State of Minnesota

District Court

County of Hennepin

Fourth Judicial District
Case Type: Wrongful Death

Edward Bermingham IV, as trustee for the next-of-kin of Nicole Bermingham, Plaintiff, vs. Patricia Eid, N.P. and Emergency Care Consultants, PA, Defendants.	Court File No. 27-CV-16-1269 **Minnesota Statute 145.682 Affidavit Identifying Harold C. Wiesenfeld, M.D.**

STATE OF MINNESOTA)
) **ss**
COUNTY OF HENNEPIN)

Chris Messerly, being first duly sworn, states as follows:

1. I am an attorney and, along with my law firm Robins Kaplan, LLP, represent Plaintiff Edward Bermingham IV on behalf of the next-of-kin of the Nicole Bermingham in his wrongful death case involving his wife, Nicole Bermingham. I provide this Affidavit pursuant to Minnesota Statute 145.682. Through this Affidavit, I will identify one of the experts Mr. Bermingham intends to call in this case with respect to standards of care, negligence and causation. I will provide the substance of the facts and opinions to which the expert is expected to testify, as well as a summary of the grounds for each opinion.

2. At the trial of this matter, Mr. Bermingham intends to call Harold C. Wiesenfeld, M.D. Dr. Wiesenfeld is board-certified in obstetrics and gynecology.

Dr. Wiesenfeld practices at the Magee-Womens Hospital in Pittsburgh Pennsylvania. Dr. Wiesenfeld is also the Associate Professor of the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of Pittsburgh School of Medicine/Magee Womens Hospital. In addition Dr. Wiesenfeld is an Associate Professor of the Division of Infectious Diseases and Department of Medicine at the University of Pittsburgh School of Medicine. Dr. Wiesenfeld is a member of the American College of Obstetricians and Gynecologists and has been responsible for the creation of practice bulletins establishing evidence-based current clinical management guidelines in gynecology. Dr. Wiesenfeld also is the Director of the Division of Reproductive Infectious Diseases and Immunology in the Department of Obstetrics, Gynecology, and Reproductive Sciences at the University of Pittsburgh School of Medicine/Magee-Womens Hospital. His curriculum vitae, which is attached, discusses his educational, clinical and professional background.

3. Dr. Wiesenfeld will explain his education, background, training, professional experience and experience in the field of reproductive infectious disease and obstetrics and gynecology. He will describe the nature of his practice that includes evaluating, diagnosing and caring for patients with obstetrical, gynecological as well as infectious conditions of the female reproductive tract. Dr. Wiesenfeld is knowledgeable about the accepted standards of medical practice for physicians who evaluate, diagnose and care for patients with obstetrical, gynecological and infectious symptoms. The standards about which Dr. Wiesenfeld will testify are national and apply to physicians

involved in obstetrical, gynecological and reproductive infectious diseases in the United States.

4. Dr. Wiesenfeld will describe a physician's responsibility when evaluating a patient who presents with infectious disease symptoms such as those Ms. Bermingham experienced. Dr. Wiesenfeld will describe the evaluation and care of patients with infectious disease. Dr. Wiesenfeld will describe the standard of care for patients with pain, fever, thrombocytopenia, elevated white blood counts, Systemic Inflammatory Response Syndrome (SIRS), sepsis, septic shock and multiple organ dysfunction syndrome. Dr. Wiesenfeld will describe the nature of Ms. Bermingham's infectious disease and the standard of care related to those patients. Dr. Wiesenfeld will also describe the expected outcomes of patients such as Ms. Bermingham who have been treated for postpartum infectious disease conditions with appropriate antibiotics and support.

5. Dr. Wiesenfeld will testify that Patricia Eid, N.P. failed to provide to Ms. Bermingham care that conformed to accepted standards of practice. Those failures played a substantial part in bringing about the progression of Ms. Bermingham's infection leading to the worsening of the systemic inflammatory response to sepsis, multiple organ dysfunction, septic shock and death.

6. In providing his opinions, Dr. Wiesenfeld has specifically been informed of, and agreed to abide by, the legal definitions of negligence that apply to malpractice cases in Minnesota. Dr. Wiesenfeld has specifically been informed that under controlling law, negligence is the failure to use reasonable care under circumstances.

Dr. Wiesenfeld has been informed that under controlling law, the failure to provide care that meets an accepted standard of care under the circumstances constitutes negligence. He has also been informed that the "direct cause" of an injury or death is a cause that has a substantial part in bringing about the injury or death. Dr. Wiesenfeld will testify that these definitions comport with his own understanding. He has agreed to these definitions, and agrees that his testimony at trial will explicitly be governed by these definitions.

7. The opinions Dr. Wiesenfeld holds and to which he will testify at the trial of this matter are all held to a reasonable degree of medical and scientific probability. His opinions are based on his education, training and medical experience and on his knowledge of the accepted standards of practice that apply to health care providers caring for patients like Nicole Bermingham. Dr. Wiesenfeld's opinions were formed through the application of well-known and generally accepted principles of medicine and science related to the management of obstetrical and gynecological patients experiencing infections. In forming his opinions, Dr. Wiesenfeld relied on his education, training, experience and expertise as well as on his knowledge of the medical literature, his care of patients such as Ms. Bermingham, and his review of Ms. Bermingham's medical records and death certificate.

MEDICAL FACTS

At the trial of this matter, Dr. Wiesenfeld will discuss the pertinent medical facts regarding Ms. Bermingham's care and treatment at Abbott Northwestern Hospital in August 2013.

1. On August 19, 2013, Nicole Bermingham was a 30 year-old who was admitted to Abbott Northwestern Hospital at 39 weeks, 3 days for a premature rupture of membranes with meconium stained amniotic fluid. Her membranes ruptured on August 18, 2013 at 2315. She slowly progressed through the latent phase of labor over 12 hours. When she was 4 cm dilated, an epidural was placed. Her cervix remained unchanged and she was augmented with Pitocin. She became complete on August 20, 2013 at 0045. The baby delivered from an OA position. The placenta delivered spontaneously intact with a three vessel cord but was noted to have a large amount of thick meconium stained fluid expressed at the time of delivery. Due to a prolonged rupture of membranes and risk of atony, Cytotec 800 mcg was placed per rectum. A third-degree perineal laceration that was repaired. Adequate approximation of tissue with good sphincter tone and no stitches in the rectum was confirmed. The baby weighed 3459 g with Apgar scores of 7 and 9. On August 21, 2013, Nicole Bermingham was discharged from the hospital. At discharge, her vital signs were stable and assessments were within normal limits.

2. On August 24, 2013 at 3:15 am, Ms. Bermingham went to the Abbott Northwestern emergency room with a chief complaint of fever. She was seen by Patricia Eid, a nurse practitioner. The records state that Ms. Bermingham had increased pain in her vagina and rectum on the afternoon of August 23, 2013. She noted that sitting on the toilet was "murder" and had been experiencing hesitancy which she believed could possibly be due to her pain. Additionally, she developed a fever and nausea without emesis that started the previous night. She reported fevers the evening of her

emergency room evaluation of 101.8° and 101.9°. At the time of her evaluation her temperature was 99.3°. She stated that she had been taking ibuprofen and Tylenol with minimal relief. She had a small normal appearing stool on August 23, 2013 and note that she was hesitant, but did not experience any problems following her bowel movement.

3. At the time of her exam she continued to experience constant pain and discomfort in her vagina and rectum. The pain did not radiate from either location and she denied any provoking or palliating factors for her pain. She denied pus or drainage from her vagina and stated she was only experiencing light bleeding following her delivery. She had no cough, congestion, or chest pain. Aside from a slight backache that emerged the day prior, she had no other concerns. She was breast-feeding. Her blood pressure was 121/86, pulse 115, respirations 16 and her SpO2 was 96%. She had bowel sounds and slight tenderness but no rebound or regarding. Her perineum was swollen with no focal areas of redness or warmth. There was a small amount of vaginal bleeding present.

4. Dr. Jeffrey Peterson performed and interpreted a pelvic ultrasound. His report dictated at 0450 on August 24, 2013 stated that there was a "heterogenous mostly hypo to anechoic areas of the cervix and the uterus without definable hyperemia. No could be debris or clot. Retained products of conception are completely excluded but this is not a classic appearance for that entity. Without the hyperemia, endometritis would not be favored. Clinical correlation suggested." The ovaries were not well seen and there was no free fluid in the pelvis. Dr. Peterson addendum on August 28, 2013 at

0221 stated that the second sentence of the first impression finding should read "retained products of conception are not completely excluded."

5. The CBC with WBC differential showed a WBC of 18.8, RBC 4.2, HGB 12.6, HCT 36.1, MCV 86, MCH 30, MCHC 34.9, RDW 13.9, PLT 50 (noted to be low) and MVP 9.0. Bands were 4.3. NEUTROPCT was 84.6 and NEUTROABS was 15.9, both noted to be elevated. The LYMPHOPCT was 0.8 and LYMPHOCABS was 0.2, both noted to be low. A urinalysis was performed and on microscopic evaluation no bacteria was seen, the RBC was 46 and the WBC was 12, both noted to be elevated.

6. According to the emergency room timeline course at 0447, Ms. Bermingham returned from radiology and at 0450, Ms. Eid spoke with radiology and paged Dr. Mainguy who was the obstetrician. At 0505, Ms. Eid had spoken with Dr. Mainguy who agreed with the impression and plan for discharge. The impression and plan were: "During the evaluation of this patient I considered multiple differential diagnosis considerations, including appendicitis, pyelonephritis, UTI, renal colic/stone, PID, cervicitis, endometritis, IUP, ectopic pregnancy, ovarian cyst/torsion, urinary retention. In consideration of the patient's history, exam and diagnostic results, my impression is that this patient has come to the ED with significant swelling of the perineum after fourth degree tear during vaginal delivery four days ago. She is given Rocephin and will be sent out with amoxicillin, Tylenol #3 and lidocaine 2% gel. She has asked also to urinate frequently and will return if worsens. She is stable at time of discharge. Dr. Mainguy agrees with this plan." The diagnosis was lower urinary tract infection, fever, perineal pain in female, anal or rectal pain, and urinary retention with

incomplete bladder emptying. She was sent home at 0445 with amoxicillin 500 mg capsules to take three times a day for 10 days. She was also given Tylenol #3 to take every four hours as needed for pain.

7. On August 24, 2013 at 1857, Dr. Fuerstenberg authored an Abbott Northwestern emergency room note when Ms. Bermingham returned with a chief complaint of being faint. According to the provider's notes, she delivered her first baby on Tuesday. During delivery, the patient had two tears in her meconium membranes. After the ruptures, she had a long time between the tears and actual delivery. Yesterday, the patient experienced back spasms, leg swelling, nausea, and a fever of 101.8°. She was admitted to the hospital with a UTI. She was discharged early this morning. She felt better for a while at home, but then began to feel lightheaded and dizzy, and fainted for about 10 seconds. She reported pain in her lower abdomen, some leg pain and swelling, and minor vaginal bleeding without discharge. She was unable to tolerate sitting up. She denied any dyspnea and stated no further concerns or complaints at that time. Her temperature was 98.6°, blood pressure 115/82 with a pulse of 123 and respirations of 18. She was orientated to person, place and time and was in mild to moderate distress.

8. On examination she had mild suprapubic tenderness with no peritoneal findings. Her skin was warm and she was diaphoretic and pale. An EKG was performed and showed a sinus tachycardia with a left posterior fascicular block. Dr. Fuerstenberg's impression and medical decision-making note indicated that Nicole had presented with tachycardia, fever, syncope, and lower abdominal pain and

discomfort in the setting of a recent vaginal delivery. She had prolonged rupture of membranes and he was concerned about potential endometritis as a source of her symptoms. Her syncopal event was clearly related to orthostatic symptoms. He suspected she was relatively hypovolemic and septic. Her urine tests that morning were abnormal but not not markedly abnormal so a urinary tract infection could be the source but he was still concerned about endometritis. His differential diagnosis included septic thrombophlebitis or retained products of conception.

9. IV access was established for volume resuscitation. Ms. Bermingham was still thrombocytopenic, suggesting DIC. The suspicion for HELLP Syndrome was lower given normal liver function tests. A consumptive process such as thrombophlebitis still needed to be considered. She had no evidence of any significant bleeding. She was given broad spectrum antibiotics given evidence for severe sepsis and OB/Gyn saw the patient in the emergency room department. Repeat imaging of her abdomen demonstrated no immediate concerning findings. She was admitted to the intensive care unit for ongoing resuscitation. Her diagnosis was severe sepsis, pelvic pain, thrombocytopenia and leukocytosis.

10. During Ms. Bermingham's hospital course she was taken to the operating room for a hysterectomy. According to Dr. Kilburg's operative report from the total abdominal hysterectomy, debridement and revision of the episiotomy repair, the preoperative diagnosis was postpartum toxic shock of unknown etiology. The postoperative diagnosis was still postpartum septic shock of unknown etiology. Also listed was disrupted episiotomy repair with apparent cellulitis of the left labia and left

perivaginal tissues and microabscesses in the endometrium on frozen section. The surgical pathology report from the uterus and cervix showed the endometrial cavity with intraluminal degenerating decidualized endometrium, hemorrhage, and acute inflammation with microabscess formation. The uterine wall had superficial degenerating decidualized endometrium with thrombosed vessels, marginating neutrophils, and associated superficial myometrial inflammation. The comment from the pathologist noted the overall histology demonstrates degenerating post-partum decidua, with the majority of the inflammation being confined to vessels and adjacent tissue. No gram positive cocci or bacilli are identified on gram stained sections. Note is made of the endometrial sample sent for microbiological staining that demonstrates 3+ E coli and 1+ streptococcus species, raising the possibility of bacterial superinfection of the degenerating decidua. There is no evidence of retained placental villi, trophoblastic tumor, or malignancy.

11. Ms. Bermingham returned initially hemodynamically stable from the operating room. She developed metabolic acidosis in addition to other metabolic derangements. Her peak airway pressures began to rise and she went into atrial fibrillation with a RVR. Initial gram stain from the OR sample was gram negative bacilli (GNB). A bicarbonate drip was started, discreet amps of bicarbonate were given. She was chemically paralyzed with some minimal improvement in her airway pressures. A stat nephrology consultation was placed and arrangements were made for bedside placement of a HD catheter. A bedside echo performed showed good LV function with a small pericardial effusion. There were concerns for possible abdominal compartment

syndrome. There was minimal improvement in her hemodynamics and airway pressures. Her labs indicated a DIC with decreased platelets, fibrinogen and elevated INR. Ms. Bermingham was transfused with platelets, cryoglobulin, and plasma as well as Vitamin K. She continued to have tachyarrhythmias and bradycardia. A hemodialysis catheter was placed and CRRT was initiated. During this time they were unable to get accurate readings for peripheral oxygen saturations. An arterial line failed and they were unable to get cuff pressures and unable to place a new arterial line. She became bradycardic and progressed to asystole, EPI times three and atropine times two were given while manual chest compressions and LUCAS chest compressions were performed. Resuscitation was stopped and at 1231 on August 26, 2013 she expired. No autopsy was performed.

12. The death certificate listed the immediate cause of death as multiorgan failure with the underlying severe sepsis and possible endometritis.

DEPARTURES FROM ACCEPTED STANDARDS OF PRACTICE

1. It is Dr. Wiesenfeld's opinion that Nurse Practitioner Eid's evaluation of Ms. Bermingham on August 24, 2013 at Abbott Northwestern Hospital departed from accepted standards of practice. Specifically, Dr. Wiesenfeld will testify that Nurse Practitioner Eid's documentation failed to outline any discussion with Dr. Mainguy regarding the significant vaginal and rectal pain that Ms. Bermingham was experiencing, the tachycardia and the thrombocytopenia with a platelet count of 50. Dr. Wiesenfeld will explain that this lack of documentation done at the time of Ms. Bermingham's evaluation by Nurse Practitioner Eid demonstrates a failure to

provide Dr. Mainguy important information related to Ms. Bermingham's clinical and laboratory presentation.

2. Dr. Wiesenfeld will testify that Nurse Practitioner Eid's failure to identify and communicate Ms. Bermingham's symptoms, complaints, tachycardia, leukocytosis, and thrombocytopenia led to an incomplete clinical evaluation. Dr. Wiesenfeld will testify that Ms. Bermingham's presentation including complaints of severe vaginal and rectal pain along with her fever, tachycardia and thrombocytopenia demonstrated that she had developed systemic inflammatory response to an infection that required aggressive treatment including IV antibiotics and hospitalization.

3. Dr. Wiesenfeld will testify that because Ms. Bermingham was not appropriately evaluated and Nurse Practitioner Eid failed to communicate essential information to Dr. Mainguy, Ms. Bermingham was discharged with the diagnosis of urinary tract infection.

4. Dr. Wiesenfeld will testify that the standard of care required that Nurse Practitioner Eid communicate appropriate and important information to Dr. Mainguy including the complaints of vaginal and rectal pain, tachycardia and thrombocytopenia so that admission to the hospital with an appropriate evaluation, additional lab work, IV antibiotics and fluids with support could have been provided.

CAUSATION

1. Dr. Wiesenfeld will testify regarding the care and treatment Ms. Bermingham would have received if Nurse Practitioner Eid had met accepted standards of care. Dr. Wiesenfeld will testify that a detailed history and physical

examination by an OB/GYN would have been performed. IV antibiotics including broad-spectrum antibiotics would have been administered along with IV fluid resuscitation. Further laboratory evaluation of Ms. Bermingham's thrombocytopenia would have identified the cause to be associated with sepsis. Hospital admission with close monitoring, surgical intervention and support would have prevented the infection progressing to the point of taking Ms. Bermingham's life.

2. Dr. Wiesenfeld will discuss and explain the concepts of systemic inflammatory response, sepsis and septic shock. He will discuss the basic pathophysiology of these conditions and the monitoring employed in these circumstances. Dr. Wiesenfeld will explain that Ms. Bermingham developed a postpartum infection resulting in a systemic response to that infection which is called Systemic Inflammatory Response Syndrome or "SIRS." The progression of SIRS leads to a decrease in tissue perfusion and can result in organ dysfunction. Treatment rests upon aggressive fluid resuscitation, antibiotics and surgical excision or drainage of the infected tissue.

3. Dr. Wiesenfeld will testify that IV fluids and antibiotics prevent the progression of organ dysfunction by promoting perfusion and oxygenation to tissues. Inadequate fluid volume and resuscitation leads to inadequate blood pressure and inadequate tissue perfusion with tissue injury. Any organ or organ system is at risk including the heart, lungs and kidneys. It is imperative that steps are taken to assess a patient's fluid status and level of the vessel constriction. Administration of broad spectrum antibiotics allows penetration of the drug in adequate and therapeutic

concentrations into the tissues. Loading doses ordered STAT allows rapid systemic treatment in the early stages. The goal of antibiotic treatment is to prevent continued bacteria growth and tissue invasion.

4. Dr. Wiesenfeld will explain that SIRS and sepsis is the body's response to an infection. If left untreated there is a greater danger of decompensation and septic shock. Nurse Practitioner Eid's failure to appropriately manage Ms. Bermingham on August 24, 2013 during her emergency room evaluation caused the infection that she presented with to progress. Accepted standards of care require that all available measures to support patients and prevent the progression of infection and sepsis be undertaken. The goal is to prevent sepsis, septic shock and death.

5. Dr. Wiesenfeld will testify that had the appropriate treatment been provided to Ms. Bermingham including the fluid support, IV antibiotics and surgical intervention earlier that it is more likely than not that Ms. Bermingham would have survived.

6. Dr. Wiesenfeld will testify that Ms. Bermingham was hemodynamically stable at the time of Nurse Practitioner Eid's evaluation in the emergency room on August 24, 2013. The delay in appropriate treatment led to Ms. Bermingham's readmission to the hospital with severe sepsis. When Ms. Bermingham was admitted to the intensive care unit for ongoing resuscitation her diagnosis was severe sepsis, pelvic pain, thrombocytopenia and leukocytosis. Dr. Wiesenfeld will testify that the hours from Ms. Bermingham's discharge on the early morning of August 24, 2013 at approximately 0445 allowed the progression of her infection and that by the time she

was readmitted on August 24, 2013 at approximately 1857 that she was hypovolemic and septic. Although Ms. Bermingham's discharge diagnosis was urinary tract infection, the testing on the urine was not markedly abnormal and her clinical condition was most concerning for pelvic infection.

7. The hemopathology report on the peripheral blood showed marked absolute neutrophilia with left shift, reactive and severe thrombocytopenia. The leukocytosis had reactive features. The combination of leukocytosis and the acute onset of thrombocytopenia would be consistent with the clinical setting of sepsis. The microscopic appearance substantiates the diagnosis according to Dr. Susan Wheaton's pathology report.

8. The tissue endometrial biopsy collected at the time of Ms. Bermingham's surgery demonstrated 1+ PMNs and 1+ gram-negative bacilli. The urine culture that was taken demonstrated no growth. The endometrial sample sent for microbiological staining demonstrated 3+ E. coli and 1+ Streptococcus species. Intraoperative pathology with frozen section demonstrated intrauterine tissue with marked acute inflammation and micro abscess formation. Blood cultures obtained following the administration of antibiotics showed no growth

9. Dr. Wiesenfeld will testify that based on the laboratory and pathology findings for Ms. Bermingham that the organisms identified were sensitive to antibiotic treatment and that Nicole Bermingham's death was the result of a delay in providing care and treatment to Ms. Bermingham when she initially presented to the emergency room on August 24, 2013 and was evaluated by Nurse Practitioner Eid.

10. Dr. Wiesenfeld will testify that there is no documentation that Ms. Bermingham refused admission to the hospital or was ever offered hospitalization or informed of her thrombocytopenia.

11. Dr. Wiesenfeld will testify that had Ms. Bermingham received an appropriate evaluation and timely treatment as discussed above that it is more likely than not the progression of her infection and septic process would have been minimized or avoided and she would have survived. It is Dr. Wiesenfeld's opinion to a reasonable degree of medical certainty that Ms. Bermingham's death would have been avoided with earlier evaluation and treatment.

ADDITIONAL OPINIONS AND SUPPLEMENTATION

This affidavit has been created prior to the disclosure of any opinions of the defendant's experts or the defendants, and is based on the information in the medical records of Nicole Bermingham.

Plaintiff reserves the right to supplement or modify Dr. Wiesenfeld's opinions as additional information make such supplementation or modification appropriate

I declare under penalty of perjury that everything I have stated in this document is true and correct.

Dated this 5th day of August, 2016 in Hennepin County, Minnesota.

/s/ Chris Messerly
Chris Messerly, #177309
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Minneapolis, MN 55402
612-349-8500
CMesserly@RobinsKaplan.com

VERIFICATION

I have read the foregoing, and agreed that it accurately provides the substance of the facts and opinions to which I will testify in this matter, as well as a summary of the grounds for each opinion.

Harold C. Wiesenfeld, M.D.

Subscribed and sworn to before me
this 3 day of August, 2016.

Notary Public
My Commission Expires: 08/15/2019

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
DARLENE B SCHRELLO
Notary Public
BALDWIN BORO, ALLEGHENY COUNTY
My Commission Expires Aug 15, 2019

CURRICULUM VITAE

Harold C. Wiesenfeld, M.D., C.M.

Home Address:	2525 Beechwood Blvd. Pittsburgh, PA 15217	Birth Date:	August 1, 1963
Home Phone:	412-422-1230	Place of Birth:	Montreal, Canada
Business Address:	Department of OB/GYN Magee-Womens Hospital 300 Halket Street Pittsburgh, PA 15213	Citizenship:	United States
Business Phone:	412-641-1403	E-mail:	hwiesenfeld@mail.magee.edu
Business Fax:	412-641-1133		

POST-GRADUATE TRAINING

1988-1992 **RESIDENCY, OBSTETRICS AND GYNECOLOGY**
McGill University, Montreal, Quebec

1987-1988 **ROTATING INTERNSHIP**
St. Mary's Hospital
McGill University, Montreal, Quebec

EDUCATION

1982-1987 **DOCTOR OF MEDICINE, MASTER OF SURGERY (M.D., C.M.)**
McGill University, Montreal, Quebec

1980-1982 **DIPLOMA OF COLLEGIAL STUDIES**
Health Sciences
Marianopolis College, Montreal, Quebec

CERTIFICATION AND LICENSURE

1994	American Board of Obstetrics and Gynecology, Board Certified
1992	Royal College of Physicians and Surgeons of Canada
1992	Medical Physician and Surgeon, Commonwealth of Pennsylvania
1991	The College of Physicians and Surgeons of Ontario
1988	Licensure of the Medical Council of Canada (L.M.C.C.)
1988	Corporation Professionnelle des Medecins du Quebec
1987	Diplomate, FLEX (Professional Licensing Examination)

ACADEMIC APPOINTMENTS- PROFESSIONAL ACTIVITIES

2002 - Present	Associate Professor Department of Obstetrics, Gynecology, and Reproductive Sciences University of Pittsburgh School of Medicine/ Magee-Womens Hospital 300 Halket Street, Pittsburgh, PA
2005 – Present	Associate Professor (Joint appointment) Division of Infectious Diseases Department of Medicine University of Pittsburgh School of Medicine
2002 – Present	Director, Division of Reproductive Infectious Diseases and Immunology Department of Obstetrics, Gynecology, and Reproductive Sciences University of Pittsburgh School of Medicine/ Magee-Womens Hospital 300 Halket Street, Pittsburgh, PA
2011-Present	American College of Obstetricians and Gynecologists Member, Committee on Practice Bulletins- Gynecology Responsible for the creation of practice bulletins establishing evidence-based current clinical management guidelines in gynecology
2006- 2011	Institutional Review Board- University of Pittsburgh Member
2005 – Present	Chair, Infection Control Committee Magee-Womens Hospital of the UPMC Health System
2001 - Present	Member, Quality Assurance Committee Magee-Womens Hospital of the UPMC Health System
1996 - Present	HOSPITAL EPIDEMIOLOGIST Infection Control Committee, Magee-Womens Hospital

1994 - 2002	Assistant Professor Department of Obstetrics, Gynecology, and Reproductive Sciences University of Pittsburgh School of Medicine/ Magee-Womens Hospital 300 Halket Street, Pittsburgh, PA
1995 - Present	Co-Director Sexually Transmitted Diseases Program Allegheny County Health Department, Pittsburgh, PA
1996 - Present	Associate Investigator Magee-Womens Research Institute
1992 - 1994	Clinical Instructor Department of Obstetrics, Gynecology and Reproductive Sciences University of Pittsburgh School of Medicine/ Magee-Womens Hospital 300 Halket Street, Pittsburgh, PA

PROFESSIONAL AND SCIENTIFIC SOCIETIES

2002 - 2005	Infectious Diseases Society for Obstetrics and Gynecology - Council Member
1995 - Present	Infectious Diseases Society for Obstetrics and Gynecology
1994 - Present	American Sexually Transmitted Diseases Association
1993 - Present	American Society for Microbiology
1989 - Present	The American College of Obstetricians and Gynecologists- Fellow

GRANTS

2011-2014	**Centers for Disease Control and Prevention** SIP 11-048: Case Control Study of Chlamydia and Infertility among Women Assessed for Tubal Disease or Treated by Assisted Reproductive Technology (Health Promotion and Disease Prevention Research Centers: Special Interest Project Competitive Supplements) **Principal Investigator**
2009-2014	**National Institutes of Health** 1 U19 AI 084024 **Co-Investigator** Sexually Transmitted Infections Cooperative Research Center (STI CRC) The University of Pittsburgh Medical Center STI CRC Dr. Toni Darville, Principal Investigator Importance of Anti- Anaerobic Therapy for Acute PID- Project 1

Project Leader

Clinical Core
Core Leader

2009-2012 **National Institutes of Health**
NIAID-HHSN-266200400074C
"Randomized Clinical Trial Evaluating Efficacy of Gentamicin/Azithromycin and Gemifloxacin/Azithromycin Combination Therapies as a Salvage Regimen for Uncomplicated Urogenital Gonorrhea"
Site Principal Investigator

2003-2009 **National Institutes of Health**
2 R01 AI41624-05A1
"Prevention of Infertility in Women with Subclinical PID"
Principal Investigator
Total Award: $2,614,312

2002-2007 **National Institutes of Health**
5 U19 AI51661-02
"Development of NNRTI's as Combination Microbicides"
Co-Principal Investigator
Total Award: $1,356,366

1999-2004 **National Institutes of Health**
5 U01 AI47785-04
"Sexually Transmitted Diseases Cooperative Research Center"
Co-Principal Investigator
Total Award: $445,092

1998-2003 **National Institutes of Health**
1 RO1 A1 41624-O1A1 BM -
"The Role of STDs in the Pathogenesis of Subclinical PID"
Co-Principal Investigator
Total Award: $1,946,954

1998-1999 **Infectious Diseases Society for Obstetrics and Gynecology**
Health Care Economic Aspects of Reproductive Tract Infections
Fellowship Award
"A Randomized Trial of an Intensive Reminder Program to Improve Compliance with Hepatitis B Vaccination Among Adolescents"
Principal Investigator

1998-1999 **Infectious Diseases Society for Obstetrics and Gynecology**
Reproductive Tract Microbiology: Host and Pathogen Infections
"The Role of Local Allergic Response to *Candida Albicans* in Candida Vaginitis
Co-Investigator

1996-1999	**Jewish Health Care Foundation Grant** "Community Based Screening for *Chlamydia trachomatis*" Principal Investigator
1996-2001	**US Department of Defense** "Self-Test Kit: Rapid Diagnosis of Urogenital Infections in Military Women" Co-Investigator
1996-2001	**National Institutes of Health** 1 RO1 HS08358 "Effectiveness of Outpatient Treatment for PID" Study Site Co-Investigator
1995-1998	**Region III Chlamydia Project Grant** "The Efficacy of Azithromycin as Single-Dose Therapy for Chlamydial Infections in Adolescents." Principal Investigator
1995-1998	**Region III Chlamydia Project Grant** "Urine Screening for *Chlamydia trachomatis* by Polymerase Chain Reaction and Leukocyte Esterase in a Youth Detention Center." Principal Investigator
1993-1995	**The Irene McLenahan Young Investigator Research Grant** Magee-Womens Hospital, Pittsburgh, PA

Industry-Supported Research

2011	"A Randomized, Double-Blind, Placebo-Controlled Phase II Study of Fluconazole Versus Fluconazole And MGCD290 for the Treatment of Moderate to Severe Acute Vulvovaginal Candidiasis" MethylGene Inc. Principal Investigator at study site
2004	"Phase 3 Randomized Multicenter Double Blind Placebo-Controlled Trial of Bacterial Vaginosis with Tinidazole Oral Tablets." Presutti Laboratories, Inc. Principal Investigator at study site
2004	"Assessment of the Clinical Performance of Candia5 and Syscan3 Elisa as aids in the diagnosis of vulvovaginal candidiasis." Rockeby Biomed Corp., Singapore. Principal Investigator at study site
2003-2004	"Open Label Treatment of *T. vaginalis* with Tinidazole Oral Tablets" Presutti Laboratories, Inc. Principal Investigator
2003-2004	"A Single-Blind, Randomized, Active-Controlled, Multi-Center Study of the Efficacy and Safety of an Intravaginal Ring Delivering Metronidazole vs. Oral Metronidazole in the Treatment of Bacterial Vaginosis"

	Warner Chilcott, Inc. (Protocol 08102.1) Principal Investigator
2000-2005	"A Multicenter, Randomized, Double-Blind, Vehicle-Controlled Study to Evaluate Maintenance Therapy with 0.75% Metronidazole Vaginal Gel to Prevent Recurrent Bacterial Vaginosis" Subcontract with Wayne State University/3 M Pharmaceuticals Co-Principal Investigator
1998-Present	"A Randomized, Double-Blind, Placebo-Controlled Evaluation of Valacyclovir for the Prevention of Herpes Simplex Virus Transmission in Heterosexual Couples." Glaxo Wellcome, Inc. Principal Investigator at study site
1997-Present	"A Randomized Double-Blind Multicenter Study Comparing Fluconazole Vs. Placebo for the Maintenance/Prophylactic Therapy of Vaginal Candidiasis in Women with Recurrent Infections." U.S. Pharmaceuticals Group, Pfizer, Inc. Principal Investigator at study site
1997-Present	"A Comparative Trial of Endotoxin Release and Cytokine Generation Following Therapy with Imipenam vs. Ceftazidime" Merck and Co., Inc. Principal Investigator at study site
1996-1997	"Miconazole Nitrate Cellulosic Vaginal Suppository Oval Shaped Tablet" Advanced Care Products/Johnson & Johnson Principal Investigator at study site
1996-Present	"Verification of the Affirm VPIII Microbial Identification Test Kit on Vaginal Fluid Samples" Becton-Dickinson Co-Investigator at study site
1996	"Treatment of Bacterial Vaginosis with Metronidazole Modified Release Tablet: A Dose Duration Study" G.D. Searle, Inc. Principal Investigator at study site
1996	"Comparative Trial of CP 99,219 and Ofloxacin/Clindamycin in the Treatment of Acute PID in Ambulatory Patients" Pfizer, Inc. Co-Investigator at study site
1996	"Randomized, Double-Blind, Multicenter Trial Assessing the Safety and Efficacy of IV CP 116,517 Followed by Oral CP 99,219/Clavulanic Acid for the Treatment of Acute Pelvic Infections" Pfizer, Inc. Co-Investigator at study site
1995	Multicenter Open Label Study to Determine the Safety and Efficacy of Ofloxacin in the Treatment of Laparoscopically-Documented Acute

Salpingitis"
Ortho-McNeil, Inc.
Co-Investigator at study site

1994-1995 "Safety and Efficacy Comparison of Two Dosing Regimens of Metronidazole Vaginal Gel in the Treatment of Bacterial Vaginosis"
Curatek Pharmaceuticals, Inc.
Co-Investigator at study site

1993-1994 "Fosfomycin Tromethamine vs. Trimethoprim/Sulfamethoxazole in Uncomplicated Urinary Tract Infections"
SmithKline & Beecham and Forrest Laboratories
Co-Investigator at study site

1992-1994 "An Open Label Comparative Study of Efficacy and Safety of Fleroxacin plus Clindamycin vs. Cefoxitin and Doxycycline in the Treatment of Acute PID"
Roche Laboratories, Co-Investigator at study site

HONORS

TOP DOCTOR, Pittsburgh Magazine **2008, 2009**

UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE FACULTY RECOGNITION AWARD 2005
For Excellence in Teaching,
Compassionate Patient Care, and
Mentorship of Medical Students

MAGEE-WOMENS HOSPITAL APGO EXCELLENCE IN TEACHING AWARD
For Excellent in Resident Education 2001-2002

CREOG FACULTY AWARD 2001
For Excellence in Resident Education

YOUNG INVESTIGATOR AWARD 1999
Infectious Diseases Society for
Obstetrics & Gynecology

PUBLICATIONS

1. Dylewski J, **Wiesenfeld H**, Latour A. Postpartum uterine infection with *Clostridium perfringens*. Rev Infect Dis 1989;11:470.

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3. **Wiesenfeld HC**, Uhrin M, Dixon BW, Sweet RL. Rapid polymerase chain reaction-

based test for the detection of female urogenital chlamydial infections. Infect Dis Obstet Gynecol 1994;1(4):182-7.

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TEXTS

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ABSTRACTS

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