Total laparoscopic hysterectomy
TNF	Tumor necrosis factor
TOLAC	Trial of labor after cesarean
TOT	Transobturator tape
TSH	Thyroid-stimulating hormone
TRALI	Transfusion-related acute lung injury
TTTS	Twin-twin transfusion syndrome
TUNEL	Terminal deoxynucleotidyl transferase-mediated deoxyuridine triphosphate-nick end labelling
TVH	Total vaginal hysterectomy
TVS	Transvaginal sonography
TVT	Tension-free vaginal tape
UAE	Uterine artery embolization
USLF	Uterosacral ligament fixation
UTI	Urinary tract infection
VAC	Vincristine, actinomycin-D, cyclophosphamide
VAIN	Vaginal intraepithelial neoplasia
VBAC	Vaginal birth after cesarean delivery
VCUG	Voiding cystourethrography
VDRL	Venereal disease research laboratory
VEGF	Vascular endothelial growth factor
VIN	Vulvar intraepithelial neoplasia
VLPP	Valsalva leak point pressure
V/Q	Ventilation/Perfusion
VTE	Venous thromboembolism
VVF	Vesicovaginal fistula
WBC	White blood cell
WES	Whole exome sequencing
WHO	World Health Organization
ZIFT	Zygote intrafallopian transfer

Appendix B: Examination Accommodation Requests

Candidate Disability

The American Board of Obstetrics & Gynecology, Inc. (ABOG) provides reasonable accommodations in accordance with The Americans with Disabilities Act (ADA) as amended by the ADA Amendments Act of 2013 (ADAAA) (collectively the ADA) and, therefore, will provide or allow the use of necessary auxiliary aids, services, or testing conditions that do not fundamentally alter the measurement of the skills or knowledge the Board assessment program and examination is intended to test. Candidates must indicate through the examination application if special testing accommodations under the ADA are needed.

The ADA defines a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activities such as walking, standing, seeing, hearing, eating, sleeping, speaking, breathing, learning, reading, concentrating, thinking, communicating, or working.

The purpose of accommodations is to provide equal access to ABOG examinations for all individuals. Accommodations offset the identified functional limitation so that the impact of impairment is minimized by means of an auxiliary aid or an adjustment to the testing procedure. Functional limitation refers to the aspects of a disability that interfere with an individual's ability to function in some capacity on a regular and continuing basis.

Accommodations for the Qualifying and Certifying Examination will only be considered with appropriate documentation. ABOG shall not exclude any candidate from the Qualifying or Certifying Examination solely because of a disability if ABOG is provided with notice of the disability in time to permit ABOG to make such adjustments in the examination as are reasonably necessary to accommodate the disability.

Notification of the need for special testing circumstances must be submitted to ABOG by a candidate at the time of application. This deadline is necessary in order to allow ABOG time to request the required documentation, to review the records, and verify the disability, if necessary.

The purpose of documentation is to validate that an applicant for test accommodations is a disabled individual as defined by the ADA and to provide guidance in determining effective accommodations. Comprehensive information by a qualified professional is necessary to allow ABOG to understand the nature and extent of the applicant's disability and the resulting functional impairment that limits access to its examinations. It is essential that an applicant's documentation provides a clear explanation of the functional impairment, the requested accommodation as it relates to testing, and a rationale for the requested accommodation.

No candidate shall be offered an accommodation that would compromise the ABOG examination's ability to test accurately the skills and knowledge it purports to measure, and no auxiliary aid or service will be provided which will fundamentally alter the examination or will result in an undue burden to ABOG.

Lactation Accommodations

Candidates who are lactating will be given an opportunity to use a pump prior to their examination. Please notify ABOG at the time of application if you know you will need the lactation facilities. At the time of notification, a lactation room will be reserved for the candidate. The rooms are booked on a first-come, first-served basis. If all the lactation rooms are full, the candidate will be given an alternate location at the ABOG Testing Center. Candidates must bring their own breast pump with them to the testing center.

All examination accommodation requests must be sent via email to exams@abog.org.

Appendix C: Complex Family Planning (CFP)

CFP Examination Topics

The content of the examination will be based on the blueprint for Complex Family Planning. The major categories and subcategories are shown below, including the percentages of the categories. Please note that due to a recent practice analysis conducted by ABOG, the topics and the weighting of these categories are likely to change. ABOG will update the bulletin in the summer of 2024, if necessary.

Contraception (35%)

1. Provide contraceptive counseling, provision, and surveillance to patients and contraceptive consultation to other health care providers
    a. Engage in person-centered counseling to identify reproductive life goals
    b. Screen patients for contraceptive coercion
    c. Implement practices to improve access to contraception (e.g., same-day IUD insertion, quick start)
2. Demonstrate advanced knowledge of pharmacology (mechanism of action, dosing, route of administration/absorption, contraindications, metabolism, excretion), effectiveness, potential side effects, and complications of all contraceptive methods
    a. Coitally-dependent
    b. Short-acting
    c. Long-acting
    d. Permanent
    e. Emergency contraception
3. Provide care for patients with specialized contraceptive needs (e.g., limited access or medical considerations)
    a. Adolescent patients
    b. Perimenopausal patients
    c. LGBTQIA patients
    d. Patients with substance and alcohol use disorder
    e. Patients with disabilities
    f. Patients experiencing intimate partner violence and sexual assault
    g. Patients who are incarcerated
    h. Postpartum or post-abortal patients (including immediate LARC)
4. Provide contraceptive counseling, provision, and surveillance for patients with pre-existing medical or anatomical conditions
    a. Evaluate and manage interactions between contraception and medications
    b. Evaluate and manage interaction between medical conditions and contraception (e.g., HIV infection, renal disease, hepatic disease, hematologic disorders, thromboembolic

disorders, cardiac disease, mental health disorders, connective tissue disorders, STIs, PID)

c. Provide care for patients with reproductive tract anomalies (e.g., uterine anomalies, leiomyomata)

d. Perform complex placement of contraceptive devices [e.g., patients with anatomic challenges (e.g., stenotic cervix, leiomyomata, reproductive tract anomalies) or physical or mental conditions impacting insertion (e.g., contractures, developmental delay)]

e. Utilize contraception for non-contraceptive benefits (e.g., management of uterine bleeding, catamenial seizures, perimenopausal)

5. Evaluate and manage side effects related to contraception

   a. Evaluate reported side effect(s) with respect for patient autonomy (e.g., modeling non-coercive practice)

   b. Counsel patients about alternative methods of contraception based on side effect history

   c. Offer management options for method side effects

6. Evaluate and manage complications related to contraception

   a. Identify severe adverse complications and refer for management (e.g., stroke, DVT, myocardial infarction)

   b. Evaluate and manage if intrauterine pregnancy occurs with contraceptive methods

7. Evaluate and manage complicated contraceptive removals, including malpositioned or broken devices, with use of imaging if needed

   a. IUD (e.g., missing strings, embedded, uterine perforation)

   b. Implants (e.g., nonpalpable implants, broken devices)

   c. Use of hysteroscopy and laparoscopy for removal of devices

   d. Determine when additional expertise and/or facilities are needed (e.g., interventional radiology, other surgical specialties, and specialty laboratories)

Early Pregnancy Evaluation and Management (15%)

1. Evaluate early pregnancy

   a. Determine pregnancy location (e.g., intrauterine, extrauterine, cesarean scar, cervical, cornual)

   b. Evaluate intrauterine pregnancy (e.g., evolution of ultrasonographic landmarks, gestational age, etc.)

   c. Demonstrate knowledge of ectopic risk factors (e.g., IUD in situ, prior tubal ligation, prior ectopic)

2. Manage early pregnancy

   a. Provide pregnancy options counseling

   b. Provide counseling about options for management of pregnancy of unknown location (PUL), early pregnancy loss (EPL), and ectopic pregnancy (e.g., intrasac injections, laparoscopy, uterine aspiration, multi-modal approach)

c. Use uterine aspiration for diagnosis and treatment of PUL and EPL
d. Use of mifepristone and/or misoprostol for PUL
e. Use of mifepristone and/or misoprostol for EPL

3. Manage and surveil gestational trophoblastic disease with other subspecialties
   a. Procedurally manage gestational trophoblastic disease (e.g., second-trimester uterine evacuation)
   b. Identify the consequences of gestational trophoblastic disease (e.g., thyroid storm and hypertension)
   c. Provide counseling for and manage contraception after treatment of gestational trophoblastic disease
   d. Diagnose gestational trophoblastic disease and refer patients

Abortion/Pregnancy Termination (40%)

1. Provide comprehensive counseling to patients about abortion and consultation to other health care providers
   a. Provide comprehensive options counseling to patients
   b. Screen patients for interpersonal reproductive coercion
   c. Facilitate identification of patient-led reproductive goals (e.g., post-abortion contraception, general contraception, reproductive life planning)
   d. Incorporate comprehensive knowledge of local laws and regulations into counseling
   e. Describe methods of abortion to patients (e.g., medication, procedure, induction, feticidal injection, third-trimester options)
2. Provide abortion counseling for patients with special reproductive needs
   a. Adolescent patients
   b. LGBTQIA patients
   c. Patients with substance and/or alcohol use disorder
   d. Patients experiencing intimate partner violence and/or sexual assault
   e. Patients who are incarcerated
   f. Patients with disabilities
3. Perform a pre-abortion evaluation
   a. Identify patients at risk for abortion complications (e.g., prior uterine surgery, uterine anomalies, cervical anomalies)
   b. Identify comorbidities that influence abortion care (e.g., cardiac disease, seizure disorders, renal disorders, coagulopathies, fetal demise)
   c. Evaluate the results of laboratory studies (e.g., Rh typing, CBC)
   d. Perform ultrasound as needed (e.g., to determine pregnancy location, determine gestational age, diagnose uterine anomalies, diagnose multiple gestations, identify placental location, and recognize signs of abnormal placentation)

e. Determine the need for additional imaging studies (e.g., MRI, CT scan, ultrasound)

f. Determine the need for consultations from other health care specialties (e.g., hematology, cardiology, anesthesiology)

g. Determine an appropriate location for completion of abortion (e.g., at home, free-standing clinic, hospital-based clinic, operating room) based on patient risk factors (e.g., gestational age, comorbidities, fetal demise)

h. Determine options for abortion method including feticidal injections

i. Counsel patients on available genetic testing options

j. Determine need for peri-abortal medications (e.g., Rh immunoglobulin, antibiotics, antiemetics, uterotonics)

k. Provide a multi-modal plan for pain management during and after an abortion

4. Provide medication abortion

   a. Demonstrate advanced knowledge of pharmacology (mechanism of action, dosing, route of administration/absorption, contraindications, metabolism, excretion) for medication abortion at various gestational ages (e.g., mifepristone, misoprostol, methotrexate, oxytocin)

   b. Counsel regarding risks and benefits of treatment regimen for medication abortion at any gestational age

   c. Determine medication regimen based on patient factors (e.g., gestational age, prior uterine scar)

   d. Surveil patients to assess abortion completion (e.g., laboratory, ultrasound, clinical)

   e. Provide complex labor inductions for second and/or third-trimester abortion (e.g., history of cesarean deliveries, leiomyomatous uterus, prolonged induction)

5. Perform procedural abortion

   a. Perform abortions for patients with comorbidities (e.g., prior surgery, fibroids, vascular malformations, multi-gestation, emergent uterine evacuation)

   b. Provide cervical preparation to patients, including those with comorbidities (e.g., cervical anomalies, previous uterine surgery, advanced gestational age, urgent uterine evacuation)

   c. Provide pain management and/or anesthesia (e.g., paracervical block, sedation, non-pharmacological pain management)

   d. Utilize ultrasound guidance during procedural abortion

   e. Perform abortion via electric or manual uterine aspiration

   f. Perform abortion via dilation and evacuation

   g. Perform abortion via dilation and extraction

   h. Assess for abortion completion (e.g., tissue examination, laboratory studies, ultrasound)

6. Evaluate, diagnose, and manage abortion complications

   a. Hemorrhage

b. Retained products of conception
c. Hematometra
d. Uterine perforation and initial management of resulting injuries (e.g., genitourinary, gastrointestinal, vascular)
e. Cervical lacerations
f. Amniotic fluid embolism (AFE)
g. Thrombotic event
h. Anesthesia complications
i. Undiagnosed placenta site abnormalities
j. Infection
k. Septic abortion
l. Heterotopic pregnancy (initially manage)
m. Vasovagal response
n. Continuing pregnancy after abortion
o. Unplanned delivery prior to scheduled procedure
p. Disseminated intravascular coagulopathy
q. Uterine rupture

Research, Health Policy, and Advocacy (5%)

1. Research
   a. Demonstrate knowledge of basic research methodology (e.g., study design, sample size)
   b. Critically analyze published studies
   c. Determine the proper biostatistical test based on data type and study questions
   d. Demonstrate knowledge of research ethics (e.g., informed consent, vulnerable populations)
2. Public Health and Reproductive Health Policy
   a. Understand how reproductive health impacts public health and health policy
   b. Identify disparities in reproductive health, including access, care quality, patient experience, and outcomes
   c. Identify professional organizations that advocate for and influence policy in reproductive health
   d. Demonstrate knowledge of social and structural determinants that create reproductive health inequities in marginalized groups
3. Advocacy
   a. Engage with stakeholders (e.g., public, other healthcare providers, policymakers) about the role of family planning in public health and health policy

b. Engage with the work of professional organizations that advocate for health policy in contraception and abortion

c. Demonstrate the knowledge and skills to advocate for equitable access to reproductive health services

Core Competencies and Cross Content (5%)

1. Ethics and Professionalism
   a. Systematically engage in practice review to identify health disparities
   b. When engaged in shared clinical decision making, incorporate patient, family, and cultural considerations in making treatment recommendations
   c. When providing care for patients, consider psychological, sexual, and social implications of various treatment options
2. Patient Safety
   a. Systematically analyze the practice for safety improvements (e.g., root cause analysis)
   b. Systematically engage in practice reviews for safety improvements (e.g., root cause analysis)
   c. Incorporate the standard use of procedural briefings, “time outs,” and debriefings in clinical practice
   d. Participate in the review of sentinel events, reportable events, and near misses
   e. Implement universal protocols (e.g., bundles, checklists) to help ensure patient safety
3. Interpersonal and Communication Skills
   a. Communicate to patient and family regarding adverse outcomes and medical errors
   b. Demonstrate sensitivity and responsiveness when communicating with a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
   c. Provide comprehensive information when referring patients to other professionals
4. Systems-based Practice
   a. Incorporate considerations of cost awareness and risk-benefit analysis in patient care
   b. Provide care with multidisciplinary teams to promote patient safety and optimize patient outcomes
5. Practice-based Learning and Improvement
   a. Design or participate in practice or hospital quality improvement activities
6. Evidence-based Medicine
   a. Incorporate evidence-based practices and national guidelines to improve practice patterns and outcomes
   b. Implement evidence-based protocols to enhance recovery after surgery (ERAS)

Case List Content for CFP Certification

Three types of cases must be submitted: (1) contraception cases, (2) early pregnancy

evaluation/management cases, and (3) abortion/pregnancy termination cases. Case lists must include ALL patients from ALL sites for which the candidate had primary responsibility during the case collection period. No patient may be listed more than once on the case list, and no patient may be included on more than one case list. Patients that are admitted multiple times may only be listed once, but all complications and procedures should be listed.

Contraception Cases

The Contraception Case List must contain a minimum of 20 contraception cases. Cases should be listed in the following categories:

1. Contraceptive counseling, including specialized contraceptive needs
2. Patients with pre-existing medical/anatomical conditions

Early Pregnancy Evaluation/Management Cases

The Early Pregnancy Evaluation/Management Case List must contain a minimum of 20 early pregnancy cases.

Abortion/Pregnancy Termination Cases

The Abortion/Pregnancy Termination Case List must contain a minimum of 20 abortion/pregnancy termination cases. Cases should be listed in the following categories:

1. Comprehensive abortion counseling, including special reproductive needs
2. Pre-abortion evaluation
3. Medication abortion
4. Procedural abortion

Appendix D: Gynecologic Oncology (GYN ONC)

GYN ONC Examination Topics

The content of the examination will be based on the blueprint for Gynecologic Oncology. The major categories and subcategories are shown below, including the percentages of the categories for the examination. Please note that due to a recent practice analysis conducted by ABOG, the topics and the weighting of these categories are likely to change. ABOG will update the bulletin in the summer of 2024, if necessary.

Consultation and Pre/Perioperative Assessment (10%)

1. Obtain a history including pertinent oncologic history to generate a differential diagnosis and obtain and interpret laboratory evaluations, imaging studies, and other diagnostics
2. Determine if surgical or non-surgical intervention is indicated
3. Complete a preoperative surgical fitness assessment through the identification of relevant medical comorbidities and clinical findings; and complete preoperative medical consultation to optimize patient outcome
4. Determine the indicated surgical intervention and approach
5. Identify alternatives to surgery and counsel patient about risks, benefits, and alternative interventions
6. Identify and counsel patient regarding fertility-sparing options
7. Use prophylaxis and preventive measures to reduce perioperative morbidity

Intraoperative Management (10%)

1. Apply knowledge of anatomy and physiology required for surgery
2. Apply knowledge of operative instruments
3. Apply knowledge of the indications for surgical staging and perform the appropriate surgical intervention
4. Perform the appropriate surgical intervention
5. Surgically manage gynecologic malignancies
6. Surgically manage complex nonmalignant conditions
7. Surgically manage gestational trophoblastic disease (GTD)
8. Surgically manage abnormal placentation
9. Perform intraoperative surgical consultation
10. Identify and manage intraoperative complications
11. Revise operative plan based on intraoperative findings and patient condition

Postoperative Management (10%)

1. Implement strategies to reduce postoperative complications
2. Evaluate, identify, and manage surgical postoperative complications
3. Evaluate, identify, and manage medical postoperative complications

4. Apply postoperative strategies, including nutritional requirements and the use of supplements, pain management, and IV fluids
5. Identify and manage the critically ill postoperative patient (e.g., hemodynamic monitoring, ventilatory support)
6. Communicate operative findings, results and complications with patient and family
7. Coordinate postoperative transition of care

Non-Surgical Management and Treatment (15%)

1. Understanding the Pharmacology, Mechanism of Action, and Toxicities Associated with Non-Surgical Management
    a. Chemotherapy
    b. Endocrine therapy
    c. Immunotherapy
    d. Molecularly-targeted therapy
    e. Identify, counsel, and manage acute and delayed radiation-related toxicities
2. Applying Knowledge of Non-Surgical Management to Patient Care
    a. Apply knowledge of indications, contraindications, and goals of treatment for primary gynecologic cancers and their precursors in order to establish a timeline for initiation and completion of non-surgical therapy
    b. Apply knowledge of indications, contraindications, and goals of treatment for recurrent gynecologic cancers and their precursors in order to establish a timeline for initiation and completion of non-surgical therapy
    c. Incorporate prognosis in treatment discussions with patient
    d. Apply knowledge of radiation therapy in the treatment of gynecologic cancers
    e. Identify indications for treatment using brachytherapy devices
    f. Counsel patients on gynecologic cancer clinical trial availability, eligibility, and participation
    g. Manage or co-manage oncologic emergencies related to cancer progression or therapies
    h. Coordinate postoperative care of GTD and choriocarcinoma

Genetics and Genomics (10%)

1. Counsel patients and perform comprehensive family history after identifying relevant genetic risk factors and indications for genetic testing.
2. Identify the indications for genetic testing and counseling
3. Apply knowledge of hereditary cancer syndromes to patient care
4. Collaborate with specialists in genetics to manage patient care
5. Counsel patient on prognosis and treatment based on genetic testing results
6. Counsel patient regarding indications for risk-reducing interventions
7. Counsel patient on treatment options based on molecular testing results

Survivorship and Surveillance (5%)

1. Manage long-term effects of surgical and medical cancer treatment
2. Develop and implement an evidence-based surveillance plan for gynecologic cancer patient, including collaborations with other disciplines
3. Collaborate with other disciplines to provide survivorship and surveillance care
4. Perform evaluation for suspected disease recurrence

Supportive and End-of-Life Care (5%)

1. Counsel patient on advanced care planning
2. Implement multi-disciplinary palliative care in management of gynecologic cancer patient
3. Counsel patient and family regarding timing and role of hospice and end of life care
4. Manage cancer-related symptoms such as pain, anorexia, fatigue, nausea, etc.
5. Counsel patient on the role of palliative procedures and interventions
6. Incorporate nutritional assessment and intervention in supportive and end-of-life patient care

Diagnostic and Surgical Procedures (10%)

1. Surgical Procedures
    a. Simple vaginal hysterectomy
    b. Total hysterectomy plus or minus BSO
    c. Modified radical or radical abdominal hysterectomy
    d. Laparoscopic hysterectomy, laparoscopic-assisted vaginal hysterectomy, and robotic abdominal hysterectomy
    e. Modified radical or radical laparoscopic hysterectomy and radical robotic abdominal hysterectomy
    f. Radical cytoreduction
    g. Lymphadenectomy and sentinel lymph node mapping (e.g., inguinal, femoral, pelvic, para-aortic area)
    h. Simple and radical vaginectomy
    i. Vulvectomy (e.g., skinning, simple, partial, radical)
    j. Pelvic exenteration (e.g., anterior, posterior, total)
    k. Omentectomy
    l. Placement of feeding jejunostomy/gastrostomy
    m. Resection and re-anastomosis of small bowel
    n. Bypass procedures of small and large bowel
    o. Mucous fistula formation of small and large bowel
    p. Ileostomy and colostomy
    q. Repair of fistula, vesicovaginal fistula with primary closure, and vesicovaginal fistula with secondary closure using interposition of autologous tissue(s)

r. Resection and re-anastomosis of large bowel, including low anterior resection and re-anastomosis
s. Splenectomy
t. Liver biopsy
u. Diaphragmatic resection
v. Partial and total cystectomy
w. Ureteroneocystostomy, including bladder flap or psoas fixation
x. Ureteral surgery
y. Urinary tract conduit (e.g., ileum, colon)
z. Incision and drainage of abdominal or perineal abscess
aa. Neovagina (e.g., split thickness skin graft, pedicle graft, myocutaneous graft)
bb. Pelvic floor reconstruction (e.g., omental pedicle graft, transposition of myocutaneous grafts)
cc. Insertion of intracavity and interstitial radiation application
dd. Laser ablation
ee. Dilation and curettage for GTD

2. Diagnostic Procedures
   a. Cystoscopy
   b. Laparoscopy
   c. Colposcopy and cone/LEEP excision
   d. Sigmoidoscopy

Application of Basic Science to Patient Care (15%)

1. Cancer genetics
2. Biologic properties of cancer cells and molecular processes involved in carcinogenesis and aging on cancer biology and cancer genetics
3. Gynecologic cancer disease burden and risk factors
4. The role of histopathology and special testing (e.g., immunohistochemistry, molecular studies)
5. Pharmacogenomics, pharmacodynamics, and mechanism of action of relevant agents
6. Fundamentals of radiobiology and radiation physics
7. Immunology in the prevention, diagnosis, and treatment of gynecologic cancers

Core Competencies and Cross Content (10%)

1. Ethics and Professionalism
   a. Systematically engage in practice review to identify health disparities
   b. When engaged in shared clinical decision making, incorporate patient, family, and cultural considerations in making treatment recommendations

   c. When providing care for patients, consider psychological, sexual, and social implications of various treatment options

2. Patient Safety
   a. Systematically analyze the practice for safety improvements (e.g., root cause analysis)
   b. Systematically engage in practice reviews for safety improvements (e.g., root cause analysis)
   c. Incorporate the standard use of procedural briefings, “time outs,” and debriefings in clinical practice
   d. Participate in the review of sentinel events, reportable events, and near misses
   e. Implement universal protocols (e.g., bundles, checklists) to help ensure patient safety
3. Interpersonal and Communication Skills
   a. Communicate to patient and family regarding adverse outcomes and medical errors
   b. Demonstrate sensitivity and responsiveness when communicating with a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
   c. Provide comprehensive information when referring patients to other professionals
4. Systems-based Practice
   a. Incorporate considerations of cost awareness and risk-benefit analysis in patient care
   b. Provide care with multidisciplinary teams to promote patient safety and optimize patient outcomes
5. Practice-based Learning and Improvement
   a. Design or participate in practice or hospital quality improvement activities
6. Evidence-based Medicine
   a. Incorporate evidence-based practices and national guidelines to improve practice patterns and outcomes
   b. Implement evidence-based protocols to enhance recovery after surgery (ERAS)

In the Certifying Examination, evaluation of the candidate will include questions related to principles of biostatistics, clinical trial and/or basic science study design and hypothetical cases. It will also include a review of the submitted case lists, a discussion of structured cases and surgical techniques. It may include interpretation of operative, radiologic, and computer-generated images and videos, and simulations (gross and microscopic pathology, imaging studies, intraoperative photographs, etc.) The candidate should demonstrate the capability of managing complex problems relating to Gynecologic Oncology. The candidate should have the scientific methodologic training to advance knowledge in this subspecialty and to be able to interpret and evaluate new concepts and their supporting data.

Case List Content for GYN ONC Certification

The listed patients must be only those for whom the candidate has had personal responsibility for the management and care during the indicated period of hospitalization. The lists may not include those women seen only in consultation or for administrative reasons only. For example,

if the patient had surgery or a radium application, the candidate must have performed a major part of the procedure in order for the patient to be included in the case list.

A preoperative diagnosis should be recorded for each surgical procedure. For patients having several hospital admissions during the time period of the report, the patient should be listed only once, with each hospitalization listed in chronological sequence. For non-surgical conditions, the admission diagnosis should be recorded. In cases without tissue for histological diagnosis, the final clinical diagnosis should be listed.

The case lists must have sufficient numbers as well sufficient breadth and depth of clinical difficulty to demonstrate that the candidate is practicing the full spectrum of Gynecologic Oncology. Cases listed must be entered into one of the three categories listed below. In total, a minimum of 50 patients with invasive or borderline cancer must be listed, regardless of category. The lists must include patients having radical surgical procedures, insertions of radioactive isotopes, and chemotherapy. For patients with cancer, both grade and stage must be listed.

Case lists will be separated into the following categories:

1. Ovarian, peritoneal, and fallopian tube cancer (include chemotherapy cases)
2. Uterine malignancies: endometrial cancer, sarcoma, GTD, other
3. Cervical, vulvar, and vaginal cancer and radiation therapy

All submitted case lists are subject to audit by ABOG to ensure completeness and accuracy.

Appendix E: Maternal-Fetal Medicine (MFM)

MFM Examination Topics

The content of the examination will be based on the blueprint for Maternal-Fetal Medicine. The major categories and subcategories are shown below, including the percentages of the categories for the examination. Please note that due to a recent practice analysis conducted by ABOG, the topics and the weighting of these categories are likely to change. ABOG will update the bulletin in the summer of 2024, if necessary.

Medical Complications of Pregnancy (30%)

1. Medical Disorders
    a. Evaluate, diagnose, and manage medical disorders
    b. Provide preconception, post-delivery counseling (including contraception) for patients with medical disorders
    c. Counsel patients about maternal physiology, fetal and neonatal implications of their medical condition(s)
    d. Counsel patients on impact of medical disorders on delivery timing
    e. Counsel patients with medical disorders regarding drugs and biologics
    f. Manage antenatal care for patients with medical disorders
    g. Manage intrapartum and postpartum care for patients with medical disorders
2. Critical Care
    a. Evaluate and diagnose critical care conditions
    b. Manage critical care conditions and interpret hemodynamic monitoring
    c. Identify critically ill patients and facilitate transfer to higher level of care
    d. Manage antenatal care and delivery timing for critically ill patients
    e. Manage intrapartum and postpartum care for critically ill patients
    f. Counsel critically ill patients regarding drugs and biologics
    g. Manage massive obstetric hemorrhage
    h. Manage obstetric coagulopathy

Obstetric Complications (30%)

1. Preterm Labor and Preterm Premature Rupture of Membranes (PPROM)
    a. Identify risk factors for preterm birth
    b. Counsel patients on risk-reduction strategies for preterm birth
    c. Counsel patients on limits of viability, prognosis, and management
    d. Manage PPROM
    e. Manage preterm labor and delivery
    f. Manage cervical insufficiency

2. Hypertensive Disorders
    a. Manage hypertensive disease in pregnancy
    b. Manage preeclampsia
    c. Manage eclampsia
3. Multiple Gestation
    a. Counsel and manage patients on associated complications and pregnancy outcomes based on chorionicity for twin gestations
    b. Counsel and manage high-order multiple gestations
    c. Counsel patients on indications and risks associated with fetal reduction
4. Fetal Demise
    a. Provide preconception counseling for recurrent pregnancy loss
    b. Evaluate and manage patients with a fetal demise and /or recurrent pregnancy loss
    c. Evaluate and manage patient for bereavement and /or postpartum depression
5. Procedures Relating to Obstetrical Complications
    a. Amniocentesis and amnioreduction for fetal lung maturation
    b. External cephalic version
    c. Peripartum hysterectomy
    d. Cervical cerclage
    e. Chorionic villus sampling
    f. Cordocentesis and fetal transfusion
6. Obstetric Anesthesia
    a. Counsel medically complicated patients regarding the different anesthetic options including benefits, risks, and contraindications (e.g., systemic analgesia and sedation, general anesthesia, regional anesthesia); for example, cardiac arrest, respiratory arrest, aspiration pneumonitis, hypotension, high spinal or total spinal, convulsions, neuropathy, headaches, hypothermia
    b. Identify, diagnose, and co-manage anesthetic complications (e.g., cardiac arrest, respiratory arrest, aspiration pneumonitis, hypotension, high spinal or total spinal, convulsions, neuropathy, headaches, hypothermia)
7. Management of Obstetrical Complications
    a. Amniotic fluid embolism (AFE)
    b. Acute fatty liver of pregnancy (AFLP)
    c. Placental abruption
    d. Abnormal placentation (e.g., accreta, increta, percreta, vasa previa, and placenta previa)
    e. Gestational trophoblastic disease
    f. Ruptured uterus

g. Cholestasis of pregnancy
h. Uterine anomalies
i. Ovarian masses
j. Dermatologic conditions (e.g., PUPPS, herpes gestationis)
k. Fetomaternal hemorrhage
l. Trauma
m. Abnormally implanted pregnancies (abdominal, cervical, and c-section scar)

Fetal Complications and Prenatal Diagnosis (20%)

1. Ultrasound
   a. Perform and interpret 1st trimester ultrasound for singleton and multiple gestations
   b. Perform and interpret 2nd and 3rd trimester ultrasound
   c. Recognize normal and abnormal maternal, fetal, and placental anatomy
   d. Apply knowledge of the limitations of ultrasound to determine need for additional imaging modalities
   e. Determine indication for and perform Doppler studies (umbilical artery and MCA, color, m-mode)
   f. Determine indication for and perform 3D and 4D ultrasound
   g. Perform and interpret cervical length assessment
   h. Manage disorders of amniotic fluid volume
   i. Perform and interpret fetal echocardiography
   j. Perform ultrasound assessment of chorionicity
2. Evaluation, Management, and Diagnosis of Fetal Complications
   a. Fetal structural abnormalities
   b. Fetal growth restriction
   c. Genetic disorders (e.g., chromosomal abnormalities, DiGeorge's, skeletal dysplasia, syndromes)
   d. Fetal hydrops
   e. Isoimmunization
   f. Alloimmune thrombocytopenia
   g. Fetal infections

Genetics and Genomics (10%)

a. Obtain a genetic history and perform a three-generation pedigree, perform preconception genetic counseling, and counsel patients on Mendelian patterns of inheritance (e.g., autosomal dominant, autosomal recessive, co-dominant, X-linked recessive, X-linked dominant) and non-Mendelian patterns of inheritance (e.g., trinucleotide repeat disorders,

imprinting, uniparental disomy, mitochondrial inheritance, germline mosaicism, multifactorial and polygenic inheritance)

b. Counsel patients on benefits and limitations of PGS/ PGD (preimplantation genetic diagnosis)

c. Counsel patients on and perform expanded and ethnicity-based carrier screening

d. Counsel patients on different methods of aneuploidy screening and interpret results

e. Counsel patients on prenatal testing (e.g., fetal karyotype, chromosomal microarray, biochemical and molecular tests, whole exome sequencing)

Core Competencies and Cross Content (10%)

1. Ethics and Professionalism
   a. Systematically engage in practice review to identify health disparities
   b. When engaged in shared clinical decision making, incorporate patient, family, and cultural considerations in making treatment recommendations
   c. When providing care for patients, consider psychological, sexual, and social implications of various treatment options
2. Patient Safety
   a. Systematically analyze the practice for safety improvements (e.g., root cause analysis)
   b. Systematically engage in practice reviews for safety improvements (e.g., root cause analysis)
   c. Incorporate the standard use of procedural briefings, “time outs,” and debriefings in clinical practice
   d. Participate in the review of sentinel events, reportable events, and near misses
   e. Implement universal protocols (e.g., bundles, checklists) to help ensure patient safety
3. Interpersonal and Communication Skills
   a. Communicate to patient and family regarding adverse outcomes and medical errors
   b. Demonstrate sensitivity and responsiveness when communicating with a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
   c. Provide comprehensive information when referring patients to other professionals
4. Systems-based Practice
   a. Incorporate considerations of cost awareness and risk-benefit analysis in patient care
   b. Provide care with multidisciplinary teams to promote patient safety and optimize patient outcomes
5. Practice-based Learning and Improvement
   a. Design or participate in practice or hospital quality improvement activities
6. Evidence-based Medicine

a. Incorporate evidence-based practices and national guidelines to improve practice patterns and outcomes
b. Implement evidence-based protocols to enhance recovery after surgery (ERAS)

In the Certifying Examination, evaluation of the candidate will include questions related to principles of biostatistics, clinical trial and/or basic science study design, and hypothetical cases. It will also include a review of the submitted case lists, a discussion of structured cases, and surgical techniques. It may include interpretation of operative, radiologic, and computer-generated images and videos, and simulations (radiologic studies, intraoperative photographs, etc.) The candidate should demonstrate the capability of managing complex problems relating to Maternal-Fetal Medicine. The candidate should have the scientific methodologic training to advance knowledge in this subspecialty and to be able to interpret and evaluate new concepts and their supporting data.

Case List Content for MFM Certification

Medical Complications of Pregnancy

A list of 30 patients (no more or fewer) from the candidate's practice with medical complications of pregnancy must be submitted online. Individual patients who presented with any of the following problems should be listed. The required number of patients in each category is listed below. Do not list more than the required number of cases, and a patient may be listed only once.

Cardiac, cardiovascular (chronic hypertension) and pulmonary (asthma, pneumonia)	5 cases
Endocrine, including pregestational diabetes mellitus and thyroid disorders	5 cases
Gastrointestinal, including inflammatory bowel disease and gastric bypass surgery	2 cases
Hematologic and oncologic, including hypercoagulable disorders and thrombophilias, hemoglobinopathies, and thrombophlebitis	5 cases
Immunological, including autoimmune disorders (collagen vascular disease) and transplants	3 cases
Infectious disease (HIV, pyelonephritis, hepatitis)	5 cases
Neurological and psychiatric, including drug or alcohol abuse	2 cases
Renal disease	3 cases

Obstetrical and Surgical Complications

A list of 30 patients (no more or fewer) from the candidate's practice with obstetrical and surgical complications must be submitted online. Individual patients who presented with any of the following problems should be listed. The required number of patients in each category is listed below. Do not list more than the required number of cases, and a patient may be listed only once.

Multiple gestations and complications, including twin-twin transfusion syndrome	5 cases
Placental abnormalities, including previa, abruption, and accreta	3 cases
Hypertension, preeclampsia, and eclampsia	5 cases
Preterm labor and preterm cervical dilation or shortening	5 cases
Preterm premature rupture of membranes (PPROM)	5 cases
Recurrent pregnancy loss, cervical insufficiency, uterine anomalies, fetal demise	2 cases
Surgical (non-obstetric surgery, burns, trauma)	2 cases
Antepartum and peripartum intensive care, including mechanical ventilation or invasive hemodynamic monitoring, massive hemorrhage, pulmonary edema, acute renal failure, septic shock, anesthesia complications, ARDS	3 cases

Genetics/Fetal Disorders/Fetal Anomalies

A list of 30 patients (no more or fewer) from the candidate's practice with genetics/fetal disorders/fetal anomalies must be submitted online. Individual patients who presented with any of the following problems should be listed. The required number of patients in each category is listed below. Do not list more than the required number of cases, and each patient may be listed only once.

Alloimmunization (Rh, thrombocytopenia), immune and non-immune hydrops	3 cases
Fetal anatomic malformations	8 cases
Fetal chromosomal and genetic abnormalities	8 cases
Fetal growth restriction	8 cases
Fetal infections (CMV, parvovirus, toxoplasmosis)	3 cases

Appendix F: Reproductive Endocrinology and Infertility (REI)

REI Examination Topics

The content of the examination will be based on the blueprint for Reproductive Endocrinology and Infertility. The major categories and subcategories are shown below, including the percentages of the categories for the examination. Please note that due to a recent practice analysis conducted by ABOG, the topics and the weighting of these categories are likely to change. ABOG will update the bulletin in the summer of 2024, if necessary.

Basic Science, Physiology, and Pathophysiology (5%)

1. Hormone structure, mechanisms of action, and signaling pathways
2. Clinical pharmacology
3. Laboratory assays
4. Pathology of normal and abnormal reproductive organs and tissues
5. Immunology of the reproductive endocrine system, implantation biology, and early pregnancy
6. Embryogenesis of male and female reproductive systems
7. Gamete biology
8. Pre-implantation embryo development

Diagnostic Techniques and Interpretation for the Management of Reproductive Disorders (10%)

1. Molecular biology (e.g., immunohistochemistry, PCR, endocrine assays)
2. Imaging (e.g., HSG, ultrasound, MRI, Saline-infusion sonography)
3. Provocative testing (e.g., ACTH stimulation, dexamethasone suppression, clomiphene challenge)
4. Andrology including methods of evaluating semen quality and fertilizing capabilities (e.g., semen analysis, post-coital test, DNA fragmentation)

Evaluation, Diagnosis, and Management of Reproductive Endocrine Function and Disease (15%)

1. Normal and abnormal puberty (e.g., delayed puberty, precocious puberty)
2. Menopause
3. Neuroendocrine disorders (e.g., panhypopituitarism, Sheehan Syndrome, Kallmann Syndrome)
4. Gonad (ovary, testes, ovotestes) disorders (e.g., disorders of sexual development)
5. Thyroid disorders
6. Adrenal disorders
7. Metabolic dysfunction (e.g., obesity)
8. Endocrinology of pregnancy
9. Abnormal uterine bleeding

10. Amenorrhea
11. Androgen disorders (e.g., polycystic ovary syndrome, idiopathic hirsutism)
12. Gender-affirming hormone therapy

Female Fertility, Female Infertility, and PCOS (7%)

1. Contraception, Preconception Counseling, and Infertility
    a. Perform comprehensive medical history and physical examination
    b. Counsel patient about contraception options
    c. Provide preconception counseling
    d. Obtain and interpret the results of diagnostic testing (e.g., ovarian reserve testing, ovulatory function, hysterosalpingography, pelvic ultrasound, hysterosonography, laparoscopy)
    e. Counsel women on fertility treatment options, side effects, and complications (e.g., ovulation induction, controlled ovarian hyperstimulation, intrauterine insemination, ART)
2. Evaluation, Diagnosis, and Management of Fertility Treatment Complications, Special Populations, and Early Pregnancy Loss
    a. Complications of fertility treatment (e.g., pregnancy of unknown location/ectopic/heterotopic/ovarian hyperstimulation, multifetal gestation)
    b. Third-party reproduction
    c. LGBTQIA family building considerations and care
    d. Early pregnancy loss
3. Specific Considerations for Polycystic Ovarian Syndrome (PCOS)
    a. Evaluate, diagnose, manage, and counsel patients regarding health consequences of PCOS (e.g., anovulation and infertility, hirsutism, abnormal uterine bleeding, metabolic disturbances, endometrial hyperplasia/cancer)
    b. Counsel and manage ovulation induction and fertility treatment for PCOS
    c. Counsel women on treatment options for hirsutism in PCOS

Male Infertility (5%)

1. Evaluation and Counseling for Male Infertility
    a. Perform comprehensive medical history (e.g., sexual development history including testicular descent, chronic disease, surgical history, medication use, infections, exposure to radiation, environmental exposures, family history, steroid use, drug and alcohol use, sexual history including libido, frequency of intercourse and prior fertility)
    b. Obtain and interpret results of diagnostic testing for male infertility (e.g., semen analysis, post-void semen analysis, hormonal testing, genetic testing including karyotype, genetic carrier testing, y-microdeletion testing, transrectal and scrotal ultrasound) and counsel patients on the results
    c. Diagnose and differentiate types of male infertility (e.g., endocrine and systemic disorders, primary testicular defects in spermatogenesis, sperm transport disorders, idiopathic male infertility)

   d. Counsel patients regarding application, efficacy, risks, and benefits of non-surgical treatments for oligospermia (e.g., clomiphene citrate, human chorionic gonadotropin, letrozole)
   e. Counsel patients on the use of donor sperm, including discussion of regulatory issues involving donor sperm
2. Counseling Patients Regarding Surgical Management of Male Infertility and Intracytoplasmic Sperm Injection (ICSI)
   a. Testicular sperm extraction, including microsurgical epididymal sperm aspiration
   b. Vasectomy reversal
   c. Varicocele repair
   d. Intracytoplasmic sperm injection

Recurrent Pregnancy Loss (3%)

1. Evaluate, diagnose, and manage recurrent pregnancy loss (RPL), including causes of euploid and aneuploid pregnancy loss (e.g., contribution of endocrine factors, immunologic factors, anatomic factors, and genetic factors and relative incidence of each) and counsel patients regarding prognosis and causes of RPL
2. Counsel patients on advantages and limitations of pre-implantation genetic diagnosis for abnormal parental karyotypes and unexplained RPL
3. Counsel patients on the indications for supplemental progesterone, thyroid hormone supplementation, aspirin, heparin, and other available medical therapies
4. Provide and counsel patients (including advantages and limitations) on genetic analysis of aborted fetal tissue

Fertility Preservation (5%)

1. Evaluation, Diagnosis, and Management of Fertility Preservation
   a. Recognize indications and counsel patients for fertility preservation (e.g., elective cryopreservation, gonadotoxic therapies, genetic conditions)
   b. Obtain and interpret results of diagnostic testing (e.g., ultrasound, ovarian reserve markers), and counsel patients regarding fertility preservation
   c. Counsel patients on the options and expectations for fertility preservation
   d. Perform ART procedures for oocyte and embryo cryopreservation
2. Specific Considerations for Patients Receiving Gonadotoxic Therapies
   a. Understand and implement modifications to conventional ART protocols for cancer patients (e.g., use of aromatase inhibitor to suppress estrogen levels, random start protocols to minimize delay)
   b. Counsel patients on ovarian transposition if pelvic irradiation is anticipated
   c. Counsel patients on fertility-sparing gynecologic surgery
   d. Counsel patients on the use of ovarian suppression with GnRH agonists for fertility preservation

e. Counsel patients on experimental options for fertility preservation (e.g., ovarian tissue cryopreservation and transplantation)

Assisted Reproductive Technology (ART) Techniques (10%)

1. Transvaginal ultrasound-guided oocyte retrieval
2. Transabdominal ultrasound-guided oocyte retrieval
3. Ultrasound-guided embryo transfer
4. Gamete and zygote intrafallopian transfer
5. Ultrasound-guided ovarian cyst aspiration
6. Paracentesis/culdocentesis

Evaluation, Diagnosis, and Management of Complex Reproductive Disorders (10%)

1. Pelvic pain (e.g., adhesive disease)
2. Endometriosis
3. Ambiguous genitalia
4. Müllerian anomalies
5. Asherman syndrome
6. Leiomyomata

Complex Reproductive Surgical Procedures (10%)

1. Diagnostic and operative hysteroscopic procedures
2. Diagnostic and operative laparoscopic procedures
3. Tubal surgeries for fertility restoration add tubal reversal and tuboplasty
4. Abdominal myomectomy
5. Laparotomy procedures
6. Surgical management of müllerian anomalies
7. Abdominal salpingo-oophorectomy
8. Abdominal salpingostomy
9. Vaginal septum excision

Genetics (10%)

1. Understanding of Genetic Testing and Screening
    a. The basic science of genetics, epigenetics, and genetic testing
    b. Inheritance patterns of genetic disorders
    c. Pre-implantation genetic screening and testing
    d. Antenatal genetic testing
2. Application of Genetic Testing and Screening to Patient Care
    a. Obtain and interpret preconception female and male screening as it relates to female and male infertility diagnosis

b. Obtain and interpret genetic testing as it relates to female and male infertility diagnosis
c. Counsel patients on prognosis and treatment based on genetic testing results

Core Competencies and Cross Content (10%)

1. Ethics and Professionalism
   a. Systematically engage in practice review to identify health disparities
   b. When engaged in shared clinical decision making, incorporate patient, family, and cultural considerations in making treatment recommendations
   c. When providing care for patients, consider psychological, sexual, and social implications of various treatment options
2. Patient Safety
   a. Systematically analyze the practice for safety improvements (e.g., root cause analysis)
   b. Systematically engage in practice reviews for safety improvements (e.g., root cause analysis)
   c. Incorporate the standard use of procedural briefings, “time outs,” and debriefings in clinical practice
   d. Participate in the review of sentinel events, reportable events, and near misses
   e. Implement universal protocols (e.g., bundles, checklists) to help ensure patient safety
3. Interpersonal and Communication Skills
   a. Communicate to patient and family regarding adverse outcomes and medical errors
   b. Demonstrate sensitivity and responsiveness when communicating with a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
   c. Provide comprehensive information when referring patients to other professionals
4. Systems-based Practice
   a. Incorporate considerations of cost awareness and risk-benefit analysis in patient care
   b. Provide care with multidisciplinary teams to promote patient safety and optimize patient outcomes
5. Practice-based Learning and Improvement
   a. Design or participate in practice or hospital quality improvement activities
6. Evidence-based Medicine
   a. Incorporate evidence-based practices and national guidelines to improve practice patterns and outcomes
   b. Implement evidence-based protocols to enhance recovery after surgery (ERAS)

In the Certifying Examination, evaluation of the candidate will include questions related to principles of biostatistics, clinical trial and/or basic science study design, and hypothetical cases. It will also include a review of the submitted case lists, a discussion of structured cases, and surgical techniques. It may include interpretation of operative, radiologic, and computer-generated images and videos, and simulations (radiologic studies, intraoperative photographs,

etc.) The candidate should demonstrate the capability of managing complex problems relating to Reproductive Endocrinology and Infertility. The candidate should have the scientific methodologic training to advance knowledge in this subspecialty and to be able to interpret and evaluate new concepts and their supporting data.

Case List Content for REI Certification

Reproductive Endocrinology Patients

The case lists must be submitted online and must include 25 reproductive endocrinology patients (no more or fewer) from the candidate's office practice who presented with any of the following. Do not list more than 3 patients from any category. (List patients with PCOS under hirsutism and hyperandrogenism.)

1. Contraception
2. Genetic counseling
3. Primary and secondary amenorrhea
4. Hirsutism and hyperandrogenism
5. Hyperprolactinemia
6. Endometriosis
7. Perimenopausal and menopausal care/premature ovarian failure
8. Abnormal uterine bleeding
9. Pediatric Endocrinology including disorders of sexual differentiation
10. Abnormalities of pubertal development
11. Premenstrual syndrome
12. Diabetes mellitus
13. Thyroid disorders
14. Adrenal Disease
15. Hypothalamic and Pituitary disorders
16. Endocrinology of Pregnancy
17. Fertility Preservation

Reproductive Surgery

A list of 25 reproductive uncomplicated surgical patients (no more or fewer) from the candidate's surgical practice must be submitted online. Individual patients who presented with any of the following problems should be listed. At least 5 of the categories below must be included. **List ALL reproductive surgery complications separately in addition to the 25 uncomplicated cases. These should be listed under the Complications category.**

1. Laparotomy
2. Operative laparoscopy
3. Operative hysteroscopy
4. Uterine myomas
5. Asherman syndrome
6. Endometriosis
7. Tubal reversal/tuboplasty
8. Ectopic pregnancy
9. Operative management of pelvic pain
10. Congenital abnormalities of the reproductive tract
11. Adnexal problems excluding ectopic pregnancy
12. Complications

Infertility/IVF

A list of 25 uncomplicated infertility/IVF patients (no more or fewer) from the candidate's office practice must be submitted online. Individual patients who presented with any of the following problems should be listed. **List ALL complications from IVF/infertility treatment separately and in addition to the 25 uncomplicated cases. These should be listed under the Complications category.**

1. Female infertility
2. Male infertility
3. Recurrent pregnancy loss
4. ART
5. Complications

Appendix G: Urogynecology and Reconstructive Pelvic Surgery (URPS)

URPS Examination Topics

The content of the examination will be based on the blueprint for Urogynecology and Reconstructive Pelvic Surgery. The major categories and subcategories are shown below, including the percentages of the categories for the examination. Please note that due to a recent practice analysis conducted by ABOG, the topics and the weighting of these categories are likely to change. ABOG will update the bulletin in the summer of 2024, if necessary.

Urinary Incontinence and Lower Urinary Tract Symptoms: Frequency, Urgency, Nocturia, and Bladder Pain (18%)

1. Diagnosis and Exam
    a. Diagnose and differentiate types of lower urinary tract dysfunction
    b. Perform comprehensive history and physical exam (e.g., POP-Q; myofascial pelvic exam; pelvic muscle tone, strength, and coordination; pelvic muscle spasm and trigger points)
    c. Select, perform, and interpret results of initial diagnostic testing (e.g., pad test; post-void residual; urinalysis, culture & sensitivities; cough stress test)
    d. Perform and interpret results of advanced diagnostic testing (e.g., urodynamics, cystoscopy)
    e. Obtain and interpret results of voiding diary tests
    f. Obtain and utilize results of sleep study tests
    g. Perform interventions to address lower urinary tract dysfunction
    h. Counsel patients on lower urinary tract dysfunction pathophysiology and diagnostic testing
2. Counseling on Efficacy, Risks, and Benefits of Non-Surgical Treatments
    a. Pelvic floor physical therapy
    b. Pharmacologic therapy
    c. Urethral bulking
    d. Onabotulinum toxin A injection
    e. Neuromodulation (Posterior Tibial Nerve Stimulation, PTNS)
    f. Pessaries
3. Non-Surgical Treatments
    a. Urethral bulking
    b. Onabotulinum toxin A injection
    c. Neuromodulation (Posterior Tibial Nerve Stimulation, PTNS)
    d. Pessaries
4. Post-Procedural Management of Non-Surgical Treatments

   a. Monitor therapeutic effects and adjust treatment
   b. Manage complications or side effects of non-surgical treatment

5. Counseling on Efficacy, Risks, and Benefits of Surgical Treatments
   a. Retropubic suspension
   b. Midurethral sling
   c. Autologous fascial sling
   d. Neuromodulation (Sacral Neurostimulation)
6. Surgical Treatments
   a. Retropubic suspension
   b. Midurethral sling
   c. Autologous fascial sling
   d. Neuromodulation (Sacral Neurostimulation)
   e. Manage complications of surgical treatment

Lower Urinary Tract Injury (12%)

1. Diagnosis of Bladder Injury
   a. Cystoscopy
   b. CT urogram
   c. Retrograde pyelogram
   d. Voiding cystourethrogram
   e. Evaluate for complex fistula
2. Treatment of Bladder Injury
   a. Cystotomy repair
   b. Vesicovaginal fistula repair (vaginal)
   c. Vesicovaginal fistula repair (minimally invasive)
   d. Vesicovaginal fistula repair (abdominal)
   e. Treatment of uterovaginal fistula repair
   f. Treatment of colovesical fistula
   g. Interpositional graft
3. Diagnosis of Ureteral Injury
   a. Cystoscopy
   b. CT urogram
   c. Retrograde pyelogram
   d. Ureterolysis
   e. Ureteral catheter / stent

4. Treatment of Ureteral Injury
    a. Stent
    b. Ureteroneocystostomy
    c. Ureteroureterostomy
    d. Percutaneous nephrostomy tube
    e. Boari flap
    f. Psoas hitch
    g. Interpositional graft

5. Diagnosis of Urethral Injury
    a. Cystoscopy
    b. Voiding cystourethrogram
6. Treatment of Urethral Injury
    a. Urethrovaginal fistula repair
    b. Martius flap

Pelvic Organ Prolapse (20%)

1. Diagnosis and Exam
    a. Diagnose and differentiate types of pelvic organ prolapse
    b. Perform and interpret results of post-void residual tests
    c. Perform and interpret results of urinalysis, culture, and sensitivities tests
    d. Counsel patients on pathophysiology and indications and results of additional testing

2. Non-Surgical Treatments
    a. Counsel patients regarding efficacy, risks, and benefits of pelvic floor physical therapy
    b. Counsel patients regarding efficacy, risks, and benefits of pessaries
    c. Perform pessary fitting
    d. Counsel patient on management of pessary care
    e. Manage complications or side effects of non-surgical treatment
3. Counseling on Efficacy, Risks, and Benefits of Surgical Treatments
    a. Vaginal hysterectomy
    b. Minimally invasive (Laparoscopic) hysterectomy
    c. Abdominal hysterectomy
    d. Anterior compartment native tissue repairs
    e. Posterior compartment native tissue repairs
    f. Vaginal mesh and graft augmented repairs

g. Open abdominal sacrocolpopexy
h. Minimally invasive (Laparoscopic) sacrocolpopexy
i. Vaginal native tissue apical suspensions
j. Minimally invasive (Laparoscopic) native tissue apical suspensions
k. Hysteropexy
l. Rectopexy
m. Obliterative procedures

4. Surgical Treatments
   a. Vaginal hysterectomy
   b. Minimally invasive (Laparoscopic) hysterectomy
   c. Abdominal hysterectomy
   d. Anterior compartment native tissue repairs
   e. Posterior compartment native tissue repairs
   f. Vaginal mesh or graft augmented repairs
   g. Open abdominal sacrocolpopexy
   h. Minimally invasive (Laparoscopic) sacrocolpopexy
   i. Vaginal native tissue apical suspensions
   j. Minimally invasive (Laparoscopic) native tissue apical suspensions
   k. Hysteropexy
   l. Rectopexy
   m. Obliterative procedures
5. Complications of Surgical Treatments
6. Augmentation of Surgical Materials
   a. Counsel patients regarding different types of mesh and graft materials (e.g., allograft, autograft, xenograft, synthetic)
   b. Identify and manage complications of mesh and graft materials
   c. Counsel patients regarding alternatives, risks, benefits, and complications associated with mesh and graft materials

Fecal Incontinence and Defecation Disorders (7%)

1. Diagnosis and Exam
   a. Diagnose and differentiate types of fecal incontinence and defecation disorders
   b. Perform and interpret results of endoanal ultrasound tests
   c. Perform and interpret results of pelvic floor ultrasound tests
   d. Perform and interpret results of anorectal manometry tests
   e. Obtain and interpret results of defecography tests

f. Obtain and utilize results of colonoscopy tests
g. Obtain and interpret results of motility studies
h. Obtain and interpret results of fistulogram tests
i. Obtain and interpret results of CT tests
j. Counsel patients on pathophysiology and diagnostic testing of fecal incontinence and defecation disorders

2. Counseling on Efficacy, Risks, and Benefits of Non-Surgical Treatments
   a. Pelvic floor physical therapy
   b. Pharmacologic therapy
   c. Bulking
   d. Neuromodulation (Posterior Tibial Nerve Stimulation, PTNS)
   e. Pessaries
3. Non-Surgical Treatments
   a. Bulking
   b. Neuromodulation (Posterior Tibial Nerve Stimulation, PTNS)
   c. Pessary fitting and placement
4. Post-Procedural Management of Non-Surgical Treatments
   a. Monitor therapeutic effects and adjust treatment
   b. Manage complications or side effects of non-surgical treatment
5. Surgical Treatments
   a. Counsel patients regarding efficacy, risks, and benefits of the surgical treatment: Neuromodulation (Sacral neurostimulation)
   b. Counsel patients regarding efficacy, risks, and benefits of the surgical treatment: Rectovaginal fistula repair
   c. Counsel patients regarding efficacy, risks, and benefits of the surgical treatment: Anal sphincteroplasty
   d. Perform neuromodulation (Sacral neurostimulation)
   e. Perform rectovaginal fistula repair
   f. Perform anal sphincteroplasty
   g. Manage complications or adverse effects of surgical treatment

Congenital Anomalies of the Urogenital Tract (4%)

1. Diagnosis and Exam
   a. Diagnose and differentiate types of congenital anomalies
   b. Obtain and interpret results of diagnostic testing (e.g., ultrasound, MRI, karyotype, hormone testing, hysteroscopy)

   c. Counsel patients on urogenital anomalies including pathophysiology and diagnostic testing
2. Non-Surgical Treatments
   a. Counsel patients regarding timing, efficacy, risks, and benefits of non-surgical treatments (e.g., expectant management, vaginal dilation)
3. Counseling on Timing, Efficacy, Risks, and Benefits of Neovagina Surgical Procedures
   a. McIndoe
   b. Laparoscopic Vecchietti
   c. Laparoscopic Davydov
   d. Resection of septum
4. Neovagina Surgical Procedures
   a. McIndoe
   b. Laparoscopic Vecchietti
   c. Laparoscopic Davydov
   d. Resection of septum
5. Complications or Adverse Effects of Neovagina Surgical Procedures
   a. Manage complications or adverse effects of neovagina surgical procedures

Urethral Mass (6%)

1. Diagnosis and Exam for Urethral Mass
   a. Diagnose and differentiate types of urethral masses
   b. Perform and interpret results of pelvic floor ultrasound
   c. Perform and interpret results of cystoscopy diagnostic testing
   d. Obtain and interpret MRI results
   e. Counsel patients on urethral mass pathophysiology and diagnostic testing
   f. Manage complications or adverse effects of treatment
2. Counseling on Efficacy, Risks, and Benefits on Treatment Options for Urethral Mass
   a. Observation
   b. Drainage
   c. Excision
   d. Urethral reconstruction
   e. Concomitant anti-incontinence procedure
3. Treatment Options for Urethral Mass
   a. Observation
   b. Drainage
   c. Excision

d. Urethral reconstruction
e. Concomitant anti-incontinence procedure

Urinary Tract Infection (UTI) and Hematuria (5%)

1. Urinary Tract Infection (UTI)
   a. Evaluate and diagnose UTIs
   b. Manage acute, chronic, and complicated UTIs
   c. Diagnose and treat urogenital atrophy
2. Hematuria
   a. Obtain and interpret results of initial diagnostic testing (e.g., post-void residual; urinalysis, culture & sensitivities; cystoscopy and biopsy)
   b. Obtain and interpret results of advanced diagnostic testing (e.g., CT urography, urine cytology, renal ultrasound)
   c. Counsel patients on hematuria pathophysiology and diagnostic testing

Application of Anatomy to Patient Care (8%)

a. Describe and apply knowledge of anatomy to safely perform surgery and avoid complications (e.g., vascular and nerve supply, bladder, urethra, anatomic supports, ureter, anal sphincter, rectum, small bowel, large bowel)
b. Describe and apply knowledge of central and peripheral nervous system anatomy as it applies to the etiology and treatment of pelvic floor disorders (urinary tract dysfunction, fecal incontinence)

General Perioperative Management (15%)

a. Identify and perform preoperative testing depending on patient comorbidities (e.g., immunosuppression, diabetes, cardiovascular disease)
b. Identify and perform preoperative testing depending on patient population (e.g., geriatric)
c. Manage perioperative anticoagulation (e.g., prevention of VTE, chronic anticoagulation)
d. Position patient to decrease adverse outcomes
e. Utilize intraoperative techniques to minimize vascular, visceral, and urinary tract injuries
f. Manage intraoperative injuries (e.g., vascular, bowel, urinary tract, and nerve)
g. Manage postoperative medical and surgical complications
h. Manage prolonged urinary catheterization

Core Competencies and Cross Content (5%)

1. Ethics and Professionalism
   a. Systematically engage in practice review to identify health disparities
   b. When engaged in shared clinical decision making, incorporate patient, family, and cultural considerations in making treatment recommendations
   c. When providing care for patients, consider psychological, sexual, and social implications of various treatment options

2. Patient Safety
    a. Systematically analyze the practice for safety improvements (e.g., root cause analysis)
    b. Systematically engage in practice reviews for safety improvements (e.g., root cause analysis)
    c. Incorporate the standard use of procedural briefings, “time outs,” and debriefings in clinical practice
    d. Participate in the review of sentinel events, reportable events, and near misses
    e. Implement universal protocols (e.g., bundles, checklists) to help ensure patient safety
3. Interpersonal and Communication Skills
    a. Communicate to patient and family regarding adverse outcomes and medical errors
    b. Demonstrate sensitivity and responsiveness when communicating with a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
    c. Provide comprehensive information when referring patients to other professionals
4. Systems-based Practice
    a. Incorporate considerations of cost awareness and risk-benefit analysis in patient care
    b. Provide care with multidisciplinary teams to promote patient safety and optimize patient outcomes
5. Practice-based Learning and Improvement
    a. Design or participate in practice or hospital quality improvement activities
6. Evidence-based Medicine
    a. Incorporate evidence-based practices and national guidelines to improve practice patterns and outcomes
    b. Implement evidence-based protocols to enhance recovery after surgery (ERAS)

In the Certifying Examination, evaluation of the candidate will include questions related to principles of biostatistics, clinical trial and/or basic science study design, and hypothetical cases. It will also include a review of the submitted case lists, a discussion of structured cases, and surgical techniques. It may include interpretation of operative, radiologic, and computer-generated images and videos, and simulations (radiology studies, urodynamics, intraoperative photographs, etc.) The candidate should demonstrate the capability of managing complex problems relating to Urogynecology and Reconstructive Pelvic Surgery. The candidate should have the scientific methodologic training to advance knowledge in this subspecialty and to be able to interpret and evaluate new concepts and their supporting data.

Case List Content for URPS Certification

Three types of cases must be submitted: (1) prolapse and reconstructive surgical cases, (2) urinary and fecal incontinence surgical cases, and (3) office practice cases. No patient may be listed more than once, and no patient may be included on more than one case list. Specifically, patients who are evaluated in the office and subsequently have surgery should only be listed on the surgical case list. Patients that are admitted multiple times or have multiple surgeries may only be listed once, but all complications and surgeries should be listed.

Surgical Case Lists

The Prolapse and Reconstructive Surgical Cases case list and the Urinary and Fecal Incontinence Surgical Cases case list must include ALL URPS surgical patients from ALL sites for which the candidate had primary responsibility during the case collection period. Each list MUST include a minimum of 25 URPS surgical cases. No patient can be listed more than once on the surgical case lists. Do not list any procedures that occurred in the office.

Prolapse and Reconstructive Surgical Cases

The list must contain a minimum of 25 prolapse and reconstructive surgical cases. Cases should be listed in the following categories:

1. Surgical Treatment of Prolapse – Apical Suspension – Vaginal
2. Surgical Treatment of Prolapse – Apical Suspension – Abdominal/laparoscopic/robotic
3. Surgical Treatment of Prolapse – Obliterative procedures
4. Surgical Treatment of Prolapse – Other Pelvic Organ Prolapse
5. Surgical Reconstructive Surgery
6. Other URPS Procedures – Any prolapse and reconstructive surgical procedure not listed elsewhere

Urinary and Fecal Incontinence Surgical Cases

The list must contain a minimum of 25 urinary and fecal incontinence surgical cases. Surgeries for urinary or bowel fistulas should be listed under “Other URPS Procedures” on the Urinary and Fecal Incontinence case list.

1. Surgical Treatment of Urinary Incontinence – Sling
2. Surgical Treatment of Urinary Incontinence – Other Urinary Incontinence
3. Surgical Treatment of Fecal Incontinence
4. Other URPS Procedures – Sacral Nerve Stimulator
5. Other URPS Procedures – Intravesical Injections (botulinum toxin)
6. Other URPS Procedures – Any urinary and fecal incontinence procedure not listed elsewhere

Office Practice Case List

A list of 40 patients (no more or fewer) who received non-surgical office management must be submitted online. A patient may be listed only once. Do NOT include any patients who are on the surgical case lists. At least 1, but no more than 10 patients must be listed in each of the following 5 categories:

1. Pelvic Organ Prolapse
2. Urinary Incontinence
3. Urinary Tract Symptoms: Urgency, Frequency, Nocturia, Voiding Dysfunction, Urinary Retention, Sensory Disorders
4. Urinary Tract Disorders: Fistulae, Diverticula, Infections, Hematuria

5. Pelvic Floor Disorders: Defection Disorders, Fecal Incontinence, Anorectal Disorders, Rectovaginal Fistulae, Sexual Dysfunction, Vaginal Pain