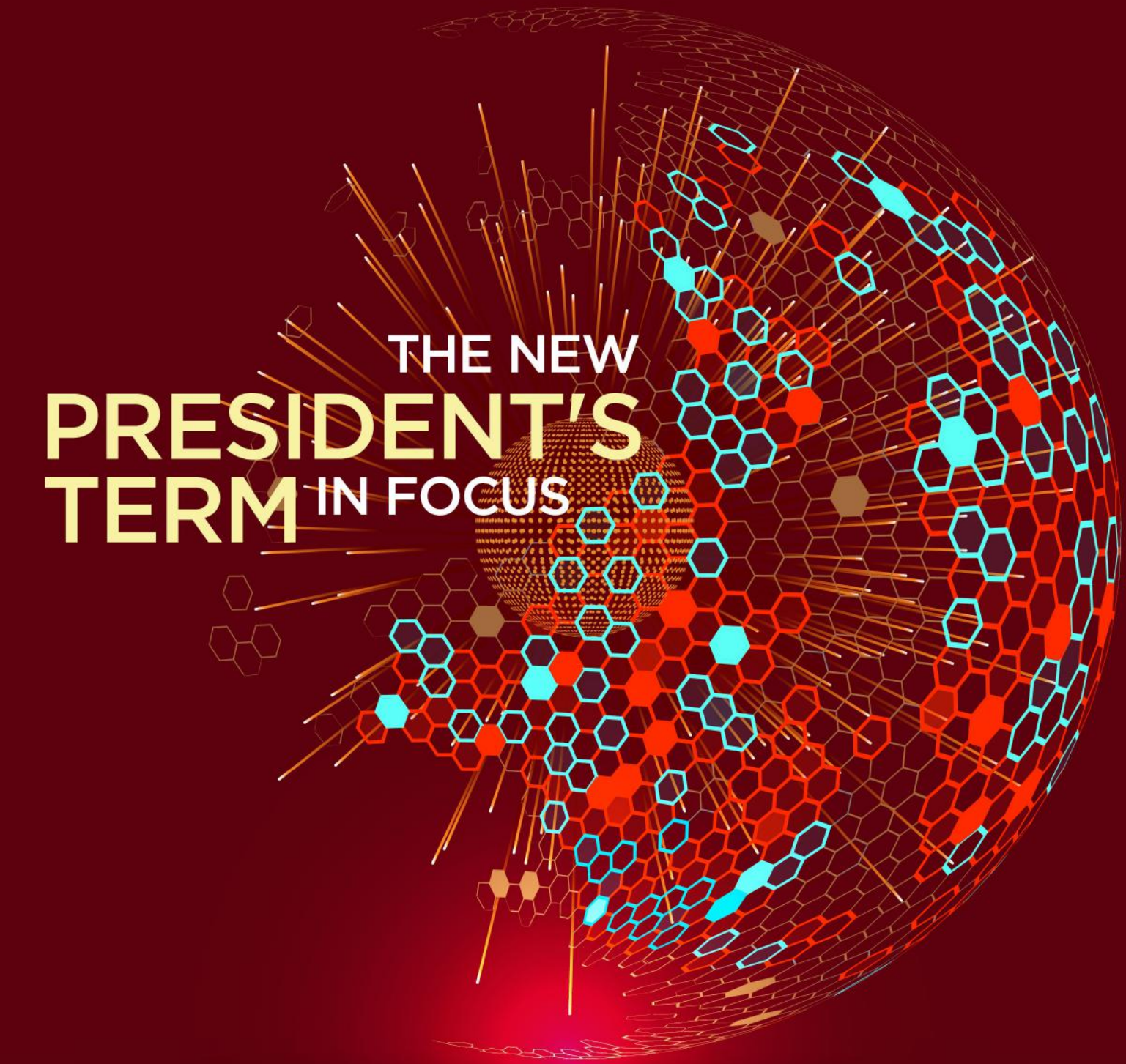
CONNECT

Obstetrical and Gynaecological Society of Malaysia

December 2021 (Issue 1, Council 2021/2022)

EMBRACING, ENGAGING & INFORMING



THE NEW PRESIDENT'S TERM IN FOCUS

Introducing The New Council

Greetings from the New Chairperson of the RCOG IRC Malaysia

A Life Well-Lived

INSIDE INBOX

A publication by the Obstetrical and Gynaecological Society of Malaysia

Contents

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From the President's Desk

Dr Hoo Mei Lin
President
Obstetrical & Gynaecological
Society of Malaysia

It has been a busy 2 months since the Council took office. We have an ambitious year mapped out. Our primary aim this year is to look into the OGSM office. At present, there are many tedious and manual tasks that leave our staff too little time to focus on important matters. We will look into streamlining the processes that are already in place and create new standard operating procedures to increase transparency and ensure fairness in the decision making of future Councils.

We will also look into how we can better serve our membership. The website and the role of our social media engagement will be scrutinised to determine how to achieve this. We aim to increase our social media presence, not only to reach our members, but also to utilise for public education. We will be running public awareness campaigns throughout the year to achieve this. Our membership register will also be undergoing a revamp. We hope that you will be patient if we contact you to update your details kept at OGSM. We are switching to electronic communications rather than relying on conventional post. Please ensure that your details kept with OGSM are up to date.

This pandemic has taught us that we need to evolve with the times to remain relevant. Webinars and virtual congresses have made the world smaller. As the world and Malaysia returns to normal, OGSM will strive to continue to include these virtual programmes to enable a wider reach to members outside of major cities. Our next congress is slated to be a hybrid congress and will be held on 21-24 of July 2022.

Please do not hesitate to reach out to us via our emails should you have any suggestions on how we can better serve you. Please continue to keep safe and hopefully we can physically meet soon.

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In combination with bevacizumab for the maintenance treatment of

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following complete or partial response to first-line platinum-based chemotherapy[1]

DISCOVER THE POTENTIAL OF 3 YEARS mPFS[1]

Individual results may vary.

PAOLA -1

~50% WERE HRD POSITIVE

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Open the opportunity
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Median PFS was 37.2 months with LYNPARZA + bevacizumab (n=255) and 17.7 months with bevacizumab + placebo (n=132); HR=0.33; 95% CI: 0.25–0.45

Data based upon a prespecified exploratory subgroup analysis, which was not controlled for

Indication LYNPARZA is a poly (ADP-ribose) polymerase (PARP) inhibitor indicated: **First-Line Maintenance HRD-Positive Advanced Ovarian Cancer in Combination with Bevacizumab** In combination with bevacizumab for the maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube or primary platinum-based chemotherapy and whose cancer is associated with either a deleterious or suspected deleterious BRCA mutation, and/or genomic instability. Select patients for therapy based on an FDA-approved companion diagnostic for LYNPARZA. **IMPORTANT SAFETY INFORMATION Contraindications** There are no contraindications for LYNPARZA. **Warnings And Precautions** ***Myelodysplastic Syndrome/Acute Myeloid Leukemia (MDS/AML):*** Occurred in approximately 1.5% of patients exposed to LYNPARZA monotherapy, and the majority of events had a fatal outcome. The median duration of therapy in patients who developed MDS/AML was 2 years (range: <6 months to >10 years). All of these patients had previous chemotherapy with platinum agents and/or other DNA-damaging agents, including radiotherapy. Do not start LYNPARZA until patients have recovered from hematological toxicity caused by previous chemotherapy (≤Grade 1). Monitor complete blood count for cytopenia at baseline and monthly thereafter for clinically interrupt LYNPARZA and monitor blood count weekly until recovery. If the levels have not recovered to Grade 1 or less after 4 weeks, refer the patient to a hematologist for further investigations, including bone marrow analysis and blood sample for cytogenetics. Discontinue ***Pneumonitis:*** Occurred in 0.8% of patients exposed to LYNPARZA monotherapy, and some cases were fatal. If patients present with new or worsening respiratory symptoms such as dyspnea, cough, and fever, or a radiological abnormality occurs, interrupt LYNPARZA treatment and initiate prompt investigation. Discontinue LYNPARZA if pneumonitis is ***Embryo-Fetal Toxicity:*** in animals, LYNPARZA can cause fetal harm. A pregnancy test is recommended for females of reproductive potential prior to initiating treatment. ***Females*** Advise females of reproductive potential of the potential risk to a fetus following the last dose. **Adverse Reactions** - First-Line Maintenance Advanced Ovarian Cancer in Combination with Bevacizumab Most common adverse reactions (Grades 1-4) in ≥10% of patients treated with LYNPARZA/bevacizumab compared to a ≥5% frequency for placebo/bevacizumab in the for PAOLA-1 were: nausea (53%), fatigue (including asthenia) (53%), anemia (41%), lymphopenia (24%), vomiting (22%) and leukopenia (18%). In addition, the most common adverse reactions (≥10%) for patients receiving LYNPARZA/bevacizumab irrespective of the frequency compared with the placebo/bevacizumab arm were: diarrhea (18%), neutropenia (18%), urinary tract infection (15%) and headache (14%). In addition, venous thromboembolic events occurred more commonly in patients receiving LYNPARZA/bevacizumab (5%) than in those receiving placebo/bevacizumab (1.9%). Most common laboratory abnormalities (Grades 1-4) in ≥25% of patients for LYNPARZA in combination with bevacizumab in the **first line maintenance setting** for **PAOLA-1** were: decrease in hemoglobin (79%), decrease in lymphocytes (63%), increase in serum creatinine (61%), decrease in leukocytes (59%), decrease in absolute neutrophil count (35%) and decrease in platelets (35%). **Drug Interactions** ***Anticancer Agents:*** Clinical studies of LYNPARZA with other myelosuppressive anticancer agents, including DNA-damaging agents, indicate a potentiation and prolongation of myelosuppressive toxicity. ***CYP3A Inhibitors:*** Avoid coadministration of strong or moderate CYP3A inhibitors when using LYNPARZA. If a strong or moderate CYP3A inhibitor must be coadministered, reduce the dose of LYNPARZA. Advise patients to avoid grapefruit, grapefruit juice, Seville oranges, and Seville orange juice during LYNPARZA treatment. ***CYP3A Inducers***: Avoid coadministration of strong or moderate CYP3A inducers when using LYNPARZA. **Use In Specific Populations** ***Lactation:*** No data are available regarding the presence of olaparib in human milk its effects on the breastfed infant or on milk production. Because of the potential for serious adverse reactions in the breastfed infant, advise a lactating woman not to breastfeed during treatment **Pediatric Use:** The safety and efficacy of Lynparza has not been established in pediatric patients. **Hepatic Impairment:** No adjustment to the starting dose is required in patients with mild or moderate hepatic impairment (Child-Pugh **Renal Impairment:** No dosage modification is recommended in patients with mild renal impairment (CLcr 51-80 mL/min estimated by Cockcroft-Gault). In patients with moderate renal impairment (CLcr 31-50 mL/min), reduce the dose of LYNPARZA to 200 mg twice daily. There are no data in patients with severe renal impairment or end-stage renal disease (CLcr ≤30 mL/min). Y ou are encouraged to report negative side effects Astra Zeneca prescription drugs to the FDA. Visit www.FDA.gov/medwatch or call 1-800-FDA-1088. **Please see the Brief Summary of Prescribing Information on the following pages.**
BID= twice daily; CI= confidence interval; HR= hazard ratio; HRD= homologous recombination deficiency; mPFS=median progression-free survival.

Reference: 1. Ray-Coquard I, et al. N Engl J Med. 2019;381:2416-2428; **2.** Ray-Coquard I, et al. N Engl J Med. 2019;381:2416-2428 Supplementary appendix; **3.** Ray-Coquard I et al. Presentation LBA2_PR presented at ESMO Annual Conference 2019, 27 September - 1 October, Barcelona, Spain **4.** NCCN Guidelines V2 2020 Epithelial Ovarian Cancer / Fallopian Tube Cancer / Primary Peritoneal Cancer.

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For further details on Prescribing, scan here or click here

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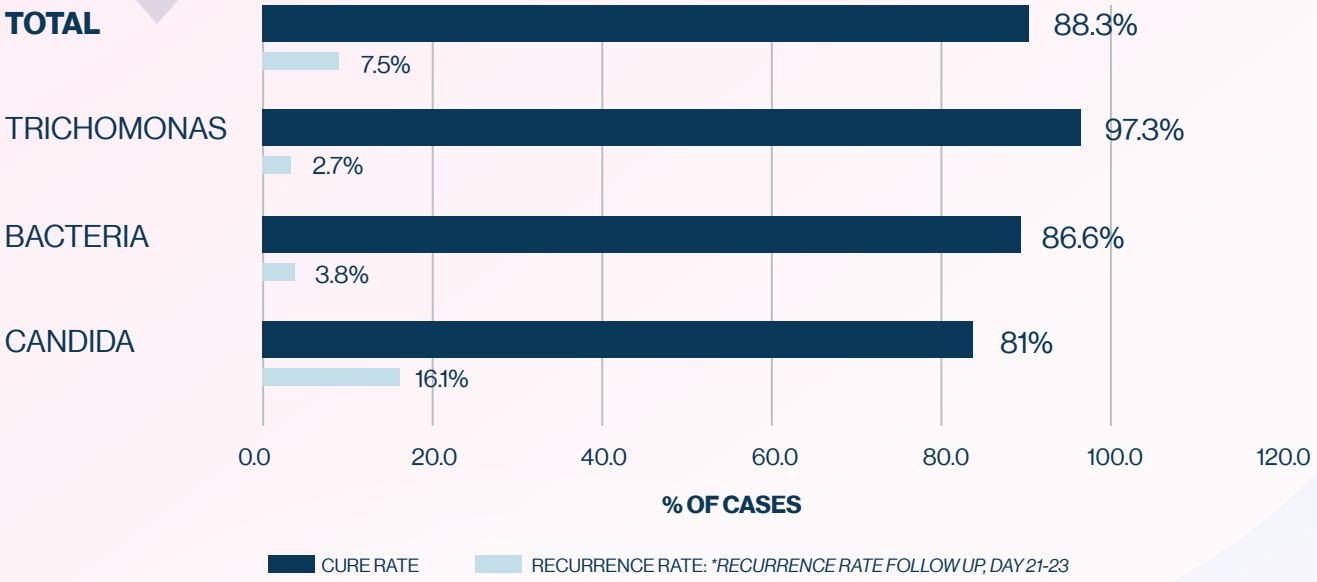

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29th International Congress of the Obstetrical & Gynaecological Society of Malaysia (OGSM 2022)

Keep this date free: **22–24 July 2022**

Dato' Dr Bala Nathan Kathirgamanathan
Organising Chairperson, OGSM 2022
OGSM President-Elect 2021/2022

The 29th OGSM Congress will be held from 22nd to 24th July 2022. We are still in the midst of a pandemic but hopefully, there is light at the end of the tunnel. Mass vaccination of the population has helped bring us to where we are now, and it can only get better. Despite the uncertainties, we will ensure that the premier educational event in our specialty will continue.

We are clearly in the internet era and will therefore be able to weather any storm and bring the Congress to all of you. The virtual platform was utilised for the last Congress, and I am happy to report that it was an enormous success. Even the non-believers among us had to buckle up and become internet savvy! It was also the first time that our AGM was virtually held. Keeping this in mind, the new Organising Committee will try their best to bring the next Congress to all members without any glitches.

The virtual platform has allowed us to connect internationally and globally, making the Congress well known. Next year, we hope to do better by holding a Congress that is different from the previous two. We may opt for a 'hybrid' version of the Congress, however this will depend on the guidelines laid down by the government. Since we must still follow the SOP, we are keeping our fingers crossed that should we need to proceed with a hybrid version, at the very least there will be an opportunity for some physical interaction between OGSM members who desire so.

Last but not least, I hope to have your support for making this a reality. We will keep our members updated as we move forward.

Thank you.

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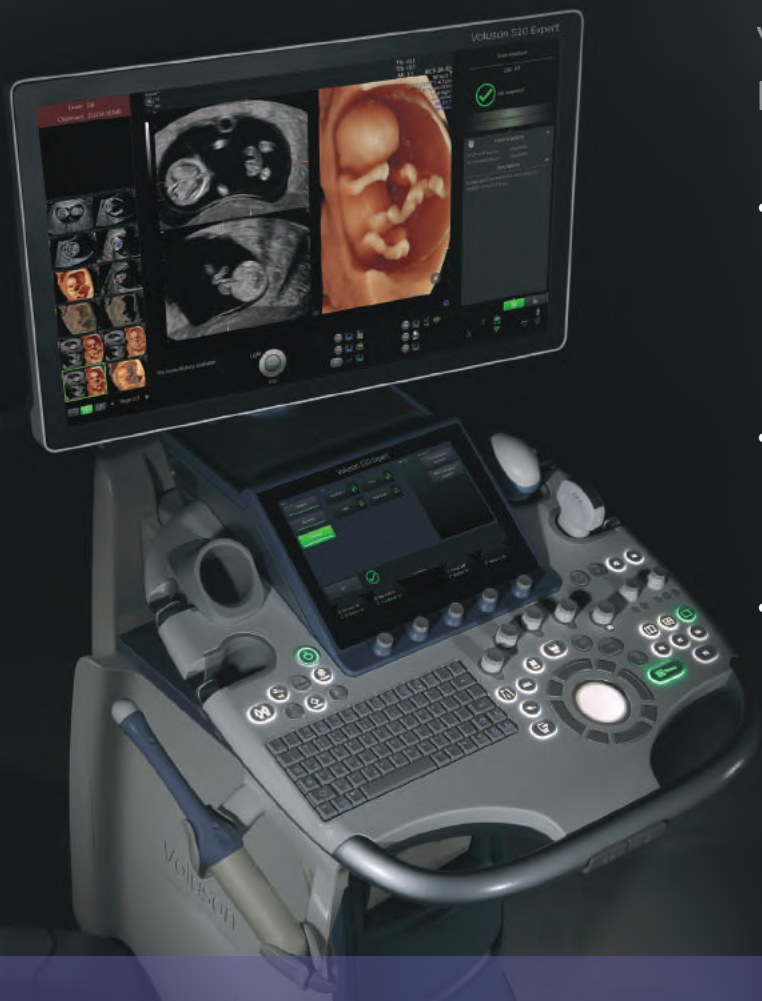

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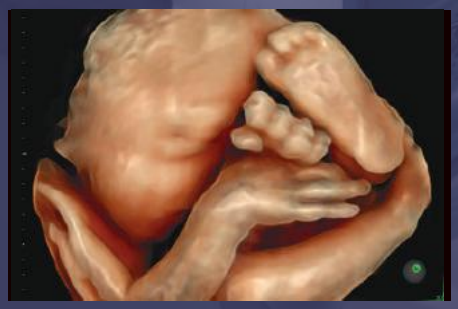

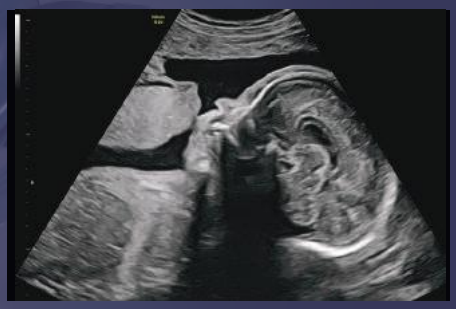

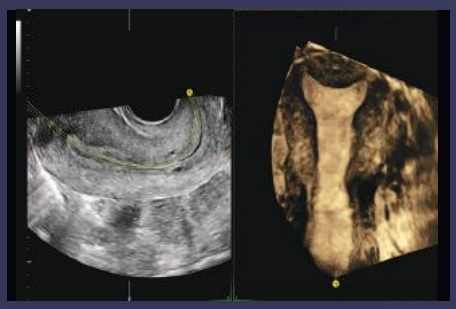

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Council Profile

PRESIDENT
Dr Hoo Mei Lin

Dr Hoo Mei Lin is the current President of OGSM as well as the Trainee Committee Chairperson. Her planned activities for year includes the tightening of the processes for the OGSM office to increase efficiency and transparency, increasing OGSM's social media presence while looking to revamp our website. As the trainee committee chair, she remains committed to look after the interests of our trainees and expanding OGSM's trainee activities.

PRESIDENT-ELECT
Dato' Dr Balanathan a/l Kathirgamanathan

Dato'. Dr. Bala is the Head, Department of O&G at Seberang Jaya Hospital and a sub-specialist in Reproductive Medicine. He hopes to contribute towards enhancing the image of OGSM.

IMMEDIATE PAST-PRESIDENT
Dr Muralitharan Ganesalingam

The healthcare industry produces tremendous amounts of data. Big data and the internet-of-things are the standards for record keeping in the healthcare industry and in the predictive analysis for healthcare. Dr Ganesalingam's aim is to introduce what is available to Obstetricians and Gynaecologists and to increase awareness on the actual impact of this on the manner we practice.

HON. SECRETARY
Dr Loh Huey Wen

Dr Loh Huey Wen is an Obstetrician and Gynaecologist at Sunway Specialist Centre Damansara. She has been involved with OGSM since she was a trainee. She was the OGSM trainee representative in 2012 where she provided a voice for trainees. She further became involved in the OGSM trainee subcommittee when it was formed. She helped develop the PACT program and was instrumental in the success of the OGSM trainee program. She served as the Assistant Secretary in 2019/2020 and was elected Honorary Secretary in 2020.

Her aspirations are to increase the involvement of young specialists in OGSM and elevate the PACT program. By making engagement with trainees a priority, she hopes to meet the training needs of aspiring Obstetricians and Gynaecologists as well as inspire them to become more involved in OGSM. She strives to help PACT evolve to better serve trainees.

In the current term, her hopes are to streamline the office by updating the current SOPs and work with the secretariat towards increasing efficiency.

ASST. HON. SECRETARY
Assoc Prof Aida Hani Mohd Kalok

Dr Aida Hani Mohd Kalok is an Associate Professor at the Faculty of Medicine at the National University of Malaysia and a Consultant Obstetrician and Gynaecologist at Hospital Canselor Tuanku Muhriz & UKM Medical Specialist Centre (UKMSC).

This is her first term on Council.

In this term, she hopes to maintain the Society's continuous support towards the training of both MRCOG and Masters in O&G candidates. She also aspires to work with Council to increase public awareness on issues surrounding women's health using social media.

HON. TREASURER

Brig Gen Dato' Dr T. Thavachelvi a/p S. Thangarajah

Dato' Dr. Thavachelvi is the Head of Department and Consultant Obstetrician and Gynaecologist at Hospital Angkatan Tentera Tuanku Mizan, Kuala Lumpur. She has been the Honorary Treasurer since 2017.

COMMITTEE MEMBERS

Dr Wong Wen Hao

Dr Wong Wen Hao is an Obstetrician and Gynaecologist with special interest in Reproductive Medicine and Minimally Invasive Surgery. He is a Member of the Royal College of Obstetricians and Gynaecologists as well as a Fellow of the American College of Obstetricians and Gynaecologists. He has a strong passion in teaching and is a well-known figure among O&G trainees throughout the country. Amid the Covid-19 pandemic, he aspires to elevate OGSM's virtual presence to remain relevant to its members and the community at large.

Dr Farah Azura

Dr Farah Azura is currently working in Sunway Medical Centre and in Sunway Velocity. She has been active in the trainees programme (PACT) since 2018. She looks forward to promoting women's health and to continue contributing to the trainee's program.

Dr Wilkinson Tan

Dr Wilkinson Tan is an Obstetrician and Gynaecologist at Serdang Hospital. He has previously served in various capacities throughout Perak, Sabah and Selangor. Dr Wilkinson aims to improve member engagement during his term. He plans to empower our social media platforms to improve engagement with OGSM members as well as to increase the medical knowledge of our public.

Dr RM Udayar Pandian Ramachandhiran

Dr RM Udayar Pandian Ramachandhiran is a Managing Director and Consultant Obstetrician & Gynaecologist as well as Fertility Specialist at Ram Fertility & Women's Specialist Clinic. He is also a sessional Lecturer and Examiner at RCSI & UCD Malaysia Campus (Formerly Penang Medical College) in Penang.

His aims are to energise the Society with more regional & national activities and increase the recruitment of new members in this term. He wishes to incentivize and galvanize our junior members with more affordable online training sessions during this pandemic.

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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.

For Medical/Healthcare Professionals Only

Adverse events should be reported to drugsafetyinfo.my@gsk.com

GlaxoSmithKline Pharmaceutical Sdn Bhd (Co. No.3277-U)
Level 6, Quill 9, 112, Jalan Professor Khoo Kay Kim,
46300 Petaling Jaya, Selangor Darul Ehsan, Malaysia.
Tel: (603) 7495 2600 www.my.gsk.com

PM-MY-BOO-ADVT-210001 07/21

Dato' Dr. Alex Mathews
OGSM Trustee & Past President

A Life Well-Lived

Datuk Dr Jagjit Singh Sambhi (1931-2021)

Datuk Dr Jagjit Sambhi, a colourful and illustrious Past-President of the OGSM, departed on the 18th of August 2021.

While President (1989-1990), the Annual AGM/Scientific Meeting was rebranded and upgraded to "The First OGSM Congress". This first Congress was held at the Equatorial Hotel KL in 1990.

It was during his tenure as President that he inaugurated the OGSM Travelling Fellowship where Professor William Dunlop from the University of Newcastle, England was invited to address audiences throughout Malaysia.

Dr Sambhi was a dignified and kind doctor who walked with equal poise, purpose and kindness alongside Kings, Sultans, Prime Ministers, Judges, Heads of The Civil Services as well as people from all walks of life.

Dr Sambhi began life as a tiny 1.3 kg premature baby who was not expected to survive beyond a few hours. He lived to be a vibrant and productive human being right up to the age of ninety.

Dr Sambhi's times were tumultuous. He was born during the Great Depression that had enveloped the entire world.

Then came the 2nd World War and the Japanese Occupation (1942-1945), followed by the "Emergency" (The Communist Insurgency) where it felt like war all over again.

Dr Sambhi went to school in Kuala Lumpur. In his final school years, he was at the Victorian Institution. Dr Sambhi was then admitted to the Medical School at the University of Malaya in Singapore from 1953-1956. He graduated in 1959.

After working in Singapore, Malaya and Brunei for a few years, he was posted to the Kuala Lumpur Government Hospital where he worked under Dr Derek Llewelyn Jones, the first Head of the Maternity Hospital in Kuala Lumpur. He had arranged an appointment in the Oxford University Hospital as preparation for his post-graduate examination. He then completed his MROCG exam soon after. While there, he found the love of his life, Margaret Rowe, who has been his companion and support throughout all these years.

Upon his return to Malaya, Dr Sambhi was posted in Sarawak. At that time, it was a little-known entity where medical services were very basic, and the needs of the people were so great. Access to good healthcare was very limited.

Dr Sambhi encountered many fascinating clinical situations that were new to him. His devoted services were very much appreciated.

When the new Medical Faculty of the University of Malaya opened in Kuala Lumpur, Dr Sambhi applied for and took up a position there.

The Hospital was brand new at the time and did not see many patients. He therefore moved on to set up his own practice – The Sambhi Clinic.

Dr Sambhi quickly acquired a reputation as a good doctor and patients flocked to see him. He was in his element since he saw a large number of patients who sought his help.

Even while busy in the clinic, Dr Sambhi pursued his passion to serve people through several charitable ventures.

Through the Rotary Club, he established the Heart Foundation of Malaysia for education and health promotion among the underserved people. He also established the Rotary Research Foundation to encourage research in medicine.

The Kuala Lumpur Home Nursing Association was a special initiative to address the after-care of needy patients discharged from Hospitals.

The Association of Little People was the result of a particular passion of his to support those who live with Dwarfism. This continued until his passing.

Datuk Dr Jagjit Singh Sambhi's contributions to society are immense.

The Obstetrical & Gynaecological Society of Malaysia is proud to call him one of our own.

We mourn the loss of a mentor, colleague and friend and we celebrate his life.

Our deepest condolences go to Datin Margaret Sambhi and his dear family at this time of parting.

President and Council
Obstetrical & Gynaecological Society of Malaysia

Diphereline®
triptorelin

Endometriosis and Fibromyomas

- Genital and Extragenital Endometriosis (Stage I to Stage IV)[1] 11.25mg 3.75mg
- Treatment of uterine fibromyomas prior to surgery[1] 3.75mg

Breast Cancer

As adjuvant treatment in combination with tamoxifen or an aromatase inhibitor, of endocrine responsive early stage breast cancer in women at high risk of recurrence who are confirmed as pre-menopausal after completion of chemotherapy[1] 3.75mg

1. Diphereline Summary of Product Characteristics IPSEN Pharma Singapore Ptd Ltd Sept 2018

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.

IPSEN
Innovation for patient care

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**

MAXIMIZED EXPOSURE. WOUND PROTECTION. SUPERIOR STRENGTH.[1]

SurgiSleeve™ Wound Protector with Retraction Ring

SurgiSleeve™ wound protector provides increased exposureand protection – in all surgical cases.

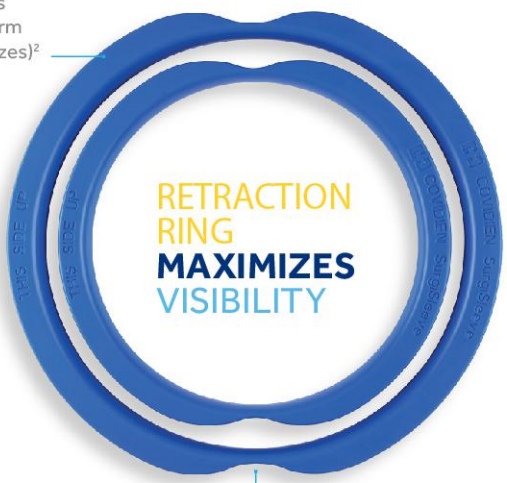
Product Details

Retraction Ring
Provides greater retraction and visibility versus standard wound protectors and a stable platform for access to the body (large and extra-large sizes)[2]

Blue Proximal Ring
Adjusts to variable thicknesses of the abdominal wall and is easy to roll down

3X Stronger Material[1]
Offers optimal wound protection

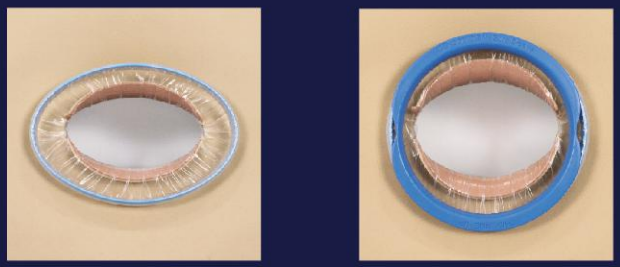
Flexible Gray Distal Ring
Easily inserted and removed through the incision



Finger Cutouts
Facilitate easy insertion and removal of the retraction ring

Maximized Wound Exposure

More incision retraction area — up to 9% on the extra-large and up to 17% on the large size.[2]



Circumferential elastic retraction ring maximizes working area for optimal exposure and visualization.

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Medtronic
Further, Together

Immunisation of expectant mothers has been shown to confer **passive protection against pertussis** in newborns[1]

Adacel®

Adacel® is the **first and only** Tdap vaccine indicated for immunisation during pregnancy in Malaysia![2-4]

HIGH VACCINE EFFECTIVENESS

> 90% effective in preventing pertussis within the first 3 months of life[2,5]

WELL-DOCUMENTED SAFETY PROFILE

> 80,000 pregnancy outcomes evaluated[2]

EXTENSIVE REAL-WORLD EXPERIENCE IN PREGNANCY VACCINATION

Widely used in routine pregnancy immunisation programmes since 2011[6]

Adacel® For the passive protection of newborns against pertussis in the first 3 months of life[2]

Tdap: Tetanus, diphtheria and pertussis.

ADACEL® ABBREVIATED PRODUCT INFORMATION

1. TRADE NAME: Adacel® Suspension for Injection **Pharmacotherapeutic class :** Bacterial and viral vaccines, combined **Dosage forms and strengths :** 0.5ml vial single dose. Each dose (0.5 mL) contains tetanus toxoid 5 Lf, diphtheria toxoid 2 Lf, Pertussis Toxoid 2.5 µg, Filamentous Haemagglutinin 5 µg, Fimbriae Types 2 and 3 (FIM) 5 µg, Pertactin 3 µg **2. THERAPEUTIC INDICATION** ADACEL® is indicated for active booster immunization for the prevention of tetanus, diphtheria and pertussis in persons 4 years of age and older. ADACEL® is not to be used for the treatment of disease caused by *B. pertussis, C. diphtheriae* or *C. tetani* infections. Passive protection against pertussis in early infancy following maternal immunization during pregnancy (see section WARNINGS AND PRECAUTIONS, Special Populations-Pregnant Women and DOSAGE AND ADMINISTRATION) ADACEL® should be used in accordance with official recommendations. **3. DOSAGE AND INSTRUCTIONS FOR USE** ADACEL® (0.5 ml) should be administered as a booster dose by the intramuscular route. The preferred site is into the deltoid muscle. ADACEL® may be administered to pregnant women during the second or third trimester to provide passive protection of infants against pertussis (see sections INDICATIONS AND CLINICAL USE, WARNINGS AND PRECAUTIONS and Special Populations-Pregnant Women). **4. CONTRAINDICATIONS** Known systemic hypersensitivity to any component of ADACEL® or a life-threatening reaction after previous administration of the vaccine or a vaccine containing one or more of the same components are contraindications to vaccination. Encephalopathy within 7 days of a previous dose of a pertussis-containing vaccine not attributable to another identifiable cause is a contraindication to vaccination with any pertussis-containing vaccine. **5. SPECIAL WARNINGS AND PRECAUTIONS** Intramuscular injections should be given with care in patients suffering from coagulation disorders or on anticoagulant therapy. ADACEL® should not be administered into the buttocks, nor by the intradermal or subcutaneous route. Do not administer by intravascular injection, ensure that the needle does not penetrate a blood vessel. Vaccination should be postponed in cases of an acute or febrile disease. However, a disease with low-grade fever should not usually be a reason to postpone vaccination. The possibility of allergic reactions in persons sensitive to components of the vaccine should be evaluated. Allergic reactions may occur following the use of ADACEL® even in persons with no prior history of hypersensitivity to the product components. If Guillain-Barré syndrome has occurred within 6 weeks of receipt of prior vaccine containing tetanus toxoid, the decision to give any vaccine containing tetanus toxoid should be based on careful consideration of the potential benefits and possible risks. Immunocompromised persons (whether from disease or treatment) may not achieve the expected immune response. If possible, consideration should be given to delaying vaccination until after the completion of any immunosuppressive treatment. Nevertheless, vaccination of subjects with chronic immunodeficiency such as HIV infection is recommended even if the immune response might be limited. Syncope (fainting) can occur following, or even before, administration of injectable vaccines. Limited data indicate that maternal antibodies may reduce the magnitude of the immune response to some vaccines in infants born to women vaccinated with ADACEL® during pregnancy. The clinical relevance of this observation is unknown. **6. PREGNANCY AND LACTATION :** Safety data. have shown no vaccine-related adverse effect on pregnancy or on the health of the fetus/newborn child. As with other inactivated vaccines, it is not expected that vaccination with ADACEL® during any trimester would harm the fetus. The benefits versus the risks of administering ADACEL® during pregnancy should be evaluated. Limited clinical data have shown there is interference with the immune response to other antigens (i.e. diphtheria, tetanus, polio, pneumococcal, meningococcal) in infants born to women vaccinated with ADACEL® during pregnancy. The effect of administration of ADACEL® during lactation has not been assessed. **7. UNDESIRABLE EFFECTS** Pain at the injection site was the most common local adverse event. Most injection site reactions occurred within 3 days following vaccination and their mean duration was less than 3 days. The most frequent systemic adverse event was tiredness in children and headache in adolescents and adults. Fever was reported in less than 10%. These adverse events were usually transient and of mild to moderate intensity. The following adverse events were included based on severity, frequency of reporting and the strength of causal association to ADACEL®. Immune System disorder -hypersensitivity reaction Nervous System Disorders -Paraesthesia, hypoesthesia, Guillain-Barré syndrome, brachial neuritis, facial palsy, convulsion, syncope, myelitis Cardiac Disorders -Myocarditis Skin and Subcutaneous Tissue Disorders -Pruritus, urticarial Musculoskeletal and Connective Tissue Disorders -Myositis, muscle spasm General disorders and administration site conditions: - Large injection site reactions (>50 mm) and extensive limb swelling from the injection site beyond one or both joints have been reported after administration of ADACEL® in adolescents and adults. These reactions usually start within 24 - 72 hours after vaccination, may be associated with erythema, warmth, tenderness or pain at the injection site and resolve spontaneously within 3 - 5 days. The risk appears to be dependent on the number of prior doses of acellular pertussis containing vaccine. **8. INTERACTIONS** ADACEL® may be administered concurrently with a dose of inactivated influenza vaccine at separate sites with separate syringes. ADACEL® may be administered concurrently with a dose of Hepatitis B vaccine in 11 and 12 year-olds at separate sites with separate syringes. ADACEL® should not be mixed in the same syringe with other parenterals. **9. OVERDOSE:** No information **10. REVISION DATE** July 2020 **Full prescribing information available on request from** Sanofi Pasteur, vaccines division of sanofi-aventis (M) Sdn. Bhd., Unit TB-18-1, Level 18, Plaza 33, No 1 Jalan Kemajuan, Seksyen 13, 46200 Petaling Jaya, Selangor Darul Ehsan, Malaysia **Ref No.** MY/ADA/V04/0720

References: 1. Gall SA, Myers J, Pichichero M. Maternal immunization with tetanus, diphtheria, pertussis vaccine: effect on maternal and neonatal serum antibody levels. *Am J Obstet Gynecol.* 2011;204(4):334.e331-5. **2.** Adacel full prescribing information. Date of revision: March 2020. **3.** National Pharmaceutical Regulatory Agency. Products approved for additional indication (DCA 346 – 9 July 2020). Available at https://www.npra.gov.my/easyarticles/images/users/1048/gambar/Maklumat-tambahan-indikasi-DCA-346_1.pdf. Accessed on 25 March 2021. **4.** National Pharmaceutical Regulatory Agency. Additional indications approved. Available at https://npra.gov.my/index.php/en/informationen/new-products-indication/additional-indications-approved.html. Accessed on 25 March 2021. **5.** Baxter R, Bartlett J, Fireman B, Lewis E, Klein NP. Effectiveness of vaccination during pregnancy to prevent infant pertussis. *Pediatrics* 2017;139(5):e20164091. **6.** Kharbanda EO, Vazquez-Benitez G, Lipkind HS, *et al.* Evaluation of the association of maternal pertussis vaccination with obstetric events and birth outcomes. *JAMA.* 2014;312:1897–904.

SANOFI PASTEUR

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MAT-MY-2100477 -1.0-04/2021

Greetings from your **RCOG International Representative Committee** (IRC)

Dr Tang Boon Nee
Past President OGSM
O&G Consultant,
Subang Jaya Medical Centre

The recent election for the IRC Malaysia was just concluded. Allow me to introduce the Committee:

Chair:
Dr Tang Boon Nee, O&G Consultant, Subang Jaya Medical Centre

Fellow Representatives:
1. **Dr Chew Ghee Kheng**, Gynae-oncology Consultant, Penang Adventist Hospital
2. **Dr Vijayan Valayatham**, MFM Consultant, Aseana O&G Specialist Clinic, The Curve
3. **Dr Nirmala Chandralega Kampan**, Associate Professor, Gynae-oncology, UKM

Member Representatives:
1. **Dr Muniswaran Ganeshan**, Head, MFM Unit, HKL
2. **Dr Kavitha Nagandla**, Associate Professor, IMU
3. **Dr Lim Ai Wei**, O&G Consultant, Thomson Hospital

We would like to thank the Malaysian fellows and members of the College for the trust placed in this Committee.

The IRC has always been active in postgraduate training activities for the present and future fellows/members. The pandemic has dented and delayed the pathway of many towards membership. Exams were postponed, modified and cancelled. The immediate past chair, Dr Shilpa, and her Committee have done a tremendous job keeping trainees motivated and focused.

Over the years, the IRC has made inroads to obtain the Part 3 MRCOG exam to Malaysia, minimising the travel and uncertainties it brings. Malaysia is due to conduct its first Part 3 MRCOG in May 2022. The present Committee, on behalf of all fellows and members, would like to place on record our sincere thanks and gratitude for all the effort and determination of the Past Committee.

This Committee has enormous tasks ahead. Trainees, in their hundreds, have been organised into groups with assigned tutors. Tutoring has been virtually conducted as small group OSCE sessions. Lectures with larger audiences are mostly conducted by local tutors and some invited guest speakers from the UK. The upcoming exams in May 2022 requires Malaysia to train up to (but not limited to) 35 examiners. We will collate and forward all applicants meeting the minimum criteria to the RCOG by the 22nd of October this year. Training will be virtually conducted this December. Role play patients and lay examiners must be identified and trained by that time.

On another front, the IRC has been invited to the table for the MOH MRCOG Parallel Pathway committee meetings to further define and structure MRCOG trainee activities. It is hoped that this effort will lead to eventual fruition, easing some burden (if not all) that trainees go through. This will further streamline training activities and hopefully provide some fringe benefits along the way.

RCOG has a long and rich history in Malaysia. We are certain that many members and fellows have still much to contribute. If anyone is happy to take on a trainee (even just for a weekend) to showcase procedures and share knowledge, we will be happy to coordinate. Other roles of the IRC include addressing issues or projects concerning women's health in general. While we are currently overwhelmed with the upcoming exams, we are open to any suggestions that anyone may have. Do email us at: rcogmalaysia@gmail.com

We look forwards to working with all.

Once again, thank you.

IRC Malaysia 2021-2024
12-10-2021

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The Only Pre-natal Milk with No Added Sugars**

NEW LOOK

- ✓ High Calcium & High Folate
- ✓ MFGM + Gangliosides (GA®)
- ✓ DHA
- ✓ Prebiotic & Probiotic
- ✓ Iron

**Sucrose, Glucose Syrup Solid, Corn Syrup Solid, Brown Sugar, Dextrose, Lactose, Fructose, Honey and White Sugar are defined as 'sugars' and 'added sugars' under CODEX Standard 212-1999 and CAC/GL23-1997. CODEX develops harmonised international food standards guidelines and code of practices. Under Malaysia Food Regulations 1985, Sucrose, Brown Sugar, Dextrose, Glucose, Fructose, Honey are defined as sweetening substances. For Anmum™ MATERNA Plain only. Anmum™ MATERNA Chocolate flavour is less sweet.

REASONS TO AVOID EXCESSIVE SUGAR INTAKE DURING PREGNANCY

- Excessive Gestational Weight Gain[1]
- Hyperglycaemia[2]
- 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.

Letter of appreciation from the Women's Aid Organisation

WOMEN'S AID ORGANISATION
PERTUBUHAN PERTOLONGAN WANITA

P.O. Box 493, Jalan Sultan
46760 Petaling Jaya, Selangor, Malaysia
Tel: 03 7957 0636 / 5636
WAO Hotline: 03 3000 8858

9 September 2021

Dear Sir/Madam,

We from Women's Aid Organisation (WAO) would like to thank the speakers and Obstetrical and Gynaecological Society of Malaysia for the generous donation of RM10,000 to our organisation. This goes a long way in our efforts to support survivors of domestic violence nationwide during COVID-19.

The Delta variant has made it extremely challenging for us to support survivors during this time. In the span of four days in the first week of July, WAO had conducted 12 rescues to help survivors escape their violent homes; and we continue to coordinate more rescues and provide case management to date. We have received in total 3317 reports on domestic violence and other types of gender-based violence (GBV) from January to June 2021.

With our limited resources, WAO has been receiving a consistently high volume of calls and enquiries from survivors all over Malaysia in seeking crisis and shelter support. Join us in our efforts to end violence against women and children by pledging to create a safe community for all!

You can make your pledge here: www.wao.org.my/donate

We are currently seeking more funds that will go into the following services:

1. Food Bank and Essential Items
2. WAO 24-hour Crisis Support Response
3. Gender-Based Violence (GBV) Survivor Psychosocial Support
4. Case Management and Social Work
5. WAO Women's Refuge (Shelter)
6. WAO Child Care Centre (Shelter)
7. Legal Aid and Medical Aid
8. Advocacy and Community Public Awareness
9. Operations

WAO has pushed on to advocate in the elimination of violence of women and children the last 39 years, working passionately to meet the needs of abused women and children in Malaysia. Should you wish to support us in any of the above areas. Please do contact amnani@wao.org.my.

Yours Sincerely,

Sumitra Visvanathan
Executive Director
Women's Aid Organisation

Registration No: 3423/83, Tax

SAVE the Date

22-24 July 2022

One World Hotel,
Petaling Jaya, Malaysia

Obstetrical and Gynaecological Society of Malaysia

29th International Congress of the Obstetrical and Gynaecological Society of Malaysia

MOVING FORWARD WITH THE NEW NORM!

College Update

The annual general meeting of the College of Obstetricians and Gynaecologists (COGAMM) was held virtually on 18th September 2021 marking the end of the first term for the newly 'refurbished' committee that took over on 4th September 2020. The initial AGM that was meant to be held on 14th August 2021, unfortunately lacked a quorum, a phenomenon that has become somewhat customary for the COGAMM. Nevertheless, the recalled AGM was executed flawlessly and there was much discussion on a variety of issues. The year past has certainly seen the COGAMM elevating itself to new heights. Several activities were carried out over the year. This included a series of online webinars that drew audience numbers that surpassed expectations. More interestingly, even after the said events were concluded, the recorded versions on Facebook continued to build viewership numbers that were impressive albeit surprising. In addition to these CPD activities, the COGAMM was also actively engaged in several other fronts including the various specialty sub-committee's that the COGAMM has representation. The COGAMM has also successfully planned and negotiated the introduction of a novel fellowship program – the Certificate of Completion of Training in Minimally Invasive Gynaecologic Surgery in collaboration with the Ministry of Health, Malaysia, several local universities and the Gynaecologic Endoscopic Society of Malaysia (GESM). It is anticipated that this program will finally provide a clear structure and curriculum for a surgical skill that is indispensable but the training for which is now piecemeal and fractured at best. Moving forward, we are certain that the COGAMM will continue on its revival path. Perhaps now that we are on a better footing, we should invest some time on self-reflection and make clear decisions on what exactly we want to achieve and how we intend to do so.

Council, College of Obstetricians and Gynaecologists,
Academy of Medicine Malaysia

The evolution of IVF laboratory culture systems leading to improved outcomes

Sharmila Thevi Ponusamy
Embryologist, Sunfert International Fertility Centre, Bangsar South.
BSc Genetics (Hons) UKM.
Currently doing her MSc in Clinical Embryology University of Leeds.

Dr Eeson Sinthamoney
Fertility Specialist and Director
Sunfert International Fertility Center
Bangsar South, Kuala Lumpur

It is undeniable that since the birth of the first IVF baby in 1978, there has been many improvements that have led to significantly better outcomes. While the clinical management has certainly changed with our increased understanding of what works and what doesn't, it is perhaps the enhanced laboratory technology that has contributed significantly to these phenomenally improved outcomes. The culture system is an integral part of ART, to support the growth of an embryo in-vitro by providing a microenvironment that improves the embryo viability and minimizes stress. This culture system is interdependent on the important elements such as culture media, incubators and the environment.

CULTURE MEDIA

Culture media is a vital component in growing embryos in-vitro where it provides all the nutrients and energy required. Tissue culture media was the foundation for the development of human embryo culture media (Chronopoulou and Harper, 2015). Initially, culture media was developed based on a simple salt solution such as Earl's medium or a more complex version, Ham's F10 medium (Chronopoulou and Harper, 2015). The first IVF baby born was cultured in Earl's simple salt solution containing maternal serum and pyruvate (Edwards et al., 1981; Cohen and Rieger, 2012). Later, Human Tubal Fluid (HTF) was developed based on the analysis of human ovi-ductal fluids and this formed the basis of various embryo culture media (Quinn, Kerin and Warnes, 1985). The two major approaches practised in development of human embryo culture medium are "back to nature" and "let the embryo choose" (Vajta et al., 2010; Chronopoulou and Harper, 2015). The first approach gave rise to development of sequential media which were based on ovi-ductal and uterine fluid analysis. The latter method is where a single culture medium was developed with all the necessary nutrients needed for the embryos, to be utilized during different stages of development (Chronopoulou and Harper, 2015; Sunde and Stormy, 2021). Both approaches have their own strengths and weaknesses.

SEQUENTIAL MEDIA

The advent of an 'extended culture' of embryos to blastocyst stage led to the development of sequential media. The intention was to provide different components and nutrients during each phase of growth to mimic what occurs in vivo. Gardner's G-series culture medium was based on ovi-ductal and uterine fluids whereby Growth 1 (G1) is used for zygote to cleavage stage while Growth 2 (G2) is to support embryos at compaction to blastocysts stage (Gardner and Lane, 2003). G1 and G2 differ in their constituency. G1 does not contain glucose or phosphate as glucose is known to cause 2 cell-block in mice embryos which inhibits embryonic genome activation (Chatot et al., 1989; Gardner and Lane, 1998; Nagaraj et al., 2017) while high phosphate have been shown to increase glycolysis and limits oxidative phosphorylation which leads to deficiency in energy present for embryo development (Quinn, 2012).

SINGLE-STEP MEDIA

Monoculture media or single-step media is based on 'let the embryo choose' approach where one single media contains sufficient concentration of all the nutrients needed for all the stages of embryo (Chronopoulou and Harper, 2015). There are two practices in single-step culture system, namely uninterrupted culture and interrupted culture. Uninterrupted culture is a continuous culture without media refreshment while in interrupted culture the media is refreshed on day 3 of development. There were no significant difference found in both interrupted culture and uninterrupted culture with single-step media (Costa-Borges et al., 2016). Thus, no renewal of medium is necessary on day 3 unless the media contains glutamine which causes toxic level of ammonium build up in the media (Costa-Borges et al., 2016; Consensus Group, 2020). However, most single-step medium contains stable dipeptide forms of glutamine (Wale and Gardner, 2016; Morbeck, Baumann and Oglesbee, 2017).

Albeit the preference for different source of carbohydrate for each stage could be a challenge when single-step medium is used, the addition of amino acids has been able to avoid the unfavourable outcomes caused by the presence of glucose during cleavage stage (Morbeck, Baumann and Oglesbee, 2017). Currently, there are no sufficient evidence to prove the superiority of culture media as both sequential and single-step media results in almost comparable development and outcome (Youssef et al., 2015; Consensus Group, 2020). Unfortunately, given the lack of transparency from commercial media manufacturers, ART practitioners are left to determine on their own which media is optimum for their laboratory (Chronopoulou and Harper, 2015; Sunde and Stormy, 2021).

INCUBATORS

Incubators are the cardinal component in a culture system. It maintains optimum pH, gas and temperature that nurtures embryo development. Incubators have evolved tremendously to better support embryo development since the usage of a

desiccator to culture the first human embryo (Edwards et al., 1981; Cohen and Rieger, 2012; Kovačič, 2021). Large volume incubators (Big box) were assimilated into IVF from conventional tissue culture whereas bench-top incubators are much smaller in volume and has the potential for rapid recovery of temperature and gaseous (Lee, Grazi and Seifer, 2008). The time taken for the recovery of temperature and gaseous in big box incubators negatively impacts the growth of embryos causing the bench-top incubators to be more sought-after incubators (Lee, Grazi and Seifer, 2008; Swain, 2014).

The most recent innovation in incubator technology is the Time-lapse (TL) incubators with individualized chambers and integrated cameras to monitor embryos (Lundin and Park, 2020; Sciorio, 2021). The microenvironment of the embryos cultured in TL are much more stable due to uninterrupted culture from insemination to blastocyst stage (Armstrong et al., 2019). Moreover, TL allows embryologists to better select embryos based on the morphokinetics which predicts embryo viability and implantation potential (Racowsky and Martins, 2017; Armstrong et al., 2019). The stable uninterrupted culture and availability of the selection tools in TL has led to higher pregnancy rate, live birth rates and reduced pregnancy loss (Pribenszky, Nilselid and Montag, 2017). Recently, artificial intelligence has been integrated into TL incubators, thereby able to better predict the probability of the embryo developing into a blastocyst as well as its implantation potential (Liao et al., 2021). There is still no sufficient proof of the superiority of TL incubators in a culture system and more studies on sibling oocytes are needed to rule out patient factors (Consensus Group, 2020).

Figure 1 : Shows different type of incubators used in an IVF laboratory.

A) Glass desiccator;
B) Big-box incubator;
C) Benchtop incubator;
D) Time-lapse incubator

MICROFLUIDIC SPERM SORTING

Microfluidics is a novel method that involves the control and manipulation of micro and nanolitre volume of liquid in a small-scaled device (Smith, Swain and Bormann, 2011). This methodology can incorporate multiple laboratory procedures in a single chip (Smith, Swain and Bormann, 2011). A recent novel innovation is a microfluidic sperm sorting device that has been proven to separate sperms with high motility and low DNA fragmentation compared to the traditional sperm preparation methods which involves centrifugation and therefore unfortunately increases reactive oxygen species (ROS) (Nikshad et al., 2021).

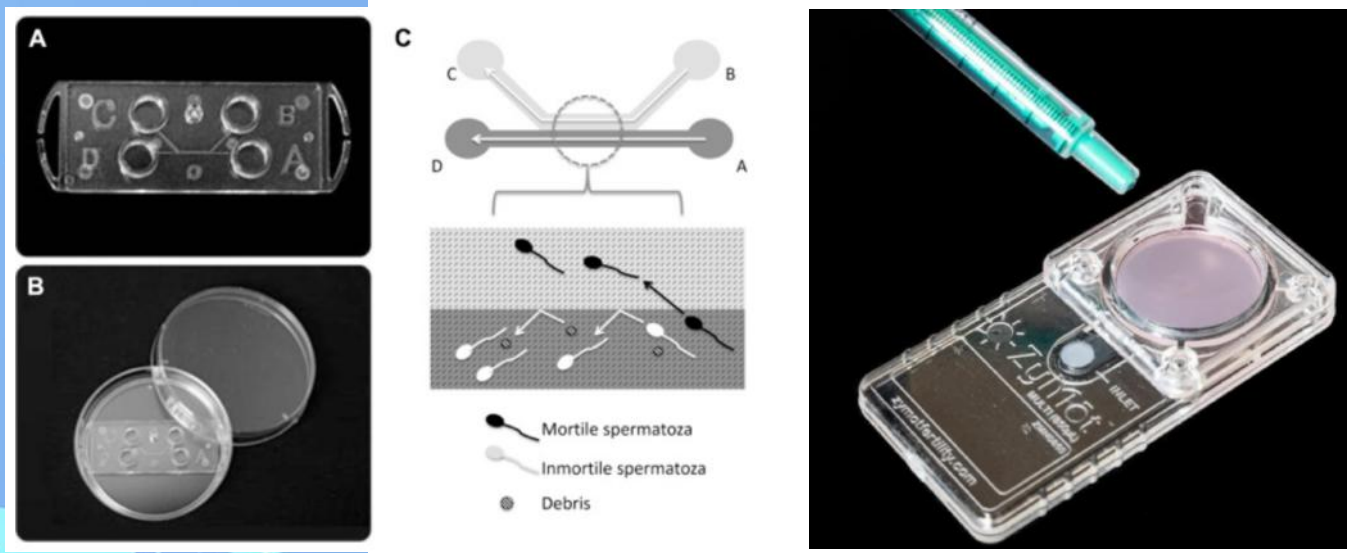

Figure 2 : Shows microfluidic sperm selection devices (Shirota et al., 2016)

CONCLUSION

While obtaining an optimal number of good quality gametes is vital to the success of any IVF treatment, it remains undoubtedly clear that the embryo culture environment remains the cornerstone of IVF treatment success. The evolution of the IVF laboratory is a reflection of the continuous desire to further optimize culture conditions. While one is often tempted to in-cooperate the newest and the latest posthaste, each decision should be made responsibly, after weighing the advantages and disadvantages. Slow incorporation of changes into the culture protocol is safer and helps to keep the system afloat. There are after all, still many controversies and unknown consequences of laboratory interventions on human gametes and embryos. Certainly, the IVF laboratory equipment industry's lack of full disclosure on the actual constituents of culture media seriously hampers research as some studies have implicated culture media in epigenetic changes, modified gene expression and even an affect in birthweight. (Chronopoulou and Harper, 2015; Wale and Gardner, 2016).

The Past, the Present and the Future

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"Declare the past, diagnose the present, foretell the future"

-Hippocrates-

Since 2004, I have been observing the progress of the Obstetrical and Gynaecological Society of Malaysia (OGSM), when I started my journey as a trainee. I seized every opportunity to be part of the Society. I made it a point of not missing any activities organised or undertaken by the society, hoping my participation and contribution will contribute to the growth of the society. Over the years my enthusiasm and love towards the society has increased many folds.

OGSM is an independent, non-profit and non-governmental organisation with affiliation to the International Federation of Gynaecology and Obstetrics (FIGO); the Asia-Oceania Federation of Obstetrics and Gynaecology (AOFOG); and the International Federation of Fertility Societies (IFFS). The society was established in 1963 and I became a member in 2004. From a society with only 20 members, it has now close to 1500 members today.

Since its inception, women's health has been the priority. Education and training are the two drivers which help to achieve its intended goal. OGSM has hosted numerous education programs and hosted O&G training programs related to the emergency management of patients which has benefitted trainees and nurses including paramedics related to O&G.

OGSM upholds the mission for the betterment of women's care. The society should play a significant role in drawing new guidelines or formulating policies related to women's care by working hand in hand with policymakers from the Malaysian government and the Royal College of Obstetricians and Gynaecologists (RCOG). The society will be the bridge between the government and women by addressing the major issues seen in their clinical care and service.

The presence of vast new information from multiple new guidelines and research has created a space for misinterpretation. To create a standardised understanding, members can be mobilized to form an internal 'expert panel'. This would generate less controversy among medical practitioners and also the lay public since this information will be seen as a clear standing from a reputable group of experts.

It would be an amazing sight to see OGSM bringing together practitioners from various backgrounds, namely from the government, private and teaching hospitals. The harmonisation formed could forge stronger collaborations besides creating a sense of togetherness. The inclusion of different chapters could represent the Society's colourful background as the society rapidly expands. The representative from each sector will also highlight issues and potential solutions to ensure all members are supported by the Society.

All specialties have multiple subspecialties and O&G is not an exception. Although each subspecialty has its respective society, the subspecialties present in OGSM should work collectively for the betterment of the Society. It would be a sight for the sore eyes to witness these entities working synchronously as it would increase the strength and reputation of OGSM and our expertise in the global arena.

OGSM should invest more in aspects that yield higher moral returns. With a mission of improving women's care, the society needs to sync better with policymakers. A foundation funded and formed by OGSM would fill the scarcity of impactful research carried out by the Society and could also support junior members for short attachments internationally to enhance their expertise in their respective subspecialties. This could further internationalise the Society and bring the Society to greater heights. OGSM lacks prioritisation of global issues such as their involvement in the COVID-19 pandemic. The Society should give a helping hand by providing funds for ventilators (for instance) or mobilising volunteers to ease the burden of healthcare facilities.

As the community is rapidly progressing, OGSM stands to be a prestigious society. OGSM could play a major role in women's health by gaining a better understanding of health issues at a grass-root level. The advancements of technology leading to the Fourth Industrial Revolution will bring numerous adaptations in the Society's management. OGSM will remain more sustainable when we move with the new area of digitalisation and artificial intelligence.

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