

## Non-Descent Vaginal Hysterectomy

Should All Hysterectomies For Benign  
Conditions Be Performed Vaginally?

Role of Vitamin D  
in Women

Mainstreaming  
Cancer Genetics

INSIDE

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# Quo Vadis OGSM?

Dr Ravi Chandran  
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One of the impressive things that the current Council has succeeded in doing is ensuring the regular and timely release of our Newsletter CONNECT and this resonates with my own efforts to ensure the regular release of the AOFOG Newsletter. Anyone involved in this endeavour will readily attest to the challenges involved and my heartiest congratulations to Dr Eeson and his team on a magnificent effort. As the name suggests, the Newsletter is a lifeline to connect and communicate with the membership at large. It also shows that the OGSM is alive and kicking and the myriad of activities carried out over this term certainly attests to this.

But are we content to be just “alive and kicking”?

Through my involvement with AOFOG, I have had the good fortune of seeing up close the workings of many national O&G organisations and believe you me, I have seen the “good, the bad and the ugly”. OGSM has certainly achieved a good level but we have the potential to reach greater heights.

As we approach the 6th decade of our existence, a great many changes have taken place around us. For starters, I believe it is timely to review our constitution to keep abreast of these changes. Having been involved in the review of the AOFOG constitution a few years ago and more recently the articles of association of FIGO, there are areas of our own constitution that need modification and updating to withstand new challenges.

I sometimes feel that we are in danger of becoming the victims of our own success. As we have grown in leaps and bounds, the way in which we conduct our daily “business” is also important. As I have been intimately involved in dealings between AOFOG and OGSM over the last 2 years, I have had a front row, un-blinkered

view of how OGSM operates. You only have to look to Japan (JSOG) and Taiwan (TAOG) to appreciate the efficiency with which they work. Even India (FOGSI) is now moving towards ISO certification. These are all large organisations with members running up to 35,000; should we not be doing better with a membership of only about 1000? To their credit, recent Councils have undertaken SWOT analyses of our Secretariat but we need to push on as change has been slow in coming.

Finally, it is a truism that the long-term success of any organisation lies with the younger generation. It is always a tricky blend of “older experience” with “younger enthusiasm” be it on Council or Committees. Going by the information gleaned from the various issues of CONNECT, the younger generation is being engaged more but perhaps we should re-examine the mechanisms by which we can give them better opportunities to progress within our organisation. Perhaps the time has also come to limit the duration that any individual can occupy any particular position.

As Heraclitus famously said, “Change is the only Constant in Life” and so we must be prepared to embrace change quickly lest we are left behind and descend to the depths of the “bad and ugly” of this region.





### Dr Ng Beng Kwang

Dr Ng is a Senior Lecturer & Specialist attached to Universiti Kebangsaan Malaysia Medical Centre and UKM Specialist Centre. While this is his first term as an OGSM council member, Dr Ng has been actively involved in several other organisations including the Malaysian Menopause Society as Vice President.



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# Looming Nightmare Of Menopause: The Genitourinary Syndrome Of Menopause

Genitourinary Syndrome of Menopause, abbreviated as GSM, is a new terminology approved by the board of directors of the International Society for the Study of Women's Sexual Health (ISSWSH) and the North America Menopause Society in 2014, to describe the symptoms related to genitourinary tract in consequence of menopause<sup>1</sup>. This new terminology includes the clinical presentation associated with oestrogen deficiency involving changes to the female genital area; i.e., labia, vulva, vagina, urethra and bladder<sup>2</sup>. Women may experience vaginal dryness, dyspareunia, burning sensation, itchiness, dysuria, etc<sup>3</sup>. Unlike vasomotor symptoms, prevalence of GSM seems to increase with the years past menopause, reaching a peak of 80% 10 years after menopause<sup>4</sup>.

According to The Vaginal Health: Insights, Views and Attitudes (VIVA) survey, which involved 3520 post-menopausal women aged between 55 to 65 years, about 63% of women failed to recognise vaginal atrophy as a chronic condition and almost half of them (46%) lacked knowledge about local oestrogen therapy<sup>5</sup>. In the same study, 80% of women considered genital atrophy as causing a negative impact on their life, with 75% claiming it affects their sexual life, and up to 33% suffer on how it affects their relationship and marriage<sup>5</sup>. In another international survey conducted by REal Women's Views of Treatment Option for Menopausal Vaginal ChangEs (REVIVE), it was found that only 10% of healthcare providers actually initiate the conversation about GSM symptoms as expected by women. Lack of efficacy and the concern about hormonal side effects were perceived as the main limitation for local oestrogen preparation use<sup>6</sup>. A similar initiative was carried out by the Pan-Asian REVICE survey, published in 2017, involving 5992 post-menopausal women across Indonesia, Malaysia, Singapore, Taiwan and Thailand. Among 638 women with GSM, only 35% were aware of this condition, whereas only 1 in 5 (21%) had been clinically diagnosed with GSM and less than a quarter (24%) was treated for their condition<sup>7</sup>.

This condition poses a medical challenge and is becoming a public health concern, because it is often under-reported by women and under-recognised by healthcare providers; hence, women continue to suffer in silence<sup>8</sup>.

Oestrogen therapy is recognised as the most effective treatment for GSM. Low-dose vaginal oestrogen therapies are effective and considered safe in treating women with GSM<sup>9-13</sup>. There are a variety of preparations, including creams, tablets and rings with minimal systemic effects<sup>14,15</sup>. In the recent Cochrane Review by Lethaby et al. (2016), no difference was found in the efficacy between various local oestrogen preparations. There is weak evidence that oestrogen cream might be associated with an increase in endometrial thickness, possibly due to the higher dose of cream as compared to the oestrogen ring<sup>9</sup>. Other possible side effects of conjugated equine oestrogen (CEE) cream include erratic uterine bleeding, breast tenderness and perineal pain<sup>16</sup>.



Oestrogen preparation is found to be clinically effective as low as 4 µg for the treatment of GSM<sup>10</sup>. Low-dose regimes (7.5 µg vaginal ring or 10 µg vaginal tablet) should be preferred to intermediate (25 µg oestradiol or 0.3 mg conjugated equine oestrogen) or high dose preparations (50-2000 µg oestradiol or 0.625-2.5 mg conjugated equine oestrogen). A study had substantiated that low-dose preparations increased plasma oestradiol levels after long term administration but not above the normal range ( $\leq 20$  pg/ml)<sup>13</sup>. The finding was consistent with another study by Rueda et al. which revealed, following treatment with local oestrogen, that the serum estradiol level rose and peaked in an hour. However, during 6 months of follow up, no rise in the level of serum estradiol was found among treated women<sup>14</sup>.

Two recent reviews on topical oestrogen concluded that there was no evidence of endometrial hyperplasia found after 2 years of its use. Thus, the literature continues to provide consistent information about the safety of local vaginal oestrogen in low doses and does not support the concurrent use of progestin for endometrial protection<sup>12,17</sup>. In the recent NAMS hormonal therapy position statement 2017, it was stated that progestogen is generally not indicated when oestrogen therapy is administered vaginally for GSM in low doses, although clinical data to support the safety of endometrium beyond 1 year usage is lacking<sup>15</sup>.

The use of ultra-low dose vaginal estradiol 0.03 mg in combination with *Lactobacillus acidophilus* KS400 in the treatment of postmenopausal vaginal atrophy has been well studied. A randomised placebo-controlled study followed by an open label follow-up demonstrated the superiority of the 0.03 mg estradiol-lactobacilli combination to placebo in which the vaginal maturation index (VMI) improved significantly (35.2% vs 9.9%). Furthermore, the VMI increased to 55.4% and remained at a comparable level (49.4-52.8%) during maintenance therapy<sup>18</sup>. Combination of ultra-low-dose vaginal estradiol with lactobacilli has been recently studied, and the Female Somatic Sexual Experience Instrument (FSSEI) revealed a non-significant trend of improvement. The local vaginal therapy with ultra-low-dose vaginal estradiol combined with lactobacilli may be a useful treatment in breast cancer survivors experiencing atrophic vaginitis<sup>19</sup>.

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Dr Ng Beng Kwang /  
Dr Janisha Silva Raju

# Non-Hormonal Therapy For GSM: An Update

Non-hormonal therapies have provided exceptional improvement for GSM. The approved treatment of dyspareunia in postmenopausal women include ospemifeme<sup>1</sup> and intravaginal DHEA<sup>2</sup>. Ospemifene is a non-oestrogen, tissue selective oestrogen receptor modulator. Ospemifene at the dosage of 60 mg/day demonstrated a significant greater Female Sexual Function Index (FSFI) score as compared to placebo at week 4 ( $p < 0.001$ ). The effect persists even at week 12 and all domains of FSFI including sexual pain, arousal and desire were significantly improved ( $p < 0.05$ )<sup>1</sup>. The same dose of ospemifene for 20 weeks also showed an improvement in physical examination findings on vulvoscopic photography in a prospective study by Goldstein SW et al<sup>2</sup>. These changes were also consistent with improvement in self-reported pain and sexual function<sup>2</sup>. Overall safety of ospemifene in phases 2 and 3 trials suggests some detrimental effects on breast and cardiovascular health<sup>3</sup>. However, it revealed a significant improvement in the percentage of parabasal and superficial cells in the vaginal maturation index (VMI). Optimisation of vaginal pH was also noted.



The majority of treatment-emergent adverse events were considered mild to moderate in severity<sup>4</sup>. Hence, ospemifene was approved by the Food and Drug Administration (FDA) and European Medicines Agency (EMA) for the treatment of moderate to severe dyspareunia.

Dehydroepiandrosterone (DHEA), a sex steroid, has been shown to improve VMI and vaginal pH in one week<sup>5</sup>. In a prospective study, the daily use of intravaginal 0.5% DHEA (Prasterone) for 12 weeks had improved sexual arousal/sensation domain by 68%, arousal/lubrication by 39%, orgasm by 75% and dryness by 57%<sup>6</sup>. Recent study by Labrie et al. (2018) revealed that percentage of parabasal cells decreased by 27.7% over placebo, and percentage of superficial cells increased by 84.4%. Whereas the vaginal pH decreased by 0.66-unit pH, and pain at sexual activity reduced by 1.42 severity unit. Upon gynaecological evaluation, vaginal secretions, epithelial integrity and epithelial surface thickness and colour improved by 86%<sup>7</sup>. However, the ISSWAH expert consensus panel review of 2018 concluded that vaginal DHEA is effective in managing dyspareunia in menopause, yet further studies are needed<sup>8</sup>.

Of late, laser therapy has been gaining popularity. It enhances the production of collagen and extracellular matrix, hence optimising the vaginal tissue thickness by making it more firm and elastic<sup>9</sup>. Salvatore S et al. reviewed 10 vaginal specimens following laser therapy and found that vaginal connective tissue was remodelled without causing damage to surrounding tissue<sup>10</sup>. A pilot study by Salvatore et al. discovered that 12 weeks fractional laser therapy was a feasible approach and is effective for improving vulvovaginal symptoms (vaginal dryness, burning, itching, dyspareunia and dysuria) as well as vaginal health index score (VHIS)<sup>11</sup>.

Pitsouni E et al. published a systematic review on the use of laser therapy in GSM. This included 14 studies involving 542 patients suffering from GSM. The author concluded that laser therapy appears promising as it may reduce the severity of symptoms, improve quality of life and restore the premenopausal vaginal mucosal status. However, the quality of evidence is poor and thus, it was still not recommended by the evidence-based modification of the current practice<sup>12</sup> until robust evidence is available.

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# Female Sexual Dysfunction



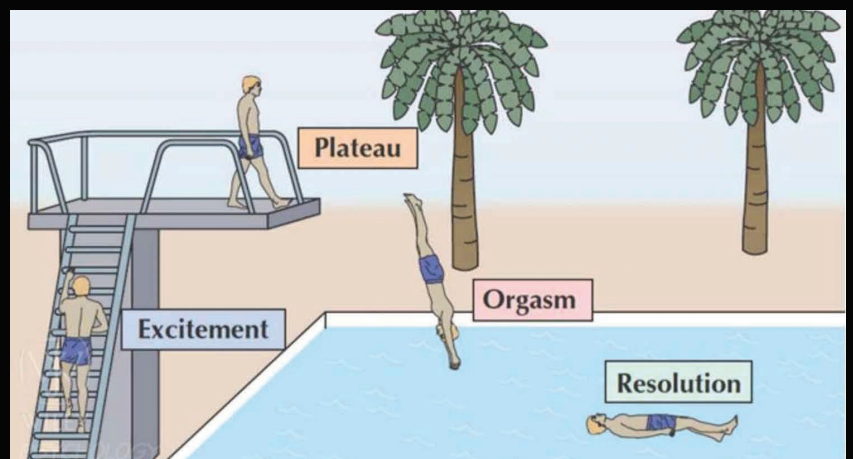
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Female sexual dysfunction (FSD) is a prevalent problem afflicting approximately 40% of women<sup>1-5</sup>. It is a sexual problem associated with personal distress. It takes different forms, including lack of sexual desire, impaired arousal, inability to achieve orgasm or pain with sexual activity<sup>6</sup>. For many women, the phases may vary in sequence, overlap, repeat or be absent during some or all sexual encounters. It is a complex and poorly understood condition that affects women of all ages. It is more typical as women age and is a progressive and widespread condition. Sexual dysfunction may be a problem since the start of sexual activity or may be acquired later in life after a period of normal sexual function.

## Female Sexual Response Model

An understanding of sexual response is helpful in the evaluation and treatment of sexual dysfunction.

In 1966, Masters & Johnson found that sexual response is divided into four phases: excitement, plateau, orgasm and resolution. These four phases occur in a linear way, with one coming after the other. The sexual response cycle isn't complete without all four occurring (Figure 1).

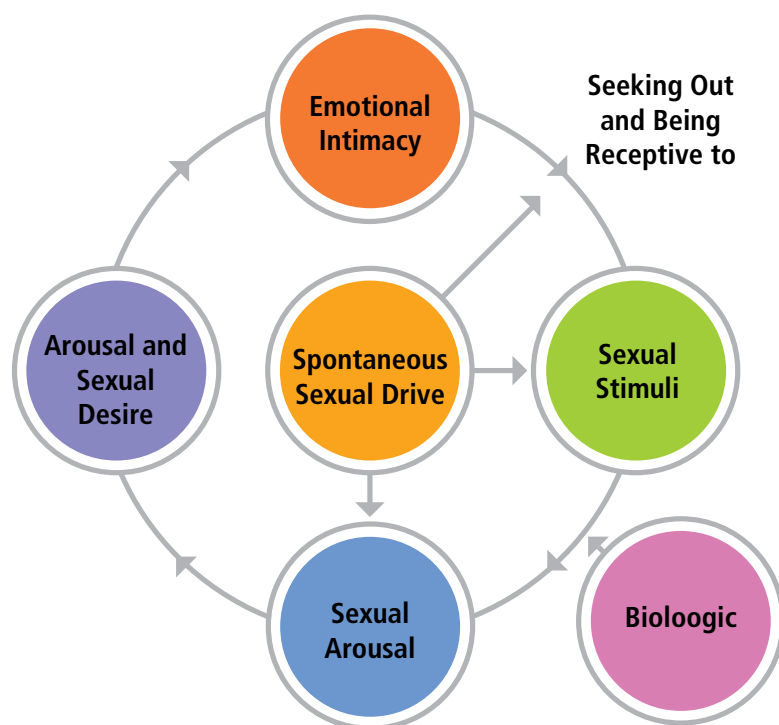


In 1974, Helen Singer Kaplan introduced another linear model. She added the concept of desire to the model and condensed the response into 3 phases: desire, excitement and orgasm. This model gives the same importance to the physiological and psychological aspects of sexual response.

Masters & Johnson and Kaplan's models were intended to reflect sexual response for males and females; however, researchers have recognised that some women do not experience all four phases of the cycle. As such, these models have been criticised since they do not reflect a woman's actual experiences.

In 2001, Rosemary Basson published a non-linear model of female sexual response that incorporated the importance of emotional intimacy, sexual stimuli and relationship satisfaction<sup>7</sup>. Basson's non-linear model of sexual response incorporates the need for intimacy, acknowledges that desire can be reactive or spontaneous and may come either before or after arousal, recognises that orgasms may contribute to satisfaction but aren't necessary for satisfaction and considers relationship factors that may impact the cycle as costs or rewards<sup>7</sup> (Figure 2).

## Female Sexual Response - Circular



### Risk Factors

The endocrinology of female sexuality is uncertain. Oestrogens and androgens are involved but the magnitude of their roles require further clarification.

**Role of oestrogens** — Declining levels of oestrogens in peri- and postmenopausal women have been associated with changes in sexual function. The major reasons are the effects of hypoestrogenism on vulvovaginal tissues and the pelvic floor. Vasomotor symptoms may also cause discomfort or sleep disturbance that impact sexual function.

**Role of androgens** — Androgens likely play a role in female sexual function; however, the magnitude of this role is uncertain<sup>8</sup>. Most physiologic models do not suggest that androgen levels correlate with female sexual function. However, supraphysiologic doses of androgen therapy have been found to increase libido or sexual frequency.

Sexual function is strongly affected by relationship and sociocultural factors, in addition to physiologic and psychological issues. A history of physical or sexual abuse is strongly associated with female sexual dysfunction.

Menopause is consistently associated with dyspareunia. The effects of age and menopause on female sexual dysfunction considerably vary among women. In general, sexual problems increase with age, but distressing sexual problems peak in midlife women.

Hormonal contraception, including oestrogen-progestin contraceptives, is unlikely to interfere with female sexual function.

Depression and anxiety are strongly associated with female sexual dysfunction. Other associated medical conditions include urinary or faecal incontinence, chronic pain conditions, substance abuse, end-stage renal disease and cancer.

Medications, specifically certain antidepressants (selective serotonin reuptake inhibitors), are associated with female sexual dysfunction. Other agents, including beta-blockers and antipsychotics, may contribute to sexual problems.

### Definition and Classification

Traditionally, female sexual dysfunction has been classified into four categories by the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV): sexual desire, sexual arousal, orgasmic or sexual pain disorders<sup>9</sup>. However, the definition of normal female sexual function was critically examined, and the accepted definition and classification of female sexual dysfunction was subsequently revised<sup>6</sup>.

### Clinical Approach

Sexual function issues should be addressed as part of every comprehensive women's health visit. Unfortunately, most sexual problems in women remain unrecognised and untreated. Asking a patient whether she has sexual concerns can be easily incorporated into clinicians' questions about gynaecologic health, along

with asking whether she is sexually active, practices safe sex, uses contraception (if indicated) and has any current or past issues with sexual abuse.

Many clinicians avoid asking about sexual concerns because they don't feel they have the time or knowledge to address these issues. A useful strategy for clinicians is if a sexual concern is raised and does not require immediate attention (e.g., patient is unsafe or at high risk of a sexually transmitted infection), the clinician may defer full evaluation and treatment until a follow-up visit or refer the patient to a clinician experienced in sexual health. The patient is often relieved at being asked and can be comforted by being told that you appreciate her sharing her concerns, many women experience sexual problems and effective treatments are available. While waiting for the follow-up visit, encourage your patient to read about sexual problems in women.

At the follow-up visit, a detailed history of the sexual problem is essential. By identifying the onset of the problem and contributing factors, the appropriate intervention is often clear. If a woman experiences low desire upon reaching menopause and this is with associated vaginal dryness, dyspareunia, hot flushes and sleep disruption, treatment of her menopausal symptoms is likely to improve her low libido. If problems with arousal and orgasmic response began after the onset of depression or initiation of a selective serotonin reuptake inhibitor, sexual function should improve with treatment of the mood disorder and/or use of an antidepressant that is less likely to affect sexual function, such as bupropion. Addressing sources of pain or discomfort during sexual activity (e.g., pain from arthritis, urinary or faecal incontinence) often improve sexual interest and satisfaction.

Sexual health concerns are usually multifactorial. Relationship and family issues often play a role as do work or other sources of stress. Women may experience poor body image or a feeling of embarrassment or shame. Women should be informed that they are not alone as sexual problems are common and just sharing a concern and wanting improvement is a good first step.

## Diagnostic Evaluation

The evaluation of female sexual dysfunction includes a medical and sexual history. A pelvic examination is only required for diagnosing sexual pain disorders, but an examination is important for all patients with sexual complaints to identify possible etiologic factors and associated conditions<sup>10</sup>. Laboratory testing and imaging are required only to evaluate associated conditions, as appropriate.

**Diagnostic criteria** — The American Psychiatric Association (APA) guidelines for sexual disorders require that a sexual problem be recurrent or persistent and cause personal distress or interpersonal difficulty to establish diagnosis<sup>9</sup>. Additionally, the problem must be present for at least six months and not be accounted for by a different diagnosis (e.g., depression).

Sexual dysfunctions are defined in relation to one or more phases of the sexual response cycle. Although in clinical practice, it is uncommon to see a disorder that is limited to a single phase<sup>9</sup>. In the diagnostic criteria published in 2013, several categories were combined, and definitions were changed<sup>6</sup>.

## Treatment

Treatment varies by disorder and cause; often, more than one treatment is required because disorders overlap. Sympathetic understanding of the patient and careful evaluation may themselves be therapeutic. Contributing factors are corrected if possible and mood disorders are treated. Explaining what is involved in the female sexual response may also help.

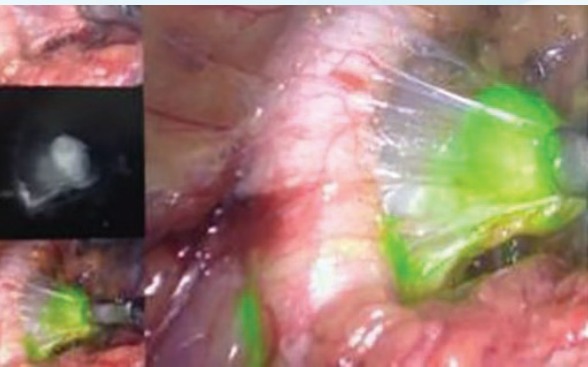
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# Role Of Sentinel Lymph Node Biopsy In Endometrial Carcinoma

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Dr Loo Kwong Sheng

Most women with Endometrial Cancer (EC) are diagnosed at an early stage. Early stage EC carries good prognosis and low relapse rate. Hence, patients are more likely to suffer from the morbidity of treatment rather than from EC itself.

In our country, around 1100 of new endometrial cancer cases were diagnosed in 2018<sup>1</sup>.

No standard practice is present on the extent of surgery for low risk/early stage endometrial cancer. Low risk patients include those with stage 1, small tumour (<2 cm), endometrioid subtype, Grades 1 or 2. Quite often, treatment include hysterectomy, removal of adnexal structures and performing a full pelvic lymphadenectomy (PLND). However, most women with early stage/low risk disease have negative lymph nodes<sup>2</sup>, and full pelvic lymphadenectomy is associated with significant lymphatic morbidity. Risk of lower limb lymphedema after full PLND is 5%-35% based on various studies<sup>3</sup>.

Performing PLND at an early stage of EC is still questionable as two randomised trials<sup>4,5</sup> have shown no survival benefit, particularly in low-risk endometrial cancer patients.

By not doing PLND during the early stage of EC, lymphedema risk can be avoided but at the expense of a small percentage of women. Hence, Sentinel Lymph Node Biopsy (SLNB) offers an answer to this dilemma.

The feasibility of Near Infrared Indocyanine Green (NIR-ICG) SLNB as an alternative to systematic pelvic lymphadenectomy for surgical staging in low risk endometrial cancer has been confirmed by a few studies<sup>6,7</sup>. In our region, a pilot study at KKH (Singapore) with SLN mapping using ICG-NIR was conducted in 35 patients with early-stage endometrial cancer who underwent laparoscopic staging surgery. SLN was first biopsied, followed by systematic pelvic lymphadenectomy. The mean lymph node count was 21 nodes and the mean number of sentinel lymph node (SLN) biopsied was three nodes per patient. The overall SLN detection rate was 97% (34 in 35 patients) and the rate of bilateral mapping – the successful identification of SLNs on both sides of the pelvis – was 88.6% (31 in 35 patients). It was found that two patients (5.7%) had positive bilateral pelvic lymph nodes, two patients (5.7%) had positive SLNs and no patient had false-negative SLNs.

During my fellowship at KKH, I was tasked to look into the comparison of lower limb lymphedema rate post NIR-ICG sentinel lymph node biopsy versus full pelvic lymphadenectomy in early stage endometrial cancer. 135 women (29 SLNB/106 PLND) were analysed; the incidence of lower limb lymphedema 3 months post-surgery in the SLNB group was 3.4% compared to 21.7% in the full pelvic lymphadenectomy group ( $p=0.023$ ). We are anticipating more data from the SLNB group and from the 9-month assessment.

In conclusion, SLNB in the early stage of Endometrial Cancer is the way forward to avoid lymphatic complications of full PLND.

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# Role Of Vitamin D In Women's Health

The role of vitamin D in women's health and perinatology is a subject of major interest in the past few years. Malaysia, despite geographically being a sun-enriched area, has a high prevalence of vitamin D deficiency. A recent study has shown that prevalence of Vitamin D deficiency was up by 71.7% among pregnant women when tested during their third trimester.

Vitamin D (calciferol) is a pro-hormone that is derived from cholesterol. The nutritional forms of vitamin D include D3 (cholecalciferol) which is generated in the skin under direct exposure to sunlight, especially ultraviolet B (UVB) photon, and Vitamin D2 (ergocalciferol) which is

**The Endocrine Society defined**

Condition	25(OH)D serum concentration [ng/ml]
Vitamin D deficiency	<20
Vitamin D insufficiency	21–29
Vitamin D sufficiency	≥ 30
Optimal vitamin D status	40–60



derived from food. Vitamin D has a well-known classical function in calcium uptake and bone metabolism. But more recent works have highlighted the importance of the non-classical actions of vitamins D in innate and adaptive immune systems, pancreatic  $\beta$ -cells, cardiovascular system and the brain. Tissue responses included effects on hormone secretion, modulations of immune response and regulations of cell proliferation and differentiation.

### Vitamin D and pregnancy outcomes

Vitamin D deficiency has been reported to increase the risk of gestational diabetes mellitus, pre-eclampsia, anaemia, bacterial vaginosis, threatened preterm labour, caesarean section and low birth weight baby. Nevertheless, some studies presented conflicting results due to multiple confounding factors. Thus, the full implication of vitamin D deficiency during pregnancy is yet to be discovered. Studies have evaluated mothers in the third trimester and correlated their serum vitamin D levels with newborn's cord blood as well. The mother's vitamin D storage is the infant's basic source of vitamin D as breast milk is poor in this nutrient.

### Polycystic ovarian Syndrome

There is increasing evidence that supports the contribution of vitamin D deficiency to metabolic disturbances in women with PCOS, including insulin resistance, obesity, hypertension and menstrual dysfunction. Evidence suggested that polymorphism in the vitamin D receptor gene was associated with vitamin D deficiency in PCOS and its metabolic and endocrine disturbances. However, the exact mechanism is still not fully understood. Vitamin D may play a role in glucose metabolism by enhancing insulin synthesis and release. It was also shown to increase insulin receptor expression and suppression of pro-inflammatory cytokines that possibly contribute to the development of IR. IR reproductively causes hyperandrogenism through elevation of ovarian androgen production and the reduction of sex hormone-binding globulin (SHBG) production.

### Infertility

Several studies investigated the role of vitamin D in ovarian physiology and its implication for reproduction. So far, studies showed conflicting results that either confirms that vitamin D may be a positive regulator of AMH production, or that its level is unrelated in the ovarian reserve or ovarian response after ovarian stimulation.

### Uterine Fibroid

Researchers found that African-American women, who are at increased risk of fibroid due to higher melanin concentration, result in decreased serum vitamin D levels and reduced expression of vitamin D receptors in the adjacent myometrium compared to white women.

Thus, vitamin D supplementation in women is considerable, but more high-quality data are still necessary. Recent evidence seems insufficient to guide new clinical recommendations.

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# Mainstreaming Cancer Genetics May Be Feasible In Malaysia

Mainstreaming Cancer Genetics may be feasible in Malaysia. It can pave the way to improving access to ovarian cancer genetic testing and help identify mutation carriers who may benefit from risk management and targeted treatment, as recently suggested by the preliminary results of the MaGiC Study presented at the 3rd MaGiC Investigators' Meeting in Subang Jaya.

"This is the first nationwide study for ovarian cancer and to assess whether we can improve access to genetic counselling and genetic testing for ovarian cancer by mainstreaming", said lead author Ms Sook-Yee Yoon, genetic counsellor, Cancer Research Malaysia, Subang Jaya, Malaysia. "Genetic testing is underutilised in our country to identify high risk individuals and their family members who may benefit for understanding their risk to cancer. The information may also have therapeutic impact".

Mainstreaming genetic counselling for genetic testing of BRCA1 and BRCA2 in ovarian cancer patients in Malaysia (MaGiC Study) was set up to: 1) assess the prevalence of germline BRCA1 and BRCA2 mutations among ovarian cancer patients; 2) determine the feasibility of mainstreaming genetic testing and counselling at local hospitals; and 3) examine the psychosocial impact of genetic testing in Malaysia.

The study was designed to recruit 800 ovarian cancer patients. Basic genetic counselling workshops were held for 68 non-genetic clinicians including gynaecologists, oncologists and clinical geneticists from 23 hospitals across Malaysia. Patients were either directed to counselling by a trained non-genetic

clinician in their local hospitals in a clinical programme led by Professor Yin Ling Woo (MaGiC's lead clinician), or to counselling by a genetic counsellor or clinical geneticist in a programme led by Professor Meow Keong Thong (lead clinical geneticist at specialised centres in Kuala Lumpur).

All blood samples were analysed for BRCA mutations by the Cancer Research Malaysia led by Dr Joanna Lim who is the diagnostic lead. Patients receive pre-test counselling, followed by test results and post-test counselling. After both pre- and post-test counselling, they were interviewed by a researcher over the phone to assess feasibility and psychosocial impact of the experience. Interviews were based on scales adapted for use in Malaysia. These included the Genetic Counselling Satisfaction Scale, the Decisional Conflict Scale, the Psychosocial Aspects of Hereditary Cancer (PAHC) questionnaire, the Distress Thermometer and the Cancer Worry Scale. Interview results were compared between the two study arms.

Two years into the study, 700 patients have been counselled and provided with genetic testing. 90 (13%) patients were identified to have BRCA mutations. "Around 13% of those tested were BRCA mutation carriers which is similar to that found in other populations," said Yoon. "We found carriers throughout the country and are working with local clinicians to establish protocols in local hospitals that have not managed patients with known BRCA mutations before".

In terms of feasibility, patients in local and specialised counselling arms were equally satisfied or very satisfied with the counselling they received. The local counselling arm has



been recruiting patients more quickly than the specialised arm. "Patients seem to prefer local appointments, so if they are referred to another centre for genetic counselling, they seem less likely to attend" said Yoon.

Preliminary results show that the answers to the psychosocial surveys were similar between the two groups. Most patients were satisfied with their counselling experience, felt informed about their choices and found it easy to decide to continue with genetic testing. Yoon mentioned, "These are preliminary results but mainstreaming of genetic counselling in Malaysia may be a feasible model to improve access to genetic testing services or patients with ovarian cancer. If successful, this model could be adopted for other cancers and in other parts of Southeast Asia".

"Cancer is still a taboo subject in Malaysia and there is a fatalistic attitude to hereditary conditions" continued Yoon. "Genetic information can cause conflict in families and the data we are collecting on the psychosocial impact of genetic testing will provide insight into the psychosocial challenges. With this knowledge, we can focus on interventions to overcome these challenges".

Commenting on the study, Prof Woo said, "In the past, genetic testing in ovarian cancer was limited to a small number of patients with the aim of identifying relatives at risk. Now that there is a drug to treat cancer patients with BRCA mutations, genetic counselling and testing is recommended for all patients with epithelial ovarian cancer. This has increased the number of patients who qualify for testing and specialised centres may become overloaded".

"Mainstreaming genetic testing and counselling to local hospitals is a strategy to cope with this increased volume of patients" continued Prof Woo. "This is ideal for a large country like Malaysia where specialised centres are concentrated in the capital, yet the majority of the population live elsewhere. Patients found to have a BRCA mutation still need to be referred

to a specialised cancer genetic clinic, but it becomes a smaller group".

"This study shows that moving the genetic counselling process to the community may be feasible and could be rolled out across Malaysia. It also is a model for other countries in the region to follow" said Prof Woo.



# Premature Ovarian Insufficiency (POI) – At A Glance



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Premature ovarian insufficiency (POI) affects 1 in 10,000 women by the age of 20 and one in 100 by the age of 40 years<sup>1</sup>. POI can be referred to as either primary ovarian insufficiency or premature ovarian insufficiency. It is characterised by a triad of 4-6 months of amenorrhoea, high levels of gonadotropins and low levels of oestradiol in women before the age of 40<sup>2</sup>. Formerly known as premature ovarian failure or premature menopause, the condition could be transient or progressive. POI is postulated to be due to three mechanisms; i.e., congenital decrease in primordial follicles, accelerated follicular atresia and the inability to recruit primordial follicles<sup>3</sup>. However, for most of the 74-90% of cases, the cause is essentially unexplained<sup>4,5</sup>. Multifactorial in aetiology (among the identifiable causes of POI) are genetic, autoimmune, metabolic dysfunction, infectious and iatrogenic<sup>6</sup>. Classical presentation is with oligo- or amenorrhoea. Some may show symptoms of oestrogen deficiency. Diagnosis of POI is life-changing and crippling as it negatively impacts physical and psychosocial aspects. Osteoporosis, accelerated cardiovascular aging, neurocognitive disorders and infertility are among the long-term effects due to oestrogen deficiency in POI. In 5-10%, varying degrees of residual ovarian function may still exist, thus they may be able to conceive spontaneously<sup>7</sup>. To date, there are still no available biomarkers to accurately predict POI. Although proper diagnostic accuracy is lacking, the POI Guideline Development Group (GDG) recommends the following diagnostic criteria:<sup>8</sup>

- i) oligo/amenorrhoea for at least 4 months, and
- ii) an elevated FSH level > 25 IU/l on two occasions > 4 weeks apart.

Investigation-wise, chromosomal analysis and karyotyping are crucial to be sent for to all non-iatrogenic POIs such as Turner's syndrome. Fragile-X pre-mutation testing is warranted. Screening for 21OH-Ab (or alternatively, adrenocortical antibodies (ACA) and thyroid (TPO-Ab antibodies) should be performed in women with POI of unknown cause or if an immune disorder is suspected<sup>8</sup>. Due to prolonged oestrogen deficiency, bone mineral density (BMD), (BMD) testing is indicated as well as diagnosis; especially if ovarian insufficiency is suspected to have occurred for a long period and once treatment commences, repeated within 5 years<sup>10</sup>.

The sequelae for POI include psychological distress and low self-esteem as a consequence of the life-altering diagnosis<sup>9</sup>. Hence, explaining the diagnosis should be done face-to-face and not via telephone. Referral to a psychologist and continuous emotional and social support are essential<sup>9</sup>.

Women with POI due to Turner's syndrome require a full work-up and referral to cardiologist, endocrinologist, geneticist (especially if there is Y chromosome) as well as to the ENT, ophthalmology specialists and psychologists. The presence of a Y chromosome requires a gonadectomy to be performed. Thyroid function tests should be done annually and the patients monitored for hypertension. They should also be counselled on the increased risks of impaired glucose tolerance and liver problems.

Hormone replacement therapy (HRT) is indicated in women with POI to induce breast development and menstruation in those with delayed puberty and also for maintenance of cardiovascular and bone health<sup>9,10</sup>. HRT should continue until the age of natural menopause; i.e., around 50 years of age. The reader is advised to read other articles on POI regarding the recommended HRT regimes for women with POI as this is beyond the scope of this article. Calcium and vitamin D supplementation as well as maintaining a healthy lifestyle are advocated for bone health. Local oestrogens may be required for dyspareunia and genito-urinary symptoms<sup>10</sup>.

Due to the possibility of spontaneous conception, women with POI who wish to avoid pregnancy may require contraception in terms of barrier method or possibly an intrauterine device<sup>9</sup>. Nevertheless, this is a rare occurrence and women with POI need to be counselled that as yet, there are no interventions to increase ovarian activity and conception rates<sup>10</sup>. Fertility options include adoption, foster parenthood, oocyte donation and embryo donation; depending on religious and local laws. Women with Turner's syndrome have very high obstetric risks thus, if they wish to conceive, they should be referred to a cardiologist for evaluation as well as have a general and medical assessment prior to conceiving<sup>10</sup>.

There is presently a lack of sufficient high-quality evidence for long-term interventions on women with POI; this should also be explained to these women<sup>9,10</sup>. Much research is being carried out at present. It is hoped that these studies will provide guidance in future. Such women require multidisciplinary care and a lot of emotional support as this diagnosis is devastating. The PAG unit in HCTM UKMMC has noticed a worryingly increasing trend of patients referred to us for primary and secondary amenorrhoea due to POI. We are active in conducting research on POI and look forward to presenting our results soon.

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# Non-Descent Vaginal Hysterectomy (NDVH): Should All Hysterectomies For Benign Conditions Be Performed Vaginally?



**Assoc Prof Dr Zalina Nusee**

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The vaginal approach is the natural route of excellence, also known as “natural orifice hysterectomy” or “no scar hysterectomy”. It seems to be the current trend in minimally invasive context for urogynecological procedure, which follows all criteria of minimally invasive surgery. Vaginal hysterectomy (VH) is a long-practiced procedure since the fourteenth century (Berengario de Carpi, 1470–1550). Non-descent vaginal hysterectomy (NDVH) was introduced later in 1934, pioneered by Haeney. In the United States, the trend is now more towards NDVH, especially with the presence of new tools (vessels sealing device), new techniques and changes in contraindications of the procedure.

The American College of Obstetricians and Gynaecologists (ACOG 2017) strongly recommends that VH is the approach of choice whenever feasible for all benign gynaecological conditions. The Cochrane

**Table 1: Indications for NADVH**

Indications	Percentage (%)
Uterine fibroid	56.7
Endometrial hyperplasia	21.3
Adenomyosis	7.3
Chronic cervicitis	6.0
DUB	6.0
CIN	2.6

*Dhivya B & Gharphalia D et al.; J Clin Diagn Res, 2016*

**Table 2: Advantages of NDVH compared to other approaches**

Abdominal	Laparoscopic
<ul style="list-style-type: none"> <li>• Less surgical time</li> <li>• Fewer post-operative complications</li> <li>• Less painful post-operative recovery</li> <li>• Fewer hospitalisation days</li> <li>• Less social cost</li> <li>• Lack of scar complications</li> <li>• Less risk in cases of other associated diseases</li> </ul>	<ul style="list-style-type: none"> <li>• No significant difference in post-operative recovery</li> <li>• More rapid learning curve</li> <li>• No complication related to pneumoperitoneum/ trocar</li> <li>• General anaesthesia is not mandatory</li> <li>• Fewer cost: less sophisticated equipment's &amp; logistic</li> </ul>

Systematic Review (2005) based on 47 studies concluded that VH has the best outcomes compared to abdominal and laparoscopic route. International Society for Gynecologic Endoscopy (ISGE) also concluded that NDVH is the best choice for many gynaecological patients where hysterectomy is indicated. However, it is difficult to explain why VH is not preferred globally among surgeons, including in Malaysia.

Advantages of the vaginal route include less surgical time. Closing the abdominal wall is also not required; therefore, there is less risk of post-operative wound complications. The incidences of post-operative paralytic ileus, flatulence and adhesions are diminished due to minimal peritoneal incision and handling of intestines. Post-operative recovery is less painful and much faster. Compared to laparoscopy, it does not require general anaesthesia, has a faster learning curve and has less risk of ureteric injury. VH requires less sophisticated instruments and logistics, therefore it involves very minimal cost.

The literature clearly reveals that VH can be accomplished in 94-97% of cases with the absence of uterine prolapse (Pierluigi et al., 2004). Surprisingly, for years, most surgeons have classified vaginal hysterectomy as a procedure limited to uterine prolapse. This reflects the ignorance of many concerning the updated literature. Treatments are considered unprofitable for the industry, hence had gained inadequate support.

The conditions that led surgeons to believe that the vaginal route is not a suitable option includes no prolapse, big uterus, history of caesarean or pelvic surgery, nullipara, no vaginal delivery or the patient needs an oophorectomy. The fact that these are just simple myths must be pointed out. It is actually the surgeon's experience and skills that play the decisive role. Common challenges that surgeon may encounter include: inadequate exposure and visualisation (especially in virgin vagina or nulliparity), entering the cul-de-sac, securing vascular pedicles in limited space, adhesion due to previous surgery, removal of big uterus, the need of oophorectomy and the

presence of extrauterine pathology. The proper positioning of the patient, good lighting, good retractor and use of vessels sealing systems make NDVH easier. When facing a large uterus, Morcellation techniques, which were widely known since 1880-1890, provide the possibility to overcome surgical limitations. The techniques include bisection, coring, myomectomy, wedge resection, spiral incision, cervical amputation and cervical wedge. Usually, these techniques are used in combination.

Prior to the removal of a large uterus, preoperative sonography is very useful and important to further confirm the diagnosis (fibroid or adenomyosis) and obtain details on fibroids, adnexal pathology and calculation of uterine volume. Antero-posterior and transverse diameter of the uterus is very important to determine the uterine-free pelvic space for operative manoeuvrability. Uterus size of 18 weeks by clinical palpation can be easier to remove compared to a 10-week size uterus but with wider transverse diameter/high volume.

Concomitant oophorectomy is successfully done in 94% of cases. The operating time increases by less than 30 minutes with no added complications (S.S Sheth, 1991; Pierluigi et al., 2004). Special equipment may be needed such as ovarian clamp, headlight and long roller gauze pack. Oophorectomy is easily performed using "the round ligament technique" introduced by Magrina JF (1999).

Preliminary laparoscopy has a role in the pelvic assessment for suspicious extra-uterine disease such as adnexal

**Table 3: Patient's selection criteria**

**Guidelines on the Selection of the route of hysterectomy as recommended by ACOG 2017**

1. Size and shape of the vagina and uterus
2. Accessibility to the uterus (e.g., uterine descent, pelvic adhesions)
3. Extent of extra uterine disease
4. The need for concurrent procedures
5. Surgeon training and experience
6. Available hospital technology, devices, and support
7. Case is emergent or scheduled
8. Preference of the informed patient

**Table 4: Contraindications for NDVH**

**Traditional**

- Previous pelvic surgeries
- Present of adnexal mass
- Nulliparity/no prior vaginal delivery
- >12 weeks size uterus
- Pelvic pain
- Endometriosis
- Inaccessibility - arch < 90° vaginal stenosis
- Malignancy

**Evidence based contraindication**

- Malignancy
- Undiagnosed pelvic mass
- Inability to access uterine vessel



pathology, severe endometriosis and adhesion. Transvaginal endoscopic oophorectomy (TVEO) is useful to remove highly located ovary.

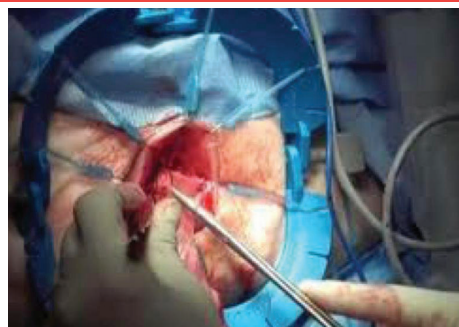
The approach is aborted if there is no further descent despite morcellation and inability to control profuse bleeding during morcellation. Complications are rare even with "difficult" cases, which includes haemorrhage prior to morcellation. Others such as vault haematoma, urinary tract infection and backache did not significantly increase (Gitsch G et al., 2004). The risk of ureteric injury is rare compared to laparoscopic surgery.

**CONCLUSION**

NDVH is the least expensive and invasive procedure with the lowest morbidity risk and the most rapid post-operative recovery. It is safe and feasible in the hands of trained, creative and determined vaginal surgeons. A thorough pre-operative assessment and examination prior to surgery is important. Debulking procedure is safe and it can be accomplished via vaginal route in most cases. Patients should be informed about the best options available and be involved in the decision making.



Lone star retractor for better visualisation



Vessels sealing device



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# Aesthetic Gynaecology – The Unspoken Revolution

Does aesthetic gynaecology merely refer to designer vaginas? Or does it go beyond that? Does it harm rather than heal?

Dato Dr Mohamad Rafi Mohammed Feizal

Founder of Hospital UMRA

Special interest in fertility, Sexual Health & Aesthetic Medicine



Indeed, there is much confusion, concern and great debate about this. While many have chosen to ignore this subject in its entirety, the inconvenient truth is that Aesthetic Gynaecology is actually a sub-component of our speciality that may actually provide health benefits to women. The fact of the matter is that our ignorance may be largely due to our lack of understanding of the intricacies of aesthetic gynaecology. This article is not meant to sing the glories of aesthetic gynaecology but to instead plead the case that we as a fraternity should be open to assessing its virtues in balanced manner.

A primary concern, especially with the purists amongst us, is that we believe that doctors are trained to treat and heal diseases. To them however, aesthetics is nothing more than simply beautifying something that is already perfect. Therefore, as there is no 'disease' to be treated, there is no 'doctoring' to be done!

The truth is that aesthetic gynaecology has a role to play in many situations.

Women who have been forcibly subjected to female genital mutilation grow up realizing that they have been butchered. Treatment is therefore not merely about removing the scar tissue. It is also to rectify the damage that has occurred over many years and bringing back the form to as close as possible as nature had intended.

Others may have suffered severe trauma following vaginal birth that has not been repaired adequately or where healing was complicated by infections. These women actually come to us dissatisfied years later, complaining of pain and disfigurement. Certainly, there can also be a psychological component to their symptoms but many can be helped.

And there are yet other women who present with a myriad of complaints. Who are we to judge if these complaints are based on 'true' pathology or 'perceived' pathology? Certainly, many of these women can also be helped. After all, aesthetic gynaecology is not only about using lasers but actually includes surgery to repair disfigured perineums, the correct and timely utilization of threads, fillers, fat transfers and possibly also PRP (but this is debatable in Malaysia). Even simple hair removal at the genital area and bleaching offers patients great psychological help. Vaginismus, which can provide a formidable strain on a marriage can now be treated with botulinum injection into the pubo-coccygeous muscle which is also the domain of aesthetic gynaecology.

Therefore, aesthetic gynaecology is not only to beautify, but it is also to improve the form and function of the female genital. Last but not least, aesthetic gynaecology is very prominent in its role in sexual dysfunction especially to increase sexual gratification. There have been much said about vaginal tightening. There are also procedures that can be done to amplify the G-spot in order to achieve higher sexual gratification.

However, whenever a procedure is being done, regulation is important because we need to be aware of the capabilities of the different machines that are available especially when usage of lasers are involved as the different modalities used can have varying effects, consequences and complications.

Training in aesthetic gynaecology has now become a contentious issue that needs to be addressed with urgency. There are at present no clear guidelines on training requirements nor regulations for doctors performing these procedures. This inevitably leaves a lot of room for mishaps, which needless to say, will give fraternity a bad name. We must therefore, recognize that although aesthetic gynaecology is a relatively new area, it is rapidly expanding due to an incredibly high demand. We as a fraternity must initiate clear guidelines that ultimately protects both the patient and the doctor.

At present, due to lack of direction from the Gynaecology fraternity, it would appear that the bulk of the gynaecological aesthetic work is by default being carried out by the general practitioners or even by many individuals without medical qualifications. It is therefore not surprising that errors and complications are becoming common. It would therefore seem only logical that the fraternity formalize a working group that can initiate a thorough review of the situation, discuss with the Ministry of Health on what an ideal training program should look like, prepare guidelines and to perhaps actually run training programs for interested members of the fraternity.

Lastly, it is entirely expected that any new field in medicine is greeted with much skepticism. The same problem greeted the fertility fraternity at the beginning. However, now the situation is dramatically different. They would not have achieved their current level of maturity without regulation. The field of aesthetic gynaecology has got the same potentials. It will help women to empower themselves and feel great about themselves, through many ways. It is time to take the bull by the horn and take the lead in this new exciting field!

# ICOE Report

## (Jan – June 2019)

Dr Gunasegaran PT Rajan  
ICOE Steering Committee



### 1. ICOE

A total of 11 ICOE activities were successfully conducted locally and overseas training 57 midwives and 165 doctors. The summary is in the table below and it continues on a punishing schedule averaging almost 2 courses monthly.

Nepal	15 – 17 Feb	24
Malaysia - Doctor	23 – 24 Feb	24
Malaysia -Midwives	16 – 17 Mar	29
Laos	30 – 31 Mar	29
Malaysia -Doctors	27 – 28 Apr	20
Mongolia	19 – 22May	23
Cambodia	8 -9 June	20
Malaysia-Midwives	15 – 16 June	28
Vietnam	29 – 30 June	35
<b>TOTAL</b>		<b>222</b>

### 2. Up scaling of regional courses

Laos, Cambodia and Mongolia are capable of conducting ICOE themselves with minimal supervision. The overseas trainers are competent and OGSM needs to only send minimum trainers to oversee the quality. They still face challenges in seeking funding to conduct the course as well as funding to purchase equipment. Laos is the best example of up scaling where they are gradually purchasing equipment and the success there is clearly from good leadership. Cambodia is the least successful in funding and we may have to relook at the MOU on whether to continue.

### 3. ICOE Handbook.

The book has sold 1820 copies both in Malaysia and overseas and the 3rd reprint for another 1000 copies is in progress. There is a strong interest from China for the handbook and the Mandarin translation is in the final stages. Discussions are continuing with the Laerdal China who is undertaking this project on protecting the copyright and royalty of the handbook

### 4. AFOG

AFOG continues to support and endorse the ICOE in Nepal, Laos, Cambodia and Mongolia. The senior officers actively engage with overseas ICOE by being present at the courses and the OGSM is grateful for this genuine commitment. There is a good likelihood this endorsement for regional work will continue for another 2 years until 2021 which is a testimony on the consistent quality of the course.

### 5. Laerdal China

Laerdal China has observed ICOE in Kuala Lumpur and they are very keen to roll out the ICOE in China. Discussions are ongoing and strategies are being discussed on the module, funding, copyright and proceeds from the sale of the handbook. This will be an important project if it takes off and the demand on the trainers will be even more challenging.

### 6. Japan

ICOE was invited to conduct a pre-congress workshop on Complicated Caesarean in Nagoya during the annual O&G Congress. This is the second time we are invited with funding taken care of by the Japanese organization.

### 7. China

ICOE was invited to conduct a workshop on PPH and Complicated Caesarean during the annual Medical Simulation Congress in GuangXou. A total of 38 participants attended this hands on course conducted with our trainers who were fluent in Mandarin.

# Menopause Sub-Division Report



Dr. Premitha Damodaran  
Consultant Obstetrician and Gynaecologist

The idea to start a CLINICAL PRACTICE GUIDELINE for Menopause Management in Malaysia was conceived soon after the last MISCOG. As the last CPG on Hormone Therapy was done in 2012, there was certainly a large void to be filled with new emerging trends, new research and a better directed approach to managing the menopausal woman.

This CPG is a joint venture between the OGSM and the Malaysian Menopause Society and funded by a total of 11 pharmaceuticals who are involved in the management of a menopausal woman. The first meeting was held on 12.08.18 and a total of 7 meetings have been held to date all in the OGSM offices.

On the 24th of February we had a representative from the MOH, Dr. Mohd Aminuddin who helped give us a clear outline of the various aspects we need to look for, how the CPG has to be written, the disclosures, the referencing and various other aspects. This gave us a clearer guideline to what needed to be done.

The compilation of data of the CPG is complete. What is needed and is an ongoing process presently is:

1. Correction of the text material
2. Filling of the missing links
3. Referencing
4. Search material data as requested by MOH
5. Review by internal (7) and external reviewers (2)
6. Submission to the CPG board.

Unfortunately this last process is tedious and may take the longer time frame. We are hoping to bring it out in the next 6 months.

The core working committee is as follows: Dr. Premitha Damodaran (Consultant ObGyn and Chairperson), Dr. Ho Choon Moy (Consultant ObGyn, President MMS), Dr. Ng Beng Kwang (Consultant ObGyn, UKM Medical Centre), Dr. Raman Subramaniam (Consultant ObGyn, FMG), Prof Emeritus Dato Dr. Nik Mohd Nasri (Professor of ObGyn, University Sains Islam Malaysia), Prof SP Chan (Consultant Endocrinologist, SJMC), Professor Jamiyah Hassan (Professor of ObGyn, University Malaya Medical Centre), and Professor Dr. Nik Haslina Nik Hussain (Professor of ObGyn, University Sains Malaysia).



## Part 2 Simulated Course

The Part 2 simulated exams were held on the weekend of 15-16 June. In response to the feedback from participants from the previous course, we extended the course to two days. It allowed for better discussion as both the trainers and participants were not exhausted. Overall, the course was well received. Special thanks goes out to Dr Ashley Chung Soo Bee and her team for coordinating the course and forming all original questions for the course. Look out for our next PACT endeavour, the trainee update in 'Labour Ward Management' which will be held on 6 July 2019

## Report On "OGSM Research Workshop 1: Road To Successful Publications In Obstetrics & Gynaecology"

By Assoc Prof Dr Ani Amelia Dato Zainuddin

Venue: Makmal Terabyte, Dome 1&2, UKM Medical Centre, Cheras, Kuala Lumpur

Date: 2nd March 2019

This research workshop series is the start of a collaboration between OGSM and the Dept. of O&G, UKMMC, to create a series of workshops that can provide guidance to the O&G fraternity; especially the young ones who are interested in conducting research and publishing their study results or case reports of their clinical work. Publishing is not only relevant to academics but also to clinicians as it is evidence of their continuing professional development. They can share experiences with others in the field which will help those facing similar clinical situations. Publishing improves a doctor's reputation in practice and can widen his/her network.

Since this is the first time such a workshop has been conducted, we decided to test the waters by focusing on how the O&G fraternity can publish as many completed studies and interesting clinical cases which have not yet been published. The workshop was conducted in a relatively new computer lab in the Preclinical Block of UKM Medical Centre. Each participant had his/her own desktop to work on their manuscripts during the sessions.

The lecture topics ranged from an overview to publishing to how to conduct literature search and review, how to report different types of work, how to report statistical results, how to write case reports and even qualitative studies. These talks were given by experienced lecturers who had extensively published various works. They are experts in their respective fields and from different areas of Medicine. Dr Ixora also went over common mistakes made in writing to guide participants to avoid such issues and to ensure successful publications. The afternoon session was a review of several manuscripts prepared by participants to help improve them before submitting to their chosen journals.

The first research workshop was a success; the participants included were not only O&G trainees, but also sonographers and experienced consultants. Everyone who participated had a great learning experience. We look forward to the second research workshop which will focus on "Writing an Impactful Proposal" planned to be held on the 29th of June at the same venue.

# And finally....



Dr Eeson Sinthamoney

Our term in office ends in a few days and it is therefore the perfect opportunity to ponder on what we have accomplished, what is still a 'work-in-progress' and perhaps consider the 'missed opportunities' as well. We are indeed fortunate that the term has progressed well, as we had from the onset, decided on the two key areas of focus for the year.

The first, was to facilitate the further growth and development of the various subcommittees. We therefore began the term by appointing new chairpersons to several committees and reappointing incumbents to the others. We then met with several of them individually to discuss their roles and the manner council could assist them in their endeavors.

The 'Out-patient Gynaecology' subcommittee was revamped and aptly rebranded 'EPOG', thereby reflecting the reality that this was the committee that would engage with the vast majority of the fraternity. Similarly, the trainee program was thoroughly reassessed and a consensus on their rightful objective reached. The new program was renamed PACT and from the very onset took off like a rocket! Most of the other subcommittees also raised their game, most notably being the Menopause and Medico-legal subcommittees. Certainly, the iCOE team persisted with their extremely hectic pace while the other subcommittees were kept busy in the usual manner. Suffice to say, it has been an incredibly busy year.

The second area of focus was to 'engage' with the membership. This was a somewhat more multifarious task due to our large numbers, diverse outlooks and disparate perceptions. The reengineered newsletter was well accepted. The sheer number of articles being submitted is a testament to this reality.

We did however encounter specific difficulties, some anticipated, others perhaps not. Fortunately, we were able to negotiate these impediments without much collateral damage. We would like to believe that we have fulfilled our 'caretaker' role satisfactorily and perhaps helped set some new benchmarks.

Finally, in parting, I believe that we must actively identify fittingly motivated and talented young members to energize our agenda. To enable this, we must reach out to them through the innumerable programs that we oversee. Only then can we aspire to reinvigorate the Society and allow it to truly achieve its full potential.

# MDM SECURE INSURANCE SCHEME



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