ABOG
American Board of Obstetrics & Gynecology
First in Women's Health®

2025 Subspecialty Qualifying Examination

Including:

Complex Family Planning (ACGME-Trained Candidates)

Gynecologic Oncology

Maternal-Fetal Medicine

Reproductive Endocrinology and Infertility

Urogynecology and Reconstructive Pelvic Surgery

Certification demonstrates to the public that a physician and medical specialist meets nationally recognized standards for education, knowledge, experience, and skills and maintains their certification through continuous learning and practice improvement in order to provide high quality care in a specific medical specialty.

This Bulletin, issued in September 2024, represents the official statement of the requirements in effect for the Subspecialty Qualifying Examination to be given on July 21, 2025.

Obstetrician-gynecologists applying as Complex Family Planning Senior Candidates should refer to the CFP Bulletin for "Senior Candidates" that can be found on the ABOG website.

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2025 QUALIFYING EXAMINATION

Introduction

ABOG certification is a two-step process that is completely voluntary. The Subspecialty Qualifying Examination is the first of the two steps in ABOG's subspecialty initial certification process. Each potential candidate is responsible for completing the application for the Qualifying Examination online at www.abog.org, submitting all required materials to ABOG at the time they are requested, and meeting all deadlines. ABOG will make the final decision concerning the applicant's admission to the examination after considering all circumstances affecting the application.

Eligibility Requirements

Each of the following is a requirement for a candidate to sit for the Subspecialty Qualifying Examination. The candidate must meet all of the requirements in effect during the year for which admission to the Qualifying Examination is requested.

1. ***Unrestricted Medical License (if applicable)*** It is not necessary to have a medical license to sit for the Qualifying Examination. However, if a medical license is held, it must be unrestricted without conditions (see Disqualification from the Qualifying Examination in Appendix B for further information.) An unrestricted medical license will be required to apply for the Certifying Examination.
2. ***Specialty Qualifying Examination*** A candidate may not apply for the Subspecialty Qualifying Examination unless they have previously passed the Specialty Qualifying Examination for Certification in Obstetrics and Gynecology.
3. ***Length of Training*** The candidate must have been registered with ABOG and will have completed training in an ACGME-accredited fellowship program in their subspecialty no later

than September 30 of the same year the Qualifying Examination is taken. Reproductive Endocrinology and Infertility, Maternal-Fetal Medicine, Gynecologic Oncology, Urogynecology and Reconstructive Pelvic Surgery candidates must have completed a minimum of 32 of 36 months of training at the time of application. Complex Family Planning candidates must have completed a minimum of 20 of 24 months of training at the time of application. Additionally, the candidate must have completed and presented their thesis to their Program Director before the completion of their fellowship. If a candidate's situation changes, and they do not successfully complete their fellowship and their thesis presentation by September 30, they will not be eligible to take the Qualifying Examination in that year. Any candidate who takes the Qualifying Exam without successfully completing fellowship and completing and presenting their thesis by September 30 of the year of the examination will have their results voided, and they will not receive a refund.

4. ***Allocation of Time and Curriculum*** In order to take the Qualifying Examination, the candidate must have completed the required experiences during fellowship and meet the curriculum requirements for their subspecialty. See the required experiences lists and curriculum in the Appendix for each subspecialty.

5. ***Leaves of Absence*** Leaves of absence and vacation may be granted at the discretion of the Program Director consistent with local institutional policy and applicable laws. The number of days that equals a "week" is a local issue that is determined by the institution and Program Director, not ABOG. Vacation weeks may be taken as part of approved leave or in addition to approved leave. For more information on leave, please review the ABOG website on Fellowship Leave Policy.

   If the limit of leave is exceeded, the fellowship must be extended for at least the duration of time that the individual was absent in excess of 16 weeks in a two-year fellowship or 20 weeks in a three -year fellowship. Such extensions of training must have an educational plan outlined for the continued training with specific educational and clinical experience goals and objectives to be achieved. This educational plan must include a description of what training was missed, how the missed training is being attained, and a block diagram that covers the entire length of training. This plan must be submitted to ABOG for approval here.

6. ***Moral and Ethical Behavior*** The candidate must have demonstrated good moral and ethical behavior in the practice of medicine and in interactions with peers, other medical personnel, and patients. A felony conviction, even if unrelated to the practice of medicine, will be considered evidence of failure to meet this standard.

7. ***Falsification of Information*** Falsification of any information or failure to disclose any adverse action will result in a deferral of a candidate's eligibility to sit for the Qualifying Examination for a period of at least three 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.

8. ***Completion and Presentation of Thesis*** The candidate must have completed and presented their thesis to their Program Director by the final date of their fellowship. If their fellowship is extended, the candidate will have until the extended final date of their fellowship to complete and present their thesis. A candidate whose fellowship is extended beyond September 30 of the year of the Qualifying Examination is not eligible to take the Qualifying Examination in that year.

Candidates must meet all of the requirements in the *Bulletin* for the year they are applying for the test.

Fellowship Training Attestations

At the end of their training the fellow will be expected to attest to the following:

1. Compliance with the ABOG Professionalism, Professional Standing, and Professional Conduct Policy.
2. Met the educational objectives of their training program.
3. Have demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.

The Program Director will attest to the fellows' satisfactory performance, professionalism, competence, and successful completion of the required months of clinical experience. The Program Director is expected to sign on behalf of the program and not as an individual.

Results of the examination will not be released until all fellow and Program Director attestations are complete.

A new attestation is not necessary for those candidates who have completed their fellowship training and sat for the Qualifying Examination in a prior year if an attestation has been previously received at ABOG.

Application Process

The applicant must supply ABOG with an email address as part of the application process and notify ABOG of any change in this email address. Applications will be accepted online beginning January 3. Late fees will apply for applications received after February 14. The last day to apply for the Qualifying Examination is February 28. The examination fee must be paid in full by credit card at the time of the application. All fees are quoted and must be paid in US dollars.

An approval email will be sent to each applicant at the email address currently listed in the Profile Section of the applicant's personal ABOG portal when they are approved to take the Qualifying Examination.

Once a candidate is approved to take the ABOG Qualifying Examination, any questions about exam protocols and processes should be submitted here.

The approval email will contain information for contacting a Pearson VUE Testing Center to schedule a seat for the examination. After the approval email from ABOG is received, the candidate must contact Pearson VUE to obtain a seat for the examination. Candidates are urged to obtain a seat as soon as possible after notification of approval to avoid long-distance travel to a site with an available seat. On April 25, the ABOG reserved seats held at the Pearson VUE centers will be released. After that date, it will be harder for candidates to reserve a seat at their preferred site. Seats in individual cities are limited and are assigned on a first-come, first-served basis. ABOG will not refund any portion of the test fee if a candidate is not able to reserve a seat at their preferred testing center.

If special accommodations are required, those requests must be received no later than the close of the application period (February 28) and should be submitted here. It may not be possible to

accommodate requests received after that date. See Appendix C for more information on requests for special accommodations.

The Qualifying Examination will be given on July 21.

Fees and Deadlines

The following table lists the deadlines and fees for the Qualifying Examination. Policies related to Assessment Fees and Refunds can be found here.

Qualifying Examination: Deadlines

January 3, 2025	Applications available online
February 14, 2025	Application deadline with no late fee
February 28, 2025	No applications accepted after this date
January 2025 to February 2025	Candidates will be notified of approval to take the examination and to make a Pearson VUE Testing Center reservation
April 25, 2025	Last day to reserve seat at Pearson VUE prior to seat block release
July 21, 2025	Qualifying Examination at testing centers

Qualifying Examination: Fees

January 3, 2025, to February 14, 2025	$2145
February 15, 2025, to February 28, 2025	$2145 + $400 late fee = $2545

Applicants Ruled Not Admissible

If a decision is made by ABOG that a candidate has not met the requirements for admission to the examination, the candidate may appeal the decision in writing here. Such appeals will be forwarded to the appropriate ABOG Committee for reconsideration. If the appeal is successful, no late fees will apply. All appeals must be received no later than one month prior to the examination date.

If the candidate's appeal is not successful, the application fee will not be refunded. Please refer to the ABOG Assessment Fees and Refunds policy which can be found here.

Exam Administration

The Qualifying Examination is scheduled to last approximately 3 hours and 45 minutes. Candidates who finish before the full time has elapsed may leave the Pearson VUE Testing Center early, but if they do so, may not return. Candidates will receive information after registering on the Pearson VUE Testing Center website concerning the location of their examination, as well as the time they must arrive. Candidates will be required to schedule their examination seat reservation with an 8:00 am start time in their time zone and at a Pearson VUE location in the United States or Canada. Requests to take the examination at a Pearson VUE location outside of the US or Canada will be considered if the reason for the request is out of the control of the candidate (e.g., military deployment).

Specific conduct and expectations on day of testing at the Pearson VUE Testing Center can be found here, including the Test Security agreement.

In the event of unforeseen circumstances that may disrupt or cancel your scheduled appointment on the day of testing, Pearson VUE will offer an option to reschedule your appointment within 5 business days of the original date (on or before the Friday of the week of the exam), and will strive to accommodate your preferred location, date, and time – pending availability at a given center. While they will unfortunately not guarantee preferences, Pearson VUE will work with you to find the best alternative within the 5-business day testing window. If the candidate does not take their exam within the required timeframe, the examination fee will not be refunded and will not be credited toward future applications.

Results and Scoring

The results of the Qualifying Examination will be reported online to each candidate on or before the last Friday in October. We recognize waiting close to 12 weeks for these important results is difficult and the format of the examination creates an expectation for immediate feedback. Please be assured during this post-examination period, extensive quality assurance checks take place to ensure your test result is fair and accurate. For example, content on the exam is re-reviewed to identify potentially flawed questions. If ABOG determines a question with more than one correct answer (or no correct answer) was on the exam, test-takers will not be penalized for that item.

When results are released, ABOG will provide the candidate their scaled test score in addition to the result of “pass” or “fail.” Each candidate, regardless of whether they pass or fail, will be provided with the percent scored in each of the major topic areas. The cut-point for passing the exam is determined using standard setting methodology every 3-5 years and is equated statistically between that time.

In order to release a result, ABOG must receive the Fellowship Training Affidavit verifying completion of training from the current Program Director. Additionally, **if ABOG does not receive notification of fellowship completion from the Program Director by January 1, 2026, the results of the examination will be voided**.

As part of the application process, the applicant will be required to irrevocably agree that the results of the applicant’s examination may be made available to the Program Director(s) of any fellowship program(s) in which the applicant may have participated or in which the applicant is currently involved, and/or the American Council of Graduate Medical Education (ACGME) for

any and all purposes. The candidate will also be given the opportunity to release their scaled score on the examination to their current Program Director. Furthermore, the applicant 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 applicant may have with regard to the effect or impact upon the applicant of the release of the applicant's examination results to the applicant's Program Director or the ACGME and waive any rights the applicant may have, if any, to have the examination results maintained in confidence.

For more information, see Appendix E on Rescores, Appeals, and Requests for Re-Examination.

APPENDIX A: DISCLAIMERS

Gender Language

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

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

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 examination, as requirements may change from year to year. The Bulletin is available under the "Bulletins & Dates" tab online at www.abog.org. It is the candidate's responsibility to become familiar with all the material contained in the Bulletin, 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 a candidate submits an application to ABOG, it is the candidate's responsibility to inform ABOG of any changes in personal information (email, phone, address, etc.) by updating the information in their profile on their ABOG portal. Because hospital and university email addresses are often closed after the completion of training, candidates should list a personal email address.

Candidate Board Status

ABOG Registered Fellowship Graduate

After completing or nearing completion of a fellowship program in Complex Family Planning, Gynecologic Oncology, Maternal-Fetal Medicine, Reproductive Endocrinology and Infertility, or Urogynecology and Reconstructive Pelvic Surgery accredited by the American Council for Graduate Medical Education (ACGME) and meeting all of the requirements listed in the Bulletin, a physician may complete an application to begin the certification process. When and if the Board determines that they have fulfilled the requirements to take the Qualifying Examination, that person becomes a “Registered Fellowship Graduate.” The term “Board Eligible” is not used or recognized by ABOG.

Active Candidate

A physician achieves “Active Candidate” status by passing the ABOG Qualifying Examination. To maintain Active Candidate status, the candidate must fulfill all of the requirements for admission to the Certifying Examination and may not have exceeded the limitations to admissibility for the Certifying Examination.

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 must achieve ABOG subspecialty certification within 8 years of completion of their 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.

APPENDIX B: DISQUALIFICATION FROM THE QUALIFYING EXAMINATION

If a candidate is found to be involved in litigation or investigation regarding ethical or moral issues, the application will be reviewed. ABOG may defer a decision for entry into the examination to gain further information.

If the candidate has one or more licenses to practice medicine in any US state or Canadian province, each license may not be restricted, suspended, revoked, or on probation. Any restrictions or conditions placed on a license, regardless of whether the limits deal specifically with patient care, will disqualify the physician from entry to the Qualifying Examination. Such restrictions and conditions include any provisions requiring the physician to complete additional training and/or practice in a specified manner.

Falsification of any of the submitted data or evidence of other egregious ethical, moral, or professional misbehavior may result in a deferral of a candidate's application for a minimum three years. The candidate must then meet all eligibility requirements in effect at the end of the deferred period.

When the Board rules an applicant not admissible to the Qualifying Examination, a new application and application fee must be submitted after the cause of the inadmissibility has been resolved.

APPENDIX C: REQUESTS FOR ACCOMMODATIONS

Candidate Disability

The American Board of Obstetrics & Gynecology, Inc. (ABOG or Board) 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. Accommodations will only be considered with appropriate documentation. In order to implement this policy, notification of the need for special testing circumstances must be submitted in writing to ABOG by a candidate 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 to verify the disability, if necessary.

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.

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 provide a clear explanation of the functional impairment 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.

ABOG shall not exclude any candidate from 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. The candidate must provide sufficient documentation to permit ABOG to verify the existence, nature, and extent of the disability. The documentation must specify the requirements or accommodations determined to be necessary to overcome or compensate for the disability. Also, the candidate must supply any additional information ABOG may subsequently request in a timely manner.

If any of the requirements cannot reasonably be provided, ABOG will notify the candidate and will indicate those alternative accommodations which ABOG determines to be appropriate in consideration of the disability claimed and documented, and the integrity of the examination.

If the candidate fails to notify ABOG of a disability at the time of application and fails to achieve a passing grade, that candidate may not appeal the results of the examination but shall be entitled to sit for the next regularly scheduled written examination but must pay a new application and examination fee. If a candidate claims that their examination results were adversely affected by illness, injury, or other temporary physical impairment at the time of the examination, that candidate may not appeal the results of the examination. However, if the candidate provides sufficient evidence of such illness, injury, or impairment, they shall be entitled to sit for the next regularly scheduled certifying examination but must pay a new application and examination fee.

Lactation Accommodations

Candidates who are lactating may request a 30-minute break and extension of their examination if they notify the ABOG office no later than the close of the application period and schedule at a Pearson VUE Testing Center by the same date. Most Pearson VUE Testing Centers have only one room that is available for breast pumping, so candidates are encouraged to make their reservations as soon as they receive approval for the test as these rooms will be assigned on a first-come, first-served basis. If a candidate requests extra time for lactation, they must schedule their testing site through the Pearson VUE accommodations department after contacting ABOG. If no seat is available at the closest center, and they have requested extra time, they will have to travel to an available location to sit for the examination. As Pearson VUE testing centers have limited lactation facilities, ABOG cannot guarantee that the candidate will be able to schedule at their preferred testing center.

APPENDIX D: APPROVED ABBREVIATIONS FOR EXAMINATIONS

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 E: RESCORES, APPEALS, AND REQUESTS FOR RE-EXAMINATION

Rescores and Appeals

Since ABOG utilizes many quality control procedures to ensure exams are scored accurately and there is no record of incorrect scoring at ABOG with any of ABOG's multiple-choice examinations, ABOG does not accept rescore requests. This includes, but is not limited to, rescoring of the exam, review of exam content, reconsideration of a correct response, reconsideration of the passing standard, and/or consideration of the acceptability of testing conditions.

In addition, ABOG does not accept appeals from candidates who seek to challenge the content 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.

A complaint concerning any other matter regarding ABOG examinations should be submitted here.

Requests for Re-Examination

Candidates who are scheduled to take the 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.

APPENDIX F: COMPLEX FAMILY PLANNING

Allocation of Time and Curriculum for CFP Fellowship Training

Allocation of Time In order to take the Qualifying Examination, the candidate must have had the following experiences during fellowship:

a. 12 months of clinical Complex Family Planning

b. 6 months of protected research

   i. Conducted research leading to a thesis that meets ABOG certification requirements

   ii. Completed written thesis and presented work before the Program Director by completion of fellowship

   iii. Research time must be scheduled in blocks of not less than one-month duration, and while in a research block, no more than 10% (4 hours) of the fellow's time in any week may be spent in clinical duties

c. 6 months of electives

   i. Focused on specific clinical and/or research areas

   ii. Selected at the discretion of the Program Director and fellow

d. Fellows may participate in non-subspecialty clinical activity or practice up to 10% of a workweek (Monday-Friday) or ½ day (4 hours) per workweek averaged over a 4-week period during all rotations.

   i. These allowances do not apply to moonlighting, weekends, or call.

   ii. Fellows may not be assigned to weeks, months, or blocks of clinical assignments or rotations to meet this allowance.

   iii. Fellows may not be assigned to night float rotations to meet this allowance.

   iv. Fellows may not aggregate this allowance to complete training early or make up extensions in training for any reason.

Curriculum The candidate must gain a diverse experience in the management of a wide variety of complex family planning patients. The candidate must have experience in the provision of contraceptives, including consultation with other physicians. Additionally, the candidate must have experience in office procedures related to family planning.

The candidate must have experience in procedural and medical abortions and in the management of abortion complications.

CFP Qualifying Examination Topics

The content of the Qualifying Examinations will be based on the blueprint for Complex Family Planning. The major categories and subcategories are shown below, including the percentages of the categories.

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)

APPENDIX G: GYNECOLOGIC ONCOLOGY (GYN ONC)

Allocation of Time and Curriculum for GYN ONC Fellowship Training

Allocation of Time The duration of training is a minimum of 36 months, and rotations must be in a minimum of one-month blocks. A program must ensure the training for each fellow is allocated as follows:

a. 24 months of clinical training

b. 12 months of protected research

   i. Conducted research leading to a thesis that meets ABOG certification requirements

   ii. Research time must be scheduled in blocks of not less than one-month duration, and while in a research block, no more than 10% (4 hours) of the fellow's time in any week may be spent in clinical duties

   iii. Completed written thesis and presented work before the Program Director by completion of fellowship

c. Fellows may participate in non-subspecialty clinical activity or practice up to 10% of a workweek (Monday-Friday) or ½ day (4 hours) per workweek averaged over a 4-week period during all rotations.

   i. These allowances do not apply to moonlighting, weekends, or call.

   ii. Fellows may not be assigned to weeks, months, or blocks of clinical assignments or rotations to meet this allowance.

   iii. Fellows may not be assigned to night float rotations to meet this allowance.

   iv. Fellows may not aggregate this allowance to complete training early or make up extensions in training for any reason.

Curriculum A fellow must be instructed in the following clinical areas: General, Colorectal, Vascular, and Urologic Surgery, as well as Medical Oncology and Radiotherapy.

Fellows must receive experience in the management of gynecologic cancer and its complications to include minimally invasive approaches.

Fellows must be provided formal instruction in the methods and techniques of radiation therapy as well as a full understanding of the principles of radiobiology and radiation physics.

Fellows must be provided the opportunity to acquire basic and clinical knowledge of the indications for chemotherapy as well as practical experience in the administration of chemotherapeutic drugs and care of complications.

Fellows must receive palliative and critical care experience.

The facility must have an active tumor registry.

Gynecologic Oncology Qualifying Examination Topics

The content of the Qualifying Examinations 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 qualifying examination and the certifying examination. The percentages across both exams are weighted the same for the categories.

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)

APPENDIX H: MATERNAL-FETAL MEDICINE (MFM)

Allocation of Time and Curriculum for MFM Fellowship Training

Allocation of Time In order to take the Qualifying Examination, the candidate must have had the following experiences during fellowship:

a. 18 months of MFM Core Clinical Experience, including at least:
   i. 3 months of ultrasonography
   ii. 2 months of outpatient Maternal-Fetal Medicine
   iii. 2 months of Genetics and Genomics
      i Ultrasonography, Genetics and Genomics, and outpatient requirements can be fulfilled by block time (e.g., one-month blocks) or by the cumulative experience of shorter experiences (e.g., half- or full-day clinics over time)
   iv. 2 months in a supervisory position on a Labor and Delivery unit
      i Minimum block is 2 weeks
      ii Night and weekend call performed throughout the fellowship does not apply towards this time requirement
   v. 1 month in a medical or surgical intensive care unit
      i Must participate in patient care
      ii No MFM or OB GYN duties, including night and weekend call

b. 12 months of protected research in one-month blocks
   i. Conducted research leading to a thesis that meets ABOG certification requirements
   ii. Completed written thesis and presented work before the Program Director by completion of fellowship
   iii. Research time must be scheduled in blocks of not less than one-month duration, and while in a research block, no more than 10% (4 hours) of the fellow's time in any week may be spent in clinical duties

c. 6 months of electives
   i. Focused on specific clinical and/or research areas
   ii. Selected at the discretion of the Program Director and fellow

d. Fellows may participate in non-subspecialty clinical activity or practice up to 10% of a workweek (Monday-Friday) or ½ day (4 hours) per workweek averaged over a 4-week period during all rotations
   i. These allowances do not apply to moonlighting, weekends, or call.
   ii. Fellows may not be assigned to weeks, months, or blocks of clinical assignments or rotations to meet this allowance.
   iii. Fellows may not be assigned to night float rotations to meet this allowance.

iv. Fellows may not aggregate this allowance to complete training early or make up extensions in training for any reason.

Curriculum The candidate must gain expertise in the comprehensive care of maternal and fetal disorders to include high-risk pregnancy, fetal evaluation and intervention, genetics, ultrasound and prenatal diagnosis, pathology, and obstetrical anesthesia. Specifically, the candidate must be trained in the following areas:

Maternal-Fetal-Neonatal Physiology
Genetics/Genomics/Tetralogy
Obstetrical Critical Care
Infection Diseases

MFM Qualifying Examination Topics

The content of the Qualifying Examinations 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 qualifying examination and the certifying examination.

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 (25%)

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 (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)

APPENDIX I: REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY (REI)

Allocation of Time and Curriculum for REI Fellowship Training

Allocation of Time In order to take the Qualifying Examination, the candidate must have had the following experiences during fellowship:

a. 18 months of clinical Reproductive Endocrinology and Infertility

b. 12 months of protected research in one-month blocks

   i. Conducted research leading to a thesis that meets ABOG certification requirements (Appendix D)

   ii. Research time must be scheduled in blocks of not less than one-month duration, and while in a research block, no more than 10% (4 hours) of the fellow's time in any week may be spent in clinical duties

   iii. Completed written thesis and presented work before the Program Director by completion of fellowship

c. 6 months of electives

   i. Focused on specific clinical and/or research areas

   ii. Selected at the discretion of the Program Director and fellow

d. Fellows may participate in non-subspecialty clinical activity or practice up to 10% of a workweek (Monday-Friday) or ½ day (4 hours) per workweek averaged over a 4-week period during all rotations.

   i. These allowances do not apply to moonlighting, weekends, or call.

   ii. Fellows may not be assigned to weeks, months, or blocks of clinical assignments or rotations to meet this allowance.

   iii. Fellows may not be assigned to night float rotations to meet this allowance.

   iv. Fellows may not aggregate this allowance to complete training early or make up extensions in training for any reason.

Note: For fellows beginning training July 1, 2022, or later, required allocation of training is 18 months clinical REI, 12 months research, and 6 months electives. All other requirements in this section will apply.

Curriculum The candidate must gain a diverse experience in the management of a wide variety of clinical problems affecting the development, function, and aging of the human reproductive system to include disorders of both men and women. Specifically, the candidate must be trained in the following areas:

Medical disorders
Surgical Techniques
Ultrasound
Laboratory procedures

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.

Basic Science, Physiology, and Pathophysiology (15%)

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 (3%)

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 (2%)

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 (5%)

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)

APPENDIX J: UROGYNECOLOGY AND RECONSTRUCTIVE PELVIC SURGERY

Allocation of Time and Curriculum for URPS Fellowship Training

Allocation of Time In order to take the Qualifying Examination, the candidate must have had the following experiences during fellowship:

a. 24 months of clinical Urogynecology and Reconstructive Pelvic Surgery

b. 12 months of protected research

   i. Conducted research leading to a thesis that meets ABOG certification requirements

   ii. Completed written thesis and presented work before the Program Director by completion of fellowship

   iii. Research time must be scheduled in blocks of not less than one-month duration, and while in a research block, no more than 10% (4 hours) of the fellow's time in any week may be spent in clinical duties

c. Fellows may participate in non-subspecialty clinical activity or practice up to 10% of a workweek (Monday-Friday) or ½ day (4 hours) per workweek averaged over a 4-week period during all rotations.

   i. These allowances do not apply to moonlighting, weekends, or call.

   ii. Fellows may not be assigned to weeks, months, or blocks of clinical assignments or rotations to meet this allowance.

   iii. Fellows may not be assigned to night float rotations to meet this allowance.

   iv. Fellows may not aggregate this allowance to complete training early or make up extensions in training for any reason.

Curriculum The candidate must gain a diverse experience in the management of a wide variety of clinical problems affecting the development, function, and aging of the female reproductive and urinary tract. Additionally, the candidate must have experience in the management of anal incontinence.

The candidate must have experience in medical disorders, surgical techniques, and office procedures to be able to manage complex pelvic floor and urinary conditions.

URPS Qualifying Examination Topics

The content of the Qualifying Examinations 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 qualifying examination and the certifying examination.

Urinary Incontinence and Lower Urinary Tract Symptoms: Frequency, Urgency, Nocturia, and Bladder Pain (21%)

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 (8%)

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 (18%)

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 (9%)

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 (7% Qualifying Examination; 4% Certifying Examination)

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 (3%)

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 (8%)

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 (13%)

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)