CONNECT

Obstetrical and Gynaecological Society of Malaysia

June 2022 (Issue 3, Council 2021/2022)

EMBRACING, ENGAGING & INFORMING

Subspeciality Training :

Merits Of Training Away From Home

Ignorance of the law excuses no one

Get to know the new JPPOG

INSIDE

INBOX

A publication by the Obstetrical and Gynaecological Society of Malaysia

Contents

Editorial Team

Editor :


Dr Eeson Sinthamoney


Prof Nazimah Idris


Dr Voon Hian Yan


Ms Premalatha B


Mr Chong KL

Creative :
Pronto Ad Sdn Bhd | **ask@prontoad.com.my**

The doctor, friends, partners and family members - it's all relative

Dr Kuharaj Balasubramaniam
Consultant Obstetrician & Gynaecologist
Assunta Hospital, Petaling Jaya

Recently there was a high profile case in a neighbouring country down south making its rounds on social media. A Singaporean psychiatrist was found to be prescribing his then girlfriend anti-depressives without ever registering her as a patient. The psychiatrist has already been suspended by the Singapore Medical Council and is currently being sued for negligence by his ex girlfriend.

In Malaysia prescribing controlled medication to any individual who is not registered as your patient and without a consultation is actionable under the Poisons Act 1952 as well as under the code of professional conduct of the Malaysian Medical Council (MMC). Most practitioners are aware of this rule, but those who aren't, should be. However many doctors do register, provide consultation, prescribe medication and even occasionally perform procedures on close friends, family members and their partners.

A registered medical practitioner can legally provide consultation and treat any patient that is registered under his/her care. The question of whether a doctor should treat a close friend, family member or sexual partner with whom they have an ongoing relationship is therefore not a legal but an ethical one.

The MMC Good Medical Practice Guidelines 2019 , states in section 3.1.7.20 that "The doctor, whenever possible, must AVOID providing medical care for any one with whom he has a close personal relationship, particularly family members. Providing care to close friends and colleagues and those who are working with you may also create situations of emotional or personal involvement leading to a lack of objectivity in the care. However, when this is UNAVOIDABLE, then good medical practice should guide careful management."

There are valid reasons for such a recommendation, as when treating close friends, sexual partners or family members, there is a lack of objectivity and even possible conflict of interest on the part of the medical practitioner. More so the close friend or family member may not be ready to reveal pertinent information to the medical practitioner due to shame and may not even consider seeking a second opinion in the fear that they may offend the doctor. Another issue that arises is when the doctor treats a family member, partner or close friend for a condition outside his/her own speciality.

A review of the published disciplinary punishments by the MMC over the last 15 years reveals that from 2006 till 2020, no doctor was reprimanded, suspended or struck off the medical register for treating a family member, partner, close personal friend or colleague . This is most probably due to the fact that no close friend, partner or family member would lodge a complaint against a medical practitioner who they knew intimately. As there are no published cases of such a breach, we do not have documented clarity as to what actually would construe as a breach of section 3.1.7.20 of the Good Medical Practice guidelines. Would prescribing antibiotics for a sore throat to a spouse be considered a breach? Or is the threshold only met when the medical practitioner conducts a major surgical procedure on a family member or partner? What about the obstetrician who conducts the delivery of his own child, would his actions be considered as professional misconduct by the MMC?

The General Medical Council of United Kingdom appears to have a very strict view. Since 2006, the Good Medical Practice guidelines by the GMC UK states “Wherever possible avoid providing medical care to yourself or anyone with whom you have a close personal relationship”. Although the language appears to have a similarly broad interpretation as our MMC guidelines, the Medical Practitioners Tribunal of the GMC has found doctors that have treated close friends and partners guilty of serious professional misconduct. The prescription of medication to a close friend by a doctor was deemed as serious professional misconduct by the medical tribunal in the UK. A doctor was even struck off the medical register for prescribing medication to himself.

In UK after two doctors were found guilty of serious professional misconduct and suspended by the medical tribunal for treating people with whom they had a close personal relationship, they appealed to the high court to challenge the medical tribunals decision. In Hussein v GMC [2013] EWHC, the court determined that an orthopaedic surgeon’s actions of ordering a pelvic ultrasound scan in his hospital for his close friend was sufficient evidence that the orthopaedic surgeon had taken the role as the patient’s doctor. This was despite the fact that the patient was under the care of a gynaecologist who was the one that recommended a pelvic ultrasound prior to a follow up visit in the first place. In Joseph Onwude v GMC [2017] EWHC, the court determined that a gynaecologist who had prescribed medication for a close friend’s foot condition was not acting as a general practitioner as the medical

tribunal had determined and therefore was not acting outside his scope of competence. As seen in the above two cases there is no blanket ban even in the UK and even the courts look at the issue of doctors treating those with whom they have a close personal relationship on a case to case basis.

The American Medical Association (AMA) has elaborated more specifically in their guidelines regarding the issue of doctors treating themselves and family members. The AMA code of medical ethics states "In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances: 1) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available, 2) for short-term, minor problems"

The AMA code of ethics also specifies when treating self or family members, physicians have a further responsibility to:

1) Document treatment or care provided and convey relevant information to the patient's primary care physician.

2) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

3) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

4) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

Although no action has been taken by the Malaysian Medical Council against a registered medical practitioner in the past 15 years for treating a family member, partner or close friend, it is important to note that the Good Medical Practice guidelines does specifically address this issue in section 3.1.7.20. Perusing section 3.1.7.20 it can be readily noted that the section can be applied quite broadly. One only has to look at what has happened in other countries as a guide to what may possibly happen here. The doctor should not risk his/her career in an attempt to help a close friend, partner or family member.

Although these regulations may appear daunting, it is unlikely that the regulatory bodies will find a doctor guilty of serious professional misconduct for prescribing antihistamines for their spouse who has a runny nose. But it would be advisable for the obstetrician not to attempt conducting the delivery of his own child unless his wife is already pushing in the car on the way to hospital.

Ignorantia juris non excusat-Ignorance of the law excuses no one. Every medical professional should know and understand the laws and rules that govern their profession.

For further information kindly refer to https://mmc.gov.my/laws-regulations/

Jawatankuasa Pengurusan Dan Perkembangan O&G

Dato'Dr.Mohd Rushdan Md Noor
Ketua Perkhidmatan Klinikal O&G

LATIHAN, CME DAN MODAL INSAN

DR.CAROL LIM KAR KOONG

OBJEKTIF

Meningkatkan kemahiran teknikal (klinikal) dan bukan teknikal petugas O&G agar mereka menjadi petugas yang kompeten, selamat dan serba boleh.

Semua petugas O&G mempunyai pengetahuanyang mencukupidan sentiasa terkini (up-to-date)

Mempunyai modal insan yang mencukupi untuk tujuan yang tersebut diatas

MATERNAL DAN PERINATAL MORTALITY

DATO'DR.ROZIHAN ISMAIL

OBJEKTIF

Mengurangkan kadar kematian ibu dan perinatal

SUBKEPAKARAN

KETUA PERKHIDMATAN O&G KKM

OBJEKTIF

Menghasilkan lebih ramai pakar yang melanjutkan latihan di dalam bidang subkepakaran.

Meningkatkan mutu dan memajukan program latihan subkepakaran.

Me n gh asilkan su b sp e cialist yang bermutu tinggi dan dapat memberi khidmat kepada lebih ramai pesakit yang memerlukan.

DATABASE DAN REGISTRY

DR.NORHANA MOHD DR. NORHKANSIAMMOHD KASIM

OBJEKTIF

Mempunyai sistem penyimpanan data-data yang lengkap dan tepat tentang pesakit, semuaparameter O&G bagi tujuan memperbaiki perkhidmatan, penyelidikan, perancangan, permohonan bantuan dan audit perkhidmatan

PERIOPERATIVE MORBIDITY AND MORTALITY

DR.VICKNESH VISVALIN GAM

OBJEKTIF

Memperbaiki mutu pembedahan supaya ianya dilakukan atas indikasi yang betul,olehpetugasyang betul, pada masa yang betuldan kaedah yang betul. Akhirnya untuk meningkatkan mutu rawatan pembedahan.

MATERNAL- FETAL MEDICINE

DATO' DR. BAVANAN DANNAIDU

GYNAECOLOGY ONCOLOGY

DR. YONG CHEE MENG

REPRODUCTIVE MEDICINE

DR.THAM SEONG WAI

URO- GYNECOLOGY

DATO'DR. ARUKU NAIDU

JAWATANKUASA PERGURUSAN DAN PERKEMBANGAN O&G (JPPOBG) 2022-2025

PENGERUSI : DATO'DR.MOHD RUSHDAN MD NOOR
TIMB PENGERUSI: DR.WAN AHMAD HAZIM WAN GHAZALI

SEKRETARIAT : UNIT PERKHIDMATAN O&G DAN PEDIATRIK, BAHAGIAN PERKEMBANGAN PERUBATAN, KKM

JAWATANKUASA KECIL (SUBCOMMITEE)

INFRASTRUKTUR, PERALATAN DAN SUMBER MANUSIA

DR. ABD RAHIM ABD GHANI

OBJEKTIF

Perkhidmatan O&G memiliki infrastruktur, peralatan dan tenaga manusia yang mencukupi bagi menyediakan perkhidmatan yang berkualiti tinggi.

Membantu KKM merancang pembangunan dan kemajuan bidang O&G

PENYELIDIKAN DAN GARISPANDUAN AMALAN KLINIKAL (CLINICAL PRACTISE GUIDELINES)

DR.RAFAIE BIN AMIN

OBJEKTIF

Menyubur dan membudayakan amalan berasaskan EBM (Evidence-based medicine) dan VBM (Value-based Medicine).

Menghasilkan lebih banyak penyelidikan O&G dijalankan bagi mencapai maksud diatas.

RISK MANAGEMENT DAN MEDICO- LEGAL

DR.YEW CHENG BOON

OBJEKTIF

Mengurangkan kes-kes medico-legal O&G dan masalah-masalah yang berkaitan dengannya.

Mengurangkan risiko aduan dan ke t id akp u asan p e sakit se masa menerima rawatan.

PROGRAM PENGAJIAN IJAZAH LANJUTAN, PEWARTAAN PAKAR DAN PENDAFTARAN NSR

DR.WAN AHMAD HAZIM WAN GHAZALI

OBJEKTIF

Menghasilkan pakar-pakar O&G yang cekap, mahir, selamat dan bermutu tinggi melalui program latihan yang berkesan.

Memperbaiki proses pewartaan Pakar dan urusan pendaftaran NSR.

Meningkatkan minat pegawai perubatan berbakat untukmemilih dan melanjutkan pelajaran di dalam bidang pengajian postgraduate O&G

Memelihara Kebajikan Pakar O&G

HOSPITAL RAKAN BAYI & IBU DAN UBAT- UBATAN

DR.FARIDAH MOHD YUSOF

OBJEKTIF

Mengekalkan status hospital rakan bayi di semua hospital di Malaysia.

Membantu KKM didalam usaha meningkatkan amalan penyusuan ibu.

Meningkatkan kepuasan ibu yang bersalin melalui perlaksanaan hospital rakan ibu.

Perolehan dan bekalan ubat-ubatan O&G yang mencukupi.

Memastikan ubat-ubatan yang digunakan adalah paling sesuai berdasarkan kepada EBM dan VBM.

KOMUNIKASI DAN PENDIDIKAN KESIHATAN MELALUI TEKNOLOGI MAKLUMAT

DR.ANITA RINA BT ALI

OBJEKTIF

Meningkatkan keberkesanan komunikasi di dalam perkhidmatan bagi tujuan menyampaikan.

maklumat, memberipendidikan dan mengemaskini ilmu serta kemahiran didalam bidang O&G melalui penggunaan media social dan teknologi maklumat secara professionaldan berkesan.

Meningkatkan kesedaran masyarakat tentangisu-isu kesihatan Wanita, ibu dan anak.

SUBSPECIALITY TRAINING: MERITS OF TRAINING AWAY FROM HOME

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.

Travel makes one modest. You see what a tiny place you occupy in the world

- Gustave Flaubert

For the newly-minted O&G specialists, one question that comes to mind after the excitement fades, is whether to pursue further subspeciality training. As I am writing this, two diets of the MRCOG Part 3 exams has taken place over the past 6 months (November and February) producing almost 60 new obstetricians and gynaecologists for the country. The pandemic (a.k.a endemic) has thrown a spanner in the works, preventing the replication of the youngest and brightest of our fraternity (pun intended).
The overall attrition rate is considerably high in O&G, and coupled with retirements over the last 2 years, this new generation of specialists is much welcomed to supplement the graduates from the Masters Programme.

Although the Ministry of Health's O&G Parallel Pathway has grown exponentially under the leadership of Dr J Ravichandran and Dr Harris Suharjono in recent years, part of its success is also down to financial logic, where the cost of training and examination is self-funded.

When resources are limited, as they always are, subspeciality training may be at risk of drastic change in future. Currently the O&G discipline is allocated a certain number of overseas subspeciality training slots. However, there is always a possibility that these may be reduced or transferred to other medical disciplines. Compared to paediatrics with almost two dozen subspecialities, O&G has maintained four main core subspecialities (Fertility, Maternal Fetal Medicine, Urogynaecology, Gynae-oncology). Perhaps there is room for expansion into other subspecialites such as Paediatric & Adolescent Gynaecology (currently a subset of Fertility) or Menopausal and Geriatric Gynaecology?

For starters, the bond for subspeciality training has been increased significantly, since the 2020 intake (Table 1)

SUBSPECIALTY TRAINING	DURATION OF TRAINING	BOND/COMPENSATION
Fully Local	3 or 4 years	4 years or RM 500,000
Combination Local & Overseas	2 or 3 years +1 (minimum 36 months)	6 years or RM600,000
Combination Local & Overseas	2 or 3 years +1 (beyond 48 months)	6 years or RM700,000
Fully Overseas	12 months	3 years or RM250,000

Table 1: Duration of bond or compensation effective year 2020 (Source: Bhg Pengurusan Latihan)

Having an MRCOG is an added advantage when applying for fellowship in certain countries such as the UK as it allows a work visa to be more easily obtained. One thing is certain with overseas training, if the tier of the visa approved only permits observership, the hands on experience would be severely restricted.

Although subspeciality training can now be completed locally for some subspecialities, CONNECT speaks to 4 different subspecialists over the years who have left their comfort zone in the pursuit of knowledge and novel skills.

PAEDIATRIC & ADOLESCENT GYNAECOLOGY

Dr Lavitha Sivapatham, Hospital Ampang

Dr Lavitha (4th from left) made lifelong bonds with friends from Royal Children's Hospital, seen here with her supervisor Professor Sonia Grover (5th from left)

Dr Lavitha (far left) with other members of the Malaysian PAG Fraternity at the 19th World Congress of PAG in Melbourne, 2019

When and where did you undertake subspeciality training?

My sub speciality training was from 2014 to 2016. I was fortunate to have received a scholarship from the Ministry of Health, Malaysia to be able to pursue one year of that overseas. I managed to secure a spot to train at the Royal Children's Hospital (RCH), in Melbourne, Australia in 2015.

What drove you to choose the center for further training?
Paediatric and Adolescent Gynaecology (PAG) is a fairly new sub-speciality and at that time there were not many centres for training in Malaysia.

Name the top 2 things you've learnt/achieved from your stint overseas (which would not have been possible/taken longer to master locally)?
My 15 months at the RCH taught me a lot not just about PAG but also about other things. I had the opportunity to be part of clinical MDT meetings, research projects and conferences. It also helped me to enhance my communication skills with patients and their families. I learnt a lot, in terms of medical and surgical management of PAG cases as the volume of patients was huge. This unit was the referral centre for the whole state of Victoria and also one of the few training centres in Australia. I do not think that I would have been able to see and learn so much in the same amount of time at a local training centre.

Above all, I had the opportunity to network and make contact with other PAG specialists all around the world through my supervisor at the RCH – Prof Sonia Grover who is a world renown authority in PAG. This networking is very important when it comes to training opportunities and also when managing difficult cases. These relationships that were forged when I was in Melbourne, continue to be relevant until today.

UROGYNAECOLOGY
Dr Tan Yiap Loong, KPJ Specialist Hospital Kuching

When and where did you undertake subspeciality training?
I was included into the Ministry of Health's Urogynecology Subspeciality training from 2011 till 2013. During these three years I had the opportunity to work and train in the Urology Department of Hospital Kuala Lumpur (Wilayah Persekutuan), Urogynecology Unit and O&G Department of Hospital Sultanah Nur Zahirah (Kuala Terengganu), Urogynecology Unit and O&G Department Hospital Raja Permaisuri Bainun (Ipoh). I also spent a year abroad (year 2012) in Urogynecology Department of Chang Gung Memorial Hospital, the only recognized training centre in asia listed under the fellowship training program directory of the International Urogynecological Association (IUGA).

What drove you to choose the center for further training?
The first, undoubtedly would be its formal international urogynecology training program as it is a university based urogynecology center. As part of the exit requirement of the Urogynecology Subspeciality program, each fellow is required to produce at least two publications within the 3 years stint. The center I went has very high SCI cited publications. Hence this was an opportunity for me to get myself engaged with research, something that was very much lacking within the public service sector.

Dr Tan with his mentor and colleagues at Chang Gung Memorial Hospital

Presenting one of his many publications in Urogynaecology in IUGA 2012, Brisbane

I believe that no matter which country or center one decides to be attached to, not only will one learn new clinical skills, you will improve your communication skills as well and perhaps most importantly, it will allow for professional international networking. Additionally, I was able to form friendship with people from different backgrounds and countries, many of which still last till today and perhaps a lifetime.

I must admit that with the encouragement of my local mentors, teachers and senior urogynecology consultants, I was able to push myself out of my comfort zone to gain new perspectives, develop personally and grow professionally.

Name the top 2 things you've learnt/achieved from your stint overseas (which would not have been possible/taken longer to master locally)?
I believe a fellowship program allows a clinician to sub-specialize and thus become an expert in a specific area of medicine. Fellowship's vital elements are clinical and surgical experience as well as research/publications. These two are the top two things I achieved from my training abroad.

MATERNAL-FETAL MEDICINE

Dr Gayathri Mariappa, Hospital Wanita & Kanak-kanak Tunku Azizah

When and where did you undertake subspeciality training?
I officially started my training on the 10th Feb 2020 at Sarawak General Hospital in the field of followed by training in Hospital Tunku Azizah. I am currently undergoing my overseas training at the West Middlesex University Hosptial (Chelsea & Westminster NHS trust) which began in November 2021.

What drove you to choose the center for further training?
Choosing to train in London was to get a different perspective and approach in the management and care of women with medical disorders and high risk pregnancies .The United Kingdom is established in the field of obstetric medicine and its ever evolving maternal medicine network.

As we all are aware,in reality most hospitals and units concentrate on fetal medicine training as it requires longer training as it requires skillful training and knowledge. On the other hand , maternal medicine has been always something "learning on-the-job" and co-managing women with other medical disciplines. Hence training here provides a structured training ground in the field of maternal medicine.

My training is under a very experienced and dedicated consultant Ms Joanna Girling, who is also the lead of the Northwest Maternal Medicine network

Dr Gayathri taking a physically-distanced photo with Ms Joanna Girling and colleague

View of the entrance to the Queen Mary Maternity Unit where Dr Gayathri is currently working

Name the top 2 things you've learnt/achieved from your stint overseas (which would not have been possible/taken longer to master locally)?
Firstly there is evidence that specialized multidisciplinary care improves outcome for both mother and baby. It's important to have a close working relationship with the varied disciplines in the field of medicines so that good ongoing care can be provided.For example, a monthly discussion with the rheumatology team regarding all women under your care so that everyone is updated on their progress.

Secondly, it's always good to create large trials and data involving the whole nation, to provide robust evidence-based medicine. It's no better way to learn and know better about a disorder or condition from our own women in Malaysia if we could incorporate a nationwide collaborative approach.

GYNAE-ONCOLOGY

Dr Sim Wee Wee, Sarawak General Hospital

Dr Sim is one of the most approachable and level-headed consultant the author knows

The entrance to heritage-listed Royal Prince Alfred Hospital in Sydney. The Gynaeoncology unit has been moved across the road at the Chris O'Brien Lifehouse, where other oncology services are based.

When and where did you undertake subspeciality training?
The overseas fellowship was circa 2008-2009 in Royal Prince Alfred Hospital in Sydney, Australia

What drove you to choose the center for further training?
RPA was and is a certified Gynaeoncology training centre. The formal training post was a "paid job" in those days. I had the opportunity to learn from Professor Jonathan Carter, amongst others.

Name the top 2 things you've learnt/achieved from your stint overseas (which would not have been possible/taken longer to master locally)?
Management of pre and malignant vulval conditions
Participation in the overall running and organization of an established Gynaeoncology centre

EPILOGUE

Exactly ten years after Dr Sim's foray to RPA, the author joined the same centre under the supervision of Professor Jonathan Hyett for Maternal-Fetal Medicine training. The exposure to a different setup which included separate dedicated high risk pregnancy and fetal medicine units, training with COGU fellows (Certification in O&G Ultrasound) was refreshing. The author even had an opportunity to observe an in-utero spina bifida surgery in the Mater, Brisbane, via direct arrangement between Prof Hyett and Dr Glenn Gardner, who Coincidentally, trained the late Dr Japaraj Robert Peter, renowned for his work with twins with TTTS.

The Ministry now has a policy whereby a paid job has to be declared and it will affect the overall amount of scholarship received. Fellowship in RPA is honorary but one could get by doing additional on-call duties as the pay per hour is significant and the fellowship comes with full approval with AHPRA (Australian Health Practitioner Regulation Agency).

The author is thankful he did not return with an accompanying accent.

Dr Voon with Prof Jonathan Hyett at the OGSM Scientific Congress in Penang, 2019

Dr Voon at one of the impromptu farewells with other fellows and sonographers from the FMU. Decoration courtesy of Malaysian glove-making companies.

Education is not the learning of facts, but the training of the mind to think- Einstein

boostrix

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

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

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

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

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

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

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

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

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

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

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

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

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

OGSM 2022

Dato' Dr K. Balanathan
Organising Chairman
29th International Congress of the Obstetrical & Gynaecological Society of Malaysia (OGSM 2022)

Dear OGSM members,

This year has brought about a lot of challenges. We are already in the endemic phase of Covid-19 infection. The past two years, during the surge in Covid 19 infections saw a lot of SOP's being put in place. The borders also have been opened which has already seen an influx of activities especially down South. Now that the restrictions are slowly being lifted, we hope to see all of you during our OGSM Congress.

As mention earlier, the important dates to remember for our members this year is 22nd till 24th July 2022 because that is when we are having our congress. As In keeping with our theme "Moving Forward with The New Norms", I hope all of you all will make it a point to attend the congress which will be held in One World Hotel, Petaling Jaya.

After a lapse about 2 years, we hope to see you all in this physical meeting. The secretariat has been busy planning for this congress since last year and we hope to make it a success with the participation from all of you. The scientific chairman is also putting some new ideas into this congress which will benefit the participants.

So, to our members, I hope you take this opportunity to attend physically this congress not only to update your knowledge but also to meet up with your fellow colleague. Once again, I reiterate that all of you mark this important date in your calendar to help make this congress successful.

Thank you very much for your participation in the upcoming congress.

Dato' Dr. K. Balanathan
President Elect
Obstetrical & Gynaecological Society of Malaysia

pharmaniaga®

Absolute freedom in a woman's journey

MOISTURE

Immediate & long lasting hydration

INTIMACY

Increases vaginal vasodilation & vasocongestion

NORMALITY

Relief from itchiness, burning and urinary incontinence

Registration Number: GMD49334241617A
Registered Under The Act 737

From the President's Desk

On the 30th March 2022, the findings of an independent review of a maternity unit in the UK was published. The Ockenden report made more than 60 recommendations or action points to improve maternity services. The themes are not unfamiliar, the problems are not unique and the solutions are not new, effective communication, continuous training, risk management and audit of practises. It made me reflect on the role that all of us can play to safeguard our patients and staff in the maternity units we work in. As an independent contractor in a private healthcare facility, it is tempting to leave issues such as staff numbers, staff training and labour ward standard operating procedures to the administrators of the hospital. Doctors working in these units are often in the best position to understand shortcomings and make recommendations to safeguard both staff and patients. We underestimate the voice we have and the authority we wield. Input from doctors often increases the ability of nursing managers to obtain funding; for equipment, boosting staff numbers and staff training.

What if we don't want to lead? As doctors, the leadership role is thrust onto us early in our career. Even as house officers, we are expected to lead our 'juniors' and in the absence of more senior doctors, lead the team. Doctors are leaders, like it or not. Not many of us are born to lead, most of us have it thrust upon us. What we do with this opportunity is up to the individual. For now, we learn to lead through observation. I was lucky to have parents who were both good leaders in the community we lived it and also have been fortunate to have had good bosses to emulate. Being involved in OGSM taught me a different set of skills and this exposure has changed the way I choose to lead. Formal training on leadership, how to mentor and develop your team and your contemporaries, conflict resolution and dealing with difficult patients/colleagues will help doctors become more effective leaders. Studies have shown that these lead to better quality of care and clinical outcomes.

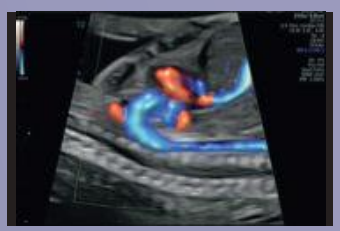
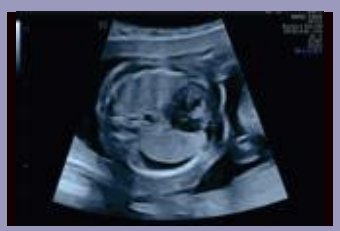
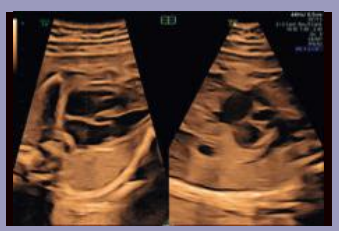
If we are leaders; even if we have had it thrust upon us; let us step up, advocate for our staff and patients, to ensure their needs are met. We should strive to improve our working conditions abd workplace, regardless of seniority, whether you are in the government or the private sector. You can make a difference.

Dr Hoo Mei Lin
President
Obstetrical & Gynaecological
Society of Malaysia

VOLUSON™ E10

THE EXCELLENCE YOU DEMAND. THE STANDARD YOU SET.

- Radiant*flow*™ delivers easy, fast visualization and 3D-like appearance of blood flow.
- *Fetal*HQ™ conduct an easy and comprehensive evaluation, size, shape and contractility of fetal heart from the 4-chamber view.
- RM7C XDclear™ volume probe provides exceptional 2D, 3D and 4D resolution and color sensitivity.
- eM6C delivers ultra-fast rates (up to 29x higher), flexible imaging formats and excellent resolution for routine to complex.
  1. Bi-plane – provides simultaneous display of high resolution, high frame rate images in two perpendicular planes.
  2. eSTIC – obtain volume data of fetal cardiac in 1.3 seconds (75% reduces in time compare to traditional STIC).
  3. VCI-A – delivers excellent contrast resolution through thick slice volume of grey scale and color doppler images.
  4. E4D Snapshot – seamless and quickly capture high quality 3D or eSTIC volumes.
- Exports files directly from Voluson system to instantly 3D print projected and full mesh data sets.


To learn more about our products, please contact:

GE Healthcare
Name: Jaffar Sadiq
Title: Product Manager (Voluson)
Mobile: 019-2220294
Email: mohamedibrahim.jaffersadiq@ge.com

IDS Medical – West Malaysia
Name: Lai Say Lim
Title: Senior Product Specialist
Mobile: 010-4039396
Email: laisaylim@idsmed.com

G Medic – Sarawak Area
Name: James Zebedee
Title: Business Development Executive
Mobile: 016-8742362
Email: james@gmedicsolution.com

G Medic – Sabah Area
Name: Jackson Yi
Title: Sales Manager
Mobile: 017-8215100
Email: JY@gmedicsolution.com

Or visit our website at **https://www.gehealthcare.com.sg/products/ultrasound/voluson**

Annual General Meeting of the College of Obstetricians & Gynaecologists, Academy of Medicine of Malaysia

1st June 2022

Dear Member

NOTICE IS HEREBY GIVEN that the Annual General Meeting of the College of Obstetricians & Gynaecologists, Academy of Medicine of Malaysia will be held virtually via zoom platform.

Date: 25th June 2022, Saturday
Time: 1630 hours
Format: Zoom online
Register in advance for this meeting:
https://us06web.zoom.us/meeting/register/tZYtdOGvrjotE93CMIIt0xIJ6CeEEjyQDT6r
After registering, you will receive a confirmation email containing information about joining the meeting.

Agenda
1. Welcome by the President of College of O&G
2. Minutes of the Annual General Meeting 2021
3. Matters Arising
4. Annual Report 2021 / 2022
5. Statement of Accounts 2021
6. Election of Office Bearers 2022 - 2024
7. Any other matters

Professor Dr Lim Pei Shan
Honorary Secretary
College of Obstetricians & Gynaecologists
Academy of Medicine of Malaysia

Dear Member

NOTICE OF ELECTION OF COUNCIL MEMBERS 2022 - 2024

Given below are the extract from Clause 10 of the By-Laws of then College pertaining to election of Council Members:

10. COUNCIL AND OFFICE BEARERS

10.1. The College shall be managed by a Council of nine which shall consist of:

1. President (Fellow) 2. Deputy President (Fellow) 3. Secretary 4. Deputy Secretary 5. Treasurer 6. Four (4) council members

10.2 The members of the Council shall hold office for a period of two years, and are eligible for re-election.

10.7. The in-coming Council shall appoint at its first meeting the office bearers from amongst those elected.

Nominations are hereby called for the election of Council Members for 2022 - 2024. Nominations must be duly signed and returned to the Secretariat via email: cogamm@acadmed.my by 5.00 p.m. on Saturday, 11th June 2022. Kindly use the attached nomination form - one form per nomination and you can nominate up to nine nominees.

Professor Dr Lim Pei Shan
Honorary Secretary
College of Obstetricians & Gynaecologists
Academy of Medicine of Malaysia

IVF beyond 40. Seriously?

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

How likely is it for a woman above the age of 40 years to conceive? Or more precisely, is it even possible for someone closer to 45 years of age, to conceive? Most gynaecologists would have been asked this question at some point in time. Regardless if it's the patient herself asking, her partner or even her mother-in-law, there is no simple answer. Certainly, we have all heard of women conceiving spontaneously at the age of 45 years. Sometimes one wonders if we all know the same 45-year-old, since spontaneous conceptions at this age are quite rare!

Obviously, we would first want to ensure that the woman wanting to conceive is medically adequately fit. While this is important to conceive, its imperative that she does not have any pre-morbid conditions that would jeopardize her health. Besides common medical conditions such as diabetes and hypertension, cardiac conditions are becoming increasingly common in women. Similarly, missing cervical smear changes or breast lumps prior to conception would be a disaster in the making. An analysis of global data published in the Lancet in 2016 clearly showed that maternal mortality rates increased dramatically with maternal age above 40 years but even more so after the age of 45 years.

So what exactly are the chances of a woman above the age of 40 years conceiving spontaneously? Data from Canada, reported in 2018, showed that 53% of women between the ages of 40 and 44 years who were delivering their first baby had conceived spontaneously. In women aged 45 years and above, only 28.1% of them had conceived spontaneously. To get a sense of perspective, the same data (which looked at the total number of deliveries in a defined geographical location) showed that only 0.2% of these nulliparous women were aged 45 years or beyond while 2.7% of them were between the ages of 40 and 45 years. This data also confirms what most us already know, that most conceptions occur in women aged below the age of forty.

If presenting with infertility, what then are the chances of women at an advanced age to conceive with treatment? It is worth knowing that the oldest woman achieving a livebirth from autologous oocytes utilizing IVF was 50 years old. She was from Mumbai, India, according to a case report published in Fertility Sterility in 2015. There were also reports on 2 other women, both aged 47 years who conceived from autologous oocytes of which one progressed to a preterm livebirth at 35 weeks. Gleicher and his team reported on 2 further livebirths in 2016 in women aged 45 years.

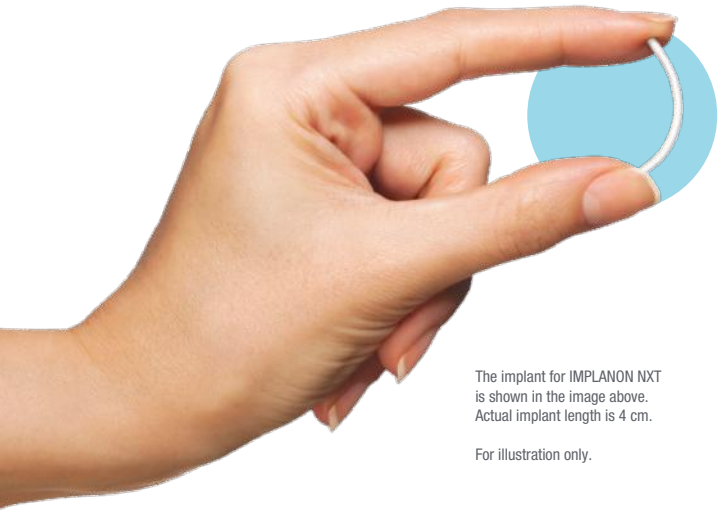
As a crude estimate, Gleicher reported on his own pregnancy rates. In 2016 the clinical pregnancy rate was 2.3% while the livebirth rate was 1.3% in women attempting IVF at the age of 45 years and above. Over a three year period (2014-2016), he achieved a grand total of 16 pregnancies from 466 cycles started and all pregnancies were after day 3 embryo transfers.

Due to the significantly lower pregnancy rates in women attempting IVF at an advanced age, many of them will need to accumulate embryos over several cycles. Certainly cycles followed through with embryo transfers, done repeatedly, without accumulation is also an option, but will inevitably prolong the time taken to achieve pregnancy. In this age group unfortunately, such delays can be potentially catastrophic as time is not in their favour. Women aged 41–44 years who undergo multiple IVF cycles achieve a reasonable long-term success rate. After six cycles of treatment, about 29% of women of advanced reproductive age are expected to achieve a live birth using their own oocytes.

While the numbers clearly indicate that the prognosis of IVF success at an advanced age is grim, the possibility of success remains. Therefore it is incumbent upon the IVF clinician to provide adequate counselling, hopefully armed with good data, and utilizing a pragmatic approach. While many believe that the forties are the new thirties, and this is certainly true in many modern aspects, the inconvenient reality is that reproductive aging has remained very much the same! Hence while in an otherwise healthy woman, pregnancy is still possible, good sensible counselling is absolutely necessary to ensure that these women are not sold short.

Implanon NXT®
68 mg etonogestrel

Simplify **BIRTH CONTROL** regimen with **IMPLANON** NXT®
(radiopaque progestagen implant)



The implant for IMPLANON NXT is shown in the image above. Actual implant length is 4 cm.

For illustration only.

1 Implant*

Provides up to 3 years† of pregnancy prevention without depending on daily adherence[1]

* Placed subdermally just under the skin in the inner non-dominant upper arm.[1]

† IMPLANON NXT must be removed by the end of the third year and may be replaced by another IMPLANON NXT at the time of removal, if continued contraceptive protection is desired.[1]

RECOMMEND BIRTH CONTROL THAT OFFERS EFFICACY[1]

Up to **3** years of pregnancy prevention[1]

>99% effective†,[1]

reversible[1]

Talk to your patients about IMPLANON NXT

* IMPLANON NXT must be removed by the end of the third year and may be replaced by another IMPLANON NXT at the time of removal, if continued contraceptive protection is desired.[1]

† Less than 1 pregnancy per 100 women who used IMPLANON NXT for 1 year.[1]

Selected Safety Information for IMPLANON NXT® (etonogestrel) **COMPOSITION:** Each radiopaque implant contains 68 mg of etonogestrel **THERAPEUTIC INDICATIONS:** Contraception. **DOSAGE AND ADMINISTRATION:** Pregnancy should be excluded before insertion of Implanon NXT. Healthcare professionals (HCPs) are strongly recommended to participate in a training session to become familiar with the use of the Implanon NXT applicator and the techniques for insertion and removal of the Implanon NXT implant and where appropriate, request supervision prior to inserting or removing the implant Subdermal insertion. No preceding hormonal contraceptive use in the past mth: Insert on day 1 & 5 of the menstrual cycle. Changing from combined oral contraceptive (COC), vaginal ring or transdermal patch: Insert preferably on the day after last active COC tab, but at the latest on the day following the usual tab-free interval or last placebo COC tab. Changing from progestagen-only method [pill, injectable, implant or intrauterine system (IUS)] Injectable contraceptives: Insert when the next injection would be due. Pill: Insert within 24 hr any day after last pill. Implant or IUS: Insert on the same day of removal. Post 1st-trimester abortion Insert within 5 days following 1st trimester abortion or miscarriage. Post 2nd-trimester abortion Insert between day 21-28 following 2nd trimester abortion or miscarriage. Postpartum with breastfeeding: Insert after 4th postpartum week. Postpartum without breastfeeding: Insert between 21-28 days postpartum. **CONTRAINDICATIONS:** Progestagen-only contraceptives should not be used in the presence of any of the conditions listed below. Should any of the conditions appear for the first time during the use of Implanon NXT, the product should be stopped immediately. • Known or suspected pregnancy. • Active venous thromboembolic disorder. • Known or suspected sex steroid sensitive malignancies • Presence or history of liver tumours (benign or malignant). • Presence or history of severe hepatic disease as long as liver function values have not returned to normal. • Undiagnosed vaginal bleeding. • Hypersensitivity to the active substance or to any of the excipients of Implanon NXT **SPECIAL WARNINGS & PRECAUTIONS:** If any of the conditions/risk factors mentioned below is present, the benefits of progestagen use should be weighed against the possible risks for each individual woman and discussed with the woman before she decides to start with Implanon NXT. • Carcinoma of the Breast • Liver Disease • Thrombotic and Other Vascular Events • Elevated Blood Pressure • Carbohydrate and Lipid Metabolic Effects • Chloasma • Body Weight • Complications of Insertion • Ovarian Cysts • Ectopic Pregnancies • Other Conditions. The following conditions have been reported both during pregnancy and during sex steroid use, but an association with the use of progestagens has not been established: jaundice and/or pruritus related to cholestasis; gallstone formation; porphyria; systemic lupus erythematosus; hemolytic uraemic syndrome; Sydenham's chorea; herpes gestationis; otosclerosis-related hearing loss and (hereditary) angioedema. **ADVERSE REACTIONS:** During the use of Implanon NXT, women are likely to have changes in their menstrual bleeding pattern. These may include changes in bleeding frequency (absent, less, more frequent or continuous), intensity (reduced or increased) or duration.Possibly related undesirable effects reported in clinical trials: Vaginal infection; headache; acne; breast pain & tenderness, irregular menstruation; increased weight. Increased appetite; affect lability, depression, nervousness, decreased libido; dizziness; hot flush; abdominal pain, nausea, flatulence; alopecia; dysmenorrhea, ovarian cyst; implant site pain & reaction, fatigue, flu-like illness, pain; decreased weight. **Before initiating therapy, please consult the full Prescribing Information.**

Reference: 1. IMPLANON NXT® Package Insert, Malaysia, LPC-MK8415-IPTx-092 Updated Sept 2020

ORGANON

Organon Malaysia Sdn Bhd
Mercu 2, Level 40, Office 39-W022, No 3 Jalan Bangsar, KL Eco City, 59200 Wilayah Persekutuan Kuala Lumpur, Malaysia.
Tel No.: +603-2386 2000 Fax No.: +603-2386 2100

MY-XPL-110004 Jan/2022