

# CONNECT



March 2022 (Issue 2, Council 2021/2022)

EMBRACING, ENGAGING & INFORMING

## “Can Health Supplements Get You In Trouble? - The Doctor's Dilemma”

Beyond OGSM : Representing  
our National Society in AOFOG

Asia Evening at  
FIGO 2021

INSIDE  
INBOX

A publication by the Obstetrical and Gynaecological Society of Malaysia

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# Health Supplements – The Doctor’s Dilemma



**Dr Kuharaj Balasubramaniam**  
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Health supplements, such as vitamins, are an integral component of healthcare. They are routinely recommended by medical practitioners, either in isolation or as an adjunct to medical therapy.

General practitioners and obstetricians routinely recommend folic acid supplements pre-conceptually and for those in early pregnancy. Recently, in the United Kingdom, the failure of a general practitioner to recommend folic acid to a pregnant mother who later delivered a child with spina bifida has resulted in a lawsuit. The role of health supplements in medicine is indisputable.

Lately, the use of health supplements as an adjunct to conventional medical therapy has increased as part of a growing trend known as “functional medicine”. More health supplements are now routinely dispensed in clinics compared to the past when patients would purchase these supplements from pharmacies. In 2019, the health supplement industry in Malaysia was valued at MYR 3 billion, a billion ringgit more than just five years prior. More players are now present in the supplement market, either producing these supplements locally or distributing imported health products. The medical practitioners must be aware of what they are prescribing and dispensing in their medical practice.

In Malaysia, the National Pharmaceutical Regulatory Authority (NPRA) is responsible for the registration, regulation and licensing of healthcare products and pharmaceuticals. Food products and food supplements are regulated by the Food Safety and Quality division, while medical devices are under the purview of the Medical Devices Authority (MDA). These three regulatory bodies are branches of the Ministry of Health (MOH/KKM).

The NPRA is a very large organisation with ranging functions such as the classification of food and health products, the licensing of health supplements and pharmaceutical products, pharmaceutical enforcement as well as other key regulatory roles. They are the Malaysian equivalent of the Food and Drug Administration (FDA) in the United States. For health supplements or pharmaceutical products to be legally sold or dispensed in Malaysia, they must have an NPRA license.

The NPRA website defines a health supplement as any product that is used to supplement a diet to maintain, enhance and improve the health function of the human body. The NPRA is responsible in determining whether a product is a food supplement or a health supplement. Although some products claim to grant health benefits, they may still be classified as food supplements if the content of the active ingredients in the said supplement is minimal and vice versa. Products that contain a significant amount of active ingredients and in the form of capsules, tablets, liquids and powders are invariably deemed to be health supplements and are under the scope of the NPRA. Any preparation that contains vitamins, minerals, amino acids, fatty acids, enzymes, probiotics or any bio-active substances, regardless of whether it is derived from a natural or synthetic source, is deemed as a health supplement according to the NPRA. The NPRA website also excludes sterile preparations, such as eye drops and injectables. They do not fall under the classification of health supplements.

Much of the public, and even some registered medical practitioners, are unaware that the sale and purchase of health supplements that are unregistered with the NPRA is illegal in Malaysia. The sale or distribution of unregistered health supplements is an offense under the Poison's Act 1952. Many seem to be under the wrong impression that if a health supplement is FDA approved, this alone is sufficient. Recently, a few registered medical practitioners have been charged under the Poison's Act 1952 for selling unregistered health supplements, resulting in court appearances and the payment of hefty fines. Apart from committing an offense under the Poison's Act 1952, which makes the registered medical practitioner liable for a large fine, the said medical practitioner will also face disciplinary action from the Malaysian Medical Council (MMC) for committing such an offense.

The use of health supplements in Obstetrics and Gynaecology is widespread across all subspecialties. It will be prudent for the practicing specialist to verify whether the prescribed or dispensed health supplements are registered with the NPRA for the very purpose that they are recommended for. Medical representatives selling health supplements should provide proof of actual NPRA certification, not mere applications for certification. The medical practitioner should also ensure that the health supplement being purchased has NPRA certification. NPRA certified health supplements will carry a registration number beginning with MAL, an eight-digit number ending with the letter N, and a KKM Meditag hologram. A quick search on the NPRA website will further confirm whether the health supplement is registered.

Medical practitioners in Malaysia must be aware that any health supplement, even vitamins, require local licensing and certification for them to be legally sold or distributed. The approval of the regulatory bodies in other countries, such as the FDA, is irrelevant regardless of the potential selling point to the public. The obstetrician and gynaecologist are already immersed in a highly litigious profession. He/she should not invite more opportunities for legal issues.

*Ignorantia juris non excusat* – Ignorance of the law excuses no one. Every medical professional should know and understand the laws that govern their profession. The courts unfortunately do not accept excuses.

For further information, kindly refer to <https://www.pharmacy.gov.my> and <https://www.npra.gov.my>



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1. Types of Stem Cell and Bone Marrow Transplants. American Cancer Society. <https://www.cancer.org/treatment/treatments-and-side-effects/treatment-types/stem-cell-transplant/types-of-transplants.html>. Accessed April 13, 2021.

2. Beatty PG, Boucher KM, Mori M, et. al. 2000. Probability of Finding HLA-mismatched Related or Unrelated Marrow of Cord Blood Donors. Human Immunology. 61, 834-840.

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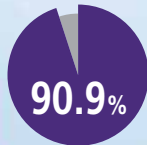
# The first Tdap vaccine with safety data in pregnancy in its label<sup>1-3</sup>



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No vaccine related adverse effect on pregnancy or on the  
health of the fetus / unborn child<sup>1</sup>

## Proven effectiveness on the protection against pertussis disease in infants <3 months of age born to women vaccinated during the third trimester of pregnancy<sup>1</sup>



vaccine effectiveness  
against pertussis disease  
in newborns based on  
a study in Spain  
(95% CI: 56.6, 98.1)<sup>1,5</sup>

83.7%  
reduction

in fatality rate in  
infants <2 months  
of age (95% CI: 63.9,  
92.6; P<0.001)<sup>6</sup>

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



More than **269** million doses  
of Boostrix have been distributed  
worldwide over the past 20 years<sup>11</sup>

**References:** 1. Boostrix Malaysia Prescribing Information, Version GDS10/IP111. 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](http://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](http://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 Organization (WHO). WHO vaccine-preventable diseases: monitoring system. 2020 global summary. Available at: [https://apps.who.int/immunisation\\_monitoring/globalsummary/schedules](https://apps.who.int/immunisation_monitoring/globalsummary/schedules); Last accessed: May 2021. 11. GlaxoSmithKline. Data on File: DTP portfolio. DNG Number: 2021M465985\_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  $\geq 40.0^{\circ}\text{C}$  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  $\geq 3$  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 DTaPs and DTaP 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 ( $\geq 1/10$ ): irritability, somnolence, injection site reactions (including pain, redness and swelling), fatigue; Common (1/100 and  $<1/10$ ): anorexia, headache, diarrhoea, vomiting, gastrointestinal disorders, fever  $\geq 37.5^{\circ}\text{C}$  (including fever  $> 39^{\circ}\text{C}$ ). **Adults, adolescents and children from the age of 10 years onwards:** Very Common ( $\geq 1/10$ ): headache, injection site reactions (including pain, redness and swelling), fatigue, malaise; Common (1/100 and  $<1/10$ ): dizziness, nausea, gastrointestinal disorders, fever  $\geq 37.5^{\circ}\text{C}$ , injection site reactions (such as injection site mass and injection site abscess sterile). **Overdose:** Adverse events following overdose, 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/IP111\_09Aug2018. API created: 2nd April 2020.

Before prescribing, please refer to the full prescribing information,  
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“ It is with great honour, pride and pleasure that the Obstetrical and Gynaecological Society of Malaysia (OGSM) invites you to attend and participate actively in the 29th International Congress of OGSM, which will be held from the **22<sup>nd</sup> till the 24<sup>th</sup> of July 2022** at the **One World Hotel, Petaling Jaya**.

Our Scientific Chairman, Dr Suresh Kumarasamy has vast experience and hopes to bring the latest knowledge and technology to all of us despite being in the pandemic and live up to the standard international benchmark or surpass it.

**By this time, all of us will be moving forward with the norms put in place so that we will be able to enjoy this meeting to the fullest.**

It is not only about the academic side but also catching up with our fellow colleagues after two years. We are looking forward to meeting all of you again in One World Hotel, Petaling Jaya this July. We hope to make this Congress an enjoyable event and also a successful one.

Thank you for your participation and support. ”



**Dato' Dr K. Balanathan**  
*Organising Chairman*  
29<sup>th</sup> International Congress of  
The Obstetrical & Gynaecological  
Society of Malaysia (OGSM 2022)

### IMPORTANT DATES

- **Abstract Submission Deadline 31 MAY 2022**
- **Early-Bird Registration Deadline 30 JUNE 2022**

### Highlights

#### Lectures

- 20 lectures including Plenaries and Keynote Lectures

#### Named Lectures

- President's Lecture, I.S. Puvan Memorial Lecture and Singapore Lecture

#### Symposia

- Symposia on Obstetrics, Gynaecology, Urogynaecology, Reproductive Medicine and Medical-negligence in Obstetrics & Gynaecology

#### Special Sessions

- ASGO Session on Gynaecological Oncology, Asia Pacific HPV Coalition Session

#### Masterclasses

- Five Masterclasses conducted by leading experts

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- Session include Lap Sacrocolpopexy, Colpocleisis, Manchester-Fothergill Repair, Fetoscopic Laser Surgery, vNOTES for Anterior Colpotomy and more

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**Reference:** 1. LigaSure™ Maryland Jaw Sealer/Divider, Nano-Coated [instructions for use]. Boulder, CO: Medtronic; 2016.

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# Beyond OGSM: Representing our National Society in AOFOG



Dr Voon Hian Yan was the recipient of the SS Ratnam Young Gynaecologist Award in 2019 and a member of the AOFOG Ultrasound Committee of 2019-2022. He is also an editor of CONNECT.

The Obstetrical & Gynaecological Society of Malaysia (OGSM) is an active member of The Asia & Oceania Federation of Obstetrics & Gynaecology (AOFOG), which consists of 28 national societies.

Coincidentally, pre-independence Malaya was one of the founding members of AOFOG in April 1957 where Dr R. Thuriapah and Dr K. Kanagasingam were present in the inaugural meeting in Tokyo (The Obstetrical and Gynaecological Society of the Federation of Malaya, the precursor to OGSM. OGSM was only established in 1963).

Three former Presidents of the OGSM have presided over the AOFOG as well, namely, Dato' Dr Ariffin Ngah Marzuki (1973-77), Dato' Professor Dr. V. Sivanesaratnam (2000-02) and most recently, Dr Ravi Chandran (2017-19). Dr Thaneemalai Jeganathan (Past President of OGSM 2017/18) is currently our national society's voice in AOFOG.

I first came across the AOFOG through my involvement in the Intensive Course for Obstetric Emergencies (ICOE) activities, which under the stewardship of OGSM Past President Dr Gunasegaran PT Rajan, has built bridges for OGSM in the region. In fact, during a week-long immersive fellowship as a recipient of the AOFOG's Young Gynaecologist Award (YGA) in Manila, contemporaries from Mongolia, Nepal and Laos have immediately associated Malaysia with ICOE.

My conversations and subsequent interactions with YGAs from less-developed countries left a mark on the apparent chasm that divides the levels of care

for women in our region. This compelled me to further contribute through the AOFOG Ultrasound Committee. Prior to the novel Coronavirus pandemic, the committee under the leadership of Dr Catherine Nelinda Panggilinan, had planned to conduct two outreach activities, one in Southeast Asia and another in the Pacific, namely, Fiji. Although they have been disrupted, we managed to organise separate virtual events for Fiji and Laos, specifically catering to their clinical needs.

Involvement with YGA allowed me to network with the YGA from Fiji, Dr Nitik Ram, and Fiji Obstetrics and Gynaecological Society (FOGS), president Dr Litia Narube, thereby identifying their training needs. With the theme "Impact on Clinical Decisions II", the committee organised a one-day event on basic yet pertinent topics such as ectopic pregnancy, molar pregnancy and mid-trimester anomaly screening. Although streaming was mostly accomplished in the capital of Fiji (Suva), we were also able to reach Fiji's O&G trainees at other islands of the archipelago.

In May 2021, the "Impact on Clinical Decisions III" was also in partnership with the Laos Association of Obstetrics and Gynaecology. As anticipated, interacting with colleagues from a previous French protectorate has its set of challenges, however, we received sufficient help with translation from local speakers. Drawing from experience, teaching in non-English speaking countries through ICOE certainly has its benefits! An excerpt from the Ultrasound Committee published in the AOFOG newsletter can be seen below:

## Ultrasound Committee Report

The Covid pandemic cannot stop the ultrasound committee's commitment to share our expertise with our AOFOG colleagues.

Because a face-to-face ultrasound workshop is currently not feasible, the committee's objectives were revised to be functional despite the bludgeoning of the pandemic and were modified to the following:

1. Integrate ultrasound in clinical OB-GYN practice
2. Promote clinic-somologic analysis in commonly encountered OB-GYN cases
3. Provide OB-GYN ultrasound updates



The ultrasound committee's commitment is to conduct a quarterly webinar lecture series among AOFOG countries. Last May 29, 2021, we conducted our second virtual lecture series in Vientiane, Laos which was entitled: OB-GYN ultrasound: Impact on Clinical Decisions III. The activity was made possible through the support of Dr. Alongkone Phengsavanh, the Vice - Dean of the Faculty of Medicine, University Health Sciences, Laos. Dr. Alongkone was assisted by Dr. Douangphachanh Xaysomphou, a young obstetrician gynecologist who is the current head of Maternal Fetal Medicine, Department of OB-GYN, Faculty of Medicine, University Health Sciences in Laos. He is also an AOFOG Young Gynecologist Awardee (YGA).

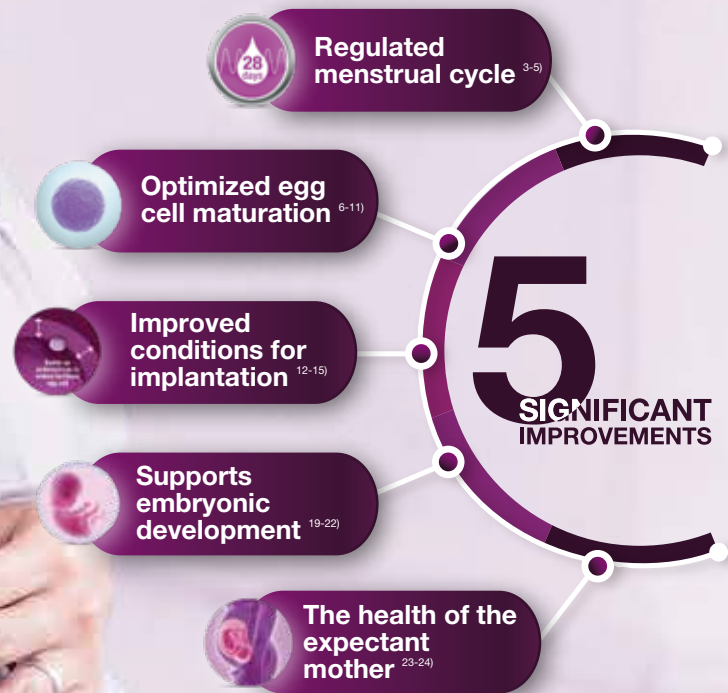


Finally, "Impact on Clinical Decisions IV" was held in August 2021 where a wide range of topics was organised for all countries under the AOFOG umbrella. We were joined this time by Dr Boonsri Chanrachakul from Thailand and Dr Balu Vaidyanathan from India.

The committee is now in the midst of finalising the programme for the biennial Asia & Oceania Congress of O&G which will be held in May 2022 in Bali, Indonesia.

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# Genetic Causes Of Male Infertility



## Ms Sharmila Thevi Ponusamy

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

Genetic defects are an extremely common but unrecognized cause of infertility. It is estimated that approximately 50% of infertility can be attributed to genetic aberrations. The sex chromosomes play an imperative role in human fertility. Therefore, any genetic aberration, in either sex, in the form of chromosomal anomalies, gene mutation or epigenetic modifications can lead to infertility. Fortunately, recent technological advancements have provided us new tools to diagnose and treat these causes of infertility.

### Numerical and structural chromosomal Abnormality

Male factor infertility accounts for one third of all causes of infertility. The normal genotype of a male (with corresponding phenotype) is a single copy of X and Y chromosome. Defects in either one or both, can lead to infertility in male.

### Klinefelter Syndrome (KS)

Klinefelter syndrome (KS), a common genetic disorder in males, has an incidence of 1 in 600 births and causes infertility due to presence of an additional X chromosome and at least one Y chromosome. Approximately 80% of KS have a genotype of 47, XXY while the remaining are usually mosaic (46, XY/47, XXY) or with multiple aneuploidies (47, XXXY/49, XXXYY). Men with KS are characterized by hypergonadotropic hypogonadism, gynecomastia, absent spermatogenesis and small testes. There is progressive atrophy of germ cells and hyalinization of seminiferous tubules that occurs at the onset of puberty.

The severity of the symptoms are largely dependent on the level of mosaicism, whereby a small percentage of KS may have normal semen parameters and therefore normal fertilisation. In the majority, impaired spermatogenesis and meiotic failure causes non-obstructive azoospermia (NOA). Additional copies of the X chromosome affects the normal secondary sexual development and increase the risk of other health issues.

### Jacob's syndrome

Jacob's syndrome, 47, XYY occurs 1 in 1000 births. The presence of an extra Y chromosome due to erroneous paternal meiosis affects the fertility of these men. Although the affected male is born with normal genitalia, there is impaired spermatogenesis and spontaneous apoptosis to remove the supernumerary Y chromosome containing germ cells. This results in oligozoospermia and NOA in some cases.

### De La Chapelle Syndrome (XX male)

Meanwhile, 46, XX is a testicular disorder of sex development with the occurrence is 1 in 20000 to 25000 male birth and affects the secondary sexual development of men. Men with this syndrome may present with normal or ambiguous genitalia and are azoospermic. They may have gynecomastia and develop hypogonadotropic hypogonadism in adulthood. They can be categorized as SRY-positive (sex-determining region Y) which accounts for 90% of cases or SRY-negative. Men who are SRY-negative have no SRY gene detected while SRY-positive men have traces of the gene sequences or part of the region found in their autosomal or X chromosome.



## Dr Eeson Sinthamoney

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

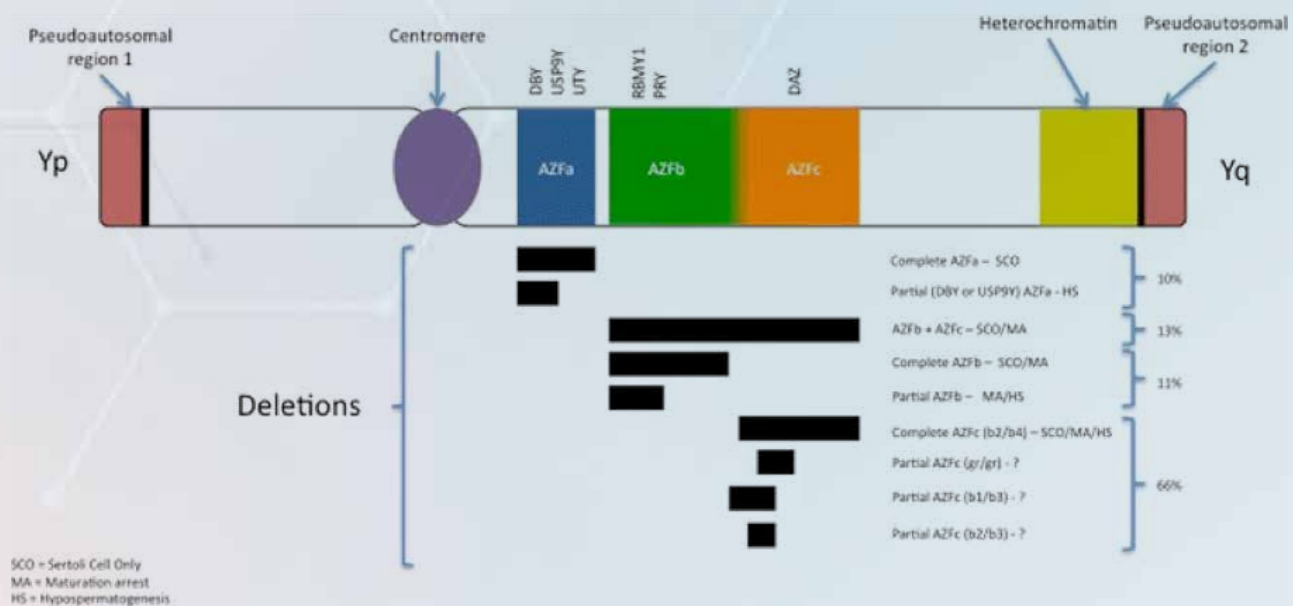
### 45, X and mosaic 45, X/46, XY

Men with a 45, X genotype, phenotypically appear female but may, or may not, have normal male genitalia. They are almost always azoospermic. This is due to the loss of genes imperative for spermatogenesis which are located on the Y chromosome. Affected men have small testes and absence of germ cells. Individuals with mosaic karyotype 45, X/46, XY present with mixed gonadal dysgenesis and some residual spermatogenesis where the phenotype varies depending on the percentage of mosaicism. The presence of sperm in the mosaic individuals shows high aneuploidy which increases the risk of having offspring with chromosomal abnormalities.

### Y chromosome Micro-Deletion

The Y chromosome contains the male-specific region (MSY) which is inherently prone to errors during meiosis. This then leads to infertility as it contains functional genes crucial for spermatogenesis. Y chromosome micro-deletion (YCMD) occurs in 15% of azoospermic and 5% of oligospermic male. The Azoospermia Factor region (AZF), located at Yq11 contains three sub-regions AZFa, AZFb, and AZFc. YCMD is deletion of the entire region or removal of single sub-region, or deletion of a combination of sub-regions. Deletion of the AZFa region causes loss of function of genes such as USP9Y and DBY which causes Sertoli-cell only syndrome and impaired spermatogenesis while AZFb deletion leads to meiotic arrest during spermatogenesis due to loss of function of the RBMY1 and PRY gene. AZFc is the region most susceptible to deletion and is associated with a highly variable phenotype, ranging from oligozoospermia to NOA.

Figure 1: Diagram shows the types microdeletion on Y chromosome, the prevalence of occurrence, and respective phenotype (taken from Neto, F.T.L., Bach, P.V., Najari, B.B., Li, P.S. and Goldstein, M., 2016. Genetics of male infertility. Current urology reports, 17(10), pp.1-12.)



SCO = Sertoli Cell Only; MA = maturation arrest; HS = Hypo spermatogenesis.

### Gene mutation and deletion

#### (Anosmin-1) / KAL (Kallman syndrome 1)

Mutation on ANOS / KAL gene causes Kallman syndrome which is more commonly seen in males (1 in 30 000) but rare in females (1 in 125 000). This is because it is an x-linked recessive inheritance and is characterized by anosmia and congenital hypogonadotropic hypogonadism due to abnormal migration of Gonadotrophin releasing hormone (GnRH) neurons. This affects the spermatogenesis due to the imbalance of hormones being luteinizing hormone (LH), follicle stimulating hormone (FSH) and Testosterone.

#### Testis Expressed 11 (TEX11)

The TEX11 gene is expressed in male germ cells and is essentially involved in meiosis and double-stranded DNA break-repairing mechanism. Mutations in this gene or complete absence of it has been shown to cause NOA in males due to meiotic arrest during spermatogenesis.

### Androgen Receptor (AR)

The AR gene located on X chromosome is a testosterone receptor that is crucial in development of secondary sexual characteristics and spermatogenesis. Mutation in the AR gene is associated with Androgen Insensitivity Syndrome (AIS) with variable severity where partial AIS has been shown to cause oligozoospermia or azoospermia while complete AIS can result in sex reversal in XY individuals.

GENE	LOCATION	KNOWN FUNCTION	PHENOTYPE
Adhesion G Protein-Coupled Receptor G2 (ADGRG2)	Xp22.13	Expressed in efferent ducts, epididymis	Congenital bilateral absence of vas deference, Azoospermia
Fetal and Adult Testis Expressed 1 (FATE1)	Xq28	Encodes protein highly expressed in spermatogonia, spermatocyte	Oligoasthenozoospermia
Deleted in Azoospermia (DAZ)	Yq11.23	Encodes RNA-binding protein essential for spermatogenesis	Oligozoospermia, Azoospermia
RNA-binding Motif protein Y-linked family 1 member A1 (RBM1A1)	Yq11.22	Encodes protein that act as splicing regulator during spermatogenesis	Azoospermia, Meiotic arrest during spermatogenesis
DEAD-box helicase 3 Y-linked (DDX3Y)	Yq11.221	Encodes protein for ATP dependent RNA helicase	Sertoli cell only syndrome, Azoospermia

Table 1: Shows the single-gene mutation in chromosome X and Y that are shown to cause infertility in men

### Diagnosis and ART treatment

Many of these chromosomal aberrations can be diagnosed by chromosomal analysis (karyotype). However, Y chromosome micro-deletions require PCR amplification followed by the utilization of specific primers which involves DNA extracted from men's leucocyte and sequence-tagged sites (STS) primers.

Tests to diagnose many of these genetic causes of male infertility exist albeit at an exorbitant cost. Making the correct diagnosis can sometimes avoid subjecting the patient to un-necessary procedures and can offer closure to many.

That said, assisted reproductive technology (ART) may allow many of these couples to conceive through procedures such as intracytoplasmic sperm injection (ICSI) and surgical sperm retrieval (SSR). More recently, even in the more severe cases such as in Kallman Syndrome, Klinefelter Syndrome and Y microdeletion, micro-TESE (wide open testicular sperm extraction done under high magnification microscopy) followed by ICSI has been shown to be a possible option to obtain sperm for ICSI where conventional TESE has been unsuccessful. For example, in partial microdeletion of AZFa and AZFb, there may be some residual spermatogenesis where micro-TESE followed by ICSI has been reported to result in life-birth although complete deletion of these two regions has less success with SSR. Y-microdeletions however, have been shown to be inherited by the male offspring. Therefore, genetic counselling and possibly Preimplantation Genetic Testing (PGT-M) can be offered to the affected couple.

\*References are available upon request. It has not been listed below due to space constraints



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# Asia Evening @ The FIGO World Congress, October 2021

Many of you would have missed the Asia Evening if you had not registered for the FIGO World Congress. We have included here a write-up from Dr Ravi Chandran, a Past President of OGSM and Immediate Past President of AOFOG, who conceptualised, curated, coordinated and hosted this successful event.

This “Asia Evening” has significance for OGSM for many reasons:

- a) OGSM was highlighted on the world stage and mentioned no less than 15 times throughout the programme
- b) a total of 12 AOFOG member countries submitted lovely videos highlighting the diversity and unity in Asia. On an impromptu poll, the OGSM video clip was judged runner-up to the video clip from India. Kudos to our President Dr Hoo Mei Lin and her team for putting together a wonderful video clip at such short notice
- c) the OGSM-ICOE programme received wide coverage and was lauded by many for its low tech but impressive effort in this region and featured comments from both Dr Gunasegaran and Dr Ravi Chandran
- d) in the Young Gynaecologist section, our very own Dr Voon Hian Yan, who impressed everyone at the last YGA session in Manila 2019, had the opportunity to give his personal impression and experience of the programme
- e) the very first AOFOG Community Fellowship Programme in Kuching Sarawak 2015, brainchild of yet another OGSM Past President Dr Farouk Abdullah, received accolades for its ground breaking concept and execution.

The link to the Asia Evening is included in the write-up. Happy viewing!

**Editor**

# The Asia Evening at FIGO 2021

As everyone is aware, the Scientific Programme for the FIGO World Congress was thrown into disarray by the COVID19 pandemic. The Congress had to be converted to a virtual event and sessions needed to be rearranged at short notice. The Scientific Committee led by Prof. Frank Louwen had to think out of the box and a novel idea that emerged was to have virtual "Regional Evenings" to showcase the 5 FIGO Regions – Africa/Eastern Mediterranean, Asia Oceania, Europe, Latin America, and North America.

Following a ZOOM meeting with Prof Louwen, our Executive Board set to work conceptualising the programme for the Asia Evening. As major issues of Obstetrics, Oncology and Sexual Reproductive Health affecting our region were already being covered by a special AOFOG Symposium at the FIGO Congress, we decided to highlight instead our efforts to move towards virtual training and our constant emphasis on nurturing our Young Gynaecologists via the YGA and Community Fellowship Programmes. Asia Oceania is easily the most diverse geographical, linguistic and cultural region of FIGO and we wanted to emphasise our strength and unity in diversity.

Translating the concept into reality in a short period of 3 months was a challenge but I am proud to say that all those involved rose to the occasion magnificently. Thanks to our member National Societies for contributing such lovely, colourful, and vibrant clips of their countries. It would be remiss of me not to recognise the contribution of the OGSMICOE team led by Dr. Gunasegaran and supported by Mr. Bhaskaran, as well as the team from Laos ably led by none other than Prof Alongkone. A special shout out too to Dr. Vincent Cheung from Hong Kong and Dr. Ryan Capitulo from the Philippines for putting together a short clip of the Community Fellowship Programmes in their respective countries in 2017 and 2019. All of this of course would not have been possible without the constant support and encouragement from the AOFOG Executive Board.

The final "product" attracted much interest from around the globe and was enjoyed by all who attended. To quote Prof. Frank Louwen " ..brilliant!! That's how it should be, you fulfill my dreams!!!.

For those of you who missed the event, we have included a link below to enable you to access and enjoy the event at your leisure.

Link - <https://vimeo.com/643382337>  
Password - Figo21RE

**Ravi Chandran.**  
Immediate Past President AOFOG  
FIGO Regional Trustee Asia Oceania

*\*This write-up was initially published in the December 2021 edition of the AOFOG Newsletter*

**Dr Ravi Chandran**  
Past President OGSM,  
Immediate Past President AOFOG,  
FIGO Regional Trustee Asia Oceania





Dr Hoo Mei Lin  
President  
Obstetrical & Gynaecological  
Society of Malaysia

# From the President's Desk

We celebrated International Women's Day recently on the 8th March 2022. This year's theme was 'Break the Bias'. When I was a medical student, there were very few women consultants to look up to. It is wonderful to see more and more women in senior positions today. Studies looking into gender equality in medicine, have noted that equal representation in Academia, senior posts and Politics is important to create policies, opportunities and systems that are more inclusive and whole.

Women in medicine often have to juggle multiple roles, "the doctor, the wife and the mother". The traditional view that women are homemakers and men have jobs, means that women tend to do more unpaid work in the domestic setting than their male counterparts. In Malaysia, support from foreign domestic help and our parents to help us manage child-rearing and domestic chores, enable women to continue in career progression and medical training. These forms of support may no longer be sustainable for the coming generations with the escalating costs of bringing in foreign workers in Malaysia and as retirement age is pushed further and further back, relying on one's parents may not be an option in the future.

Understanding the obstacles that women face is key to developing mechanisms to improve the lives of women doctors. I have seen my colleagues returning to work two weeks after delivering their child, foregoing their postpartum recovery when they chose to have their children during their training to avoid the extension of their training period. On the other side of the coin, I also have many colleagues and patients who then struggle with fertility when they chose to delay their child bearing until they completed their training. Changes in our systems to protect career progression (e.g. part time or job share training posts), Protection of maternity leave, Provision for breastfeeding in the workplace, Child care support at the workplace as well as Protected parental/ caregiver leave are some strategies that have been employed in countries like Australia and the UK to enable women to pursue their careers with minimal disruption. Having more women in senior leadership roles will hopefully lead to the development of policy where women are not forced to choose between family and career.

These situations do not apply only to women in medicine. Women need to be empowered to stand out, speak out and advocate for each other. As doctors caring for women, we are in a unique position to do so, regardless of gender. In line with this, OGSM collaborated with the Malaysian Health Coalition and the Women's Aid Organisation (WAO) in writing

the statement below urging for the improvement of maternal, sexual and reproductive health rights of women.

“On International Women’s Day 2022, the Obstetrical and Gynaecological Society of Malaysia (OGSM) and the Malaysian Health Coalition jointly call for progressive steps to improve maternal, sexual, and reproductive health of women for all residents of Malaysia.

Women’s health is a prime global focus, reflected by United Nations Sustainable Development Goals 3 (Good Health & Well-being) and 5 (Gender Equality). Despite recent gains in Malaysia, we must do more to ensure that all women in Malaysia will receive fair care and treatment. We call for the government, especially the Ministries of Women, Family, and Community Development (MWFCD), Health (MOH), and Education (MOE) to:

**1. Embed maternal, sexual, and reproductive health metrics into Malaysia’s public agenda and international commitments.**

*Metrics for maternal, sexual and reproductive health include the maternal mortality rate (MMR), rate of teenage pregnancies and percentage of women able to access safe contraception. These metrics should not be hidden in statistics or obscure reports. These metrics are not taboo, shameful or stigmatizing. Instead, these statistics should be front-and-centre in Malaysia’s public agenda and international commitments through international treaties, conventions and declarations. When these metrics are front-and-centre, progress will happen, like how Malaysia’s MMR dropped from 280/100,000 (1957) to 25/100,000 (2018) partly due to our international commitments. However, while we call for health issues to become political priorities, we urge all stakeholders to address implementation gaps at the same time.*

**2. Reframe women’s health issues as public health issues, not as women’s issues.**

*Women makes up half the total population of Malaysia. Therefore, women’s health is public health. The goal of public health is to improve health outcomes of populations. Here, we must ensure easy access to information, screening services, self-education, and self-management tools to encourage self-informing and help-seeking behaviours in relation to women’s*

*sexual and reproductive health. This can be achieved through the synergistic collaboration between the MWFCD, MOH and other relevant stakeholders, including governmental and non-governmental organisations. Moreover, effective and collaborative research and data collection on maternal, sexual, and reproductive health must be implemented and included in Malaysia’s public health analysis. This includes mainstreaming gender into the national budget, and monitoring allocations directed to women’s health services, sexual and reproductive health services and services for survivors of gender-based violence. Importantly, a clear and consistent strategy must be implemented to increase the effectiveness and accessibility of services for survivors of gender-based violence, like One-Stop Crisis Centres (OSCCs).*

**3. Strengthen the primary healthcare response to gender-based violence and domestic violence.**

*The prevalence rate of domestic violence within a public primary healthcare clinic vastly exceeds that of the national prevalence rate (22% versus 9%), as revealed by a Universiti Malaya study in 2019. Yet, a systematic response to domestic violence remains sorely absent at the primary care level. Survivors who seek help from Klinik Kesihatan do not receive adequate support as healthcare providers are not well-equipped to identify signs of abuse or offer first-line support, while referral pathways to other resources remain unclear. Therefore, we must improve the primary healthcare infrastructure in Malaysia through the 2000-plus Klinik Kesihatan, to enable victims of gender-based violence and domestic violence to receive the support and interventions that they need.*

4. **Implement laws to ensure that every woman has a right to health.** There is no dedicated or universal law on women's health in Malaysia. Sometimes, employment contracts for migrants prohibit relationships, marriages, and pregnancy, infringing not only basic human rights, but causing many of these women to obtain unsafe abortions. Therefore, it is crucial to pass new laws to protect the health rights of all women in Malaysia, and to support these laws by appropriately strengthening our health system. In specific terms, this means that all women should have access to healthcare, removing physical, cultural, religious, emotional or financial barriers, and ensuring protections against discrimination on the basis of gender, nationality, race, disability, socioeconomic status, institutionalization, and other factors. This requires a multi-stakeholder approach led by the MWFC and MOH working together with Ministries of Labour, Trade, Religious Affairs and Education.



**Dr Hoo Mei Lin**  
President

*The lack of access to adequate maternal, sexual, and reproductive health services is a global issue, and Malaysia is not spared. This issue is more pronounced in certain populations such as adolescents, unmarried women, documented and undocumented migrants, refugees, stateless people, women living with HIV, women with disabilities, and LGBTQ+ groups. Healthcare must not condone discrimination. Regardless of circumstance, every person must receive fair and non-judgemental medical treatment. Women's rights are not only basic human rights, but a global public health issue."*

*I hope that this will garner the attention that gender equality deserves and that it inspires more of us to stand up for women.*

*"I raise up my voice, not so that I can shout, but so that those without a voice can be heard. We cannot all succeed when half of use are held back"*  
Malala Yousafzi



**Dr Loh Huey Wen**  
Hon. Secretary

*The 2021/2022 OGSM council has equal gender representation. For the first time since OGSM was founded, the top 3 positions are held by women.*

**#breakthebias**



**Brigadier General Dato' Pahlawan  
Dr Thavachelvi Thangarajah**  
Hon. Treasurer

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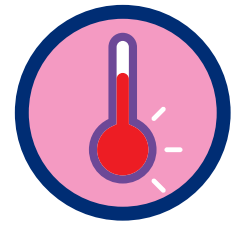
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References:

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.  
\*\* 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. Applicable for plain variant only.



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# RCOG International Representative Committee Malaysia



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

Greetings from your local RCOG International Representative Committee. Here are updates on some activities that we have conducted since the inception of the new committee last September 2021.

The November 2021 Part 3 Exam concluded with 85% (18/21) pass rate. One of the highest there has been. The IRC would like to put on record all those who had been involved in their training. Most trainees feel they have been aided by internationally run courses, the local PACT & SAMS courses and as well as the regular IRC training talks and tutorials. The IRC managed to obtain a series of trainers from Oxford University, UK, Singapore and local expertise to conduct talks. Many more trainers participated in IRC conducted small group sessions online on a regular basis. There are too many to mention here. The IRC on behalf of the RCOG would like to extend our sincere thanks.

The more recent Part 1 and 2 Exams have recently concluded and we hope many will migrate from our Part 1 and Part 2 Trainee WhatsApp groups to their new Part 2 and Part 3 groups respectively. Many who have graduated from the Part 3 group are now actively assisting with the training of new batches. Long may this strong run by our local candidates continue.

The RCOG has tried very hard to provide more seats available for MRCOG Part 3. Since the pandemic started, there has been a backlog of candidates waiting to sit for this exam. In February 2022, the RCOG added an extra Part 3 diet for over 700 candidates worldwide. As a result, 51 Malaysian candidates managed to finally secure a seat. Their results are now pending and we wish them every success.

As part of the RCOG's effort to increase space for Part 3 diet, Malaysia will be recognised as a Part 3 centre in May 2022. The selection process for examiners have already completed. We look forward to this continued and long-lasting relationship between the Malaysian O&G fraternity and the RCOG.

The IRC's local standing is now more stable with the recent Registrar of Societies' approval of our society, "Persatuan Perwakilan RCOG Malaysia". The IRC needed a society mainly for a bank account to formalize and make transparent our cashflow, especially when conducting training and mock exams. The majority of training sessions conducted are FOC. Mock exams however are not free with costs incurred, especially for the online platform, Standardized Patients (talents) and Lay Examiners. It must be emphasized here that the Persatuan is not geared towards profit making endeavours but instead cost covering activities as was the recently conducted mock Part 3 Exam.

We have also recently decided to participate in the RCOG's global health initiative programme and have taken up ovarian cancer as our theme. We will, from time to time, announce more strategic talks by RCOG luminaries.

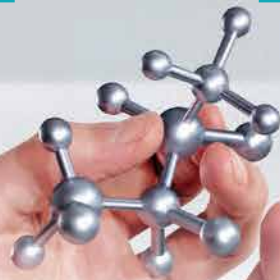
The IRC, in collaboration with OGSM, managed to recently help organize the talk by Prof Sir Sabaratnam Arulkumaran on "Post-partum Haemorrhage" on 12 February 2022. It was well attended online with about 200 live audience. The 2nd talk by Prof Sir Sabaratnam Arulkumaran on 12 March 2022 on "Climate Change: O&Gs should take Part of the Blame" was also well received.

To keep abreast with your local IRC activities, please follow us via Facebook at fb/IRC Malaysia [https://www.facebook.com/IRC-Malaysia-108208281803064/?ref=page\\_internal](https://www.facebook.com/IRC-Malaysia-108208281803064/?ref=page_internal) Do visit it and follow it.

## IRC Malaysia

Dr Tang Boon Nee, Dr Chew Ghee Kheng, Dr Vijayan Valayatham, Assoc Prof Nirmala Chandraleaga, Assoc Prof Kavitha Nagandla, Dr Muniswaran Ganeshan, Dr Lim Ai Wei, Dr Joyce Lee

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- Genital and Extragenital Endometriosis (Stage I to Stage IV)<sup>1</sup> 11.25mg 3.75mg
- Treatment of uterine fibromyomas prior to surgery<sup>1</sup> 3.75mg



Full prescribing information is available upon request, please refer to full prescribing information before prescribing. For adverse events reporting, please report to [pharmacovigilance.my@ipssen.com](mailto:pharmacovigilance.my@ipssen.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.

# MyO&G 2022

MyO&G 2022 was organized by the College of Obstetricians and Gynecologists, Academy of Medicine, Malaysia (COGAMM) on 12th and 13th of March 2022. The theme "New Beginnings" was specially coined to mark the elevation of the College into a more prominent and distinctive role in the academic field.

Initially planned for a physical event at Pullman Hotel, Bangsar, the surge of Covid "Omicron" sadly converted the meeting into the virtual platform, just one month before the actual event. Despite the last minute turn around, MYO&G 2022 ably led by Professor Datuk Dr. Siti Zawiah and Professor Dr. Mukhri Hamdan turned out to be a complete success.

Twenty-three invited speakers (from Malaysia, Singapore, United Kingdom, Finland and Australia) covered a wide range of topics in obstetrics and gynaecology. The COGAMM Invited Lecture was given by Professor Dr. Tan Lay Kok (President of the College of Obstetricians and Gynecologists, Academy of Medicine, Singapore) who spoke on "Safety in Obstetrics" whilst the COGAMM Special Lecture was on medicolegal matters "A World without Obstetricians" by Mr. Harikannan Ragavan, a lawyer familiar with medicolegal issues.



Dr Premitha Damodaran  
Scientific Chair, MyO&G 2022

There were 1062 registrants for MYO&G 2022, of which 886 were delegates and the rest exhibitors and speakers. The total number logged in stood at 910 delegates with the highest traffic of 580 delegates during the opening ceremony. Parts of the event was also carried out 'Live' on the Academy's Facebook page. This event could not have taken place without the twenty-two sponsors who came on board at various levels to help fund, get speakers and disseminate information.

General feedback was positive and encouraging, providing impetus for MyO&G to become an annual event of the College. We are looking forward to a physical meeting in 2023, allowing an interactive, challenging and mentally stimulating encounter and also allowing us to catch up with old friends and make new ones. For future updates on college activities, please like and follow us on Facebook.



The Organising Committee,  
MYO&G 2022



Part of the Virtual Platform Vendors, Anderes Fourdy, hard at work during the event.



Getting ready for the Final Act.



Fun Moments at the PhotoBooth, MyO&G 2022



Dr Aini Hanan Azmi  
Hospital Seberang Jaya

# MRCOG Part 3 November 2021: A True Blue Super Ardua Journey

Specialty training is not as straightforward as getting from Point A to Point B, everyone will tell you that. Prior to embarking on this journey and choosing the Parallel Pathway, each trainee would have factored in and from all angles possibly considered our adult responsibilities, family and financial commitments and support, on top of our own personal capabilities.

Though we saw the global pandemic coming, none of us expected it to significantly stall our training. Of course, “Unprecedented” has been and is still an ongoing theme globally.

Since November 2019, which was the last Part 3 Exam held before the pandemic hits, trainees’ lives have been in limbo and shrouded in uncertainties for almost two long years. Most of the trainees, myself included had our own timelines that we have set to achieve and on the other hand other aspects of our lives put on hold until we pass the Exams.

With rising number of Covid-19 cases and fatalities, our public healthcare system had to adapt to cope with the patient load, which meant withholding non-urgent services, shutting down operation theatres and converting normal wards into isolation wards. As much as we would have liked maternity services to continue ‘business as usual’, we were not spared. Dire times called for dire measures, and service took precedence over training.

Trainees across specialties were deployed to work in Covid wards and quarantine centers, something that was not at all familiar to what we have been training for (I had to work in a male ward for the first time in ten years!). While our counterparts in Masters Programme had to a certain extent an upper hand – some universities decided to bring their trainees back to the campus so that their training could continue uninterrupted. As for us in the parallel pathway, at certain point it seemed like there was no light at the end of the tunnel.

The Exam was nowhere on the horizon, and seeing batches after batches of trainees from Masters Programme passing their Part 2 MOG Exams and starting gazettelement rubbed salt on our already sore wounds. Morale was at an all-time low, and “Imposter Syndrome” took a toll on our mental health.

That was until somewhere in June 2021, when our consultants and specialists forwarded to us a WhatsApp message that said “If you have trainees stuck at Part 3 due to pandemic, Dr Tang Boon Nee asked to PM her”. Desperate as we were, we did, though admittedly some of us were skeptical as to what she could do and how much she could help.

The rest was history. Dr Tang spearheaded the new RCOG-IRC Malaysia and organized us into WhatsApp groups where we disseminated info and divided into smaller tutorial groups to start practicing for the exam, despite not knowing if there will even be an exam in 2021. “It may spring on you suddenly”, Dr Tang said, so she wanted us to be ready for it when it comes.

Through the IRC, Members and Fellows of the RCOG across Malaysia, from private and public hospitals alike volunteered their time and were roped in to become our tutors. We had online lectures by speakers from Malaysia, Singapore and the United Kingdom. Zoom meetings and Google meets became permanent fixtures of our after-work evenings. For the first time ever, it felt like the whole O&G fraternity was working tirelessly to make us pass our exam. No trainee was left behind and no stones were left unturned.

In August 2021, the RCOG announced that the Part 3 Exam would resume on a virtual platform for global candidates. After a painstaking exam booking process, 21 of us managed to secure seats for November 2021 Exam. Virtual exam is somewhat a different ballgame compared to traditional face-to-face exams, but we continued to do what we have been doing for two years – we adapt.

We were very privileged to be able to attend three homegrown Mock Circuit Exams: the OGSM PACT Circuit, Sarawak MRCOG Survival Course and the debut of the IRC Circuit, all held virtually via Zoom. The real exam itself were held via the OSLER platform, which was thankfully very user friendly and required minimal troubleshooting on the candidates part.

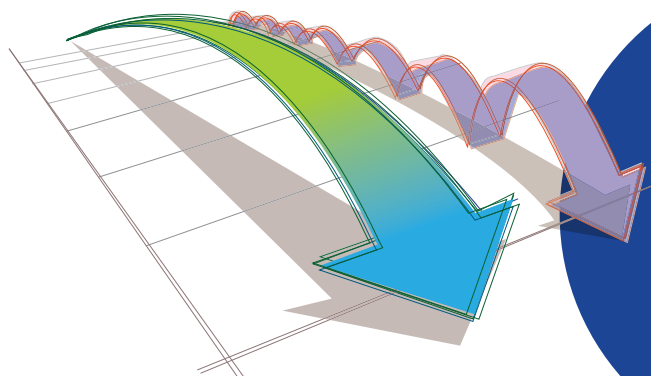
Alhamdulillah, against all odds, we finally sat for the Exam in November 2021, and 18 of us passed. Of course, this can only be said in retrospect, but personally, I have to say that this experience is something worth sharing as it has made me a better person and a better Obstetrician & Gynaecologist. Training is not about knowledge and surgical skills alone – we learnt about the importance of resourcefulness, networking, adaptation and improvisation.

We would like to thank everyone who has helped us directly or indirectly. Of course, a very special thanks to Dr Tang Boon Nee and the rest of the tutors, to whom 18 of us would be eternally grateful. The O&G fraternity has shown us a very important example of selflessness and giving back and that lesson is something we wish to pay forward to the next generation of trainees.

We have overcome the difficulties!

Dr Aini Hanan Azmi was a Medical Officer and O&G Trainee in Hospital Sungai Buloh. She passed her MRCOG Part 3 in November 2021 and is currently working in Hospital Seberang Jaya.

# The Sustained Follicle Stimulant With Proven Efficacy in 3 Large IVF Clinical Trials<sup>1</sup>



## Three randomized, double-blind, clinical trials<sup>1,2,3</sup>

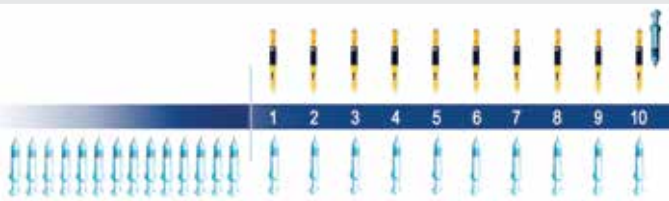
- PURSUE Study (N=1,390) compared ELONVA® (150 µg) with 300 IU recombinant FSH (rFSH)<sup>1</sup>
- ENGAGE Study (N=1,506) compared ELONVA® (150 µg) with 200 IU rFSH<sup>1,2</sup>
- ENSURE Study (N=396) compared ELONVA® (100 µg) with 150 IU rFSH<sup>1,3</sup>

ELONVA® (corifollitropin alfa) is indicated for controlled ovarian stimulation (COS) in combination with GnRH antagonist for the development of multiple follicles in women participating in an assisted reproductive technology (ART) program.

<sup>a</sup> Ongoing pregnancy rate defined as presence of at least one fetus with heart activity at least 10 weeks after ET as assessed by ultrasound or Doppler, or confirmed by live birth.<sup>2,3</sup>  
<sup>b</sup> Vital pregnancy rate defined as the presence of at least one fetus with heart activity, as assessed 5 to 6 weeks after ET in the COS treatment cycle.<sup>1</sup>  
 CI: Confidence Interval; GnRH: Gonadotropin-releasing Hormone; hCG: human Chorionic Gonadotropin; IVF: In Vitro Fertilization; ET: Embryo Transfer

## One Single Injection of ELONVA® Replaces 7 Injections of Daily rFSH<sup>2,4</sup>

### Conventional daily gonadotropin in a long GnRH agonist protocol



### ELONVA® in a GnRH antagonist protocol



Not actual size, for illustration purpose only.



Adapted from de Greef R, et al.<sup>4</sup>

**Selected Safety Information for ELONVA® (Corifollitropin alfa)** **THERAPEUTIC INDICATIONS:** Controlled Ovarian Stimulation (COS) in combination with a GnRH antagonist for the development of multiple follicles in women participating in an Assisted Reproductive Technology (ART) program. **DOSAGE AND ADMINISTRATION:** Treatment with Elonva should be initiated under the supervision of a physician experienced in the treatment of fertility problems. In the treatment of women of reproductive age, the dose of Elonva is based on weight and age. A single 100-microgram dose is recommended in women who weigh less than or equal to 60 kilograms and who are 36 years of age or younger. A single 150-microgram dose is recommended in women: • who weigh more than 60 kilograms, regardless of age. • who weigh 50 kilograms or more and who are older than 36 years of age. Women older than 36 years of age who weighed less than 50 kilograms were not studied. The recommended doses of Elonva have only been established in a treatment cycle with a GnRH antagonist that was administered from stimulation day 5 or day 6 onwards. Elonva should be administered as a single subcutaneous injection, preferably in the abdominal wall, during the early follicular phase of the menstrual cycle. Subcutaneous injection of Elonva may be carried out by the woman herself or her partner, provided that proper instructions are given by the physician. Self administration of Elonva should only be performed by women who are well-motivated, adequately trained and with access to expert advice. **CONTRAINDICATIONS** • Hypersensitivity to the active substance or to any of the excipients. • Tumours of the ovary, breast, uterus, pituitary or hypothalamus. • Abnormal (not menstrual) vaginal bleeding without a known/diagnosed cause. • Primary ovarian failure. • Ovarian cysts or enlarged ovaries. • Fibroid tumours of the uterus incompatible with pregnancy. • Malformations of the reproductive organs incompatible with pregnancy. • Pregnancy • Risk factors of OHSS – A history of Ovarian Hyperstimulation Syndrome (OHSS). – A previous COS cycle that resulted in more than 30 follicles 11 mm measured by ultrasound examination. – A basal antral follicle count > 20. – Polycystic ovarian syndrome (PCOS). **SPECIAL WARNINGS AND PRECAUTIONS FOR USE** • **Infertility Evaluation Before Starting Treatment** Before starting treatment, the couple's infertility should be assessed as appropriate. In particular, the woman should be evaluated for hypothyroidism, adrenocortical insufficiency, hyperprolactinemia and pituitary or hypothalamic tumors, and appropriate specific treatment given. Medical conditions that contraindicate pregnancy should also be evaluated before starting treatment with Elonva. • **Dosing During the Stimulation Cycle** Elonva is intended for single subcutaneous injection only. Additional injections of Elonva should not be given within the same treatment cycle. After administration of Elonva, no additional FSH containing product should be administered prior to stimulation day 8. • **Renal Insufficiency** In patients with renal insufficiency the rate of elimination of corifollitropin alfa may be reduced. Therefore, the use of Elonva in these women is not recommended. • **Not Recommended with a GnRH Agonist Protocol** There are limited data on the use of Elonva in combination with a GnRH agonist. Therefore, the use of Elonva is not recommended in combination with a GnRH agonist. • **Ovarian Hyperstimulation Syndrome (OHSS):** Women with known risk factors for a high ovarian response may be especially prone to the development of OHSS during or following treatment with Elonva. For women having their first cycle of ovarian stimulation, for whom risk factors are only partially known, close observation for early signs and symptoms of OHSS is recommended. • **Multi-fetal Gestation and Birth** Multiple pregnancies and births have been reported for all gonadotropin treatments, including Elonva. The woman and her partner should be advised of the potential risks for the mother (pregnancy and delivery complications) and the neonate (low birth weight) before starting treatment. In women undergoing AR procedures the risk of multiple pregnancy is mainly related to the number of embryos transferred. • **Ovarian Torsion, Ectopic Pregnancy, Congenital Malformations, Ovarian and Other Reproductive System Neoplasms, Vascular Complications** **UNDESIRABLE EFFECTS:** The most frequently reported adverse drug reactions during treatment with Elonva in clinical trials (N=2,397) are pelvic discomfort (6.0%), OHSS (4.3%), headache (4.0%), pelvic pain (2.9%), nausea (2.3%), fatigue (1.5%), and breast tenderness (1.3%). In addition, ectopic pregnancy and multiple gestations have been reported. These are considered to be related to the ART procedure or subsequent pregnancy. **Before initiating therapy, please consult the full Prescribing Information.**

**References:** 1. EU Summary of Product Characteristics for ELONVA; MSD, November 2014. 2. Devroey P, Boostanfar R, Koper NP, et al; on behalf of the ENGAGE investigators. A double-blind, non-inferiority RCT comparing corifollitropin alfa and recombinant FSH during the first seven days of ovarian stimulation using a GnRH antagonist protocol. Hum Reprod. 2009;24(12):3063–3072. 3. Mannaerts B on behalf of the corifollitropin alfa Ensure study group. Corifollitropin alfa for ovarian stimulation in IVF: a randomized trial in lower-body-weight women. Reprod Biomed Online. 2010;21(1):66–76. 4. de Greef R, Zandvliet AS, de Haan AFJ, et al. Dose selection of corifollitropin alfa by modeling and simulation in controlled ovarian stimulation. Clin Pharmacol Ther. 2010;88(1):79–87.

In women with BRCA-mutated advanced ovarian cancer following response to first-line platinum-based chemotherapy

## Sustained PFS In 1L Maintenance<sup>1,2</sup>

For the potential of more time progression free<sup>1</sup>

**DARE TO DREAM**

SOLO -1

After 5 Years Follow-Up

**>4.5 YEARS**

LYNPARZA

**13.8 months**

PLACEBO

**Open the opportunity**

for years of PFS<sup>1</sup> with LYNPARZA through HRD testing<sup>2</sup>

HR = 0.33; 95% CI: 0.23 -0.41; p<0.0001 Median follow-up was 41 months in both treatment arms. LYNPARZA demonstrated sustained PFS vs placebo<sup>1</sup>

**Pharmaceutical Form:** Lynparza 100mg film-coated tablets: Each film-coated tablet contains 100 mg olaparib; Lynparza 150mg film-coated tablets: Each film-coated tablet contains 150 mg olaparib.

**Indications: Ovarian cancer:** Lynparza is indicated (i) in combination with bevacizumab for the maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency (HRD) positive status defined by either: a deleterious or suspected deleterious BRCA mutation, and/or genomic instability (ii) as monotherapy for maintenance treatment of adult patients with advanced (FIGO stages III and IV) BRCA1/2-mutated (germline and/or somatic) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy (iii) as monotherapy for maintenance treatment of adult patients with platinum sensitive relapsed high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to platinum-based chemotherapy. **Breast Cancer:** Lynparza is indicated as monotherapy for the treatment of adult patients with germline BRCA1/2-mutations, who have HER2 negative metastatic breast cancer. Patients should have previously been treated with an anthracycline and a taxane in the neoadjuvant, adjuvant or metastatic setting unless patients were not suitable for these treatments. Patients with hormone receptor (HR)-positive breast cancer should also have progressed on or after prior endocrine therapy, or be considered unsuitable for endocrine therapy. **Adenocarcinoma of the pancreas:** Lynparza is indicated as monotherapy for the maintenance treatment of adult patients with germline BRCA-mutated metastatic adenocarcinoma of the pancreas whose disease has not progressed on first-line platinum-based chemotherapy. **Prostate cancer:** Lynparza is indicated as monotherapy for the treatment of adult patients with deleterious or suspected deleterious germline and/or somatic BRCA or ATM mutated metastatic castration resistant prostate cancer (mCRPC) who have progressed following prior treatment with a new hormonal agent (e.g. abiraterone or enzalutamide).

**References:** 1. Moore K, Colombo N, Scambia G, et al. Maintenance olaparib in patients with newly diagnosed advanced ovarian cancer. N Engl J Med. 2018;379(26):2495-2505. 2. Ray-Coquard I, et al. N Engl J Med. 2019;381:2416-2428.

For Healthcare Professionals only

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