DIVISION OF REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY

RESIDENTS' RESPONSIBILITIES

Welcome to the Division of Reproductive Endocrinology and Infertility. Dr. William Kutteh is director of the division; Dr. Raymond Ke directs clinical services, and Dr. Laura Detti is participating in resident education. Residents are welcome to all clinical activities in the division, but remember, this is also a private practice. Therefore, all clinical activities and decision-making will be under the direct supervision of Drs. Kutteh, Ke, and Detti. If patients request not to see residents, then these wishes have to be honored. Similarly, while all residents wish to gain more experience with procedures, in some cases, observation and assisting will have to suffice. If you have any concerns, then please discuss this with Drs. Ke or Kutteh.

The purpose of this document is to orient the resident to the curriculum, routine, responsibilities and expectations of the Reproductive Endocrinology service at the University of Tennessee Department of Obstetrics and Gynecology. It is our goal that the individuals rotating on our service will become familiar with the physiology, diagnosis, and treatment of reproductive and hormonal problems as described by the CREOG Educational Objectives. The series of clinical interactions, lectures, and readings that are outlined are not optional, and the evaluation of the resident will directly reflect his/her level of knowledge and preparedness. It is expected that each resident will own and completely read the latest edition of Clinical Gynecologic Endocrinology and Infertility by Speroff during this rotation. Ideally, this should be completed twice during the residency; once during the second year and again in the third year.

GENERAL ADMINISTRATIVE ISSUES

1. Dr. Kutteh or Ke must approve all personal leave that occurs during the Reproductive Endocrinology Rotation prior to the rotation. There will be no vacations or absences from this rotation. Medical leave and emergencies should be discussed as they arise.

2. Residents are expected to dress professionally and have clean white coats. Men are expected to have shirt and tie and women will follow our dress code policy. Clean scrubs are acceptable only if the resident had surgery with one of our staff and reported immediately to the clinic.

3. A resident should be available by beeper every weekend. During this time, residents cannot have other call responsibilities as they may be needed to see patients at any hospital or assist in emergency surgery. Notify the faculty and nurses on call for the weekend on Friday.

4. Generally more than two activities will be occurring at the same time. Please refer to the Resident Assignment instructions to determine resident responsibilities.

5. If emergencies arise on another service, a resident on RE can only be pulled from this rotation with prior approval of Dr. Ke or Dr. Kutteh.

6. Use of Internet in the office is restricted. A resident desk is provided and the library has textbooks and journals in all areas of Ob/Gyn to review when time allows.

OUTPATIENT CLINICS

New Patients

New patients expect to be seen by the physician they were referred to on their initial visit. In most cases the resident will observe and learn interview techniques from the attending physician (Look, listen, learn teaching method). The resident should become familiar with our patient history form. The patients fill out the left hand side of the form themselves and the right side is for notes. Any positive findings on history are fully explored by asking the patient or reviewing the old records. The date of tests and the results available are recorded on the right hand side of the page. Staff will ensure that all diagnoses are noted along with their appropriate CPT codes.

Specific Objectives

1. The resident will observe and learn interview techniques with specific reference to potential contributors to infertility or reproductive problems.

2. The resident will develop the ability to present patient problems and plans in an organized and comprehensive manner, learn the subtleties of the basic infertility evaluation, and the indications for each of the diagnostic techniques.

3. The resident will understand and be able to outline steroid biosynthesis and abnormalities as they may relate to various reproductive problems.

4. The resident will understand the principles and practice of ovulation monitoring and ovulation induction.

5. The resident will learn the technique of vaginal sonography to specifically include appreciation of normal anatomy, identification of ovaries, identification of early intrauterine pregnancy and pregnancy abnormalities, and identification and diagnosis of follicular development.

6. The resident will be expected to understand current coding techniques using CPT (Current Procedural Terminology) and ICD-9-CM (International Classification of Diseases) used for outpatient clinics used in Reproductive Endocrinology.

Return Patients

For return patients, first ask your attending physician if it is appropriate for you to see that particular patient. For infertility patients, please document a progress note as noted by the example attached. This is an easy and organized way of ensuring that no facts are missed. Check on lab and pathology results, operative reports and old records. Include date of tests, lab values and units. Quickly review these with the patient and see if there are any other pertinent findings in the history since the last visit. Try not to get into a discussion with the patient on treatment plans, as this will be reviewed with the staff physician. After updating the history, review with staff physician and they will see the patient with you.

EXAMPLES OF PROGRESS NOTES

Notes should be legible, organized as listed below, dates of tests listed, and units of labs listed.

RECURRENT PREGNANCY LOSS PROGRESS NOTE

3/1/08 36 yo $G_4P_0A_4$ with primary RPL, here for F/U

Genetic: 2/1/08 46, XX wife; 46, XY husband

Endocrine 2/1/08 CD 21 Prog 12 ng/ml, TSH 1.2 µIU/ml, Prol 14 ng/ml, fasting insulin 12U/L, fasting glucose 82 mg/dl

Anatomic 2/8/08 SHG Abnormal uterine cavity, linear filling defects in midbody

Immune 2/1/08 LAC dRVVT 42 seconds, PTTLA 44 seconds, IgG ACA 12 GPL

2/1/08 APA negative IgG, IgM, IgA

Microbiologic: 1/3/08 PAP normal, 2/1/08 Mycoplasma/ureaplasma,Chlamydia/GC neg

Thrombophilic 12/1/06 APCR 2.6, fasting homocysteine 12u, Prot C Activity 112%, Protein S Activity 92%, Antithrombin Activity 104%

Obstetrical: 2/1/08 O+, Rub I, RPR NR, Hct 42%,HBsAg –, HCAb -, HIV –

To be completed after discussion with staff physician:

Assessment:

1. Primary RPL (CPT 629.81)
2. Asherman's Syndrome (CPT 621.5)

Plan:

1. Discussed intrauterine adhesions and increased risk of pregnancy loss. Counseled on need for Op HS with LOA. Discussed risks of bleeding, infection, possible injury to bowel, bladder, uterus, blood vessels and chance of open laparotomy. Questions answered. An information booklet was given to patient to reinforce the above. Patient to call if she desires surgery desired or further questions.

INFERTILITY PATIENT PROGRESS NOTE

3/10/08 33 yo G0 with primary infertility, male factor here for F/U

Anatomic: 12/6/07 HSG Normal uterine cavity, bilateral fill & spill (films seen).

Endocrine: 11/28/07 Prog 12.4 ng/ml, TSH 1.2 µIU/ml, and Prolactin 44 ng/ml.

Male: 12/3/07 SA 1.0cc/2.0 x 10^6/cc/ 58% motile/12% normal

Obstetric: 12/1/07 O+/Rub I/RPR–/HBsAg –/Hct 42%/HIV –

(To be completed after the discussion with staff physician

Assess: 1) Male factor infertility (CPT 628.8), 2) Hyperprolactinemia (CPT 253.1)

Plan: 1) Repeat fasting prolactin may need CT of sella and visual fields.

2) Counseled about TDI. Information given.

3) Counseled about IVF/ICSI. Information given.

EARLY IUP ULTRASOUND PROGRESS NOTE

7/20/08 33 yo female G1 PO pregnant at 7 weeks after first cycle of IVF.

Patient denies N/V, F/C, C/D, bleeding/spotting

IVF: Embryo transfer of one blastocyst on day 5 grade AAB on 6/15/08

MEDS: Prog in oil 50 mg/q hs, Prog vag supp 100 mg/bid, PNV, aspirin 81mg/d,

LABS: 6/30/08 QhCG 234 miu/ml. Repeat 7/2/08 504 miu/ml

SONAR: viable pregnancy CRL 9.3 mm = 7 weeks 1 day, FHM = 132 bpm, gest sac 25 mm
ASSESSMENT: 1. Twins, viable at 7 weeks (640.03)

PLAN: 1. Scan for growth next week

2. Schedule OB initial visit in three weeks
3. Wean progesterone per protocol
4. Call if any bleeding, cramps, or problems.
5. Counseled about risks of multiples.

SURGERY

Surgical schedules vary. Although each staff physician will have designated days to perform most of their surgery, check the weekly schedule for cases and check with OR Schedule log on the computer at the nurse's station to look for changes in surgical scheduling. A resident is expected to attend all surgical procedures. For patients who are admitted, the resident who assisted with the case is expected to round on the patient twice a day and report to the staff. Appropriate discharge summaries should be dictated with a copy sent to our office, prescriptions completed, and discharge orders completed.

Most hospitals (exception is EMSC) will require a pre-operative visit a few days before surgery. The Resident should review general medical history with the patient and make sure she understands her procedure. Perform a general physical exam, including the cardiovascular and respiratory systems. Document the exam, the planned procedures, and a brief counseling note about risks in our chart. Generally, the pelvic exam can wait until the time of surgery to be performed under anesthesia. It is required to dictate the preoperative H&P at Methodist and Baptist. Our routine pre- and post-op orders are attached.

Physician	Baptist Dictation #	Methodist Dictation #
Kutteh	556199	03794
Ke	556122	02734
Detti		

Specific Objectives

1. The resident will be expected to fully understand the diagnosis, indications for surgery, and potential management alternatives of every patient going to the operating room. The resident should read about the case prior to surgery. Any resident may be dismissed from the OR if the attending staff realizes that the resident is not prepared to participate in the case.
2. The resident will learn the principles of diagnostic laparoscopy for infertility as well as the techniques of performing laparoscopy with one or more accessory punctures.
3. The resident will become familiar with instrumentation for advanced laparoscopy including safe use and appropriate maintenance of the equipment.
4. The resident will learn the common complications of laparoscopy, the best techniques to avoid these complications, and techniques and management of all major complications of laparoscopy.
5. The resident will increase his/her technical skills in operative laparoscopy to include lysis of adhesions, treatment of endometriosis, tuboplasty, and tubal anastomosis procedures under direct and ongoing supervision by the attending.
6. The resident will learn indications and techniques of both diagnostic hysteroscopy and operative hysteroscopy in a manner analogous to objectives of laparoscopy.
7. The resident will be expected to maintain surgical care experience logs and document all surgical cases attended will on the service.

PRE-OP ORDERS

Dx L/S and/or H/S	**If Laparotomy, add**	**If over 40, add:**
1. Anesthesia to prep	Type & Screen	12 lead EKG
2. Consents signed and on chart	Ancef 2.0 gm pre-op	CXR
3. Hct, basic metabolic profile		
4. U/A, urine hCG		
5. Ancef 1.0 gm IV preop		

POST-OP ORDERS

1. Diet NPO until alert, advance as tolerated
2. Condition stable
3. Activity Assist with first ambulation
4. Vitals q 15 minutes x 4, then per protocol
5. IV LR at 100 cc/hr, DC when PO and alert
6. Notify M.D. If BP > 160/90 or < 90/60, HR > 110 or < 40,
   Temp > 100.4, more than 1 soaked pad
7. Medications Toradol 30-60 mg IV or IM x 1 prn
   Phenergan 12.5 mg IV x 1 prn
   Percocet 5/325 PO prn pain x 1 prn.
8. Discharge when alert, stable VS, tolerates PO liquids, spontaneous void.
9. Nurses may I&O catheterize x 1, but must void spontaneously before discharge.
10. D/C meds: Ibuprofen 800 mg PO q 8h prn #20 (Dr. Ke)
    Phenergan 25 mg PO q 6h prn #10
    Percocet 5/325 take 1 or 2 PO q 4hr prn #20 (Dr. Kutteh)

POST-OP PATIENTS IN CLINIC

The resident will staff the post-op clinic. During this clinic, all patients who were operated on last week are seen and patients needing preoperative evaluation being operated on next week are seen. The purpose of this clinic is to make sure post-op patients are having a normal recovery, that the dictated op note is on the chart, and that the pathology report is reviewed and on the chart.

POST-OP NOTE (use post-op form)

33 yo female with RPL here for post-op.

S/P Op H/S with resection of myoma and Diag L/S on 2/4/07.

PATH: leiomyomata, benign

Patient states she is doing well. Denies F/C, C/D, excessive bleeding from vagina or incisions. Tolerating po liquids and solids, voiding well and had BM on 12/12/06. Ambulating well. Took Percocet x 1 day now only Tylenol.

VS 116/68 98.6 HR=72wt 118

Abd: Soft, NT, incisions clean and dry. Sutures removed (Ke patients). + BS.

Pelvic: vagina moist, pink. Cx closed and NT. Ut midline NT. Adnexa NT.

Assem: 1. RPL (629.9)

2. Submucous myoma (218.0)

Plan: 1. Wait 2 months before attempting conception.

2. Call with missed period for pregnancy test.

LABORATORY PROCEDURES

Residents are expected to observe an oocyte retrieval procedure and to observe a semen analysis in the Andrology laboratory. Please discuss the oocyte retrieval with the attending and schedule the semen analysis observation with our laboratory staff. You are welcome into the Embryology laboratory to observe laboratory procedures, as long as you change into the appropriate attire and are accompanied by one of our staff. Please schedule these observation times in advance with our Chief Embryologist.

TRANSVAGINAL SONOGRAPHY (TVUS)

SONOHYSTEROGRAPHY (SHG)

As a part of the TVUS training program in the Department, residents will become skilled in the performance of early pregnancy scans and sonohysterograms. TVUS is performed Monday, Wednesday, and Friday from 9 am to 1pm. Simultaneously, SHG is being performed with our staff. This is an excellent opportunity to improve your sonography. PGY-3 residents are expected to learn and perform sonohysterography procedures.

Specific Objectives

1 The resident should understand the indications for hysterosalpingogram and sonohysterograms, as well as the information obtained by a well-performed study.

2. The resident should be familiar with the varying techniques of performing sonohysterograms.

3. The resident will be expected to observe initially and ultimately to perform sonohysterograms.

4. The resident will be expected to understand TVUS skills and measurements of CRL, gestational sac, yolk sac, and FHM in early pregnancies from 6 to 9 weeks.

5. TVUS and SHG case experience lists must be maintained by the resident.

DIDACTIC TEACHING CONFERENCES

All residents rotating on Reproductive Endocrinology will be given a pre-test at the start of their rotation to assess their foundation of knowledge. In addition, during the final week of the rotation, a post-test will be given to evaluate the changes in knowledge based on their experience during the one month rotation. These results will be used to enhance the resident rotation experience, to evaluate the knowledge of our residents at the second and third year level, and to use the results as a component of our evaluation of each resident.

Teaching conferences will be with Drs. Kutteh, Ke, and Detti at a mutually agreeable time. These will generally be unscheduled and spontaneously scheduled when time permits based on the current rotation schedule. During both the second and third year rotation, he residents should read entire 7th Edition of Speroff and Fritz, Clinical Gynecologic Endocrinology & Infertility, and review the appropriate chapters and be prepared for discussion. Also, read Chapters from 3rd Edition Comprehensive Gynecology. Common topics for discussion will be as follows:

		Speroff
Regulation of Menstrual Cycle	Dr. Ke	6
General Infertility	Dr. Ke	27, 30, 31
Polycystic Ovarian Syndrome	Dr. Ke	12, 13
Puberty	Dr. Ke	10
Endometriosis	Dr. Kutteh	29
Recurrent Pregnancy Loss	Dr. Kutteh	28
Assisted Reproduction	Dr. Kutteh	32
REI Orientation	Dr. Kutteh	this handout
Pre- Test	Dr. Detti	
Dysfunctional Uterine Bleeding	Dr. Detti	15
Ectopic Pregnancy	Dr. Detti	33
Post-Test	Dr. Detti	

JOURNAL CLUB

We place emphasis on learning the skills necessary to continue your education after formal training is complete. Each month the resident will be expected to present one original article from within the last six months of Fertility and Sterility or Human Reproduction. Case reports and review articles are not appropriate. Each resident will review one paper and give a short (10-15 minute) presentation. He or she will be expected to read methods section and provide some background as to the relevancy of this article. He or she will also be asked their opinion about the quality of the research. See attached guidelines for reviewing a medical report. Faculty will assist in article selection and discussion.

GUIDELINES FOR REVIEWING A MEDICAL REPORT

A. Objective or Hypothesis

1. What are the study objectives (what are the questions to be answered)?
2. To whom will the findings be applied (what is the population targeted)?

B. Methods

1. What was the study design (i.e., experimental, planned observations, retrospective)?
2. Who were the subjects and the control group (sample population, number, possible selection biases)?
3. What were the inclusion/exclusion criteria for the study group?
4. Who were the controls?
5. What were the descriptive variables of the sample population?
6. What outcome variables were measured and analyzed?

C. Findings/Results

1. Are findings presented clearly, objectively, and in sufficient detail?
2. Is there appropriate use of tables?

D. Analysis

1. Are the data worthy of statistical analysis?
2. What are the methods of analysis?
3. Are analysis methods appropriate?
4. What level of significance will be accepted?

GUIDELINES FOR REVIEWING A MEDICAL REPORT - continued

E. Conclusions

1. What conclusions are justified by the findings?
2. Are the conclusions relevant to the hypothesis posed?

F. Comments

1. How does this study contribute to the medical literature?
2. How could this study be improved?
3. Did the study answer the initial question?
4. Will this article impact your medical practice?

Evaluation and Summary

The faculty will assess the performance of each resident by observing his or her ability to evaluate outpatients, preparedness at didactic sessions, self-initiated learning, and technical skills. In general, faculty will give residents “real-time” evaluations. For example, at the end of a surgery session, the faculty may comment on surgical technique and resources for the resident to read to enhance the knowledge base. During individual didactic sessions, residents will receive immediate feedback as to their fund of knowledge in comparison to other residents at their level. The faculty will provide an assessment of the resident to the Chairman's office with individual comments by each faculty member. Time will be scheduled during the last week of the rotation for a conference to discuss resident performance.

The Division of Reproductive Endocrinology has introduced a specific written test that will be administered to all residents on service. The written test is given during the first week and repeated during the last week of each rotation during both the second and third years. The purpose of the structured test is to assist residents in identifying areas of strength and areas where additional reading will be beneficial.

The faculty of the Division of Reproductive Endocrinology understands that only a small percentage of residents will choose to pursue careers in this discipline. However, we also recognize that the time spent with our division is likely to be the only formal exposure of a resident to reproductive endocrinology. Therefore, there is significant pressure for both faculty and residents to get the most out of this time. Residents should expect that an enthusiastic commitment to learn would be rewarded with an enthusiastic commitment to teach.

2008-2009 REI Rotation

PGY-3

	AM	PM
MONDAY	Ke Clinic (0900)	COCC (1300)
TUESDAY	Pre-op (0900)	Sonohyst clinic (1300)
WEDNESDAY	Detti clinic (0900)	Kutteh clinic (1300)
THURSDAY	Kutteh OR (0730)	Didactics (1300)
FRIDAY	Ke OR (0730)	Post-op clinic (1400)

PGY-2

	AM	PM
MONDAY	Martin clinic (0800)	Martin clinic (1300)
TUESDAY	Kutteh clinic (0900)	COCC (1300)
WEDNESDAY	Martin OR/clinic (0730)	Detti clinic (1300)
THURSDAY	Ke clinic (0900)	Didactics (1300)
FRIDAY	Martin OR/clinic (0730)	Martin OR/clinic (1300)

REI Didactics

MONDAY*	**0630** with Dr. Martin (3rd floor conference room of BWH)
MONDAY	**1100** with Dr. Kutteh @ FAM (1st Monday will be orientation)
TUESDAY	**1100** with Dr. Detti @ FAM (1st Tuesday will be pretest)
WEDNESDAY	**1300** with Dr. Ke @ FAM

*** PGY2 will also meet with Dr. Martin and M3s @ 0630 on Wed and Fri at BWH**

-- OR cases will supersede clinic when available
-- If Kutteh and Detti have OR cases on Thurs, second year will operate with Detti
-- If Martin is in OR on Tuesday AM, PGY-2 will assist, and PGY-3 will be in Kutteh clinic after pre-op is completed
-- Clinics that must be covered by a resident each week are pre-op, post-op, and sonohyst
-- FAM = Fertility Associates of Memphis, Suite 307 of 80 Humphreys Center
-- Dr. Martin's clinic is located at the Wolf River UTMG complex