

CONNECT



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**Burnout Among Trainees:
Between Resilience &
Change in Workplace
Environment**

**The Reality of
Legal Practice**



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Ultrasound (Mal)Practices in Malaysia - O&G Perspective Maternal Fetal Medicine Subcommittee, OGSM



Dr Vijayan V

The evolution of use of ultrasound in Malaysia

Vijayan V, FRCOG, MFM,
Aseana O&G Specialist Clinic Chairperson, OGSM MFM Sub-Committee

The first ultrasound machine brought into Malaysia for O&G occurred approximately during the 1980s. State hospitals were able to provide scan services soon after.

As one may imagine, strict referral criteria were necessary and one had to be specially-trained to provide services at the time. Indications for an ultrasound examination must have been rare. Localisation of placenta was the most vital indication and probably the only indication for a state-wide referral for a scan. Fetal presentation and weight estimation was still largely regarded as an essential clinical skill. Fetal anomaly screening was a very distant speck in the horizon.

How things have changed come the millennium. We now have the widespread availability of ultrasound machines and services in every O&G department in state hospitals and antenatal clinics at the "Klinik Kesihatan". In the private sector, consultants invariably cannot function without one. Obstetric scans are also provided by general practitioners (GPs) and standalone scan centres, of which the latter's validity as a healthcare provider remains to be established.

The indications for ultrasound scans in obstetrics, as will be discussed, remain limited – dating of the pregnancy, first trimester screening scan and the fetal anomaly scan are the established indications. Routine scans at each antenatal visit has not been shown to be better than symphysio-fundal height assessment and has not positively impacted perinatal outcome in the low-risk population. One would then question the availability of widespread ultrasound services. The fact of the matter is that most scans being performed are unnecessary. High-risk pregnancies, where regular well-being assessment of the fetoplacental unit is required should be under the purview of specialist care.

Currently, we are seeing fetal anomaly screening services spreading like wildfire. Neither national standards nor service frameworks exist. Training courses producing sonographers have also started popping-up. Are patients and aspiring sonographers being taken for a ride?



Dr Hoong Farn Weng Michael



Dr Rafaie bin Amin

Combine the flourishing volume of obstetric scans being performed and the unchecked production of sonographers and untrained practitioners-the situation is quite alarming from the aspect of patient safety and business ethics. Where are we heading, in terms of the provision of antenatal care in this country?

The Role of Ultrasound in O&G

Dr Hoong Farn Weng Michael, Consultant, MFM Specialist, Hospital Wanita & Kanak Kanak Likas Sabah

Ultrasound is a non-invasive imaging technique that uses high-frequency sound waves to create images of the internal organs and structures of the body. In obstetrics and gynaecology, ultrasound plays a vital role in the diagnosis and management of various conditions.

In obstetrics, ultrasound is used to monitor the growth and development of the fetus during pregnancy. It can be used to determine the gestational age of the pregnancy, exclude ectopic pregnancy, assess fetal well-being and detect abnormalities in fetal anatomy, amniotic fluid and the placenta. In addition, ultrasound can be used to guide procedures, such as amniocentesis where a sample of the amniotic fluid is taken for diagnostic testing. In gynaecology, ultrasound can be used to diagnose a range of conditions affecting the female reproductive system. For instance, it can be used to detect ovarian cysts, fibroids or abnormal thickening of the uterine lining. It can also be used to guide procedures such as biopsies or to assist with the placement of intrauterine contraceptive devices. In addition to its diagnostic role, ultrasound is also employed for therapeutic purposes. It can guide the placement of needles during amnioreduction, fetal blood transfusions and other fetal therapies.

Overall, ultrasound plays a crucial role in obstetrics and gynaecology, providing valuable diagnostic and therapeutic information to healthcare providers. Its non-invasive nature and ability to provide real-time images make it a safe and effective tool for monitoring the health of both the mother and fetus during pregnancy, as well as for diagnosing and managing a range of gynaecological conditions.

The Use of Ultrasound in Primary Care

Dr Rafaie bin Amin, Head of Department & Maternal-Fetal Medicine Consultant, Sarawak General Hospital. Sarawak State O&G Advisor.

Obstetric ultrasound scans are widely performed in primary care settings, both in the public and private sectors, by medical officers in Maternal and Child Health (MCH) clinics and in private clinics. The competency and credentials of the medical officers who perform these scans warrant further scrutiny, since there is currently a lack of oversight as to who has the credential to perform this medical procedure.

The adequacy of competency training requires further examination. Most perform without any prior proper training or credentialing process. Training during the housemanship period is barely adequate and can be regarded as merely an exposure to this modality. The number of cases that one must "log-in" during housemanship training is minimal, yet junior medical officers are required to perform obstetric scans when posted to the MCH clinics. A similar

narrative occurs in the private sector. Any medical officer with an ultrasound scan in their clinic is allowed to perform obstetric scan. The potential for diagnostic errors is substantial.

Ultrasound training for medical officers in the government sector is confined to those who work in Obstetrics units and MCH clinics. This is done in most units/clinics as a continuous, on-the-job training without any structural training program. The criteria for credentialing may vary from one unit to another. It is only this year (2023) that Bahagian Pembangunan Kesihatan Keluarga (BPKK), Ministry of Health has implemented guidelines/modules for training and credentialing medical officers in MCH (Credentialing & Privileging Procedure Ultrasound Obstetrik Asas Bagi Pegawai Perubatan).

It is sufficient to say that most of the obstetrics scans conducted in primary care settings are performed without proper credentialing. There is already an effort for improvement in the government sector, but remains lacking in the private sector.

The Street Experience Today

Dr Anna Liza Roslani, Consultant Obstetrician & Gynaecologist, Maternal Foetal Medicine, KMI Kuantan Medical Centre

It began at around the year 2010 when 3D, 4D and 5D scans were marketed to impress women, but also hoodwinked them into thinking that such scans are better at detecting fetal anomalies compared to the conventional 2D scan. Many were under the impression that the 3D, 4D and 5D scans of the face could detect all fetal anomalies! Since then, many women have been requesting the 4D and 5D scans to the point where it had become a trend to post 4D and 5D baby photos on social media. This grossly misleading ideology has prevailed, no thanks to cunning marketing strategies.

Around 2015, due to greater public awareness that 4D and 5D scans were not anomaly scans and that midtrimester morphology screening or “detailed scans” are the ones that can confirm normality or abnormality, more and more women wanted to have a detailed scan. The sonography market started booming. It became a marketing strategy for GPs to engage sonographers to perform such scans in their clinic.

The problem with such an arrangement is that sonographers are only trained to scan (with minimal hands-on training), take measurements and report anything that does not lie within strict guidelines. They are unable to clinically interpret what they see in the fetus. Since sonographers are not allowed to function individually, their employer (the GP) will need to countersign a report produced by the sonographer. However, most GPs know even less than the sonographer about soft markers and fetal anomalies but end up signing the report anyway. They are unable to explain to the patient regarding the sonographer’s findings. Instead, they advise the patient to see an O&G doctor, often without a proper referral. Even when there is a referral to the O&G clinic in the nearest government hospital, the appointment given may be days or weeks away due to full schedules. As such, the woman leave the GP clinic upset and distraught. Some end up crying for days, worried about the health of their babies. Those who are more privileged may seek out a private Maternal Fetal Medicine consultants themselves for an earlier reassessment. Unfortunately, they will eventually be paying again for a credentialed detailed scan. This is completely unnecessary.



Dr Anna Liza Roslani

There are 4 potential issues arising from scans performed by sonographers:

1. Reporting the fetus to be structurally normal when in fact, they have missed an anomaly (this provides false reassurance to the patient);
2. Reporting the fetus to have a structural anomaly (or soft marker, such as cardiac echogenic foci) when in fact, the fetus is structurally normal;
3. Reporting the fetus as abnormal, but unable to diagnose the anomaly accurately;
4. Saying inappropriate things when there is an abnormal or ambiguous finding (sonographers are meant to only scan and not start a consultation process).

The situation is even worse in the 'ultrasonography centres' which are standalone centres run by sonographers only. There is no doctor involvement. By touching patients, they are already committing an offence as they are not licensed in any way to examine patients. They are unable to provide consultations as well, since they are not accredited. They also use patients as 'models' for student sonographers to train on. I am uncertain whether patients are aware of this practice. How much supervision is given to these students is also unknown. Most are learning on the job, yet patients are paying for their services.

Sonographers are also offering aneuploidy screening by way of Nuchal Translucency & Nasal bone measurements. The key component to any screening test, and even more so when it comes to aneuploidy screening, is the pre-test and post-test counselling. Unfortunately, there is no counselling whatsoever given by these sonographers. The patient seems to think it is a good idea to have this test done based on the 'marketing' of these scans. But as with all screening tests, it causes great anxiety when the presented outcome is 'high risk'. Once again, the sonographer (or GP) will not be able to explicitly explain what the results mean and merely advise the patient to either book an appointment with the O&G clinic in the nearest government hospital or look for a Maternal Fetal Medicine private consultant themselves. This practice is very unethical.



Dr Kuharaj Balasubramaniam

Potential Malpractice

Dr Kuharaj Balasubramaniam, Consultant Obstetrician & Gynaecologist, LLB (London), Asunta Hospital

Beneficence, non-maleficence, patient autonomy and justice are the four pillars of medical ethics. Breaking any one of these pillars will cause the collapse of the roof under which our profession exists. It has been a long-established principle in medical ethics that the registered medical practitioner should always practice within their certified competency since breaching this covenant will not break only one, but two pillars of medical ethics. Just as surely as a Maternal Fetal Medicine (MFM) consultant should not be performing an echocardiogram on an adult patient as they are trained to use an ultrasound, the cardiologist should not be performing an ultrasound for the hepatobiliary system either just because they are "ultrasound competent".

Fetal anomaly screening scans are complex examinations that require years of training under direct supervision of experts in dedicated units. The KKM Guidelines on Ultrasound Usage In Medical Practice (3rd November 2022) classified anomaly scans as Level 3 scans. It states that to be qualified to perform a Level 3 ultrasound examination of the fetus, a registered medical practitioner must have completed at least 50 level 3 scans under direct supervision and subsequently assessed by a Maternal-Fetal Medicine (MFM) subspecialist. Looking at the requirements of these guidelines, even non-MFM Obstetricians and Gynaecologists may fall short of this minimum requirement.

Unfortunately, there has been a rising trend among many GP clinics claiming to perform detailed ultrasound scans for pregnant mothers. GPs remain the cornerstone of primary healthcare, however, they are as the name itself implies: GENERAL practitioners. They are not practitioners of specialised procedures let alone subspecialised procedures, such as "detailed scans" that require advanced training. Any registered medical practitioner should practice within their field of competency. GPs performing such scans clearly break this ethical caveat and also violate the KKM guidelines.

The introduction of "sonographers" in the Malaysian healthcare system has been gradual over the past three decades. Initially, in public university hospitals and in some KKM facilities, nurses as well as medical assistants were trained to perform ultrasounds to help alleviate the backlog in the public healthcare system. The public university hospitals introduced the overt concept of "sonographers" in their facilities to perform screening scans. However, at no point was there an act of parliament that was introduced to give legitimacy to these "sonographers", no regulatory body set up to govern these "sonographers" or for them to register under and at no point were their qualifications or training ever accredited by KKM. The introduction of the Allied Health Professions Act 2016 regulated all allied healthcare professionals, from audiologist to the medical science officer. There are 23 recognize allied health professionals under the act but sonographers are NOT one of them. The Medical Devices Act 2012 also clearly stipulates who can actually use a medical device. Diagnostic ultrasounds are class B active medical devices that can only be used on a 3rd party with recognized qualifications by the Minister of Health.

An individual performing diagnostic procedures on any patient, let alone pregnant mothers and the unborn fetus, requires approved qualifications and legal recognition as

a professional entity. "Sonographers" in Malaysia have neither. Hence, they should not even touch a patient with a medical device let alone perform diagnostic medical procedures for a fee, especially complex Level 3 ultrasound scans such as detailed scans. Registered medical practitioners should be aware that employing individuals who are not adequately certified or unlicensed in their medical centre is a direct contravention of the laws stipulated in the Private Healthcare Facilities and Services Act 1998. They are subject to hefty fines and even potential closure of said medical facility, until they are certified under provisions provided by the new ministry guideline.

Considering the current guidelines and legal requirements, it begs the question whether diagnostic ultrasounds should be allowed in a primary healthcare facility such as GP clinics in the first place? After all, with such stringent legal requirements and guidelines, why bother with having such a device? The simple answer is that although complex diagnostic procedures are not within the capability of the GP, basic diagnostic ultrasound procedures are. Level 1 ultrasounds have always been carried out by the GP. GP clinics are far more accessible in terms of location, timing and pricing of operations for the public. Basic ultrasound scans (such as assessing the presence of the fetal heartbeat, fetal presentation, confirming the viability of an early pregnancy and fetal parameter measurements) can be conducted by the GP. Competency will be mandatory moving forward, as outlined by the Ministry of Health's guideline on the "Guidelines on the Usage of Ultrasound in Medical Practice", issued in November 2022.

The rising number of medicolegal cases is an issue that most registered medical practitioners are only far too aware of. However, some have chosen not to take the necessary precautions. Many GPs are performing obstetric ultrasounds without taking the additional obstetric coverage offered by the medical indemnifiers. They will be in for a rude awakening should an issue of misdiagnosis arise after performing obstetric ultrasound on a patient. The medical indemnifiers will refuse to cover the cost of the legal fees and the potential compensatory pay-out deemed by the courts since they failed to take the additional obstetric coverage which the usual policy does not include. Those who employ "sonographers" to perform ultrasound examinations on patients in their centre will be facing a harsher reality since not only will the medical indemnifiers refuse to cover any misdiagnosis, but the registered medical practitioner in charge of the clinic/medical centre (PIC) will also be subject to a six figure fine under the Private Healthcare Facilities and Services Act 1998.



Dato' Dr Bavanandam Naidu

Potential Fraud

Dato' Dr Bavanandam Naidu, Consultant Obstetrician & Gynaecologist, Maternal Fetal Medicine, Hospital Sultanah Bahiyah, Alor Setar. Head of MFM services KKM (at the time of writing).

The misconception among patients regarding ultrasound in pregnancy is caused by the misinformation in advertisements and social media. This information has enticed pregnant couples to believe that a 'detailed scan' can absolutely rule out any possible condition in the baby. The catch phrases "3D and 4D scans", although misleading, has caught on. Patients come requesting a 3D scan when what they mean is a detailed or fetal anomaly scan. Now, providers are touting 6D viewing with goggles! Ultrasound is a medical investigative equipment and should be used with medical indications only. There seems to be poor enforcement and regulation with regards to misinformation disseminated by certain irresponsible parties. Authorities appear to be left behind in this media-savvy environment.

There has also been widespread unlicensed practice by sonographers providing unverified reports. To make matters worse, there is no structured chain of referral to a Maternal Fetal Medicine specialist or an O&G specialist for counselling and confirmation of findings in cases of suspicious or ambiguous findings. Patients are charged exorbitantly for such services provided, only to be charged again when they arrive at doors of legitimate services.

As for the sonographers, there is a dire need for a registry and a regulatory body to monitor the practice. Once registered, they need (just like medical practitioner) a continuous CPD program to maintain their accreditation. And again, once legit, they must be placed within a defined and regulated service provision within the MOH. Where can they work? Under which specialties? Answerable to whom? Who can employ them? Currently, there is a widespread unregulated practice providing various ultrasound examinations, including detailed ultrasound. A trainee in sonography must be told about the current state of practice in Malaysia and the prospects before being accepted into a training program. The authorities can do well with a statement and guidance on this matter for all those who are thinking of sonography as a career.

How widespread is this problem?

The committee members are all practicing MFM consultants in various sectors. We can all vouch that we regularly see this phenomenon in our practices where pregnant women come in with a detailed scan already performed at an unaccredited centre or by an uncredentialed sonographer. On the other hand, one only needs to search for the term "detailed scan" online to see the hits. Worryingly, if one searches the term "3D scan", the hits become astronomical. At the time of writing, the subcommittee is waiting on the OGSM council's decision regarding the final draft letter for action from the Minister of Health.

We invite further discussions on this matter. Please email administrator@ogsm.org.my cc vj1vela@gmail.com with any views or facts you may have on this matter. Subject: Ultrasound Malpractice.

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CHALLENGES IN MAINTAINING WEIGHT REDUCTION¹⁻³



Despite several weight reduction attempts, only **23%** of people with obesity reported a **10% weight reduction** within three years¹



Only **10%** were able to **maintain** the weight reduction for more than one year¹



On average, an individual with obesity has attempted **seven** serious weight reduction attempts³

BARRIERS TO MAINTAINING WEIGHT REDUCTION

- Inability to afford healthy food choices²
- Previous unsuccessful weight reduction attempts²
- Illnesses/ physical conditions²
- Lack of self-perception of body image²
- Work commitments e.g. long working hours²
- Sedentary lifestyle and lack of physical activity²

Physiological changes after weight reduction can drive weight regain, making it hard to keep it off⁴⁻⁷

Scan to connect for more information



* From randomization to week 56, weight decreased an additional mean 6.2% (s.d. 7.3) with liraglutide and 0.2% (s.d. 7.0) with placebo (estimated difference 6.1% (95% class intervals 7.5 to 4.6), P<0.0001). ** Patients treated with Saxenda® experienced an observed mean waist circumference reduction of 8.2 cm vs 3.9 cm with placebo (P<0.001). † Participants (n=422) lost a mean 6.0% of screening weight with 12 weeks of low-calorie diet followed by additional mean weight loss of 6.2% with Saxenda® and 0.2% with placebo (P<0.0001) after 56 weeks. ‡ Liraglutide induced greater weight loss than placebo at week 160 (-6.1 [SD 7.3] vs -1.9% [6-3]; estimated treatment difference -4.3%, 95% CI -4.9 to -3.7, p<0.0001).

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Abbreviated prescribing information (Malaysia)

Saxenda® (Liraglutide injection) 6 mg/mL Solution for injection in pre-filled pen

Presentation: Prefilled, disposable pen containing 18 mg of liraglutide in 3 mL of solution. **Indications:** Saxenda® is indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adult patients with an initial Body Mass Index (BMI) of ≥ 30 kg/m², or ≥ 27 kg/m² to < 30 kg/m² in the presence of at least one weight-related comorbidity such as dysglycaemia (pre-diabetes or type 2 diabetes mellitus), hypertension, dyslipidaemia or obstructive sleep apnoea. Treatment with Saxenda® should be discontinued after 12 weeks on the 3.0 mg/day dose if patients have not lost at least 5% of their initial body weight. Saxenda® is indicated as an adjunct to a healthy nutrition and increased physical activity for weight management in adolescent patients from the age of 12 years and above with obesity (BMI corresponding to ≥ 30 kg/m² for adults by international cut-off points) and body weight above 60 kg. Treatment with Saxenda® should be discontinued and re-evaluated if patients have not lost at least 4% of their BMI or BMI z score after 12 weeks on the 3.0 mg/day or maximum tolerated dose. **Dosage and administration:** For adult, the starting dose is 0.6 mg once daily. The dose should be increased to 3.0 mg once daily in increments of 0.6 mg with at least one week intervals to improve gastro-intestinal tolerability. If escalation to the next dose step is not tolerated for two consecutive weeks, consider discontinuing treatment. For adolescents from the age of 12 to below 18 years old a similar dose escalation schedule as for adults should be applied. The dose should be increased until 3.0 mg (maintenance dose) or maximum tolerated dose has been reached. Daily doses higher than 3.0 mg are not recommended for both adult and adolescents. Daily doses higher than 3.0 mg are not recommended. For adolescents (Saxenda® is administered once daily at any time, independent of meals, subcutaneously injected in the abdomen, thigh or upper arm, preferably around the same time every day. Saxenda® must not be administered intravenously or intramuscularly. Patients with type 2 diabetes mellitus receiving liraglutide in combination with insulin and/or sulfonylurea may have an increased risk of hypoglycaemia. The risk of hypoglycaemia may be lowered by a reduction in the dose of insulin and/or sulfonylurea. Saxenda® should not be used in combination with another Glucagon-like Peptide-1 (GLP-1) receptor agonist. Blood glucose self-monitoring is necessary to adjust the dose of insulin or insulin-secretagogues (e.g. sulfonylureas). No dose adjustment is required for adolescents from the age of 12 years and above. The safety and efficacy of Saxenda® in children below 12 years of age has not been established. **Contraindications:** Hypersensitivity to liraglutide or to any of the excipients. **Special warnings and precautions:** In patients with diabetes mellitus. Saxenda® must not be used as a substitute for insulin. Diabetic ketoacidosis has been reported in insulin-dependent patients after rapid discontinuation or dose reduction of insulin. There is no clinical experience in patients with congestive heart failure. New York Heart Association (NYHA) class IV and liraglutide is therefore not recommended for use in these patients. Due to limited experience, Saxenda® is not recommended in patients with inflammatory bowel disease or diabetic gastroparesis. Saxenda® is not recommended in patients: aged 75 years or more, treated with other products for weight management, with obesity secondary to endocrinological or eating disorders or to treatment with medicinal products that may cause weight gain, with severe renal impairment, with severe hepatic impairment. Saxenda® must be used with caution in patients with mild or moderate hepatic impairment. Acute pancreatitis has been observed with the use of GLP-1 receptor agonists. Patients should be informed of the characteristic symptoms of acute pancreatitis. If pancreatitis is suspected, liraglutide should be discontinued; if acute pancreatitis is confirmed, liraglutide should not be restarted. In clinical trials for weight management, a higher rate of cholelithiasis and cholecystitis was observed in patients treated with liraglutide than in patients on placebo. Patients should be informed of the characteristic symptoms of cholelithiasis and cholecystitis. 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Patients with type 2 diabetes mellitus receiving liraglutide in combination with insulin and/or sulfonylurea may have an increased risk of hypoglycaemia. Episodes of clinically significant hypoglycaemia have been reported in adolescents (≥ 12 years) treated with liraglutide. **Pregnancy and lactation:** Saxenda® should not be used in women who are pregnant, who wish to become pregnant, or who are breastfeeding. **Undesirable effects:** The most frequently reported adverse reactions in patients treated with Saxenda® are headache, nausea, vomiting, diarrhoea and constipation. Common adverse reactions include dyspepsia, upper abdominal pain, gastritis, flatulence, abdominal distension, gastro-oesophageal reflux disease, eructation, dry mouth, dizziness, dysgeusia, insomnia, fatigue, asthenia, injection site reactions, increased lipase, increased amylase, hypoglycaemia and cholelithiasis in adults. Uncommon adverse reactions include dehydration, tachycardia, urticaria, pancreatitis, cholecystitis, malaise and delayed gastric emptying. Rare adverse reactions include anaphylactic reaction, acute renal failure and renal impairment in adults. The frequency, type and severity of adverse reactions in the adolescents with obesity were comparable to that observed in the adult population. Vomiting occurred with a 2-fold higher frequency in adolescents compared to adults. **Overdose:** From clinical trials and marketed use overdoses have been reported up to 72 mg (24 times the recommended maintenance dose). Events reported included severe nausea, severe vomiting and severe hypoglycaemia. In the event of overdose, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms. The patient should be observed for clinical signs of dehydration and blood glucose should be monitored. **Full prescribing information is available upon request. Edition: 6.0**

“ From the President ”



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

We are now in 2023 and time has flown by. We made it through the pandemic and are ready to start functioning as near normal as possible. The pandemic has taught us to engage with social media and to use the internet to spread our message across to not only our members, but also the public. Everything can be accessed with the click of a button. Knowledge seems infinite. Throughout the pandemic, we made ourselves visible through our Facebook page and by webinars. The webinars were very impressive and the response from our members have been encouraging. They were able to attend from their own comfort zone.

OGSM also began returning back to the usual by organising face-to-face courses which started with our congress last year. The response was tremendous considering we were just leaving the pandemic behind. The trainees were also not forgotten. The PACT component reintroduced the physical programme, which was a relief for trainees and those involved since there is physical engagement. The ICOE programme, which is the brainchild of OGSM, also began setting out overseas to restart teaching in regions within the federation (AOFOG; Asia & Oceania Federation of O&G). We were very welcomed there.

Serving our members better has always been our target. At the last AGM, we made some constitutional amendments. These amendments were diligently reviewed by the council and subsequently put forth at last year's AGM. Through the hard work of the council and staff, we were able to have the amendments passed by the registrar of society. The council and staff are also streamlining processes so that it will be easier for our members to communicate with us. Our next congress will be held on the 20th–23rd of July, 2023. So please keep these dates free so that you can all attend.



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From the Secretary's Desk



Dr Loh Huey Wen
OGSM Hon. Secretary 2022-2023

Warm greetings from OGSM and the council! After several years of not being able to physically meet, it was a true pleasure to personally get reacquainted with our members this year at the 29th International Congress of the Obstetrical & Gynaecological Society of Malaysia (OGSM 2022). With an exciting scientific program, the success of the congress was reflected in the smiles of members attending the event.

OGSM began to embrace the new normal ever since the movement control order has been lifted. Despite the increase in physical events, it has been observed that our members also appreciated the virtual events where one does not have to battle weather or traffic. As a result, the Expert Webinar Series continued to host webinars for the enrichment of our members.

Our subcommittees have been hard at work. The subcommittee of Gynaecological Endoscopy organised a "Cross-border Malaysia-Singapore Fertility and Minimally Invasive Surgery Symposium" while the Paediatric & Adolescent Gynaecology Subcommittee organised a symposium entitled "Gynaecological Disorders in Obese Adolescent Girls". ICOE has been busy with numerous local and regional courses. 'I Love Me' event at the Cititel Hotel, Mid Valley, KL

was held in conjunction with the International Women's Day and Endometriosis Awareness Month.

In an endeavour to streamline OGSM, new accounting software was purchased by the last council year. Unfortunately it was not possible to integrate the old software in our website to assist in the management of our members. Therefore, the secretariat completed the transfer of the accounting data last year. This new software has reduced the amount of paperwork for our secretariat, which will allow them to concentrate their efforts on other portfolios. Members may have noticed emails reminding them to pay their subscription fees. The new system now makes payment more efficient.

As we strive to further streamline OGSM, credit must be given to all the subcommittees for their hard work in keeping OGSM relevant. We hope that we can continue to serve our members and meet once again at the upcoming 30th International Congress of the Obstetrical & Gynaecological Society of Malaysia (OGSM 2023).



DYSMENORRHEA

By Dr Susan Adongo
Paediatric & Adolescent Gynaecology Fellow
Universiti Kebangsaan Malaysia

Dysmenorrhea is a Greek term for 'painful monthly bleeding'¹ and can be defined as chronic, cyclical, low abdominal or pelvic pain related to menstruation. It is commonly seen in young females. The global prevalence varies among different populations, mostly because it has become socially normalised, but is estimated to be approximately 70%². A study conducted by Mariappen et al. in 2021 revealed that dysmenorrhea affects 60–93% of adolescents in Klang valley, Malaysia³.

It is thought to be the most common gynaecological complaint among women regardless of age and nationality. In Klang Valley, from the menstrual problems studied, dysmenorrhea was the most common at 30.9%. Unfortunately, only around 11.1% would seek medical consultation for this problem³. Therefore, the evaluation and management of dysmenorrhea is a key aspect of maintaining adolescent reproductive health.

The onset of dysmenorrhea is usually 6-12 months after menarche and is limited to the first 48–72 hours of the menstrual cycle⁴. It can be accompanied by other symptoms such as nausea, vomiting, diarrhoea, lethargy, irritability, headaches, sleep disturbances, tender breasts and depressive symptoms^{2,5}. This can severely hamper the quality of life of adolescent girls, causing them to be withdrawn and depressed. This can further lead to frequent absenteeism from school or the inability to participate in usual daily activities. In Klang valley, more than half of the girls affected by dysmenorrhea miss school, leading to poor academic performance and limited outdoor activities³.

Dysmenorrhea can be classified as either primary or secondary in relation to its pathophysiology and has been known to have significant emotional,

psychological and functional health impact¹. The emotional impact of dysmenorrhea in adolescents can cause anxiety around the onset of menses every month since they know it will be accompanied by pain. Adolescents with dysmenorrhea may develop feelings of depression, hopelessness and low self-esteem. Some may avoid social situations such as school or school-related activities due to the pain and discomfort associated with their menstrual cycle. This, in turn, may lead to feelings of loneliness and poor body image.

Primary dysmenorrhea has no underlying pathology or organic cause but is associated with biochemical causes; mainly excess production of prostaglandin F₂ and E₂, leukotrienes and vasopressin, which then stimulate myometrial contractions and ischemia leading to pain^{2,6}. Secondary dysmenorrhea usually has an identifiable underlying pathology such as endometriosis, uterine anomalies, pelvic inflammatory disease, intrauterine devices, ovarian cysts, adenomyosis, uterine myomas or polyps, intrauterine adhesions and cervical stenosis⁴. In the adolescent age group, primary dysmenorrhea is more common than secondary dysmenorrhea. Those with an underlying organic cause are usually diagnosed with Mullerian duct disorders such as Obstructed Hemivagina with Ipsilateral Renal Agenesis (OHVIRA) or transverse vaginal septum.

The diagnosis of dysmenorrhea is based on a comprehensive history and physical examination. The clinician must ask about the onset, location, duration and characteristics of pain as well as aggravating or relieving factors⁶. Other symptoms, such as pain during bowel movements, intermenstrual bleeding, menorrhagia or abdominal distension, may point to secondary dysmenorrhea.

Dr Susan Diane Akinyi Adongo (MChB, MMed Obs/Gyn, Fellow PAG) is an Obstetrician Gynaecologist from Kenyatta National Hospital and Associate Lecturer at The University of Nairobi, Kenya. For Dr Susan, the road to obstetrics-gynaecology began with a fascination with women's health, developed through intellectual stimulation, clinical satisfaction and personal exploration. Prior to medical school, Dr Susan found every opportunity to volunteer and work in women's health. These experiences led her to medical school and throughout her classroom years, she developed a keen sense of wanting to further her passion through a career in obstetrics-gynaecology.

Aside from Obs-Gyn, Dr Susan is dedicated to literature and medical education, and publishes captivating medical-interest stories on her blog – Medroomeyes.com. She values service, growth, consistency and autonomy as her core principles.

Adept with 14 years of experience in clinical work and research as a medical doctor, Dr Susan is currently a fulltime clinical PAG fellow at Hospital Universiti Kebangsaan Malaysia. She is on her way to becoming the first Paediatric and Adolescent Gynaecologist in the entire continent of Africa.

Treatment of dysmenorrhea in adolescent girls should aim to improve their quality of life and should include non-pharmacological and pharmacological interventions. Pharmacological interventions include: the use of non-steroidal anti-inflammatory drugs (NSAIDs) for the full 72 hours after pain begins⁴. This is used as the first line of treatment. However, if there is no improvement after three menstrual cycles of NSAID usage, then hormonal therapy is warranted⁷. The most common complication of using NSAID is gastritis which can be mitigated by the concurrent use of antacids or protein pump inhibitors. Administration of oral contraceptive pills is indicated for those in whom primary treatment has failed. If pain persists after six months of NSAID and combined oral contraceptive use, then laparoscopy is indicated to rule out secondary dysmenorrhea⁷.

Alternative therapies exist and include: heat therapy applied to the lower abdomen using a heating pad or hot water bottle, transcutaneous electrical nerve stimulation (TENS), thiamine, magnesium and vitamin E₆. Mariappen et al. found a positive association between dysmenorrhea and obesity was found, therefore, eating a healthy diet rich in fruits, vegetables and nuts as well as reducing the intake of caffeine, sugar and processed foods may alleviate symptoms of dysmenorrhea. Exercise has also been thought to improve symptoms of dysmenorrhea. Adolescents are encouraged to participate in jogging, walking or swimming or try relaxation techniques such as yoga.

In conclusion, dysmenorrhea is a common gynaecological condition that presents itself in the first 6-12 months post menarche. It remains underdiagnosed and undertreated. Many young females silently suffer since it is believed that this

is a pain that must be tolerated. Clinicians should take a comprehensive history and perform a physical exam for girls with dysmenorrhea to rule out any underlying pathology. Simple analgesics and NSAIDs are effective in up to 70% of patients. It is essential for adolescents with dysmenorrhea to receive appropriate medical care and emotional support to help them manage the physical and emotional symptoms of this condition.

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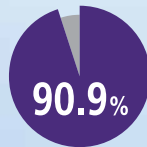
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The Memorable Community Fellowship Programme in my AFOG YGA Journey

Dr Yong Soon Leong was the recipient of the Shan S Ratnam Young Gynaecologist Award in 2022. He is currently a Maternal-Fetal Medicine fellow in Hospital Tengku Ampuan Afzan, Kuantan, Pahang.

I was extremely honoured to receive the Shan S. Ratnam Young Gynaecologist Award at the 27th Asia & Oceania Federation of Obstetrics and Gynaecology Congress, Bali, Indonesia in May 2022. I would like to express my deepest gratitude to the Obstetrical & Gynaecological Society of Malaysia (OGSM) for submitting the nomination to The Asia & Oceania Federation of Obstetrics & Gynaecology (AFOG), which was truly unexpected for me. I was also grateful to be selected by OGSM to participate in the 3-day Community Fellowship Programme (CFP) which was held before the congress. The aim of CFP is to expose young gynaecologist awardees (YGAs) to different healthcare systems of member countries in the Asia and Oceania regions so that they can recognise the challenges related to their unique cultural backgrounds and recommend solutions.

On 20th May 2022, my wife and I boarded a flight from Kuala Lumpur to Bali, Indonesia. We were incredibly excited about going on our first overseas trip which had been put off for two years due to the COVID lockdown. Upon arrival at Bali Ngurah Rai International Airport, we received a very warm welcome from the CFP organising team

at the arrival gate. They greeted us cheerfully, placed a garland of flowers around our necks and assisted us into a car which they had arranged to take us to our hotel. We were blown away by their incredible hospitality. At night, I attended a welcoming dinner and ice-breaking session. Besides it being our first social event of the CFP, it was also my first time getting to know nine other YGAs from the Asia and Oceania regions. When we met, we naturally began discussing women health issues and challenges we faced in our respective countries. This informal session marked the beginning of our friendship.

The CFP officially started on the 21st of May, 2022. The most enriching and satisfying activity of the first day programme was a morning field trip to Posyandu Puskesmas Kelurahan Benoa, which is a primary health centre in South Kuta, Bali. Although the centre was a small, sheltered space, we witnessed the comprehensive care provided to the local people, including health screening for senior citizens, educational programme on reproductive health for adolescents and antenatal care for pregnant mothers. As a maternal-fetal medicine fellow, it was my great pleasure to be invited to demonstrate an obstetric ultrasound scanning on an antenatal mother and to have a brief case discussion with my colleagues and local doctors. In the afternoon, we listened to two plenary lectures on how to reduce maternal death in Asia and Oceania. At the end of the day, our ice-breaking activity resumed where all of us practised a local Indonesian dance for our upcoming performance on the President's Night.

On the 22nd of May, we watched a documentary titled "Voices from the Field" by Karen Day, a prestigious journalist and filmmaker who is passionate about humanitarian issues around

the globe. The documentary revealed that postpartum haemorrhage (PPH) remains the number one killer of birthing mothers in resource-poor countries. The obstetricians working there still struggle to save mothers lives. After watching it, we felt overwhelmed. We also thought that it was irrelevant to talk about costly high-tech interventions when delivering mothers suffering from PPH in remote regions still face challenges to gain access to fundamental inventory such as a USD0.80 uterine tamponade balloon, which is a life-saving device for PPH. The next session that made our heart race was "Be Impactful Speakers" where we were instructed to deliver a short public speech. Our performance was evaluated, and we were given a score on the spot. Personally, I really found that the speaker's tips and tricks on how to communicate effectively were well-elaborate. The second day agenda ended with a sight-seeing tour of the Uluwatu temple, followed by a dinner at Jimbaran.

The 23rd of May was the last day of CFP. In the morning, we were given a task to draw up a proposal about conceptualising pathways to reduce maternal mortality in Asia-Oceania. We were then asked to present it on the President's Night, which would be held in twelve hours' time. Immediately, we began brainstorming ideas and expanding them into actionable strategies and solutions. One of us played "scribe" and marked each idea on the board in order to capture the thoughts of everyone. Finally, we came up with a powerful acronym called "ACTiOnS" which stood for:

- A : Advocacy & communications
- C : Collaborations and global partnership
- Tion : Training & educatIOn
- S : Sustainable development of health facilities

We believe that establishing a strong partnership among the Asia-Oceanic countries maximises opportunities for creating collaborative funds, intensifying government commitments of member countries to massively invest in infrastructure and upgrade existing facilities. This will optimise maternal healthcare services where more doctors and midwives are trained, continuously producing trainers to ensure sustainable training for next generations. It was truly satisfying to see the moment of sharing ideas across the table during the discussion. In the afternoon, we participated in team building activities and lastly, the CFP ended by releasing a dove, which symbolised the unity of YGAs in working together to reduce maternal death in the region.

At the President's Night, I was excited to see many O&G leaders from RCOG, FIGO and national O&G societies of various countries attending the event. On behalf of all 10 YGAs, I had the privilege of partnering with Dr Shafaq Ismail Makhdoom, a YGA from Pakistan, to present our proposal. After the presentation, I handed the proposal over to Professor Dr Kazunori Ochiai, the President of AOFOG. We received positive responses about our work from the esteemed guests, and Dr Jeanne Conry, the president of FIGO, was so impressed with our ideas, she instantaneously sent a copy of the proposal to Karen Day. Afterwards, each of



Sharing ideas on reducing maternal death among YGAs during interactive discussions, as well as brainstorming the YGAs' "ACTiOnS" proposal.



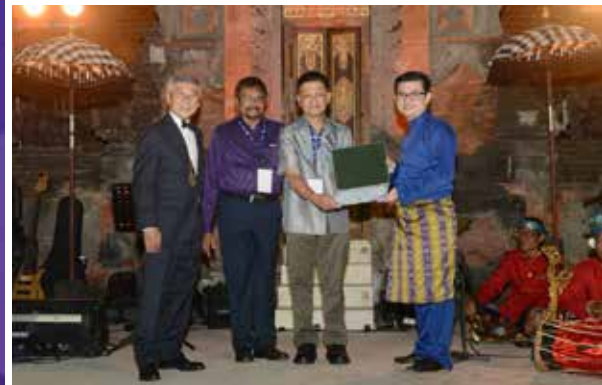
We participated in various activities during CFP.

us received our YGA certificates, and this was followed by our performance where we presented the local Indonesian dance which we had been practising for two days.

I am delighted that I could represent OGSM in the CFP. This fellowship programme has provided a platform for networking and sharing ideas. It was such a pleasure meeting and making friends with the CFP attendees who are our future O&G leaders in their respective countries. It has been 10 months since we last met, but we still keep in touch with each other and look for opportunities to collaborate in the hope of translating our YGA "ACTiON5" concept into reality. Being a YGA also compelled me to contribute through various channels. As a trainer of the Intensive Course in Obstetric Emergencies (ICOE), I had travelled abroad to Sri Lanka in September 2022 together with two other senior trainers, Dr Thaneemalai Jeganathan and Dato' Dr Zaridah bt Shaffie. The plan was to collaborate with six Sri Lankan probationary trainers to conduct a Caesarean section workshop for their postgraduate trainees in order to meet their training needs. In October 2022, I delivered a talk about current management of prelabour rupture of membranes in the SAFOG-AOFOG International Academic Exchange Webinar. Within Malaysia, I have been volunteering to help conduct ICOE activities to train local doctors and midwives. These events have given me the personal satisfaction of being able to contribute. The AOFOG YGA and CFP nominations for 2024 are now open and I hope that the one selected will truly enjoy the YGA journey, appreciating the same or even more than what I had experienced before.



Our YGAs' friendship began at the CFP welcoming dinner.



I received the YGA certificate from Professor Dr Pisake Lumbiganon, the President Elect of AOFOG.



A warm welcome from the CFP organising team at the Bali Ngurah Rai International Airport arrival gate.



All 10 YGAs were ready for the presentation of the YGAs' proposal at the President's Night. After the presentation, the proposal was handed over to Professor Dr Kazunori Ochiai, the President of AOFOG.

We also spent good time on ice-breaking and team-building activities, and the CFP officially ended by releasing a dove.

The XY females with female gender identity and timing of gonadectomy, an uncommon cause for primary amenorrhoea



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This article describes two patients who were presented with primary amenorrhea to the Paediatric & Adolescent Gynaecology (PAG) clinic at HCTM UKM. The diagnosis was reached when all the missing pieces were pieced together to complete the puzzle.

XY Differences of Sexual Development (DSD) females refer to individuals who are phenotypically female with a male genotype. The most frequent causes of XY females are androgen insensitivity syndrome (AIS) and gonadal dysgenesis. Other rare causes are enzymatic defects in the androgen biosynthesis including five alpha-reductase deficiency, 17-beta hydroxysteroid dehydrogenase deficiency and Leydig cell dysfunction¹³ This article discusses two common causes of XY female and emphasises their main presentation of primary amenorrhea.

Case 1

A twenty-six-year-old female, who was otherwise well, presented with primary amenorrhea. She had seen her general practitioner for this complain at the age of fourteen, and was prescribed with combined oral contraception pill (COCP) for the induction of menses. When her menses failed to occur after a year on OCP, she had an ultrasound scan done and was told that her uterus was absent. At this time, she and her family accepted the news and did not proceed with further treatment.

However, at age twenty-five, she again sought treatment and on this occasion, was assessed by a gynaecologist. On examination, she was tall and had well-developed breasts. Her axillary hair was absent with scanty pubic hair. A vague mass was bilaterally felt at the inguinal regions. She had normal external female genitalia with a 4 cm blind vagina. She was sexually active two years ago and had no sexual problems. Hormonal profile showed: Estradiol 103 pmol/L, Testosterone 23.48 nmol/L, Follicular stimulating hormone 22.11 IU/L and Luteinizing hormone 35.14 IU/L. Karyotyping confirmed: 46XY. Her MAGNETIC RESONANCE IMAGING reported the absence of uterus and noted gonadal structures in both inguinal regions. Initially, the radiologist interpreted this as suggestive of ovaries in view of the presence of cystic lesions within which may represent follicular cysts. Bilateral inguinal gonadectomy was performed. However, histopathology examination of the right gonad 17.9 gram (50x35x20mm) and left gonad 21.9 gram

(65x40x20mm) were consistent with bilateral testes with no evidence of malignancy. She is genotypically male with a female phenotype. The final diagnosis was Complete Androgen Insensitivity Syndrome (CAIS).

Case 2

A twenty-three-year-old married woman was presented with primary amenorrhea. Her first presentation to the gynaecologist was at the age of eighteen years old. She is a medium-sized woman with underdeveloped breasts (Tanner stage 2), presence of scanty pubic hair and no axillary hair. There were no masses felt at the abdomen and bilateral inguinal regions. Her external female genitalia was normal with 6 cm vaginal length. Hormonal profile showed: Estradiol 40 pmol, Testosterone 0.5 nmol/L, Follicular stimulating hormone 106.1 IU/L and Luteinizing hormone 29.18 IU/L. Karyotyping confirmed: 46XY. Pelvic ultrasound showed hypoplastic (underdeveloped) uterus and absent gonads. Further inguinal ultrasound also confirmed no gonads visualised at the inguinal region or labia majora. Her first MAGNETIC RESONANCE IMAGING (MRI) had reported hypoplastic uterus with normal vaginal length but there were difficulties in visualizing the gonads. A repeated MRI was done 2 years later. This time, the MRI interpretation was done by a radiologist with expertise in diagnosing Mullerian anomalies. She reported the presence of 2 cm-sized right gonad at the extrapelvic region lateral to the right iliac vessels at the pelvic brim (which can be easily misinterpreted as an enlarged lymph node) and also the left gonad seen, which was only 9 mm in size, located next to the sigmoid colon with no enlarged abdominal or pelvic lymph nodes. Laparoscopy findings revealed an underdeveloped uterus about 3x2cm (Fig. 1), right gonad about 2x2cm (Fig. 2) and left streak gonad 1x0.5cm (Fig. 3). Both were removed. Unfortunately, the histopathology examination of the right gonad came back as dysgerminoma, FIGO stage 1A and the left streak gonad was a gonadoblastoma. She was informed of the diagnosis and referred to the gynaecology team for further surveillance.

Discussion

Complete Androgen Insensitivity Syndrome (CAIS)

Complete androgen insensitivity syndrome (CAIS) is a rare condition. The incidence ranges between 1:40,000 and 1:60,000 births.¹ These individuals have a male genotype of 46 XY, however, they are phenotypically female and known as XY female. Typically, the uterus is not visualised by the ultrasound. The gonads in CAIS are testes. These individuals may be misdiagnosed as Mayer-Rokitansky-Küster-Hauser (MRKH) Syndrome; a condition whereby a woman's vagina and uterus are underdeveloped or absent. The difference is MRKH individuals are genotypically female 46XX with the presence of both ovaries who do not have menstrual periods due to the absence of a uterus. In CAIS individuals, Anti-Müllerian hormone (AMH) is prenatally produced by the Sertoli cells in their testes and this causes the regression of Müllerian ducts such as fallopian tubes, uterus or upper third of the vagina. However, due to the androgen receptors on the target organs which are insensitive to the stimulation of testosterone and dihydrotestosterone (produced by the Leydig cells of their testes), no virilisation of these organs (such as the external genitalia) occurs, resulting in phenotypically female external genitalia.² CAIS individuals



Figure 1: Underdeveloped uterus



Figure 2: Right gonad 2x2cm; HPE shows dysgerminoma



Figure 3: Left streak gonad 0.5x1cm; HPE shows gonadoblastoma

will typically have high levels of testosterone (high for females, normal for males) as compared to the gonadal dysgenesis in Swyer Syndrome who have low levels. Given the evidence of 1-2% incidence rate of CAIS in the inguinal hernia population, a karyotype should be considered in all female children diagnosed with a hernia.³

Another scenario that can cause confusion is their unique pelvic ultrasonography findings in pre-pubertal age. Pelvic ultrasound is the first line of investigation in the child and adolescent, with or without the need of transperineal complimentary scans for the evaluation of the lower genital tract as well as urinary and vagina.⁴ In the pre-pubertal age group, the uterus is smaller relative to the cervix, has a tubular shape and a Fundus-Cervical ratio of 1:1. Up to the age of 9 years old, the mean average volume of the uterus only ranges from 1 to 2 cm³, which can be easily missed. The discovery of an absent uterus presents a sensitive situation in which sonologists or clinicians must be very careful with their words. Distinguishing between uterine agenesis and uterine hypoplasia can be very challenging on a transabdominal scan, especially in pre-pubertal age, hence the gold standard for imaging in this population is the MRI which should be utilised for confirmation.⁵

However, in a CAIS individual, MRI interpretation can further confuse the condition when the presence of cystic lesions within the gonads can be reported as representing follicular cysts in the ovaries. Intraoperatively, these cystic features within the gonads can also lead to the same assumption that these gonads are ovaries. In reality, these cystic findings on the MRI were then histopathologically confirmed to actually be paratesticular cysts in 96% of cases.⁶

At present, there is controversy regarding the timing of gonadectomy in CAIS individuals. MRI cannot depict premalignant changes in the gonads, nor can any other imaging modality. Based on recent studies, the literature recommends postponing gonadectomy until at least puberty in order to allow spontaneous breast development in CAIS individuals. Therefore, gonadectomy should be avoided even in patients presenting evidence of an inguinal hernia in the first years of life in phenotypic female children.^{7,14}

However, what are the benefits of delaying gonadectomy until adolescence or young adulthood? In CAIS individuals, puberty spontaneously occurs within the normal age range with standard breast development, an appropriately timed growth spurt and bone health. The breast development is due to the peripheral aromatization of the testosterone produced by the testes. Hence, delaying the gonadectomy to after puberty is completed will enable good breast development and it is also important for the bone health of these individuals. The risk of gonadal malignancy in CAIS before puberty is low. However, what is the proposed medical surveillance if surgery is deferred after puberty? Although tumour markers, such as hCG and LDH, are found to be elevated in patients with seminomas, there is lack of literature evaluating the use of these tumour markers for diagnosing germ cell tumours in CAIS patients. Current recommendations do not implement tumour markers as surveillance modality. Protocols vary between different units, however, yearly measurements of tumour markers in conjunction with ultrasound imaging twice a year can be seen as an effort in conservative surveillance.⁶ Once gonadectomy is performed, the patient will require estrogen therapy but not combined estrogen-progesterone because they do not have a uterus.

In future, it would be useful to prospectively monitor the age at presentation and the age at gonadectomy. For greater understanding of the practice of gonadectomy,

it would be helpful to have further information on gonadal position, patient and parental decisional regret, complications of gonads that are left in situ, geographical differences in social attitudes, local health care resources and, most importantly, the extent of information provision to patients and parents.¹³

Complete Gonadal Dysgenesis (Swyer syndrome)

Swyer syndrome affects approximately 1:30.000 and 1:80.000 of children that have a female phenotype, no genital ambiguity at birth and the presence of Müllerian structures. They usually have primary amenorrhea and delayed puberty, since the gonads have no reproductive or hormonal potential, as can be seen in the second case. Contrasting with CAIS, Swyer Syndrome carries a high incidence of “germ cell malignancies” as the gonads are dysgenetic. Gonadectomy must be performed as soon as the diagnosis is made.⁸ Dysgerminomas are the most common types of tumours found among these patients. For early-stage patients, the recommended procedure is unilateral salpingo-oophorectomy since this surgery preserves a patient’s fertility. Although the uterus of Swyer syndrome patients is small, there are a few case reports about the success of having a baby via egg donation. In the advanced stage, hysterectomy and chemotherapy are required. Dysgerminomas are highly sensitive to chemotherapy and its use remarkably increases patient survival. However, their survival rates are lower in advanced cases (stage 2-4; 53.9%) than early stage 1 (96.9%).^{9,10}

Patients with this condition therefore require gonadectomy at diagnosis and require oestrogen therapy for pubertal induction (breast and uterine development). Once withdrawal bleeding is attained, progestin should be added at least 12-14 days each month. They will need the hormone replacement therapy until age 50-52 years for maintenance.

In both the above conditions, from the Islamic perspective, they may be considered as “Khunsa”, defined as individuals born with both genitalias or only an orifice from where the urine comes out of or those who have both male and female biological features.¹¹

There are a few learned facts that I wish to share in this article with the aim of clearing the confusion. Among various differential diagnoses of primary amenorrhea, there is a need to create awareness among clinicians regarding the differential diagnosis of Swyer syndrome and other chromosomal abnormalities associated with high incidence of malignant gonadal tumours. In fact, disclosing such diagnoses to patients definitely puts them in complete shock, thus requiring great sensitivity. Enabling the clinician to first understand the condition before meeting these individuals can help them disclose the diagnosis in a clearer way.

Conclusion

It is hoped that with the awareness of these conditions, O&G specialists who see these patients will refer them to the PAG units in advance. With improved awareness of DSD conditions in the medical field, it can further enhance patients’ holistic care.

Table 1. A simplified table showing the difference between CAIS and Swyer syndrome

	Karyotype	Phenotype	Gonads	Mullerian Organs	Pubertal characteristics	Management
CAIS	46 XY	Female	Testis	No	Breast development present Sparse / absent pubic and axillary hair	Delay gonadectomy until puberty since low risk of malignancy change prepubertally
Swyer Syndrome	46 XY	Female	Streak / Dysgenetic	Yes	No breast development	Gonadectomy at diagnosis as higher risk of malignancy

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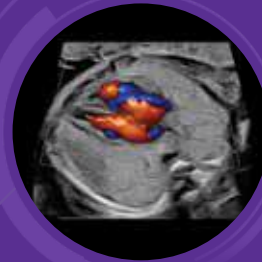
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Burnout Among Trainees: Between Resilience & Change in Workplace Environment



By Dr Aini Hanan Azmi
Obstetrician and Gynaecologist
Hospital Seberang Jaya

Burnout is a global issue that is now taking centre stage. Unfortunately, openly discussing burnout is still largely frowned upon, brushed off or shied away from, especially among healthcare workers. Mentioning the word “resilience” may significantly irk trainees that they would tune out whatever else you have to say, regardless of how well-intentioned you may be. On the other hand, demanding a change in the workplace environment would grant you the risk of being labelled “snowflakes” or “strawberries” by the seniors or “ungrateful” and “entitled” by the general public.

Since 2019, the World Health Organisation has recognised burnout as a disease in ICD-11. However, some experts believe that the responsibility of managing burnout has now shifted from the employers onto the employees. Christina Maslach (the brains behind the eponymous Maslach Burnout Inventory, which is the current gold standard of measuring burnout) argued that, “categorising burnout as a disease was an attempt by the WHO to provide definitions

for what is wrong with people instead of what is wrong with organisations. Then, it becomes that person’s problem, not the responsibility of the organisation that employs them”. Hence we see band-aid solutions offered to trainees such as practicing boundaries, taking mental health days and learning to say ‘no’, to name a few.

In October 2022, a few junior O&G Specialists decided to address the elephant in the room by having a debate on this issue at the inaugural O&G Trainees Conference, organised by the Royal College of Obstetricians and Gynaecologists (RCOG) and International Representative Committee (IRC) in collaboration with the Obstetrical and Gynaecological Society of Malaysia (OGSM) and the College of Obstetricians and Gynaecologists, Academy of Medicine Malaysia (COGAMM).

Ahead of the conference and debate, an informal online survey was performed to assess burnout at ground level and obtain anonymous feedback from trainees across the country. 96 respondents participated in this survey. Although the survey’s sample size may have been small and the method was informal and not powered to actually scale and score burnout and resilience among our trainees, we should still consider it as an eye opener and a nudge to start the ball rolling in the right direction.

How burnt out are our trainees?

6 out of 10 trainees responded that they often or always feel physically and mentally drained at the end of their working day. At least 4 out of 10 admitted to often feeling stressed and tense at work, while 1 out of 10 trainees suffer from anxiety and panic attacks at work.

Are our trainees resilient?

Half of the trainees who responded feel that they effectively adapt to changes at work, and up to 7 out of 10 said that when things get hard, they tend to focus on what they want to achieve. They try to find positives from the most difficult situations at work.

What did the survey reveal about workplace environment?

Although at least 6 out of 10 trainees agree that they are given opportunities to provide input on management and procedures at work, 5 out of 10 never or rarely receive credit or acknowledgement for their work. Similarly, half of them voiced that they are not given the opportunity to express grievances or complaints.

Most trainees call for more manpower, better pay, better working hours and more support from senior colleagues. "I cannot be doing everyone's job all the time and get penalised if I don't", said one trainee. Many have echoed, "give credit where it's due". A trainee also suggested to "change the workplace environment so people would have motivation and genuine enthusiasm to work."

Undeniably, several suggested solutions (such as workforce and pay raise) require political and administrative willpower. What can we do to overcome burnout among trainees at an individual or small organisational level? Liz Wiseman, a talented development researcher, wrote the following in an article for Harvard Business Review in December 2021: "When it comes to burnout, it's natural to assume that by reducing our workload we can find the culprit. On the contrary, research has shown that when people are overworked but intellectually underutilised, they most frequently report feeling exhausted. Simply put, burnout isn't necessarily a function of too much work; burnout is more often the result of too little impact". Perhaps, at bare minimum, we should focus on how to empower our trainees to make meaningful impacts at work, no matter how small, and give them credit for such impacts.

In our field where the fear of litigation looms, the tendency to practice defensive medicine, retrospective dissection and blame after an adverse outcome contributes to making the workplace environment more hostile. While patient safety is paramount, the methods of communication used to achieve good clinical

outcomes are often overlooked. An article published in The Obstetrician and Gynaecologist in August 2022 entitled "Understanding authority gradient: tips for speaking up for patient safety (and how to enhance the listening response)" emphasised the importance of cultivating 'shallow authority gradient' to empower junior colleagues to raise concerns in patient safety. It further highlighted how senior doctors can support their juniors who raise such concerns. Several useful non-confrontational tools to speak up were also shared. Senior doctors were then advised to be more open when challenged.

In 2016, Monique Valcor wrote an article in the Harvard Business Review, titled "Beating Burnout". She shared how to resolve burnout at both individual and team levels. Among the suggested measures regarding the individual level, she stated that it is helpful to change perspectives by determining which aspects of your situation are fixed and which can be changed. At the team or organisational level, she called for leaders to set realistic work limits, boost the team's sense of control and provide meaningful recognition.

Perhaps the above survey and this article raises more questions than solutions. However, it is clear that there is a limit as to how much one can be resilient and bend over backwards before one breaks. Changes in workplace culture and environment will not occur overnight. While we continue to push our policymakers and administrators to do their part, I personally believe that we should take a step back and realise that we, as individuals, are part of the environment. We can be the change that we want to see. Hopefully, by being better colleagues and better leaders, we can start a ripple effect that can become the next wave of change that our trainees and our fraternity need.

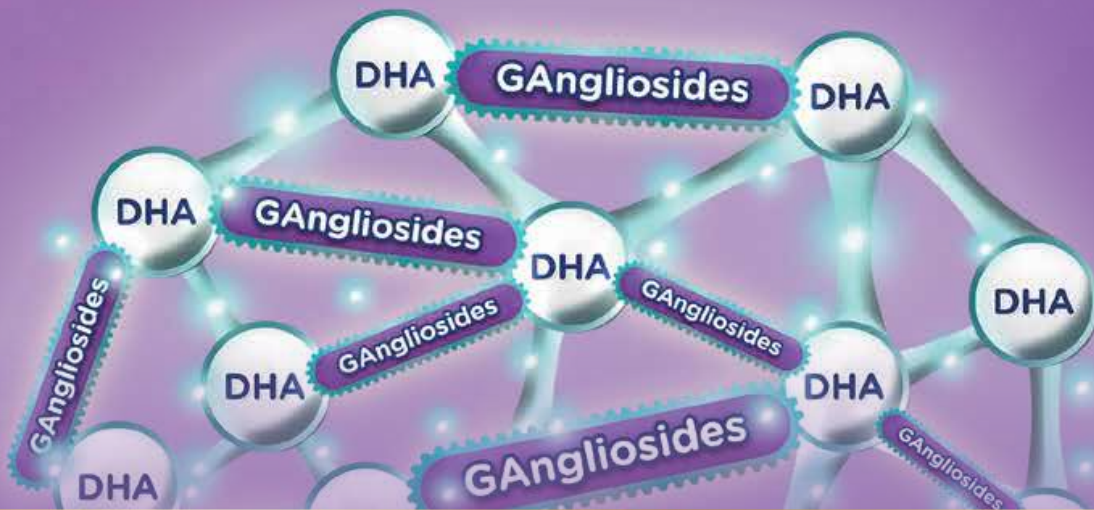


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The Reality of Legal Practice



Prof Dato' Dr NKS
Tharmaseelan
Chairperson, OGSM
Medico - legal Matters
Subcommittee

I qualified as an Obstetrician & Gynaecologist (OBG) in 1982. I then went on to serve the public sector for 10 years before leaving for the private sector to establish my own centre. Life as an OBG in the public sector significantly differs from the private sector. In the public sector, you are cocooned by the weighty shell of government machinery. In the private sector, you are left on your own. You must wear different hats in the system (from paramedic to HO, MO and consultant) during various scenarios that may arise. The private sector is a minefield. Anything can go wrong even without any negligent act on your part. Your best patient, the friendliest one, will not hesitate to sue you when things go wrong, even if you are not responsible for the misadventure. Medical negligence cases are rising at an alarming rate and insurance premiums have been increasing.

Having read many reports on medical negligence cases, I found that various decisions were made without understanding the basics of medicine. This is to be expected since we members of the medical fraternity would not fully appreciate the finer nuances of the law. The lawyer who is more convincing in his assertions will have a higher chance of tipping the scales of justice in his favour. Although decisions can be appealed, it would require more financial clout and perseverance.

Of course, private medical practice is financially rewarding but sometimes you wonder whether it is worth the stress, not forgetting the toll it takes on you.

Therefore, I decided to take up the study of law with a passion. I completed my LLB with Honours in 1998, achieving my CLP the next year and a Master's in Law (LLM) 2 years later. However, a busy

O&G practice did not allow me the luxury of time to complete the mandatory full-time 9-month pupillage or chambering to be called to the bar. I kept procrastinating on this chambering for many years until 2022. Finally, 24 years after my LLB and CLP, I enrolled and completed the pupillage at a leading firm in Kuala Lumpur. I completed the pupillage tenure without any hurdles and was called to the Malaysian Bar in January 2023. This opened up a whole new world for me!

If you think doctors are paid peanuts, lawyers are paid crumbs. Many pupillage students are generally not paid, and the Bar Council has capped it at RM 600 per month at their last AGM following protests by junior lawyers. This is less than the statutory minimum of RM 1500 salary for workers. This payment is considered a stipend or allowance and not a salary. Fortunately, the firm I worked for paid me "generously" in comparison.

I completed my chambering (Housemanship or HO) and looked forward to becoming an associate medical officer. The offers were pathetic, but that is the norm. Despite your experience and age, you are considered just like an MO and thus, the paltry remunerations are much lower than even the HO's pay. Across the board, law firms do not pay much. Seniority also hinders learning since most senior lawyers treat you with kid gloves and thus, the expected rigorous training is missed. You basically stick out like a sore thumb.

Only study law if you are passionate about it. Start your legal practice when you are still young to ensure a successful career. Many legal firms collect hefty amounts for handling cases. The cost of medicolegal cases can tip over half a million, but it does not percolate down to the foot soldiers. It goes towards the maintenance of the firm which requires a large entourage to run and sustain it. Thus, only go for law if you are much younger or if you are passionate about it. You would need to make more sacrifices to ensure a successful career so do not study law as an afterthought or start late.

AFOFG Report Re-igniting ICOE Training in Laos



Dr Ong Zhong Wei,
MRCOG Trainer, ICOE, OGSM

The ICOE team from OGSM had our first opportunity to introduce our curriculum to Laos counterpart since March 2020. A group of passionate young obstetricians and gynaecologist were then trained as participants and volunteered themselves as pioneer trainers. The mission shared by both Malaysian and Laotian trainers is Laos would eventually run ICOE suited to their local settings, with initial supervision from Malaysian trainers, guided by The Handbook in Obstetric Emergencies, the course's key resource and the ICOE Trainer Manual.

The strategic roll out plans for Laos was forced on hold due to unexpected COVID-19 pandemic. After a hiatus of 3 years, with great support from AFOFG and OGSM, a team of 5 Malaysian trainers, armed with COVID-19 vaccinations and fueled with vehemence to reignite ICOE in Laos, travelled to Vientiane, Laos on 12 to 15 Jan 2023. Incidentally there are no direct flights to Vientiane, which pushes us to our wits' end to travel with 120kg equipment



Arrival at Vientiane, 12th Jan 2023



Return to KLIA 2, 15th Jan 2023

Lecture hall in Vientiane Mother and Child Hospital



After a brief transit in Don Mueang Airport, Bangkok. We arrived on Vientiane Airport on 12 January 2023. We were warmly welcomed by the local trainers. First destination was to Hospital and set up pre skill test stations. Local trainers underwent a refresher regarding the run down for 2 days course, and guidance given on how to set up each breakout stations. A conducive lecture hall well equipped with audio visual system provided by committee were one of the keys to our course's success.

Initial challenge faced was language barrier, where majority of local participants are not well versed in English communication. This was promptly rectified by translating our messages into Laos language by the local trainers. Local trainers are able to retain, retrieve and reproduce all teaching points given by Malaysian trainers effectively. We had ample opportunity to exchange ideas with local trainers, and gained much more from their experience.



Welcome speech by Professor Pisake Lumbiganon, AOFOG President

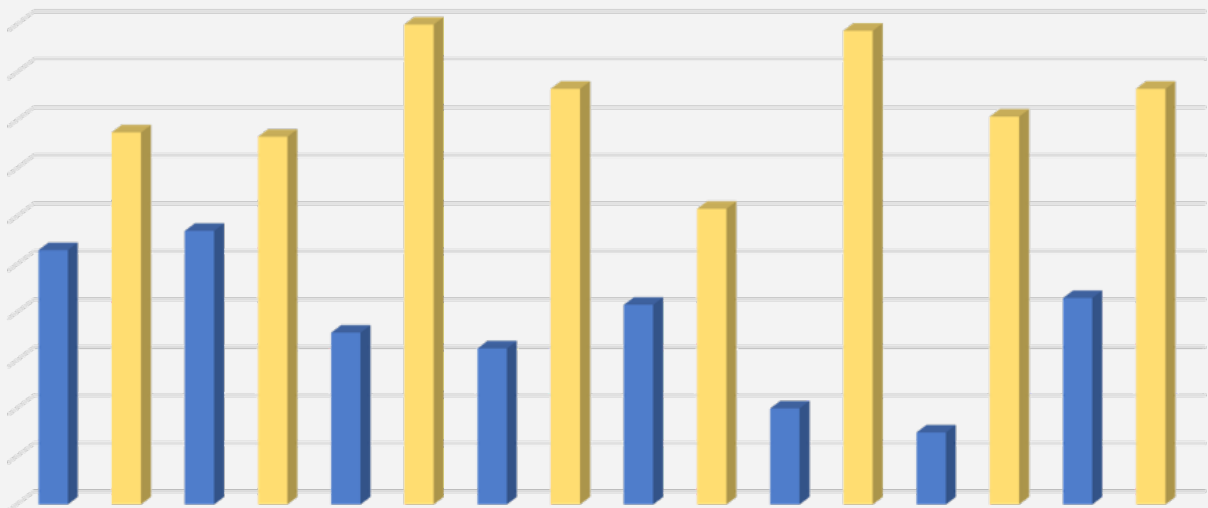
The one who teaches, learns the most

Overall, participants and local trainers were overwhelmingly satisfied with our course. It was a delightful honour to know that materials from The Handbook of Obstetric Emergencies are currently incorporated into Laos post graduate O&G training. Some participants commented that this ICOE is an eye-opening experience to them, as they have not been exposed to simulation training in healthcare. In fact, this is the first experience for most of the participants to practice CPR and defibrillator on mannequins. Apart from experiencing some of the new advancement in simulation training, they have also learnt some cost effective but potentially life-saving methods such as ; IV Tranexamic Acid, Aortic Compression and Bimanual Compression.

Training Outcomes

A total of 24 postgraduate doctors from the various provinces participated in the course. They were provided with a E-Handbook and videos 2 weeks before the course. This allows self-paced adult learning online. They were then tested with an online knowledge test which they completed before the course.

Average Results Pre and Post Training



Looking forward, O&G Society of Laos are working hand in hand with their Ministry of Health, with allocations provided to set up a local simulation healthcare training center in 2025. They are planning to kick start their own version of “mini-ICOE” in May and August this year, with the objective to roll out awareness and exposure to other regions beside Vientiane. The Laos committee had also graciously invited us for another ICOE in October this year. We are truly impressed by their ministry’s political will and society’s commitment towards improving safe pregnancy and safe childbirth. The success of the training for the past few years lies in the committed leadership provided by the industrious Professor Dr Alongkone to which ICOE is indebted.



Sitting (from Left): 1) Dr Gunasegaran Rajan, ICOE principal trainer, 2) Dr Angela Chin Yeung Sing, ICOE course coordinator, 3) Dr Alongkone Phengsavanh, Vice Dean, University of Health Sciences



Soft uterus model to practice compression sutures. Attaching soft uterus model to PROMPT model for better fidelity. Innovative effort by Mr Baskeran, ICOE Executive



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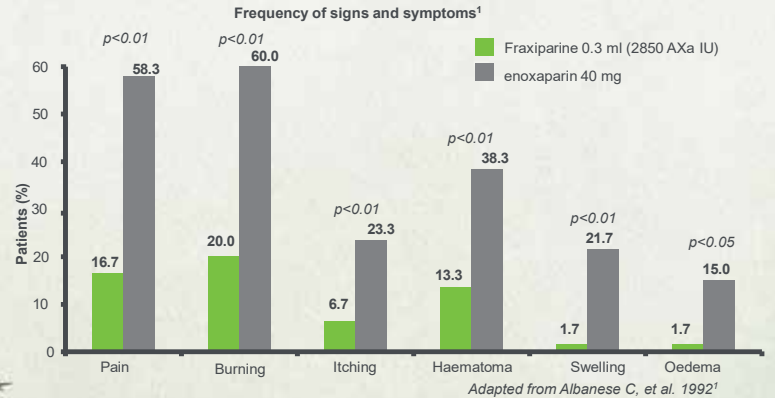
Sophisticated CTG alarm identify specific dangerous fetal heartbeat waveform

The EDAN F15 device features a large 15.6-inch color TFT-LCD screen displaying fetal heart rate (FHR) and uterine contraction (TOCO) waveforms. The screen shows a green shaded area for FHR, a blue shaded area for TOCO, and various numerical readouts including 137, 139, 127, 45, 5, 14, 99, 116, 113, 73, 71, and 37.1. The device is white with a black base and a black 2-in-1 TOCO-MHR sensor attached to the side.



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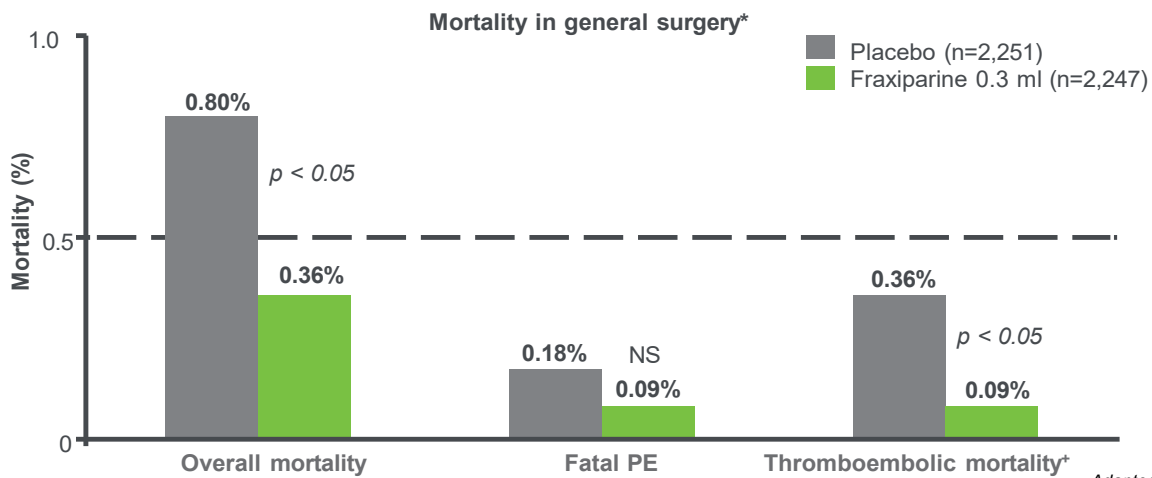
Local Tolerability of Fraxiparine vs Enoxaparin¹



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- **Primary endpoint:** Effectiveness in preventing fatal PE.
- **Secondary endpoints:** Overall mortality and mortality due to extrapulmonary thromboembolism.
- Odds reduction in overall mortality in general surgery patients 55.7%.



LMWH = Low Molecular Weight Heparin; PE= Pulmonary Embolism; NS=Not Significant; += including fatal PE; *=Study population included 33.5% patients after cancer surgery.

References: 1. Albanese C, Bellani M, Longatti S, et al. Comparison Of The Local Tolerability Of Two Subcutaneous Low Molecular Weight Heparins: CY216 And Enoxaparin. *Current Therapeutic Research*, Mar 1992;51:3:469-472. 2. Pezzuoli G, et al. Prophylaxis of fatal pulmonary embolism in general surgery using low-molecular weight heparin Cy 216: A multicentre, double-blind, randomized, controlled, clinical trial versus placebo (STEP). *International Surgery*, 1989; 74 No. 4: 205-210.

Abbreviated Prescribing Information

C: Nadroparin Ca I: FRAXIPARINE 2850 AXa IU / 0.3mL Prophylaxis of thromboembolic disorders in patients undergoing general surgery **D: PROPHYLAXIS OF THROMBOEMBOLIC DISORDERS IN GENERAL SURGERY** Recommended dose of 0.3 ml administered subcutaneously 2 to 4 hours before surgery, and then once daily on subsequent days. Treatment should be continued for at least seven days, and throughout the risk period, until the patient is ambulant. **CI:** Hypersensitivity to the active substance nadroparin or any of the excipients of nadroparin injections, history of thrombocytopenia with nadroparin, active bleeding or increased risk of haemorrhage, in relation to haemostasis disorders, except for disseminated intravascular coagulation not induced by heparin, organic lesion likely to bleed (such as active peptic ulceration), haemorrhagic cerebrovascular accident, acute infectious endocarditis, severe renal impairment (creatinine clearance less than 30ml/min) in patients receiving treatment for thromboembolic disorders, unstable angina, and non-Q wave myocardial infarction. **SP:** Cross-reactivity between heparins and LMWH. Pregnancy & lactation. Heparin-induced Thrombocytopenia. Increased risk of bleeding in the following situations i.e. hepatic failure, severe arterial hypertension, history of peptic ulceration or other organic lesion likely to bleed, vascular disorder of the chorio-retina, during the post-operative period following surgery of the brain, spinal cord or eye. Renal Impairment. Elderly. Paediatric patients <18 years. Hyperkalaemia. Spinal / epidural anaesthesia / spinal lumbar puncture and concomitant drugs. Concomitant use of salicylates, NSAIDs and anti-platelet drugs. Skin necrosis. Latex Allergy. **AR:** Haemorrhage. Transaminases increased (usually transient). Injection site haematoma. Injection site reaction. **INT:** Oral anticoagulants, system (gluco-) corticosteroids and dextran. **P/P:** Soln for inj 0.3 mL x 10's.

Abbreviated prescribing information prepared Jul 2022, based on Fraxiparine PI dated 15 Sep 2021.

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