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August 2021 (Issue 4, Council 2020/2021) EMBRACING, ENGAGING & INFORMING


## The Use Of Genomic Tests In Prenatal Diagnosis

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INSIDE INBOX

A publication by the Obstetrical and Gynaecological Society of Malaysia

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# The Use of Genomic Tests in Prenatal Diagnosis

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## Introduction

About 3 to 5 % of babies are born with a birth defect and about one fifth of stillborn babies have a birth defect. Based on data collected from a population-based study, Feldkamp and colleagues[1] in 2017 were able to show that 20% of foetal malformation was caused by chromosomal aberration. When a structural abnormality is found on ultrasound scan, an amniocentesis or a chorionic villous sampling is offered. Karyotype abnormalities are expected in 8% to 10% of cases. However, microdeletions or micro-duplications are found in another 6.0%. Overall, QF-PCR will identify 30% of autosomal trisomy. Chromosome microarray analysis (CMA) detects imbalances of up to 6.5% of structurally abnormal foetuses. That leaves two thirds without a proper genetic diagnosis[2].

Although diagnostic rates do vary across studies, WES (whole exome sequencing) has emerged as an invaluable test to have when counselling patients. However, about 60% of these pregnancies do not have a proper genomic diagnosis to guide clinicians to a better understanding of the underlying pathology which will optimise perinatal management and prognosticate the pregnancy[3].

Technological advances in genetics have been dramatic in the last few decades. Genomics is a sub-discipline of genetics and it is devoted to the mapping, sequencing, and functional analysis of the human genome.

Genomics, the study of genes and their function, has transformed medicine in many ways. Towards the end of 2018, the Human Genome Project[4] sequenced its 100,000th genome with an aim to harness the whole genome sequence to uncover new diagnoses. Invariably, it would improve subsequent patient care management. This is crucial for those with rare, inherited conditions and various forms of cancers. It spurred the interests on advanced testing in cases of foetal anomalies.

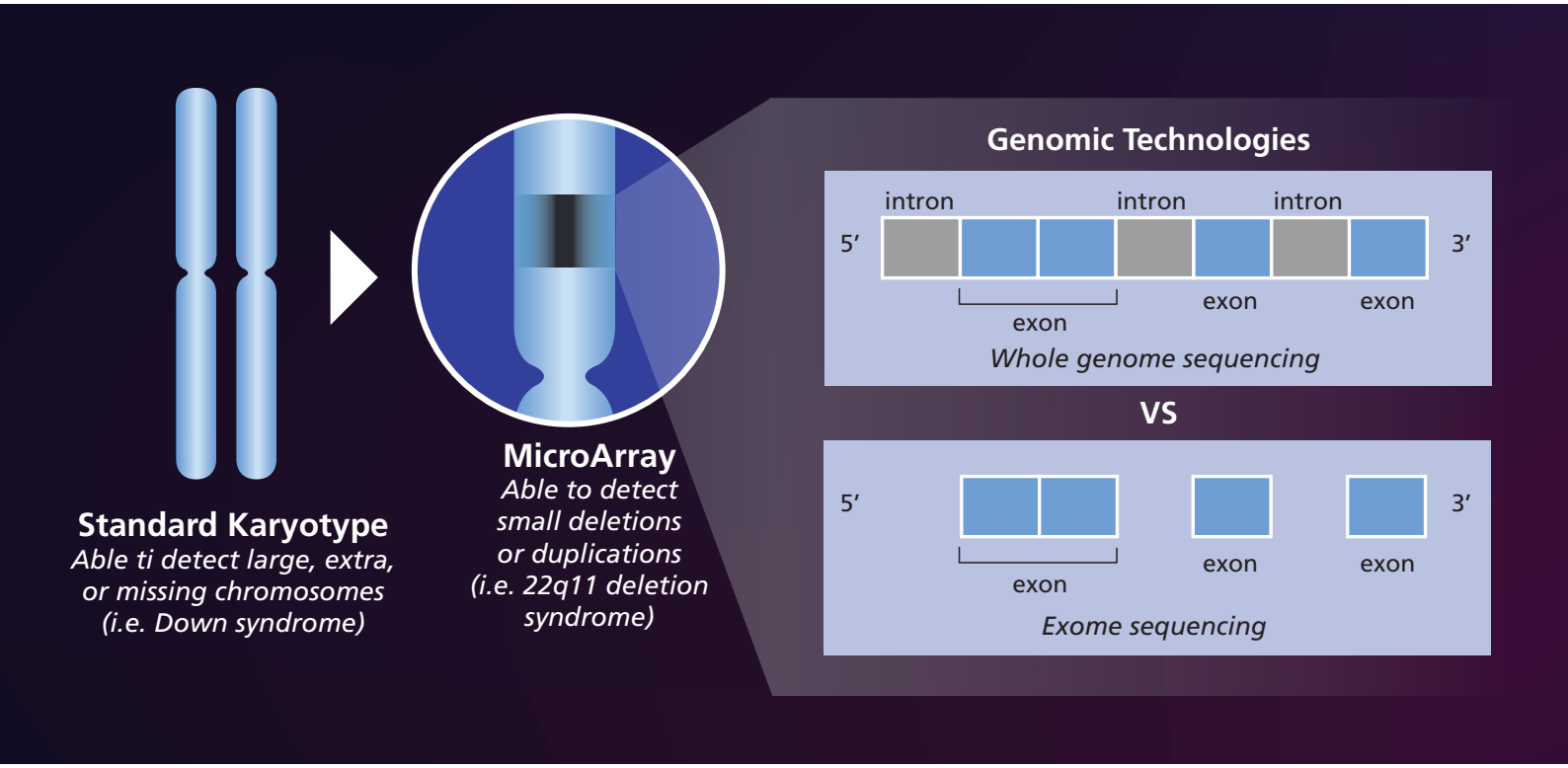


*Figure 1: shows the range of genomic array of tests that are available for us to use.*

The causes of birth defects are not known in 80% of cases. Of the 20% of the known causes, they tend to be multi-factorial. We are increasingly seeing a genetic cause as aetiologically responsible for congenital defects as the human genome project database advances.

This review discusses the new and more advanced genetic tests, what they are, when it would be best used and what is locally available. It will highlight the benefits and limitations of these genetic tests and what the tests results mean and how they should be interpreted in the light of the clinical scenario faced. The current test options would include conventional karyotyping, Chromosomal microarray analysis (CMA) and the targeted gene specific molecular testing in a suspicious disorder (or the monogenic disease).

## The evolution of the advanced genomic tests.

Prenatal diagnosis of chromosomal abnormalities has been offered since the 1960's. In the last 50 years, cytogenetics had been considered the cornerstone test by the standard G-banding of the conventional karyotype. Karyotyping to visualise mega base-scale copy number variants (CNV's) and balanced chromosomal abnormalities was pivotal of cytogenetic testing for several decades. Newer diagnostic algorithms have developed over the years, designed to detect the clinically significant and can pick up extra (or duplicated) or deleted (or missing) segments aka CNV's.

In the early 2000's, microarray had shown its usefulness with a 6.0 % diagnostic yield in picking up microscopic CNV's because of its higher resolution platform used CMA is like the traditional karyotype but with higher resolution, which will detect the major chromosomal imbalances such as in aneuploidies and in unbalanced rearrangements. CMA uses array comparative genomic hybridisation (CGH) or single nucleotide polymorphism (SNP) array to investigate the foetus with structural birth defects.

These small imbalances involve specific genomic regions that are associated with a poor clinical outcome. However, not all CNVs are associated with adverse clinical outcomes, and its significance may be unknown.

In prenatal diagnostic samples with a normal karyotype, CMA will diagnose a clinically significant mutation in approximately 1.0% of structurally normal pregnancies and it increases to 6.0% in those foetuses with a structural anomaly detected on routine ultrasound scan.

## The limitations of CMA are known.

MA does not detect 1) Single gene disorders (point mutations) 2) Small or deletions such as fragile X syndrome. 3). Balanced rearrangements of chromosome (balanced translocations, inversions). 4) Most CMA cannot detect mosaicism below 20-25%. 5) It cannot detect excessive homozygosity or triploidy.

It was in the last decade that genomics was introduced to prenatal diagnosis. Whole-Genome Sequencing (WGS) is a next-generation sequencing technology that analyses the entire genome, including non-coding and coding regions.

From 2012, next generation sequencer (NGS) became widely available for use in genetic labs. It boasts of being able to analyse the entire genome, all at the same time. It is comprehensive and very thorough. The Sanger's NGS then became available as a new and powerful tool in the armamentarium of genomic testing, used to interrogate the entire genome. This approach aims to identify "genetic variants" or "sequence variants" which may be pathological can alter protein sequences. WGS entails sequencing all coding (exons) and non-coding (introns) nuclear DNA as well as mitochondrial DNA. The costs are much lower by comparison to the older methods of whole-genome sequencing. WGS sequences the complete DNA of an organism. In humans, there's about three billion base pairs of DNA.

By contrast, the Whole-Exome Sequencing, (WES), also a next-generation sequencing technology that analyses only the coding regions of a genome. It is offered when structural fetal anomalies are detected on ultrasound examination, the identification of monogenic abnormalities defining prognosis and recurrence of anomalies[8]. Routine WES will enable more molecular diagnoses of the aetiology of genetic variation in the foetuses with structural anomalies when compared with the older conventional cytogenetic methods[9]. Prenatal Exome Sequencing may have significant impact on clinical management, some of which would not be possible if testing is deferred until after birth[10].

The PAGE study (Lord et al 2019) reported a clinically significant genetic variant in 8·5 % of foetuses, with an additional 3·9% of foetuses harbouring variants of possible [8.5+3.9%=12·4% in total] clinical significance, and the study by Petroski et al (2019) found diagnostic genetic variants in 10.3 % of fetuses.

| Test | CMA | RPL | Petrovski et al 2019 | Lord et al 2019 | Stillbirth |
|---|---|---|---|---|---|
| Diagnostic yield (%) | 6.0 | 50.0 (+4.5) | 10.9 | 8.5 (+3.9) = 12.4 | 20 |

*Table 1.1 The diagnostic yields for conditions showing the variability of the results.*

**Other indications**: Pregnancy loss

According to WHO, there were 2.6 million stillbirths in 2009, that is, 8200 deaths per day. Stillbirth affects about 1-2% of pregnancies in the United States. There are two areas that demand our attention and consideration.

1) Perinatal fetal demise or stillbirth or perinatal losses is always devastating to a mother, and it is crucial within the framework of good antenatal care is to use the advanced tools to look for a genetic cause for the demise. In an infant who is stillborn, about 20 % will have a birth defect. The authors concluded that an autopsy including micro array analysis will improve the counselling of the parents about risks in future pregnancies[10, 11, 12].

2) Recurrent Pregnancy Loss (RPL) affects 1 to 5% of couples. Up to 50% of the products of conception (POC) in RPL have gross genomic rearrangements. Couples with RPL experienced an additional 4.5 % increase in diagnosis after testing with WES.

Exome Sequencing is often favoured over WGS as it targets only coding regions (exons), which represent 1-2% of the entire genome, but contains around 85% of mutations that cause genetic disorders.

Diagnostic yield means the proportion of patients in whom a medical technique yields a definitive diagnosis out of the total number of patients who receive the diagnostic procedure. In research, diagnostic yield is a common metric for reporting results and assessing testing.

## What do we look for?

**Copy Number Variants:**
Duplicated or deleted sections of DNA at least 1,000 base pairs in size that differ from a representative reference genome. CNV's can be deemed as pathogenic or benign to clarify clinical relevance.

**Variants of Uncertain Significance:**
VUS or VOUS or as variants of uncertain clinical significance (VUCS). VUCS are identified DNA changes that either cannot be characterized reliably as benign or pathogenic at the time of the study because of limited data describing outcomes in association with the changes or that are associated with a variable phenotype (because of incomplete penetrance or variable expressivity).

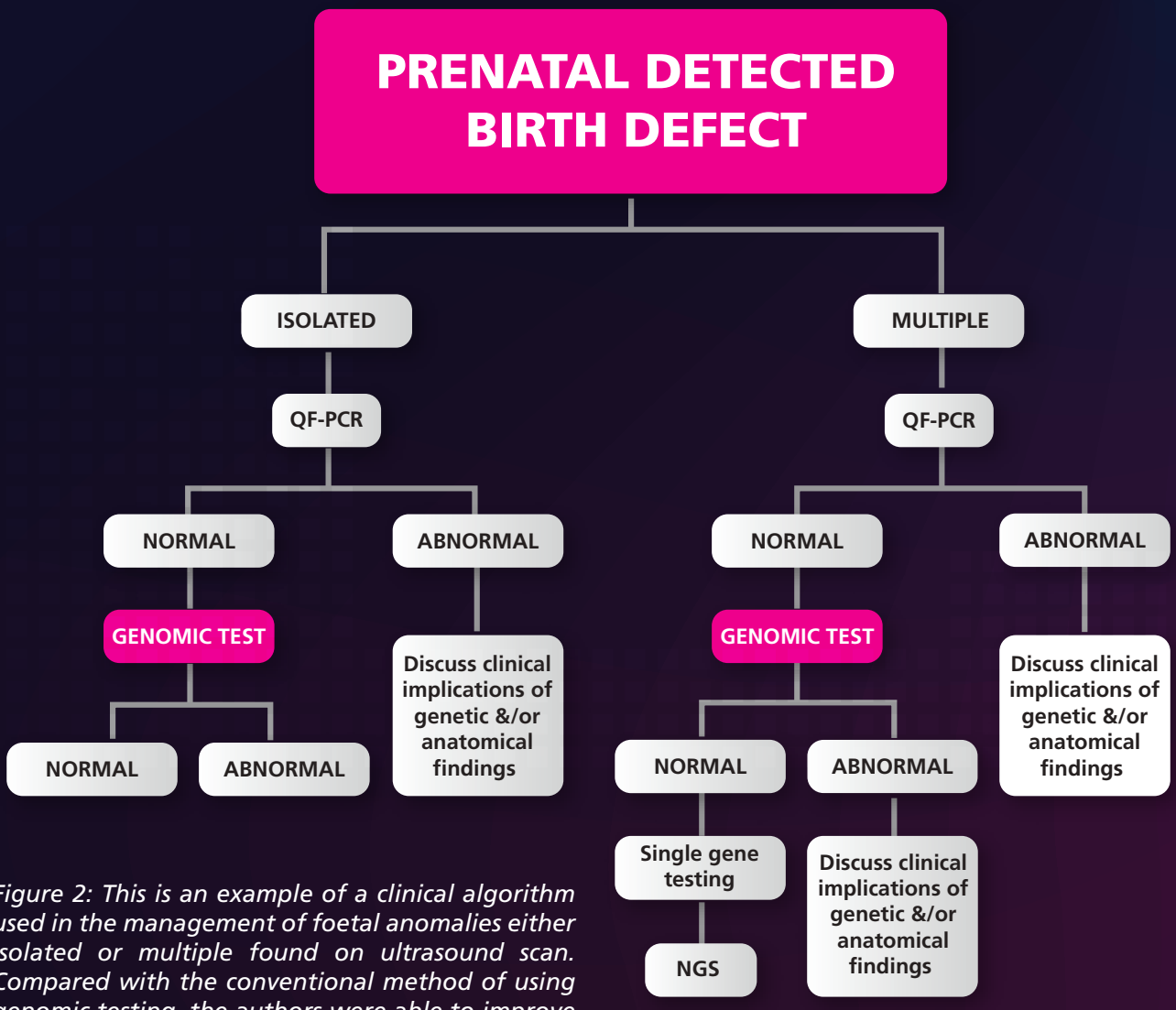


*Figure 2: This is an example of a clinical algorithm used in the management of foetal anomalies either isolated or multiple found on ultrasound scan. Compared with the conventional method of using genomic testing, the authors were able to improve the diagnostic yield to 50%*

## Conclusion:

The recent years have seen prenatal diagnosis of birth defects becoming increasingly frequent due to the adoption of the diagnostic ultrasound scan. The simultaneous advancement in genetics has propelled us to increase our diagnostic capabilities. Incremental increases of 10-30% in detecting a genetic aetiology is not uncommon.

Sequencing the foetal exome has not only become affordable but also, NGS has allowed a shorter TAT (Turn-Around-Time) with improved yields and diagnostic accuracies. This will make counselling of the parents easier and a less daunting experience, optimizing the management of such patients. One can look forward towards the non-invasive prenatal diagnosing with advancement towards non-invasive exome, whole genome sequencing and continued improvements in diagnostic yields.

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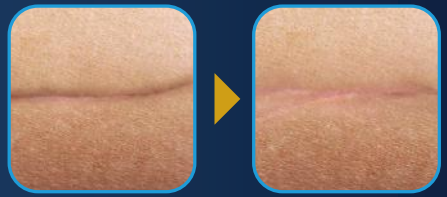

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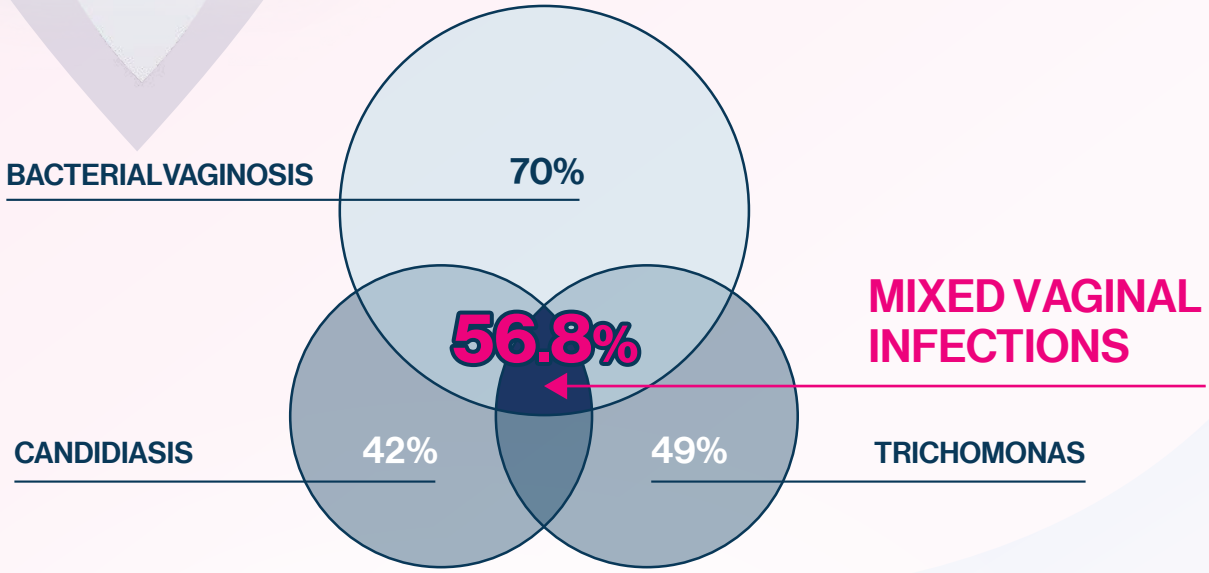


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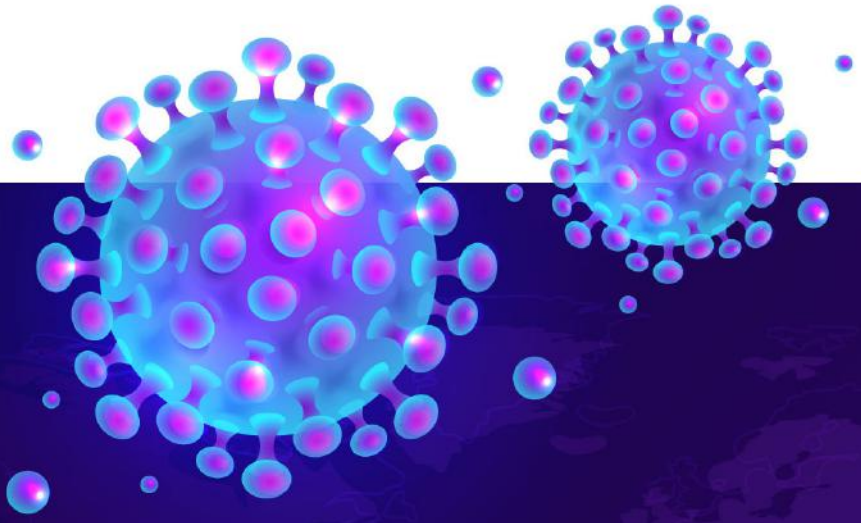

# From the President's Desk

Dr Muralitharan Ganesalingam
President 2020/2021

The world is in the midst of the toughest and most trying times, facing the deadly Covid pandemic. Be it either in a personal or professional capacity, one must renew and refresh the way we function and to keep ourselves and our practice relevant.

The pandemic caught the world by surprise and brought it to its knees. The impact is felt across all sectors, and no one is spared, least of all our medical professional bodies. Last year, we postponed our annual congress to July 2021 and had plans for at least a partial physical meeting, but even that did not materialize. Thankfully, a virtual scientific conference was successfully organized in September 2020, paving the way for the virtual congress this year.

Professional bodies such as ours traditionally played instrumental roles in providing advocacy, information, networking opportunities and professional advice. We also play a key role in education, training, and mentorship.

Traditionally, we organized meetings focusing on education and research. We targeted skills and career development and provided input in policy making. We also provided opportunity to members of the fraternity to experiment with novel equipment and technology. All these interactions occurred on a platform where physical interaction was the norm, in the form of industry-sponsored talks, physical workshops and seminars.

The pandemic has taken us to a digital age where we need different platforms to reach out and engage members and keep our professional body relevant. It was obvious that we would have arrived here anyway. It was only a question of time. The pandemic has only hastened the process.

OGSM needs to gauge the needs of its members. Senior member of the fraternity who form the most active group of members may have varying needs compared to the younger recruits and therefore may need a different approach to the dispensation of information.

From an organizational perspective, we will need to streamline operations to improve efficiency, better manage our finances and focus on longer-term sustainability to remain relevant. As a forward-thinking organization, we will need to embrace change and make difficult decisions. Reduced attendance at future meetings and declining revenue will be a reality, the impact of which may be phenomenal.

The most crucial area that needs to be addressed is Career Development and Personal Skills. The society must actively set up programmes where students and teachers can communicate, to enhance knowledge and skills as well as to discuss clinical problems and possible solutions. Wherever possible, these initiatives should be personalized, specific to areas of need and interest, and enable trainees to have a more immersive learning experience.

We should establish Chatbots, have virtual facilitators and create assessment tools that help appraise and streamline grading of trainees to ensure that we continue to produce professionals who are suitably qualified to practice our skill. We need to have an archive of real-time surgery by senior practitioners that can be accessed by trainees to improve their skills. Societies such as ours, should also launch short competency-based initiatives to micro-credential trainees and members on specific procedures. These badges will help communicate an individuals' competencies and skills to employers, supervisors, and peers.

Professional societies such as the OGSM, have established themselves as an avenue for the various components of healthcare such as the pharmaceutical and medical technology industries to highlight improvements and newer therapeutic modalities that are available. Therefore, having a platform which is user-friendly, which integrates with social media and with good backend support is essential for the survival of professional societies in the future.

Future yearly meetings will probably move away from the large, physically congestive forums of the past. We need to look at hybrid conferences with limited physical participation but with a large virtual presence from an assemblage from all over the map.

As the current health crisis has shown, constitutions of any society is vulnerable to crises. The ability of a society to adapt to a changing social climate, and seamlessly embracing contemporary methods of functioning especially with regards to holding an AGM or EGM, utilizing electronic methods of communicating and performing financial transactions should be incorporated into the constitution, to remain relevant. Financial integrity is the cornerstone of how a society functions and perhaps, more importantly how it is perceived to function.

Professional societies are expensive organizations to manage. When income is curtailed in a crisis such as this, it has grave implications on the function of organizations. We therefore need to have a robust marketing entity that can explore new methods of generating income.

Perhaps in the final analysis, the doom and gloom brought about by the pandemic may have given us the impetus to reinvent ourselves, to keep ourselves relevant and sustainable and most importantly, to help launch us into the future.

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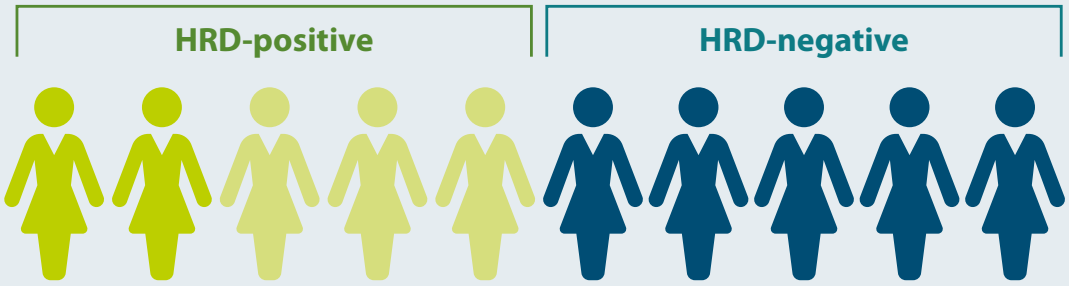


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# Message from the Incoming President

Dr Hoo Mei Lin
President-Elect
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As we start the 2021/2022 council term, no one could have imagined that we would be in a situation where COVID-19 is still raging, the number of cases is at an all-time high with no end in sight. The past 2 years have been challenging with council members juggling work commitments, the pandemic as as well as trying to find ways to continually engage our members and find effective ways to communicate. There is, however, always a silver lining in every cloud. This pandemic, social distancing and lockdowns have made all of us embrace the virtual world. COVID-19 has provided the incentive for OGSM to embrace technology. OGSM now banks electronically, holds council meetings over Zoom, has forayed into webinars, virtual scientific meetings/congresses and even a virtual AGM.

Conducting our activities virtually has also reduced our carbon footprint (e.g. no paper programmes at congress). It has forced us to move with the times, and reduce dependence on paper and traditional mail, which in turn, has reduced costs and wastage. OGSM will be beginning to reduce our communications via traditional mail, and will be relying more on electronic communications hence forth. Please ensure that your personal data filed with OGSM is up-to-date so that you do not miss any important communications from us.

Translating our normal activities onto the virtual stage has made us scrutinise the standard operating procedures within the organisation. During Dr Murali's tenure as president, we began to make inroads into formalising these SOPs and I hope to continue his good work in this coming year. These changes may be perceived as a 'depersonalisation' of OGSM, but as our fraternity grows in numbers and OGSM grows in strength, we will need these to remain fair and transparent.

I would welcome any suggestions and/or volunteers to help us with this task. OGSM works for her members but it is only through active participation of her members that she can continue to remain relevant. Please do not hesitate to contact me via president@ogsm.org.my or via the OGSM secretariat on administrator@ogsm.org.my

Please stay safe and stay well.

Dr Hoo Mei Lin
President-Elect
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- VARIVAX® [VARICELLA VIRUS VACCINE LIVE (Oka/Merck)]

HPV=human papillomavirus

**References 1.** Malaysia Review of Income Tax Relied for Medical Treatment Expenses for Self, Spouse and Child 2020

**Merck Sharp & Dohme (Malaysia) Sdn. Bhd.**
B-22-1 & B-22-2, The Ascent Paradigm, No. 1, Jalan SS 7/26A, Kelana Jaya, 47301, Petaling Jaya, Selangor Darul Ehsan.
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MY-PNX-00125 Feb/2021

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MSD

# PROGESTOGENS IN THE MANAGEMENT OF MISCARRIAGE AND PRETERM LABOUR



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The OGSM has recently released the first edition of Guidelines on Progestogens in the Management of Miscarriage and Preterm Labour. It is arguably an area within the field of obstetrics & gynaecology where clinical practice varies widely, perhaps a reflection of the paucity of robust evidence. The guideline was chaired by Dr Eeson Sinthamoney and peer-reviewed by respected international and local obstetricians and gynaecologists. Here are some snippets from the guideline[1]:

## PREVENTION OF MISCARRIAGES

This component was largely made up of three clinical scenarios- threatened miscarriage, recurrent pregnancy loss and luteal phase prophylaxis.

## THREATENED MISCARRIAGE

Recommendations for the use of oral progestogen were based on randomized controlled trials which showed a significant reduction in miscarriage (RR 0.57, 95% CI 0.38 to 0.85; 3 trials; 408 women). Two of these studies used oral dydrogesterone while another used oral micronized progesterone, where the primary outcome was actually on the change in fetal-placental volume[2,3,4]. Data from the large multicentre PRISM trial where progesterone was administered vaginally has shown no benefit, especially in women without prior miscarriages[5]

## RECURRENT PREGNANCY LOSS

Use of progestogens in recurrent miscarriages may result in lower rates of miscarriages compared to placebo or controls (average RR: 0.73, 95% CI: 0.54 to 1.00, 10 trials; 1684 women). However, the trials did not exhibit much uniformity in terms of the types of progestogens used, dosage or mode of administration and included studies as far back as 1953[6]. Therefore, no recommendation was made on the type of progestogen to be used although vaginal micronized progestogens are unlikely to be beneficial.[7,8]

## SUGGESTED CLINICAL PROTOCOL ON USE OF PROGESTOGEN

| CONDITION | DOSE | INITIATION | CESSATION |
|---|---|---|---|
| **Threatened miscarriage**<br><br>**-No previous miscarriage** | Oral dydrogesterone 40mg stat then 10mg BD | At diagnosis | 1 week after bleeding has stopped |
| **-1 or > previous miscarriages** | Vaginal/Rectal micronized progesterone 400mg BD<br><br>**OR**<br><br>Oral dydrogesterone 40mg stat then 10mg BD | | 16 weeks of gestation<br><br>1 week after bleeding has stopped |
| **Prevention of recurrent miscarriage** | Oral dydrogesterone 20mg OD | Once pregnancy diagnosed | Up to 20 weeks |
| **Luteal phase support in IVF** | Oral dydrogesterone 10 mg daily TDS<br><br>**OR**<br><br>Vaginal micronized progesterone 200 mg TDS<br><br>**OR**<br><br>8% intravaginal progesterone gel 90 mg daily<br><br>**OR**<br><br>Vaginal progesterone pessaries 400 mg BD | On the day of oocyte retrieval<br><br>**OR**<br><br>Day after retrieval | 12 weeks |
| **Prevention of preterm labour in singleton pregnancies** | Vaginal micronized progesterone 200 mg OD | At the time of diagnosis of short cervix <25 mm and <24 weeks | 36 weeks |
| **Prevention of preterm labour in twins** | Vaginal micronized progesterone 400 mg OD | At the time of diagnosis of short cervix <25 mm and <24 weeks | 36 weeks |

## LUTEAL PHASE PROPHYLAXIS IN ASSISTED REPRODUCTION

Use of progestogens are associated with higher live birth/ongoing pregnancy rates compared to placebo/no treatment for luteal phase support (OR 1.77, 95% CI 1.09 to 2.86; 5 trials; 642 women)[9].

## PREVENTION OF PRETERM BIRTHS

Recommendations for the use of progestogens in early pregnancy pales in comparison to the robust evidence available in prevention of preterm birth, specifically in women with short cervix and a singleton pregnancy. The use of progestogens in multiple pregnancies is less robust. Micronized progesterone administered vaginally should be used here as there is no role for dydrogesterone[10,11].


The full guideline is available from the OGSM website>Resources> Guidelines>Clinical Practice Guidelines on Miscarriage Management, under the resources tab.

N.B The guideline is due to be published in the Medical Journal of Malaysia in the coming months. Watch this space!

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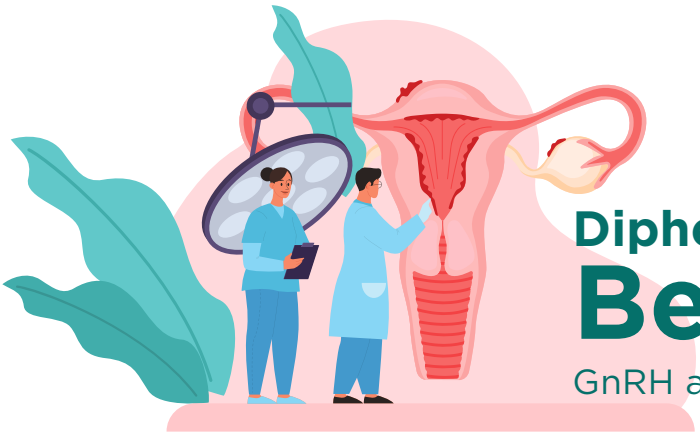
Diphereline®
triptorelin



# Diphereline®: Co-administration Before surgery

GnRH analogues induce endometrial thinning[1]

**Surgery is most effective when endometrial thickness is <4mm**

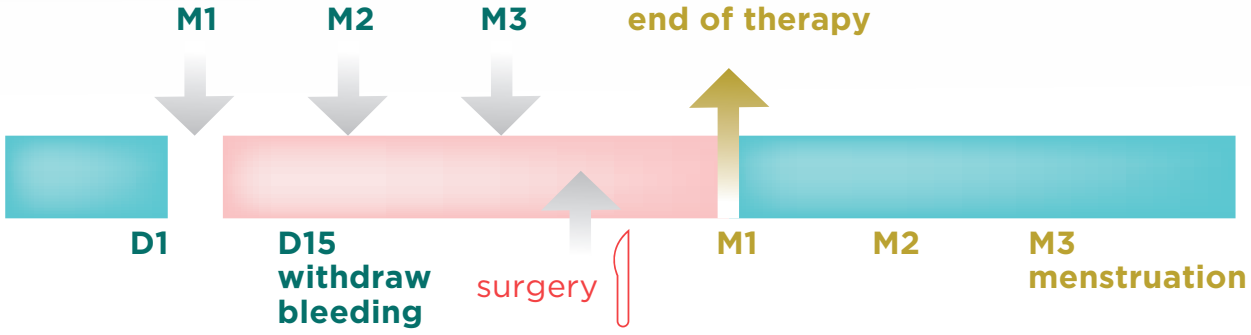
**GnRH analogues induce endometrial thinning**

**GnRh analogues thin the lining of the womb better and more consistently than danazol and are associated with**

- Shorter duration of surgery
- Greater ease of surgery
- Reduction in post-operative dysmenorrhea
- Higher rate of post-operative amenorrhoea at 12 months
- No effect on intra-operative complication rates

## Administered Diphereline® intramuscularly once every 28 days for 3 months before the surgery[1]

- Hormonal treatment is not recommended post-operatively to improve the outcome of surgery for pain
- However, hormonal treatment does have a role in the prevention of recurrence of disease and painful symptoms in women surgically treated for endometriosis
- The choice of intervention depends on patient preferences, costs, availability and side effects




**Reference: 1. Tan Th et al, Sytemativ Reviews 2013; Issue 11. Art. No: CD010241.**

Full prescribing information is available upon request, please refer to full prescribing information before prescribing. For adverse events reporting, please report to pharmacovigilance.my@ipsen.com

FOR HEALTHCARE PROFESSIONAL USE ONLY

**Abridged Prescribing Information** (Refer to full prescribing information before prescribing)

**Trade Name**: Diphereline® (Triptorelin)P.R. Powder and Solvent for Suspension for Injection 3.75mg/vial. **Administration**: Prostate Cancer: One intramuscular injection every 4 weeks Endometriosis: One intramuscular injection every 4 weeks (initiated in the first 5 days of the menstrual cycle and should not be administered for more than 6 months) Uterine fibromyomas prior to surgery: One intramuscular injection every 4 weeks (initiated in the first 5 days of the menstrual cycle, studies were conducted for durations between 3 to 4 months). Central precocious puberty: children under 20kg: (1/2) a dose by intramuscular route, every 4 weeks children between 20 and 30kg: 2/3 of the dose by intramuscular route, every 4 weeks; children over 30kg: one intramuscular injection every 4 weeks. Breast cancer: one intramuscular injection every 4 weeks in combination with tamoxifen or an aromatase inhibitor, treatment should be initiated after completion of chemotherapy (once pre-menopausal status has been confirmed) and at least 6-8 weeks (minimum 2 injections) before starting aromatase inhibitor treatment.
**Trade Name**: Diphereline® (Triptorelin) P.R. Powder and Solvent for Suspension for Injection 11.25mg/vial. **Administration**: Prostate Cancer: One intramuscular or subcutaneous injection repeated every 3 months. Endometriosis: One intramuscular injection repeated every 3 months (initiated in the first 5 days of the menstrual cycle and should not be administered for more than 6 months). Central precocious puberty: Children (before 8 years in girls and 10 years in boys): One intramuscular injection every 3 months. **Contraindications**: Hypersensitivity to GnRH, its analogues or to any of the excipients; pregnancy and breast feeding. **Special Warnings & Precautions**: Non-pregnancy should be confirmed, a non-hormonal method of contraception should be used. Treatments may cause reduction in bone mineral density; may reveal the presence of a previously unknown gonadotroph cell pituitary adenoma; increase risk of incident depression. Caution should be given to patients treated with anti-coagulants or drugs having an impact on QT interval. **Undesirable Effects**: In men: libido decreased, paraesthesia in lower limbs, hot flush, hyperhidrosis, back pain, erectile dysfunction, hypertension, asthenia. In women: sleep disorder, headache, hot flush, acne, hyperhidrosis, breast disorder, dyspareunia, genital bleeding, ovarian hyperstimulation syndrome, ovarian hypertrophy, pelvic pain, vulvovaginal dryness, asthenia, nausea, fatigue, musculoskeletal disorders, osteoporosis, insomnia, libido decreased, depression, urinary incontinence, dyspareunia, and diabetes; In children: vaginal bleeding, hypersensitivity, headache, hot flushes, abdominal pain, acne, injection site reaction, weight increase.

**Malaysia PI (December 2020)** **Revision date: 20th March 2021** **Ipsen Pharma Singapore Pte Ltd** **Twenty Anson, 20 Anson Road, #10-03, 079912, Singapore 079912** **+65 6850 0700** **DIP-MY-000172 May 2021**

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Diphereline®
triptorelin

# Diphereline®: Co-administration After surgery

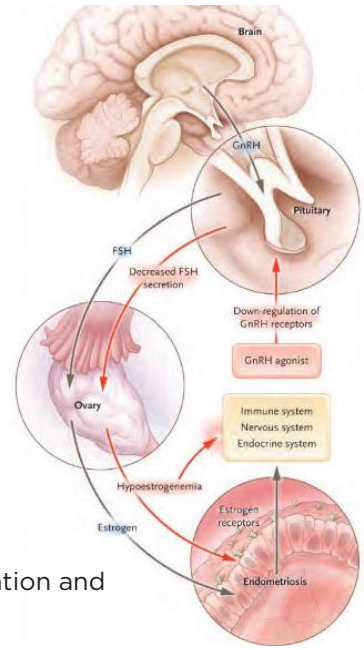
50% of patients experience a painful symptoms after surgery[1]

## Diphereline®: The Mechanism of Action[2]

**Surgery does not affect the pathogenic mechanisms of endometriosis**

**Up to 50% of patients experience a recurrence of symptoms by the 5-year follow-up**

**GnRHa therapy has become more frequently prescribed as a first-line option after the surgery because of its improved effectiveness in reducing recurrent episodes**




Prolonged binding of Diphereline® PR to GnRH receptors causes receptor downregulation and desensitization, resulting in the suppression of gonadotropin secretion[2]

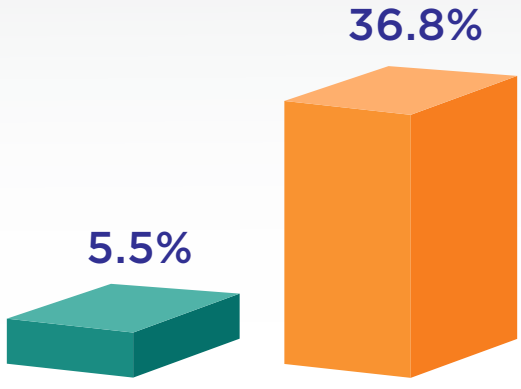
**Low level of estrogen**

# 6 months

**post-operative Diphereline treatment can reduce recurrence rate[1]**

- Up to 36.8% of patients experience a recurrence of symptoms by the 2-years follow up
- Diphereline therapy has become more frequently prescribed as 1st line option after the surgery because of its improved effectiveness in reducing recurrent episodes

**Relapse rate within 2 years**




**References:** 1. TChin J Pharmacoepidemiol 2004, Vol. 13, No.4. 180-2. 2.Wu B, et al. BJOG 2018 Mar;125(4):469-477.

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# WEBSITES
## YOU MAY WANT TO EXPLORE

**Dr Voon Hian Yan**
Maternal Fetal Medicine Specialist,
Sarawak General Hospital
Editorial Board Member, CONNECT (2019-current)

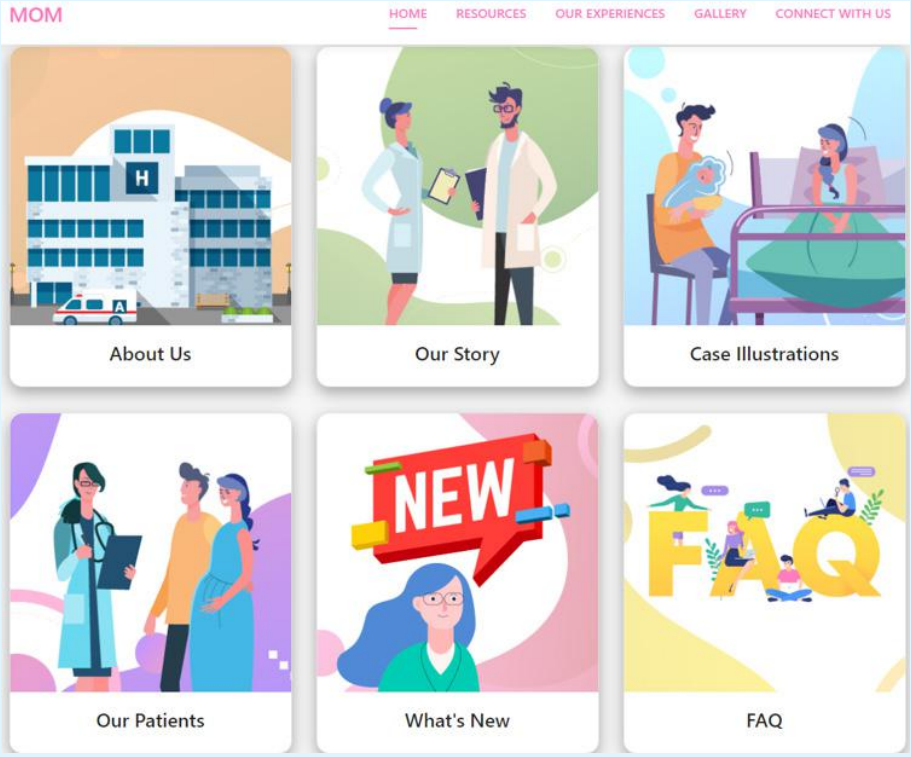
***The society is peppered with talented individuals who go beyond their call of duty to pursue areas of their interests. I came across two websites recently, brought to life by OGSM members, as they continue to connect and reach out to their local and international peers.***

## 1. MALAYSIAN OBSTETRIC MEDICINE (MOMS)

Led by Dr Muniswaran Ganeshan of Hospital Tunku Azizah and his team (Dr Tan Chin Aun, Dr Nicole Asha, Dr Lorenzo Raj, Dr Jagdeesh Kaur and Mr Yap Chun Hoong) the MOMS website gives an overview of the Maternal Fetal Medicine subspeciality and the services it provides. It also serves as the virtual home of the MOMS Scientific Congress, held every two years. Based on the traffic generated by the website, there appears to be significant browsing time by users based in United States, Oceania and China, in addition to Malaysia.

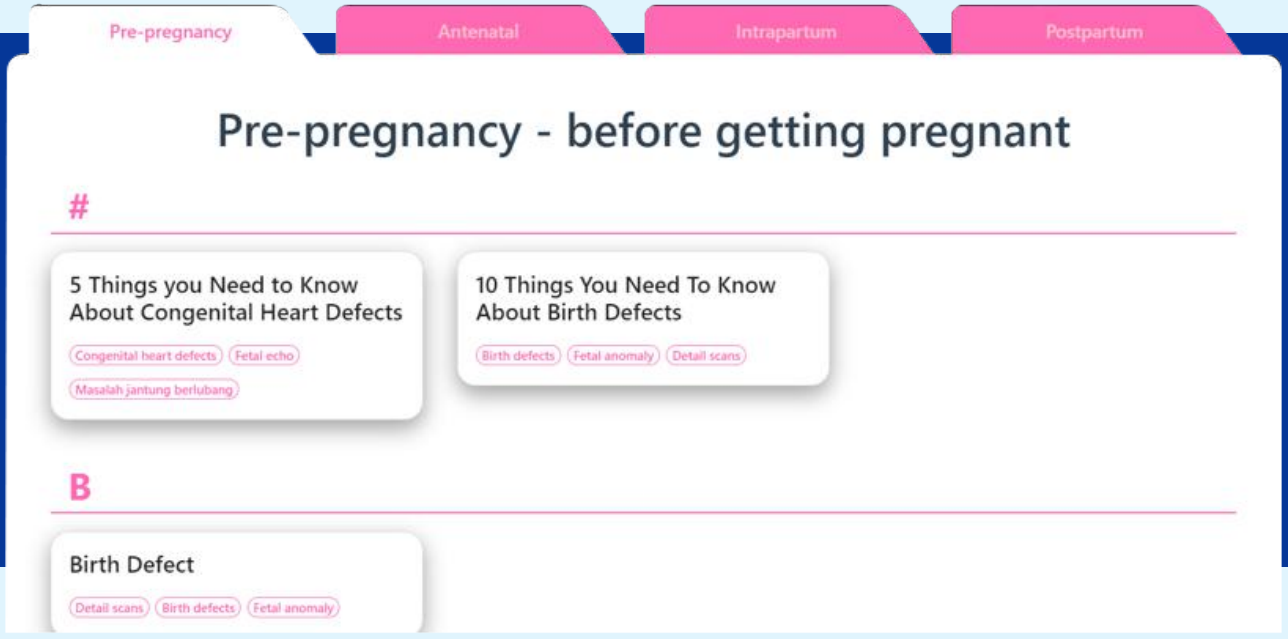

**AESTHETICS** ★★★★★
Easy on the eyes, this website is both futuristic in design and quirky

**USER INTERFACE** ★★★★
I initially explored the website using Windows on my laptop then tried it with my Android phone. The experience was equally good on my phone. Loading time was not excessive and there were no annoying pop-ups or adverts. It was easy to navigate within the different sections




**CONTENT** ★★★★★
It has a component for both the medical practitioner and patient. You can find landmark trials attached here, which I found really practical for the trainee. The way the patient information is presented was also attractive. Even browsing through the titles make you want to find out more. The contents appear up to date and new material has been added in recent months.

**MUSIC** ★★★★★
Soothing original background music created by Njoo, the talented son of the immediate past president of OGSM, Dr Harris Njoo Suharjono. The tone and pace of the music was appropriate and can be switched off as well for those who prefer it that way.




**WHAT COULD BE BETTER**
There were one or two minor typos. The tab labelled "CONNECT WITH US" encourages patient to send in queries and while I am all for being accessible to patients, I wonder if the team could cope with patients' demands in a timely manner. For example if a patient submits queries about a life-threatening disorder, such as suicidal ideation, it may result in delay in seeking help. In all fairness, the webmaster did mention that the tab is only for non-urgent matters.

**OVERALL** ★★★★★
I particularly relished the group photos taken by the website team, enthusiastic and budding Obgyns in their own right. Future office bearers of the society, no doubt! I also found the hashtag "#deliveringmiracles" rather attractive

WHERE CAN I FIND IT?
**https://obstetricmedicine.my**

## 2. INTENSIVE COURSE IN OBSTETRIC EMERGENCIES (ICOE)

The ICOE Steering Committee led by Dr Gunasegaran PT Rajan has put OGSM on the world map, with regional national societies within the Asia-Oceania region (AOFOG) incorporating ICOE contents in their national training. There is also work underway with FIGO (International Federation of Gynaecology & Obstetrics) as the editor has expressed interest in sharing multimedia contents developed by ICOE and OGSM.

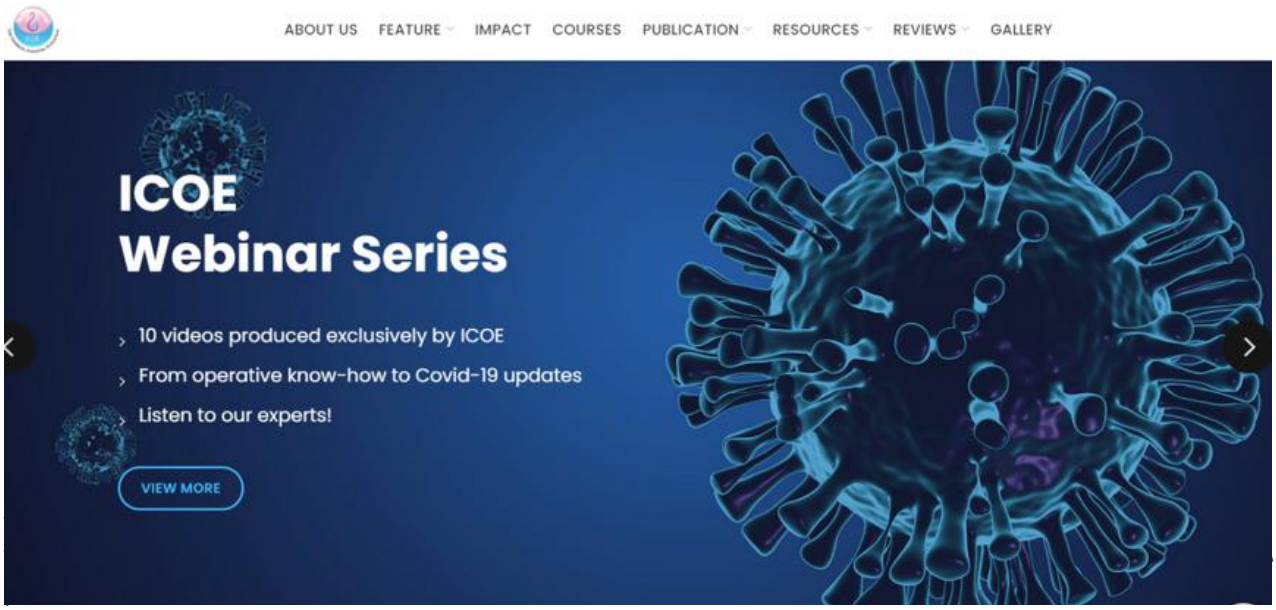
One feature which has caught the eye attention is the newly-minted ICOE website. The team comprising of ICOE-certified trainers videlicet Dr Yong Soon Leong (HTAA), Dr Melanie Kuan, Dr Michael Hoong (HWKKS) and Dr Woon Shu Yuan (Sarawak GH) committed six months of their time as it evolved from its previous version, taking it to another level altogether (#spacetourismanyone?)

**AESTHETICS** ★★★★★
The ICOE Handbook of Obstetric Emergencies is filled with high-quality images and it is not surprising that this was used in many parts of the website. Just look at this example of a cord prolapse-artistic!


**USER INTERFACE** ★★★★
I explored the website using both Windows on my laptop and my Android phone. Loading time was not excessive and there were no annoying pop-ups or adverts. The font size was just right and the layout did not require me to switch the orientation of my phone or make my fingers do additional work to read.

**CONTENT** ★★★★★
Greeting you on the "home" page of the website is some promotional material for the next ICOE activity. The ICOE 5 year report and useful resources are also archived on the website such as podcasts and previous webinars. However, my favourite part of the website is the ICOE Guru's Chops! Rather than a typical curated testimony to greet you, the ICOE trainer's (Guru) share off the cuff stories of their experience learning and then organizing the course. I do wonder though, if they all had professional photographers to take their pictures?


**MUSIC** ★★★★★
The original background music created by Njoo accompanies the website and reminds me of having a nice post-call aperitif of mulled wine on a cold winter day.




**OVERALL** ★★★★★
I found the website much more attractive than the previous version and I particularly liked the futuristic-looking SARS-CoV2 virus which has punished us into webinology. In addition, through this website, I found out that the ICOE Handbook has been fully translated to Chinese language. As one of the most spoken languages in the world, this endeavour will definitely keep ICOE and OGSM's flag flying high.

**WHERE CAN I FIND IT?**
**https://icoe.org.my**

Up to **80%** of pregnant women experience reflux symptoms during pregnancy, which adversely affect quality of life [1,2,14]

ARM
Appropriate Reflux Management

# GAVISCON PROVIDES EFFECTIVE REFLUX RELIEF FOR EXPECTANT MUMS

- Relieves reflux in 90% of pregnant women[14]
- Reduces night-time reflux symptoms by 20%[14]
- Non-systemic and well tolerated[15-19]
- Proven safety profile in pregnant women[20-21]


"HELP EXPECTANT MUMS GET BACK TO DAY-TO DAY LIFE"
REFLUX SYMPTOMS COMMONLY OCCUR ACROSS ALL STAGES OF PREGNANCY [1,3-5]

MAL05121192X

## *Fast and Long-Lasting*# *Relief from Reflux*

GAVISCON ADVANCE

**Abbreviated Prescribing Information:**
Gaviscon Advance (Sodium alginate, potassium bicarbonate)
**Description:** Each 10 mL of oral suspension contains sodium alginate 1000 mg and potassium bicarbonate 200 mg. The other ingredients are calcium carbonate, carbomer, methyl (E218) and propyl (E216) hydroxybenzoates, sodium saccharin, sodium hydroxide, peppermint flavour and purified water. Gaviscon Advance is sugar-free and gluten-free.
**Indications:** Heartburn, indigestion, hiatus hernia, reflux oesophagitis. Symptomatic treatment of gastro-oesophageal reflux such as acid regurgitation, heartburn, indigestion after gastric surgery, hiatus hernia, during pregnancy or accompanying reflux oesophagitis.
**Recommended Dose:** Adult, elderly & child and above 12 years old 5-10 mL, take after meals & at bedtime.
**Special Precautions:** Children under 12 years old. Na-restricted diet. **Side Effects:** Allergic to any ingredients as skin rashes and difficulty had been reported.

# Last up to 4 hours
* Gaviscon Advance

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reckitt
**RB (Health) Sdn. Bhd. (1297081-V)**
Level 17, Menara 1 Sentrum. No. 201, Jalan Tun Sambathan, 50470 Kuala Lumpur, Malaysia.

73/29/1006893-27 May 2021
For healthcare professionals only.

boostrix

Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed

# The first Tdap vaccine with safety data in pregnancy in its label[1-3]

## Proven immunogenicity and safety profile in pregnant women[1,4]

No vaccine related adverse effect on pregnancy or on the health of the fetus / unborn child[1]

**Proven effectiveness** on the protection against pertussis disease in infants <3 months of age born to women vaccinated during the third trimester of pregnancy[1]

**90.9%** vaccine effectiveness against pertussis disease in newborns based on a study in Spain (95% CI: 56.6, 98.1)[1,5]

**83.7% reduction** in fatality rate in infants <2 months of age (95% CI: 63.9, 92.6; P<0.001)[6]

- Maternal immunisation with Tdap is recommended by international and local guidelines such as WHO, CDC, MSIDC[7-9]; and in >30 countries globally[10]
- 1 Tdap dose per pregnancy
  Vaccinate between 27 – 36 weeks of gestation[1,7-9]


More than **269** million doses of Boostrix have been distributed worldwide over the past 20 years[11]

**References: 1.** Boostrix Malaysia Prescribing Information, Version GDS10/IPI11. **2.** Sanofi Pasteur MSD Ltd. DTaP vaccine SmPC, 2018. [accessed January 2019]; available at www.hpra.ie/img/uploaded/swedocuments/LicenseSPC_PA2131-010-002_21022018164037.pdf. **3.** Sanofi Pasteur MSD Ltd. DTaP/IPV vaccine SmPC, 2018. [accessed January 2019]; available at www.hpra.ie/img/uploaded/swedocuments/LicenseSPC_PA2131-006-001 _18012018144214.pdf. **4.** Perrett KP et al. Vaccine 2020;38:2095–2104. **5.** Bellido-Blasco J, et al. Euro surveillance. 2017;22:1-7. **6.** Vizzotti C. et al. Vaccine 2015;33:6413–6419. **7.** World Health Organization. Pertussis vaccines: WHO position paper – August 2015. Wkly Epidemiol Rec 2015;90:433–460. **8.** CDC. Available at: https://www.cdc. gov/vaccines/schedules/hcp/imz/adult-conditions.html. Last accessed: Mar 2021. **9.** Malaysian Society of Infectious Disease and Chemotherapy (MSIDC). Guidelines for Adult Immunisation, 2020, 3rd edition. Retrieved from: https://msidc.com.my. **10.** World Health Organisation (WHO). WHO vaccine-preventable diseases: monitoring system. 2020 global summary. Available at: https://apps.who. int/immunization_monitoring/globalsummary/schedules; Last accessed: May 2021. **11.** GlaxoSmithKline. Data on File: DTP portfolio. DNG Number: 2021N465985_00.

**Name of medicinal product:** ***Boostrix*** **Diphtheria, tetanus and pertussis (acellular, component) vaccine (adsorbed, reduced antigen(s) content). Qualitative & quantitative composition:** 1 dose (0.5 mL) contains: Diphtheria toxoid not less than 2 International Units (IU) (2.5 Lf), Tetanus toxoid not less than 20 IU (5 Lf), *Bordetella Pertussis* Antigen: Pertussis toxoid 8 µg, Filamentous Haemagglutinin 8 µg, Pertactin 2.5 µg. **Indications:** is indicated for booster vaccination against diphtheria, tetanus and pertussis of individuals from the age of four years onwards. **Dosage and administration:** A single 0.5 mL dose of the vaccine is recommended. Boostrix can be given in accordance with the current local medical practices for booster vaccination with adult-type combined diphtheria-tetanus vaccine, when a booster against pertussis is desired. Boostrix may be administered to adolescents and adults with unknown vaccination status or incomplete vaccination against diphtheria, tetanus and pertussis as part of an immunisation series against diphtheria, tetanus and pertussis. Based on data in adults, two additional doses of a diphtheria and tetanus containing vaccine are recommended one and six months after the first dose to maximize the vaccine response against diphtheria and tetanus. Repeat vaccination against diphtheria, tetanus and pertussis should be performed at intervals as per official recommendations (generally 10 years). Boostrix can be used in the management of tetanus prone injuries in persons who have previously received a primary vaccination series of tetanus toxoid vaccine. Tetanus immunoglobulin should be administered concomitantly in accordance with official recommendations. Boostrix is for deep intramuscular injection, preferably in the deltoid region. **Contraindication:** Boostrix should not be administered to subjects with known hypersensitivity to any component of the vaccine or to subjects having shown signs of hypersensitivity after previous administration of diphtheria, tetanus or pertussis vaccines. Boostrix is contra-indicated if the subject has experienced an encephalopathy of unknown aetiology, occurring within 7 days following previous vaccination with pertussis-containing vaccine. In these circumstances pertussis vaccination should be discontinued and the vaccination course should be continued with diphtheria and tetanus vaccines. Boostrix should not be administered to subjects who have experienced transient thrombocytopenia or neurological complications following an earlier immunisation against diphtheria and/or tetanus. **Warnings and Precautions:** If any of the following events are known to have occurred in temporal relation to receipt of pertussis-containing vaccine, the decision should be carefully considered: Temperature of ≥40.0°C within 48 hours, not due to another identifiable cause; Collapse or shock-like state (hypotonic - hyporesponsive episode) within 48 hours of vaccination; persistent, inconsolable crying lasting ≥3 hours within 48 hours of vaccination; Convulsions with or without fever, occurring within 3 days of vaccination. In children with progressive neurological disorders, including infantile spasms, uncontrolled epilepsy or progressive encephalopathy, it is better to defer pertussis (Pa or Pw) immunization until the condition is corrected or stable.Boostrix should be administered with caution to subjects with thrombocytopenia or a bleeding disorder since bleeding may occur following an intramuscular administration to these subjects, should under no circumstances be administered intravenously. Extremely rare cases of collapse or shock-like state (hypotonic-hyporesponsiveness episode) and convulsions within 2 to 3 days of vaccination have been reported in DTPa and DTPa combination vaccines. **Interactions:** When considered necessary, Boostrix can be administered simultaneously with other vaccines or immunoglobulins, the products should always be administered at different sites. **Pregnancy and Lactation:**Pregnancy: The use of Boostrix may be considered during the third trimester of pregnancy. Safety data from a prospective observational study where Boostrix was administered to pregnant women during the third trimester (793 pregnancy outcomes) as well as data from post-marketing surveillance where pregnant women were exposed to Boostrix have shown no vaccine related adverse effect on pregnancy or on the health of the foetus/newborn child. Lactation :The safety of Boostrix when administered to breast-feeding women has not been evaluated. ***Boostrix*** should only be used during breast-feeding when the possible advantages outweigh the potential risks. **Adverse Reactions:** ***Children from 4 to 9 years of age:*** Very Common (≥ 1/10): irritability, somnolence, injection site reactions (including pain, redness and swelling), fatigue; Common (1/100 and <1/10): anorexia, headache, diarrhoea, vomiting, gastrointestinal disorders, fever ≥ 37.5°C (including fever > 39°C). ***Adults, adolescents and children from the age of 10 years onwards:*** Very Common (≥ 1/10): headache, injection site reactions (including pain, redness and swelling), fatigue, malaise; Common (1/100 and <1/10): dizziness, nausea, gastrointestinal disorders, fever ≥ 37.5°C, injection site reactions (such as injection site mass and injection site abscess sterile). **Overdose:** Adverse events following overdosage, when reported, were similar to those reported with normal vaccine administration. **Pharmacodynamics:** *Effectiveness in the protection against pertussis disease in infants born to women vaccinated during pregnancy:*Boostrix vaccine effectiveness (VE) was evaluated in three observational studies, in UK, Spain and Australia. The vaccine was used during the third trimester of pregnancy to protect infants below 3 months of age against pertussis disease, as part of a maternal vaccination programme. Please read the full prescribing information prior to administration, available from: **GlaxoSmithKline Pharmaceutical Sdn Bhd (3277-U) Level 6, Quill 9, 112 Jalan Semangat, 46300 Petaling Jaya, Selangor Darul Ehsan, Malaysia.** Abbreviated Prescribing Information Version 1.0 based on **GDS10/IPI11_09Aug2018.** API created: 2nd April 2020.

**Before prescribing, please refer to the full prescribing information, which is available upon request.**

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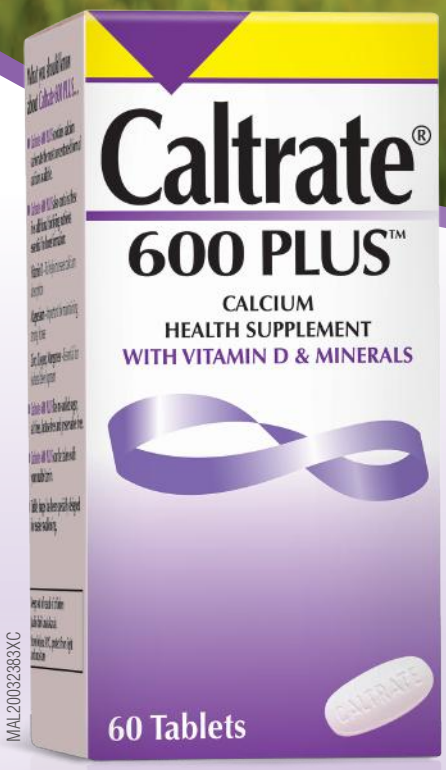


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# IRC and the MRCOG Examinations

**Dr Tang Boon Nee**
Chair IRC (2021-2024)
Past President OGSM

IRC (International Representative Committee) Malaysia represents the RCOG in Malaysia.

As a result of an uncontested election (due to the increasingly stringent criteria where only a Fellow of the College who has served in a previous IR Committee would qualify), I became the Chair of the IRC from June 2021.

It was a compulsory passing over from the one Chair to the next as extension of term beyond 3 years for the IRC is not allowed under the RCOG rules. Otherwise, I am sure Dr Shilpa Nambiar (Chair 2019-2021) would have carried on ably, in the same manner that she had been, for another 3 years.

After taking over the Chair, it was immediately obvious to me that the largest challenge for the IRC is the MRCOG examinations.

## MRCOG Examinations

Covid had not spared the MRCOG examinations, if anything they have been ravaged. Several examination diets have been cancelled and there is practically no examination carried out in year 2020.

For everyone's knowledge, for a few years now, the MRCOG examinations are Part 1, 2 and 3; no longer Part 1 & 2 only. Part 1 tests Basic Sciences, Part 2 consists of Multiple Choices, Best Answer Questions (previously the written Part 2); and Part 3 consists of OSCE Stations.

The MRCOG remains a Parallel Pathway for attaining O&G specialisation in Malaysia, unlike some of the other surgical-based disciplines. The MRCOG candidates are largely (if not all) doctors working in the Ministry of Health Hospitals.

## Part 1 & 2 MRCOG

The RCOG has endeavoured for some time to bring the Part 1 & 2 examinations to an online platform. Covid has hastened this process. Gone are the days when for Part 1, the examiner from the UK will physically bring all the exam papers over on a long flight, run the examination with a local partner (usually one of the universities and recently the IRC committee), return to UK, with papers marked physically.

From 2020 onwards, the Part 1 & 2 are conducted online, by examination centres appointed by Pearson Vue (an international examination provider appointed by the RCOG to run these diets all over the world). Therefore, candidates travelled to these examination centres, appointed by Pearson Vue dotted all over the country. Most centres are small institutions running IT

courses, doubling as examination centres for all sorts of courses.

Due to the MCO, in January 2021, the Part 1 & 2 diets were cancelled in some of the Malaysian centres rather abruptly. Most centres were afraid of repercussions if they opened for examinations, even though by the guidelines given, International Examinations were allowed. Candidates were taken by surprise and of course understandably, were not pleased. Eventually, only about 20% of the candidates were able to sit and these candidates were in Kuala Lumpur.

The July diets would have suffered the same fate with cancellations due to the MCO again so the IRC had to intervene promptly. The morale of the 50 Part 1 and 60 Part 2 Malaysian candidates whose examination were already deferred from January, would have been dented if the July examinations were put-off once more!

After countless phone calls, online meetings and emails, with a great deal of help from Dr J Ravichandran, Datuk Dr Soon Ruey and Dr Harris Suharjono, the relevant letters and permissions were obtained. Most examination centres felt confident enough to carry on with the diets even during the MCO. Therefore, in July, all candidates (except for about 10% who chose to defer) sat for their MRCOG Part 1 & 2 papers. Without the intervention of IRC, most of the Part 1 & 2 examinations in Malaysia would have been cancelled again.

However, there are still many (I believe about 100) candidates who are eligible for Part 2 still waiting for the next opportunity to attempt the examinations. The next diet will be in September 2021, with limited numbers. It remains to be seen if this diet would be a challenge to organize for the respective centres but if the MCO is lifted, we do hope it will proceed as planned.

## Part 3 MRCOG

There has been no Part 3 diet for Malaysian candidates since Nov 2019 due to the pandemic. The May 2020 examinations were cancelled. There was a limited number who were allowed to sit for a diet held at the end of 2020 through February 2021 but these were restricted to candidates in the UK.

In May 2021, the RCOG ventured into an online platform for the Part 3 OSCE examinations. Examinations were then carried out, online, in Singapore, Hong Kong, India and the UK. Candidates from any other countries, including Malaysia, were not allowed to book for examinations. Therefore, the Malaysian Part 3 candidates understandably felt very 'neglected' by the College and again disappointed.

Currently, there are at least 70 candidates who are eligible for Part 3 but with no opportunity to sit and attain membership to the distinguished College. Unlike many years ago when there was only a handful sitting for Part 3 and moreover, those days the opportunity to sit for an exam was ample.

Finally, news came from the RCOG that the November examinations will be opened for other international candidates including Malaysia. If the candidates can secure a seat (this they do by logging online on the day of booking as fast as they possibly can!), then they will be sitting for the Part 3 online, likely from their own homes.

## IRC and the Candidates

There has been a lot of stress amongst the candidates due to the uncertainty surrounding the examinations and therefore the candidates' career progression. They have worked hard, doing on-call duties most days of the week and looked after patients during these turbulent times in our country. The MRCOG thus far is a 'self-driven' attempt on the candidates' part. There are no universities to support their learning. The local universities have their hands full with Masters training program.

MRCOG candidates have to look for information, form their own study groups, seek teaching when there is an opportunity. During Covid when physical meetings are scarce, there is little opportunity for teaching and learning unlike before. MOH consultants are busy with the pandemic. The RCOG in UK has its hands full with its own battle with Covid. Neither can our candidates with their income, afford the costly online overseas courses.

This challenge of the MRCOG candidates is not new, but certainly made worse by the pandemic. I believe that we as a fraternity, should support as much as we can, their training and learning. The IRC with its limited resources will, short of moving mountains, go the extra mile for our next generation, as it leverages its position within the Ministry of Health's Parallel Pathway Committee to negotiate with the RCOG. But as I had said to the candidates, the IRC will try to facilitate, but it is still them, the candidates, who have to sit for their examinations and do them well.

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# 28th International Congress of the Obstetrical and Gynaecological Society of Malaysia (OGSM 2021)

It was a congress of many firsts. Prolonged in its conception, born during an unrelenting pandemic, debuting onto the virtual stage at a time when virtual fatigue had well and truly set in, it was a congress that went against the odds. Our scientific programme underwent multiple transformations as the congress went from the traditional congress, to a hybrid model and then a fully virtual one. Having 73 speakers from 14 countries made for a very exciting programme but a true logistical nightmare juggling time differences and internet connectivity. Despite numerous webinars and congresses which were offering free or almost free registrations, we had 960 delegates registered at our congress and we had close to full attendance at our scientific sessions across the 3 days.

We wish to thank our compact committee for being steadfast and unwavering when the bold decision was made to push the congress to a fully virtual one. It was a difficult decision to make as we all really wanted to have a physical congress where we could meet, interact and enjoy the OGSM hospitality.

This year, the organising committee made the decision to donate RM10,000 towards the Women's Aid Organisation (WAO) in lieu of speakers' gifts. We thank those speakers who so generously donated their gifts toward this cause. The WAO was chosen in recognition of the rising incidence of domestic violence during this pandemic. The WAO typically sees 1,000 cases per annum but in 2020 alone, this number rose to 7,500. The lockdowns, meant to protect us from COVID-19, have meant that victims of domestic violence are more vulnerable than ever and this is reflected in the increased number of calls to WAO's helpline as well as the number of families rescued.

The profits from the congress have not been finalised as yet but we are confident that we have made enough to cover the society's budgeted expenses for the upcoming year. This comes as a huge relief as traditionally, the congress profits go towards the running of the OGSM office as well as provide funds for the many activities that we run. Moving forward, it has become abundantly clear that relying on the profits generated from the annual congress alone will not be feasible in the near future. The society will need to look into other avenues in which to generate funds, as well as constantly re-examine expenditure to improve efficiency and reduce costs where possible. The committee is producing a report and will include recommendations for future improvements.

Thank you for continuing to support OGSM and the annual congress. We sincerely hope that next year will see a return to normal and a physical congress.

Till then, stay safe.

Dr Muralitharan Ganesalingam
President, Obstetrical & Gynaecological Society of Malaysia
Organising Chairperson,
28th OGSM Congress 2021

Dr Hoo Mei Lin
President-Elect, Obstetrical & Gynaecological Society of Malaysia
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- Pre-eclampsia[3]

References: 1. Olafsdottir et al. (2006). *International Journal of Obesity.* 30, 492-499. | 2. Ley et al. (2011). *Am J Clin Nutr.* 94, 1232-1240. | 3. Borgen et al. (2012). *European Journal of Clinical Nutrition.* 66, 920-925.

# THE NATIONAL OBSTETRICS AND GYNAECOLOGY TRAINING UPDATE

## From the MMC SSC-Edu for O&G

Prof Dr Zaleha Abdullah Mahdy
Chairperson of the MMC SSC-Edu for O&G

The Specialty Subcommittees under the Malaysian Medical Council Medical Education Committee (MMC SSC-Edu) was formed to develop standards specific to the specialty programme based on the Malaysian Standards for Medical Specialist Training. The quality standards for the implementation and recognition of the specialty programmes include standards and criteria for:

- selection of candidates;
- recognition of training facilities and trainers;
- monitoring and assessment of the programme;
- qualifications for entry into the National Specialist Register (NSR); and
- competencies required for independent practice in the specialty and the maintenance of competencies.

Members of the SSC-Edu were appointed by the President of MMC after the nominations have been tabled to the council by the Ministry of Health and Academy of Medicine of Malaysia.

The National Curriculum for O&G training has been finalized by the working committee led by the University of Malaya and copyrighted under the Malaysian Public Universities Deans Council. This forms the main framework, upon which all O&G training programmes will essentially be based.

The MMC SSC-Edu for O&G consists of

1. Prof Dr Zaleha Abdullah Mahdy (Chairperson)
2. Dato' Dr Bavanandan Naidu
3. Dato' Dr Tham Seng Woh
4. Prof Dr Nazimah Idris
5. Dr Eeson Sinthamoney
6. Dr Michael Samy

Several engagements were held with senior consultants who are closely involved in O&G training activities:

1. Dr J Ravichandran (National Head of O&G Service).
2. Prof Dato' Dr Siti Zawiah Omar (President of the College of O&G, Academy of Medicine of Malaysia).
3. Prof Dr Nur Azurah Abdul Ghani (Chairperson of the O&G Specialty Committee, previously known as the Conjoint Board, under the Medical Deans Council) (taking over from Assoc Prof Dato' Dr Hamizah Ismail).
4. Dr Harris Suharjono (senior member of the MOH Committee on Parallel Pathway Training).
5. Dr Shilpa Nambiar (previous Chair of the IRC).

Meetings are conducted ad hoc, as and when necessary, among the group or with the Specialty Education Committee (SEC) of the MMC. The minimum standards for O&G training have already been drafted and submitted to the MEC of the MMC. I would like to thank all members of the group for their invaluable contribution.


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**REFERENCES: 1.** Kohler G, et al. A dose-ranging study to determine the efficacy and safety of 1,2 and 4 mg of dienogest daily for endometriosis. Int J Gynaecol Obstet. 2010 Jan;108(1):21-5. **2.** Strowitzki T, et al. Dienogest is as effective as leuprolide acetate in treating the painful symptoms of endometriosis: a 24-week, randomized, multicentre, open-label trial. Hum Reprod. 2010 Mar;25(3):633-41. **3.** Kitawaki J, et al. Eur J Obstet Gynecol Reprod Bio. 2011 Aug;157(2):212-6. **4.** Morotti M, et al. Eur J Obstet Gynecol Reprod Biol. 2014 Dec;183:188-92. **5.** Imai A, et al. in Endometriosis - Basic Concepts and Current Research Trends, Prof Koel Chaudhury (Ed.), ISBN:978-953-51-052404, InTech.

**ABBREVIATED PRESCRIBING INFORMATION** **Brand name of product** Visanne 2 mg tablets (Dienogest). **Indications** Treatment of endometriosis. **Contraindications** Active venous thromboembolic disorder, past or present arterial & cardiovascular disease (eg myocardial infarction, cerebrovascular accident, ischemic heart disease); diabetes mellitus with vascular involvement; presence or history of severe hepatic disease & liver tumors; known or suspected sex hormone-dependent malignancies; undiagnosed vaginal bleeding. Pregnancy & lactation. Children prior to menarche. Hypersensitivity to the active substances or to any of the excipients. **Special warnings and special precautions for use** Serious uterine bleeding; Changes in bleeding pattern may occur; Circulatory disorders including those at risk of VTE; discontinue use if any symptoms of arterial or venous thrombotic events occur. Breast cancer, liver tumors. Osteoporosis. History of depression; Hypertension. Discontinue use upon recurrence of cholestatic jaundice &/or pruritus which occurred 1st during pregnancy or previous use of sex steroids, Diabetes Mellitus especially gestational diabetes mellitus, chloasma (especially chloasma gravidarium); Persistent ovarian follicles. Rare hereditary problems of galactose intolerance, Lapp lactose deficiency or glucose-galactose malabsorption. Regular physical & gynecological examination during use. Adolescents (menarche to 18 yr). **Undesirable effects** Common: Metabolism and nutrition disorders: weight increase, Psychiatric disorders: depressed mood, sleep disorder, nervousness, loss of libido, altered mood, Nervous system disorders: headache, migraine, Gastrointestinal disorders: nausea, abdominal pain, flatulence , abdominal distension, vomiting, Skin and subcutaneous tissue disorders: acne , alopecia, Musculoskeletal and connective tissue disorders: back pain, Reproductive system and breast disorders: breast discomfort, ovarian cyst, hot flushes, uterine / vaginal bleeding including spotting, General disorders and Administration site conditions: asthenic conditions, irritability. **For further prescribing information, please contact** Bayer Co. (Malaysia) Sdn Bhd B-19-1& B-19-2, The Ascent Paradigm, No. 1, Jalan SS7/26A, Kelana Jaya, 47301, Petaling Jaya, Selangor. Subject to medical prescription. **Date of text revision** 14.03.2016

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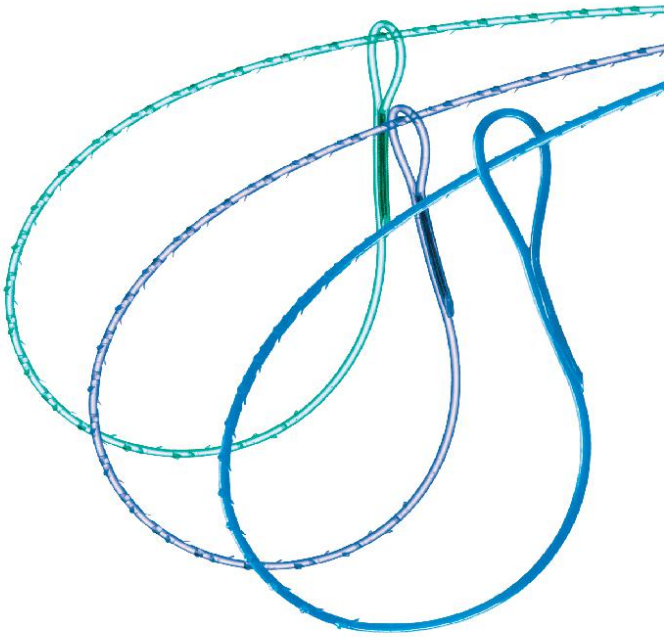

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*Austrian case study, feedback via MRS questionnaire (n =

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