Obstetrical & Gynaecological Society of Malaysia

The OGSM newsletter

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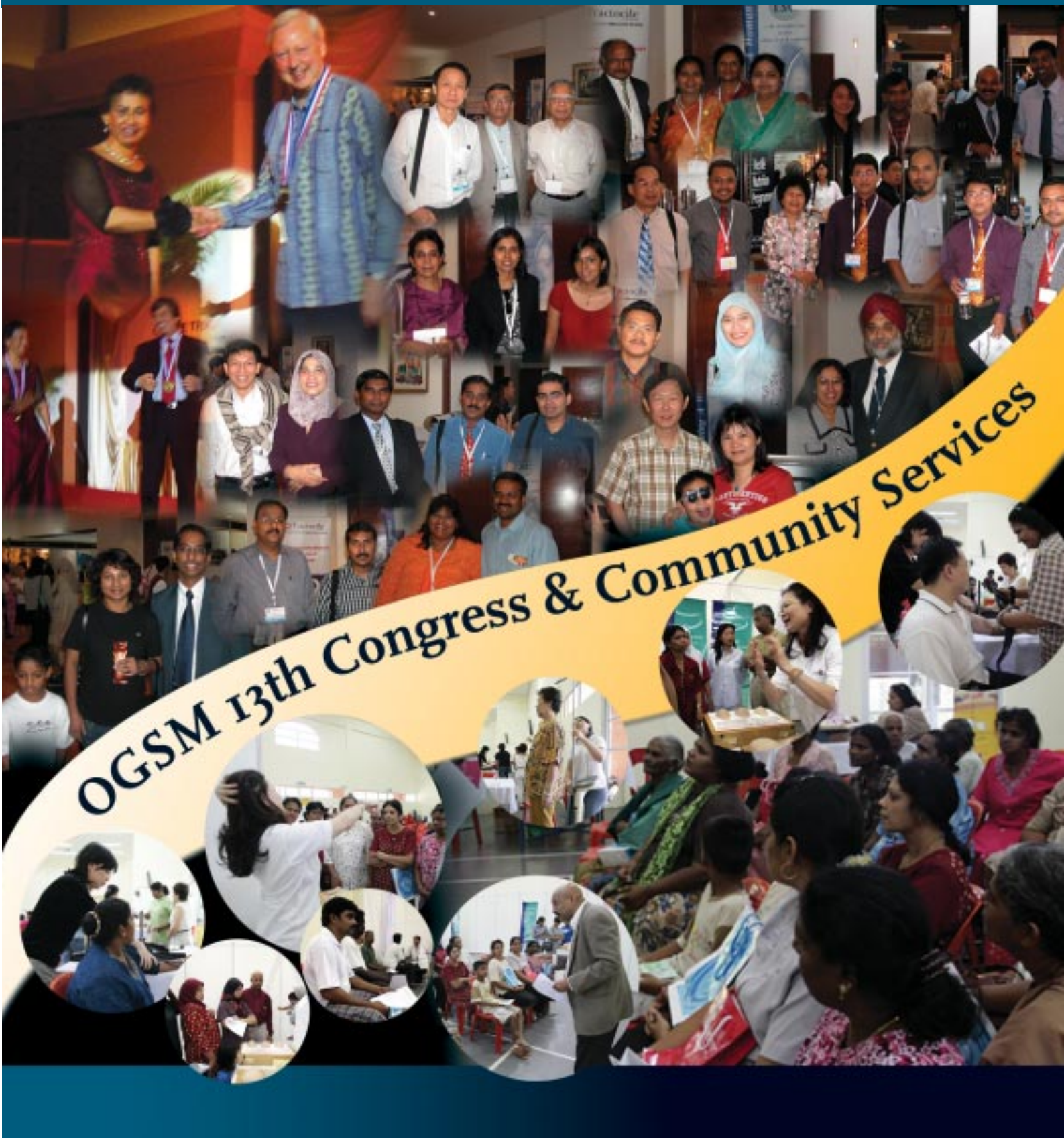

OGSM 13th Congress & Community Services

COUNCIL 2004/2005

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Council would like to thank the respective members who have kindly consented to accept the various appointments as subcommittee chairmen and state coordinators.

The President's Message

Obstetrics as a profession is currently almost under siege. In Australia, it is no longer practical nor feasible to do deliveries in the private sector due to the exorbitant medical defence insurance premiums. It is the same in the United States, where currently an Obstetrician is being sued because he delivered a baby who grew up to have a normal IQ. You see, both the parents have above average IQs! In the UK, the recent MRCOG part 2 examination showed a marked decline in the number of UK based candidates. This might suggest that Obstetrics and Gynaecology, particularly the former, is no longer viewed as a career of choice for many postgraduates, at least in the UK.

On the home front, our Medical Insurance premiums are rising very rapidly, none more so than for Obstetrics. Fortunately, or unfortunately we have our Cosmetic Surgeon colleagues for company in our misery. The OGSM will address this issue with representatives of the Medical Insurance Organisations to see if we could come up with innovative ways to keep the premiums still affordable in the years ahead.

Meanwhile, the profession needs to tighten up on clinical discipline and self regulate while we still can. The OGSM will, amongst other things, work actively with the MOH and the College of O&G, to come up with a comprehensive guideline for Credentialling and Privileging in O&G.

The next MMA Fees Schedule (5th edition) is due in 2006. Dr Hj Abdul Onny Yahya is chairing the committee for the O&G fees schedule. He has made some preliminary work evolving a new scale structure different from the BUPA scales, consolidating, deleting and adding procedures, making it more reflective of our everyday workload in Malaysia. We will keep you updated as and when details are more firmed up.

The OGSM must play an active role in encouraging interest and enthusiasm in O&G, both at the postgraduate as well as undergraduate level. As a modest start, the OGSM proposes to set up a Study Award with the agreement of the Conjoint Board for the top Masters in O&G candidate each year. At the under graduate level OGSM has plans to start an Annual Essay Competition for perhaps final year medical students in all our local Universities to write on selected topics of current interest in O&G. The details are being worked by our Council members in academia and other interested academics.

OGSM's community service programme of health clinics for women, initiated by the previous Councils is still ongoing. This year, if plans come to fruition, we hope to organise road shows on awareness of problems of pelvic pain, in collaboration with a sponsor and the Ministry of Women, Family and Community Development.

In a joint meeting coming up soon with the College of O&G, I would like to propose a collaborative effort to document the history of O&G in Malaysia. It would be a painstaking task, but I feel it would be well worth the effort.

On a lighter note, we will again have a Treasure Hunt this year, and I hope that many more members will be able to participate.

The 15th Malaysian Congress of O&G will be held outside KL. We will announce details shortly.

In closing, I hope members of OGSM will come forward and contribute their thoughts and ideas on how we could make the society more effective and more responsive to the interests of the members. Your views and constructive criticisms are most welcome.

Regards and best wishes,

Dr Mohd Hafetz Ahmad
President, OGSM
2004/2005

Secretary's Report

The changing over of the President and the formation of the new Council took place at the Berjaya Times Square Hotel during the 41st Annual General Meeting on 5 June 2004. The new President, Dr Mohd Hafetz got down to business as soon as he took over at the hotel by briefing the new council of his plans for the coming year.

The Council is trying to ensure greater participation of the members of the society. In doing so the extended committees of the OGSM would see new faces. We are at present initiating new activities for CME programmes, community projects and social/fellowship programmes.

The recent OGSM community project carried out at PJS 1, off Old Klang Road, Petaling Jaya on 18 July 2004 was a huge success. 110 female residents had Pap smears and breast screening. The male residents in the area were also screened by doctors from the Guru Dharma Society. These were done in cooperation with Johnson & Johnson and we look forward to similar cooperation with other companies for our community projects.

In this similar light, we would like to congratulate Dr Tang Boon Nee for successfully organising this community project along with all doctors and nurses who had sacrificed their time for this project.

The second project will be held in Bagan Terap and we hope the other state coordinators will carry out similar projects. Dr Japaraj has taken the lead by organising this project at Pantai Remis on 3rd October for the state of Perak.

On the social front, the society is organising a Treasure Hunt on 12 September 2004 for all members. The event will flag off at the Souled-out Cafe car park in Desa Sri Hartamas and Sanofi-Synthelabo has kindly ensured smooth organisation of this event. We look forward to your participation and attractive prizes are up for grabs.

OGSS provided 20 complimentary registrations to OGSM members to attend the 8th Postgraduate Refresher Course in O&G from 11-14 August 2004 at the CRC Auditorium, Faculty of Medicine, National University of Singapore.

15 members took up the offer to attend the course. The society was also represented in the debate series that was held in conjunction with the course. Dr Shahila Tayib and Dr Lim Yun Hsuen from Hospital UKM represented the society. They won the first hurdle in opposing the theme "There is no place for routine antenatal CTG for uncomplicated pregnancies before 40 weeks" against the team from KK Women's and Children's Hospital. In the final, the OGSM team won against **NUH** on the theme "Elective cesarean section should not routinely be carried out before 39 weeks". Syabas to our debaters and to Prof Jamil & Prof Zainul Rashid for organising the winning team.

We at Council look forward to greater interaction with fellow members and state coordinators. Please email the OGSM office your comments or suggestions.

I do hope that this newsletter is informative enough, updating our knowledge and entertaining. Happy reading and Selamat Hari Merdeka ke 47.

Dr K K Iswaran
Hon Secretary

I.S. Puvan OBGYN Foundation

The Foundation had its first meeting for the year on 22 July 2004 chaired by Dato' Dr P Boopalan. It was decided that the Foundation would explore new avenues for its role as a charitable organisation. Some of the areas looked into are organising events related to charitable functions/outright donation, research/educational grants, loans/ scholarship, CME activities and awards for the Free Communication sessions of the annual OGSM Congress. Some of the activities proposed in this newsletter will be organized under the Foundation & OGSM.

It must be stressed that up to 70% of its yearly income must be utilised to retain its status as a tax exempt Foundation. Therefore we must actively seek out activities which are worthwhile for the Foundation to be involved in. Should any member have a charitable cause that can be considered for the Foundation to be involved in, please forward the request to the society's office. We also look forward to members and corporate bodies to donate to the Foundation as all contributions will be tax exempted.

XVIII FIGO World Congress

Kuala Lumpur
5-10 November 2006

1 PCO
Asian Overland Services (AOS) is the official FIGO Convention Organiser and the contract is in the final stages. They would handle almost the entire event and the Local Organising Committee would be like a shadow committee providing an advisory role. AOS will handle all the finance and budget and the thrust of the local committee is in the social programme.

2 The logo is finally approved and is as shown.

3 First Announcement
The first announcement is in the final stages of preparations and is awaiting final input from the main FIGO Organising Committee.

4 Scientific Programme
Prof PC Ho from Hong Kong is the scientific chairman and the programme is also in the final stages.

5 Social Programme
Various venues are being explored for the social programme, namely, the Opening Ceremony, Cultural Evening, Evening for All and the Gala Dinner.

Local FIGO 2006 Organising Committee Members

Chairman	Dr Abdul Aziz Yahya
Deputy Chairman	Dato' Dr Alex Mathews
Secretary	Dr Gunasegaran PT Rajan
Assistant Secretary	Dr A Baskaran
Treasurer	A/Prof Jamiyah Hassan
Assistant Treasurer	Dr Tang Boon Nee
Advisor to PCO	Dr Prashant Nadkarni
Audio-Visual	Dr Wong Sum Keong
Catering/Reception	Dr S Sevellaraja
Contracts & Negotiations	Dr Sheik Johari Bux
Hotel Accommodation	Dr Lim Cheng Lim
Liaison Officers	
AOFOG	Prof A Kulenthran
DBKL	Dr Zainol Ariffin
MOH	Dr Ng Kok Ying
Press Liaison	Dr Premitha Damodaran
TDC Liaison	Dr Nor Ashikin A Mokhtar
Manpower	Prof M A Jamil
Maternal/Child Health	
Fellowship Programme	Dato' Dr Narimah Awin
	Dato' Dr Alex Mathews
Medical Facilities	Dr Mohamed Roslan
Protocol	Datuk Dr JS Sambhi
Publicity/Promotions	Dr Gunasegaran PT Rajan
Registrations	Dr S P Rachagan
Scientific Programme	Dr S Raman
Social Events	Dr KK Iswaran
Souvenirs	Dr Ng Soon Pheng
Speakers Facility	Dr A Puraviappan
Spouses Programme	Dr & Mrs Arthur V Samuel
Trade Exhibition	Dr Michael Samy
Transportation	Dr Ong Sing Kwee
Tours	Dr Divakaran T Govindan
Venue	Dr T P Baskaran

FIGO Announcements

1 FIGO Fistula Activities
The prevention and treatment of Fistula in Africa is one of FIGO's main current priorities. FIGO is keen to find out whether there are any obstetrician-gynaecologists or urogynaecologists with some experience who are either familiar with or are keen to become involved in this area of expertise. FIGO is building a strategy to provide assistance for them to be trained in Africa.

Please contact the OGSM secretariat, if you are interested.

2 FIGO would like to draw your attention to a new web portal called ObGynWorld.com, the scientific content of which is endorsed by FIGO.

The website address is
http://www.obgynworld.com.

OGSM / Johnson & Johnson Community Health Clinic

A Community Health Clinic was organised on 18 July 2004 at the PJS 1 Community Hall, Petaling Jaya. This charity community clinic was organised jointly by the Obstetrical & Gynaecological Society of Malaysia, Johnson & Johnson Sdn Bhd and Centraid, the welfare arm of the Guru Dharma Society.

In an effort to encourage the concept of health screening to all the PJ South area residents, the male residents were also encouraged to take advantage of this Women's Wellness clinic where a separate section was set aside for their general screening on body mass index, blood pressure and blood sugar level. In addition to the general screening, the female residents were also provided with pap smear screening and screening of breast cancer. A total of 63 male residents and 110 female residents registered for the screening and they were all given a chance to have a private consultation on their health status and to seek advice from the group of volunteer doctors present.

Besides information leaflets, the women were also taught how to conduct a self-breast examination on a demo set. At the clinic, Dr Puravi gave a talk on the importance of family planning and regular health screening whereas Dr Subitha from Hospital Kuala Lumpur talked on breast cancer.

Funding for the free community clinics were provided by Johnson & Johnson. The idea for a regular series of FREE "Women Wellness Clinics" for women was conceptualized and sealed in a formal partnership agreement between OGSM & Johnson & Johnson last year. The Charity Community Clinics aim to educate women especially those in the lower income group and underserved on the need for early health screenings to prevent the onset of cervical cancer and breast cancer which are the two major health issues affecting women in Malaysia.

The community clinics health screening revealed that out of the 170 residents of PJ South who came for the health checks, about 27% of them were unaware that they are suffering from hypertension and diabetes. The doctors on hand issued appropriate medical referrals for further treatment and screening at the nearest government health facilities. On the Women Wellness health checks, it is found that most of the women folk have not consulted a doctor or gynecologist since their last child birth which may be more than 10 years ago and about 70% had not had a health screening in the last 3 years. There were 5 cases of breast lumps detected in the patients and they were also given appropriate referrals to the nearest government health facility for further tests and treatments.

On behalf of the society, I would like to record my deepest appreciation to the doctors and especially the nurses from Taman Desa Medical Centre for contributing to the success of the community clinic.

The society would also be organising similar clinics at the Bagan Terap Community Clinic towards the end of August and there are also plans for Pantai Remis, Perak and Malacca in October. The society would welcome doctors who would like to volunteer for this charitable cause.

ANTENATAL CORTICOSTEROIDS TO PREVENT RESPIRATORY DISTRESS SYNDROME

This is the third edition of this guideline, which was previously published in April 1996 and December 1999. Revised February 2004.

1. Effectiveness of antenatal corticosteroid therapy

Clinicians should offer antenatal corticosteroid treatment to women at risk of preterm delivery because antenatal corticosteroids are associated with a significant reduction in rates of RDS, neonatal death and intraventricular haemorrhage.

Healthcare organisations and services should have policies and protocols in place for antenatal steroid treatment because the cost and duration of neonatal intensive care is reduced following corticosteroid therapy.

The optimal treatment-delivery interval for administration of antenatal corticosteroids is more than 24 hours but fewer than seven days after the start of treatment.

The use of antenatal corticosteroids in multiple pregnancies is recommended, but a significant reduction in rates of RDS has not been demonstrated.

In preterm labour it is reasonable not to use tocolytic drugs, as there is no clear evidence that they improve outcome. However, clinicians should consider the use of short-term tocolysis if the few days gained can be put to good use, such as completing a course of corticosteroids, or in utero transfer.

If a tocolytic drug is used, ritodrine no longer seems to be the best choice. Atosiban or nifedipine appear to be preferable, as they have fewer adverse effects and seem to have comparable effectiveness. Atosiban is licensed for this usage in the UK but nifedipine is not.

2. Safety

Women may be advised that the use of a single course of antenatal corticosteroids does not appear to be associated with any significant maternal or fetal adverse effects.

The use of antenatal corticosteroids in pregnancies complicated by maternal diabetes mellitus is recommended, but a significant reduction in rates of RDS has not been demonstrated. If commenced, inpatient supervision by an experienced diabetic/obstetric team is essential to regulate diabetic control.

3. Indications for antenatal corticosteroid therapy

Every effort should be made to initiate antenatal corticosteroid therapy in women between 24 and 34 weeks of gestation with any of the following:

. threatened preterm labour
. antepartum haemorrhage
. preterm rupture of membranes
. any condition requiring elective preterm delivery.

Between 35 to 36 weeks obstetricians might want to consider antenatal steroid use in any of the above conditions although the numbers needed to treat will increase significantly.

4. Contraindications and precautions

Corticosteroid therapy is contraindicated if a woman suffers from systemic infection including tuberculosis. Caution is advised if suspected chorioamnionitis is diagnosed.

5. Dose and route of administration

Betamethasone is the steroid of choice to enhance lung maturation. Recommended therapy involves two doses of betamethasone 12 mg, given intramuscularly 24 hours apart.

6. Repeated doses

If repeat courses of antenatal corticosteroids are contemplated then senior opinion should be sought as, at present, there is a lack of evidence to show significant benefit. Obstetricians should consider enrolling their patients in randomised controlled trials if repeat corticosteroid therapy is contemplated.

7. Effectiveness of thyrotrophin-releasing hormone

The use of thyrotrophin-releasing hormone is not recommended in combination with antenatal corticosteroids.

8. Audit

Auditable standards for antenatal corticosteroid therapy include:

. the proportion of women delivering between 24 and 34 weeks receiving a full course of corticosteroid therapy
. the proportion of women delivering between 24 and 34 weeks receiving at least one injection of steroids
. the proportion of women with PPROM who receive a full course of corticosteroid therapy.

MANAGEMENT OF HIV IN PREGNANCY

Published April 2004.

1. Antenatal care

Pregnant women should be offered screening for HIV early in pregnancy because appropriate antenatal interventions can reduce maternal-to-child transmission of HIV infection.

Women diagnosed as HIV positive during pregnancy should be managed by a multidisciplinary team.

Women diagnosed HIV positive during pregnancy should be informed that interventions (such as antiretroviral therapy, caesarean section and avoidance of breastfeeding) can reduce the risk of mother-to child HIV transmission from 25-30% to less than 2%.

All women with HIV during pregnancy (whether diagnosed before or during pregnancy) should be reported to the National Study of HIV in Pregnancy and Childhood at the Royal College of Obstetricians and Gynaecologists.

All pregnant women who are HIV positive should be screened for genital infections during pregnancy. This should be done as early as possible in pregnancy and repeated at around 28 weeks. Any infection detected should be treated according to UK national guidelines.

Screening for Down syndrome and fetal anomalies should be offered. A detailed ultrasound scan for fetal anomalies is important after first-trimester exposure to HAART and folate antagonists used for prophylaxis against PCP. The risks of mother-to-child transmission with chorionic villus sampling or second-trimester amniocentesis are uncertain. Where invasive prenatal diagnosis is contemplated, the advice of the fetal medicine specialist and HIV physician should be sought and prophylaxis with HAART considered.

Presentation with symptoms or signs of pre-eclampsia, cholestasis or other signs of liver dysfunction during pregnancy may indicate drug toxicity and early liaison with HIV physicians should be sought.

2. Recommendations for prescribing anti-retroviral therapy in pregnancy

All women who are HIV positive should be advised to take anti-retroviral therapy during pregnancy and at delivery. The optimal regimen is determined by an HIV physician on a case-by-case basis. The decision to start, modify or stop anti-retroviral therapy should be undertaken by an HIV physician, in close liaison with other health professionals, notably the obstetrician and paediatrician.

Women who do NOT require HIV treatment for their own health require anti-retroviral therapy to prevent mother-to-child transmission. Anti-retroviral therapy is usually commenced between 28 and 32 weeks of gestation and should be continued intrapartum. A maternal sample for plasma viral load should be taken at delivery. Anti-retroviral therapy is usually discontinued soon after delivery but the precise time of discontinuation should be discussed with the HIV physician. Zidovudine is usually administered orally to the neonate for four to six weeks.

Women with advanced HIV should be treated with a HAART regimen. The start of treatment should be deferred until after the first trimester, if possible, and should be continued after delivery.

Women who conceive while taking HAART should continue their HAART regimen if it is effectively suppressing plasma viraemia. For women whose regimen is not suppressing viraemia, a change in therapy after the first trimester may be indicated.

3. Mode of delivery

Women who are HIV positive who have a detectable plasma viral load and/or who are NOT taking HAART should be offered a planned caesarean section as it reduces the risk of mother-to-child transmission of HIV. A zidovudine infusion should be started four hours before beginning the caesarean section and should continue until the umbilical cord has been clamped. A maternal sample for plasma viral load should be taken at delivery. The cord should be clamped as early as possible after delivery and the baby should be bathed immediately after the birth. Further research is needed to evaluate the effect on mother-to-child transmission and maternal health of planned caesarean section for women who are taking HAART or who have very low viral loads.

Women who opt for a planned vaginal delivery should have their membranes left intact for as long as possible. Use of fetal scalp electrodes and fetal blood sampling should be avoided. Women should continue their HAART regimen throughout labour and if an intravenous infusion of zidovudine is required it should be commenced at the onset of labour and continued until the umbilical cord has been clamped. A maternal sample for plasma viral load should be taken at delivery. The cord should be clamped as early as possible after delivery and the baby should be bathed immediately after the birth.

4. Postpartum management for the mother

In the UK all women who are HIV positive should be advised not to breastfeed their babies.

5. Management of the neonate

All infants born to women who are HIV positive should be treated with anti-retroviral therapy from birth.

6. Prepregnancy management

For couples discordant for HIV infection who wish to conceive, appropriate advice should be given to optimise the chance of conception while minimising the risk of sexual transmission. In vitro fertilisation (IVF) is now considered to be ethically acceptable for couples with subfertility.

THE MANAGEMENT OF GESTATIONAL TROPHOBLASTIC NEOPLASIA

This guideline replaces The Management of Gestational Trophoblastic Disease, issued in April 1999 as Guideline No.18. Published February 2004.

1. Diagnosis of gestational trophoblastic neoplasia

Early complete molar pregnancies are commonly associated with the ultrasound diagnosis of delayed miscarriage or anembryonic pregnancy. Complete moles may be associated with suggestive ultrasonographic changes in the placenta. However, ultrasound has limited value in detecting partial molar pregnancies. In twin pregnancies with a viable fetus and a molar pregnancy, the pregnancy should be allowed to proceed.

2. Evacuation of molar pregnancies

Surgical evacuation of molar pregnancies is advisable. Routine repeat evacuation after the diagnosis of a molar pregnancy is not warranted.

3. Histological examination of products of conception

All products of conception obtained after evacuation (medical or surgical) should undergo histological examination. Products of conception from therapeutic terminations of pregnancy should be examined if there is no evidence of fetal tissue.

4. The management of women with gynaecological symptoms after evacuation of a molar pregnancy

In cases where there are persisting symptoms, such as vaginal bleeding, after initial evacuation, consultation with the screening centre should be sought before surgical intervention.

5. Persistent GTN after a nonmolar pregnancy

Women with persistent abnormal vaginal bleeding after a nonmolar pregnancy should undergo a pregnancy test to exclude persistent GTN. Persistent GTN should be considered in any woman developing acute respiratory or neurological symptoms after any pregnancy.

6. Registration of women with molar pregnancy

Registration of any molar pregnancy is essential.

7. Treatment of persistent GTN

Women with persistent GTN should be treated at a specialist centre with appropriate chemotherapy.

8. Placental site trophoblastic tumour

Advice on the management of these rare tumours should be sought from the appropriate registration centre.

HORMONE REPLACEMENT THERAPY AND VENOUS THROMBOEMBOLISM

Revised January 2004.

1. Women starting or continuing HRT

Women starting or continuing HRT should be counselled with regard to the perceived benefits and possible risks for their individual situations including consideration of alternative therapies.

All women commencing HRT should be counselled about the risk of VTE, should be aware of the signs and symptoms of VTE and should be able to access medical help rapidly if they suspect that they have developed a thrombus.

Universal screening of women for thrombophilic defects prior to or continuing the prescription of HRT is inappropriate.

Prior to commencing HRT, a personal history and a family history assessing the presence of VTE in a first- or second-degree relative should be obtained.

HRT should be avoided in women with multiple pre-existing risk factors for VTE.

2. Women with a personal or family history of VTE

Testing for thrombophilia should be discussed with and available for women with a personal or family history of VTE.

It is recommended that, in women with a previous VTE, with or without an underlying heritable thrombophilia, oral HRT should usually be avoided in view of the relatively high risk of recurrent VTE.

In women without a personal history of VTE but with an underlying thrombophilic trait that is identified through screening, HRT is not recommended in high risk situations such as Type 1 antithrombin deficiency or with combinations of defects or additional risk factors for VTE and specialist advice should be sought.

In women over 50 years with a history of VTE within the previous year, a full clinical history and examination with appropriate investigations is warranted for underlying disease.

It is recommended that, when a woman who is on HRT develops a VTE, HRT should be discontinued. It is recommended that, if a woman requires to continue on HRT after a VTE, long-term anticoagulation should be considered.

3. Risk of VTE in users of selective oestrogen receptor modulators (SERMs)

SERMs should be considered to carry the same risk of thrombosis as oestrogen-containing HRT.

4. Women on HRT undergoing surgery

HRT should be considered a risk factor for VTE when assessing women preoperatively. However, HRT does not require to be routinely stopped prior to surgery provided that appropriate thrombo-prophylaxis, such as low-dose or low-molecular-weight heparin, with or without thromboembolic deterrent stockings, is used.

THROMBOPROPHYLAXIS DURING PREGNANCY, LABOUR AND AFTER VAGINAL DELIVERY

Published January 2004

1. Preconceptual antenatal risk assessment

All women should undergo an assessment of risk factors for VTE in early pregnancy or before pregnancy. This assessment should be repeated if the woman is admitted to hospital or develops other intercurrent problems.

Women with previous VTE should be screened for inherited and acquired thrombophilia ideally before pregnancy.

2. Thromboprophylaxis during pregnancy and the puerperium

Regardless of their risk of VTE, immobilisation of women during pregnancy, labour and the puerperium should be minimised and dehydration should be avoided.

Women with previous VTE should be offered postpartum thromboprophylaxis with LMWH. It may be reasonable not to use antenatal thromboprophylaxis with heparin in women with a single previous VTE associated with a temporary risk factor that has now resolved.

Women with previous recurrent VTE or a previous VTE and a family history of VTE in a first-degree relative should be offered thromboprophylaxis with LMWH antenatally and for at least six weeks postpartum.

Women with previous VTE and thrombophilia should be offered thromboprophylaxis with LMWH antenatally and for at least six weeks postpartum.

Women with asymptomatic inherited or acquired thrombophilia may qualify for antenatal or postnatal thromboprophylaxis, depending on the specific thrombophilia and the presence of other risk factors.

Women with three or more persisting risk factors should be considered for thromboprophylaxis with LMWH antenatally and for three to five days postpartum. Women should be reassessed before or during labour for risk factors for VTE. Age over 35 years and BMI greater than 30/body weight greater than 90 kg are important independent risk factors for postpartum VTE even after vaginal delivery. The combination of either of these risk factors with any other risk factor for VTE (such as pre-eclampsia or immobility) or the presence of two other persisting risk factors should lead the clinician to consider the use of LMWH for three to five days postpartum.

3. Timing and duration of thromboprophylaxis

Antenatal thromboprophylaxis should begin as early in pregnancy as practical. Postpartum prophylaxis should begin as soon as possible after delivery (but see precautions after use of regional anaesthesia).

4. Agents for thromboprophylaxis

Low molecular weight heparins are the agents of choice for antenatal thromboprophylaxis. They are as effective as and safer than unfractionated heparin in pregnancy.

Warfarin should usually be avoided during pregnancy. It is safe after delivery and during breastfeeding.

5. Care during labour and delivery for women on thromboprophylaxis

Once the woman is in labour or thinks she is in labour, she should be advised not to inject any further heparin. She should be reassessed on admission to hospital and further doses should be prescribed by medical staff.

6. Topics suitable for audit

Key recommendations

All women should undergo an assessment of risk factors for VTE in early pregnancy or before pregnancy. This assessment should be repeated if the woman is admitted to hospital or develops other intercurrent problems.

Women with previous VTE should be screened for inherited and acquired thrombophilia, ideally before pregnancy.

Regardless of their risk of VTE, immobilisation of women during pregnancy, labour and the puerperium should be minimised and dehydration should be avoided.

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Women with asymptomatic inherited or acquired thrombophilia may qualify for antenatal or postnatal thromboprophylaxis, depending on the specific thrombophilia and the presence of other risk factors.

Women with three or more persisting risk factors should be considered for thromboprophylaxis with LMWH antenatally and for three to five days postpartum.

Women should be reassessed before or during labour for risk factors for VTE. Age over 35 years and BMI greater than30/ body weight greater than 90 kg are important independent risk factors for postpartum VTE even after vaginal delivery. The combination of either of these risk factors with any other risk factor for VTE (such as pre-eclampsia or immobility) or the presence of two other persisting risk factors should lead the clinician to consider the use of LMWH for three to five days postpartum.

Antenatal thromboprophylaxis should begin as early in pregnancy as practical. Postpartum prophylaxis should begin as soon as possible after delivery (but see precautions after use of regional anaesthesia).

LMWHs are the agents of choice for antenatal thromboprophylaxis. They are as effective as and safer than unfractionated heparin in pregnancy.

Warfarin should usually be avoided during pregnancy. It is safe after delivery and during breastfeeding.

Once the woman is in labour or thinks she is in labour, she should be advised not to inject any further heparin. She should be reassessed on admission to hospital and further doses should be prescribed by medical staff.

PREGNANCY AND BREAST CANCER

Revised January 2004.

1. Reproductive factors and breast cancer risk

Women should be advised to breastfeed if possible, as this is likely to reduce their risk of breast cancer in addition to any other benefit.

2. Treatment of breast cancer during pregnancy

There is no evidence that termination of pregnancy after diagnosis of breast cancer is necessary to improve prognosis

3. Pregnancy after treatment of breast cancer

Women planning a pregnancy after treatment for breast cancer should consult their obstetrician, breast surgeon and clinical oncologist.

Long-term survival after breast cancer does not appear to be affected by pregnancy.

It is recommended that pregnancy should be deferred for at least two years after treatment.

4. Breastfeeding

There is no evidence that women who have completed treatment for breast cancer cannot breastfeed safely from the unaffected breast. Breast-conserving surgery may not inhibit lactation but radiotherapy causes fibrosis and lactation is unlikely in an irradiated breast. During treatment for breast cancer with chemotherapy or radiotherapy, women should not breastfeed.

THE MANAGEMENT OF TUBAL PREGNANCY

This guideline replaces The management of tubal pregnancies, produced in October 1999. Published May 2004.

1. Surgical management of tubal pregnancy

A laparoscopic approach to the surgical management of tubal pregnancy, in the haemodynamically stable patient, is preferable to an open approach.

Management of tubal pregnancy in the presence of haemodynamic instability should be by the most expedient method. In most cases this will be laparotomy.

In the presence of a healthy contralateral tube there is no clear evidence that salpingotomy should be used in preference to salpingectomy.

Laparoscopic salpingotomy should be considered as the primary treatment when managing tubal pregnancy in the presence of contralateral tubal disease and the desire for future fertility.

2. Medical management of tubal pregnancy

Medical therapy should be offered to suitable women, and units should have treatment and follow-up protocols for the use of methotrexate in the treatment of ectopic pregnancy.

If medical therapy is offered, women should be given clear information (preferably written) about the possible need for further treatment and adverse effects following treatment. Women should be able to return easily for assessment at any time during follow-up.

Women most suitable for methotrexate therapy are those with a serum hCG below 3000 iu/l, and minimal symptoms.

Outpatient medical therapy with single-dose methotrexate is associated with a saving in treatment costs.

3. Expectant management of pregnancy of unknown location

Expectant management is an option for clinically stable women with minimal symptoms and a pregnancy of unknown location.

Expectant management is an option for clinically stable asymptomatic women with an ultrasound diagnosis of ectopic pregnancy and a decreasing serum hCG, initially less than serum 1000 iu/l.

4. Persistent trophoblast

When salpingotomy is used for the management of tubal pregnancy, protocols should be in place for the identification and treatment of women with persistent trophoblast.

5. Service provision and training

All NHS trusts should provide an early pregnancy assessment unit with direct access for general practitioners and accident and emergency departments. Available facilities for the management of suspected ectopic pregnancy should include:

- diagnostic and therapeutic algorithms
- transvaginal ultrasound
- serum hCG estimations.

Clinicians undertaking the surgical management of ectopic pregnancy must have received appropriate training. Laparoscopic surgery requires appropriate equipment and trained theatre staff.

6. Anti-D immunoglobulin

Nonsensitised women who are rhesus negative with a confirmed or suspected ectopic pregnancy should receive anti-D immunoglobulin.

7. Patient involvement

Women should be carefully advised, whenever possible, of the advantages and disadvantages associated with each approach used for the treatment of ectopic pregnancy. They should participate fully in the selection of the most appropriate treatment.

On the Lighter Side

Ask The Doctor

A woman pregnant with her first child paid a visit to her obstetrician's office. After the exam, she shyly said, ''My husband wants me to ask you...,'' to which the doctor replies, ''I know, I know,'' placing a reassuring hand on her shoulder. ''I get asked that all the time. Sex is fine until late in the pregnancy.''

''No, that's not it,'' the woman confessed. ''He wants to know if I can still mow the lawn.''

How much will this cost me?

Patient : How much to have this tooth pulled?
Dentist : $100.00.
Patient : $100.00 for just a few minutes work?
Dentist : Well, I can extract it very slowly if you like.

A doctor is complaining to a mechanic

A doctor is talking to a car mechanic, "Your fee is several times more per hour then we get paid for medical care."

"Yeah, but you see, doc, you have always the same model, it hasn't changed since Adam; but we have to keep up to date with new models coming every month."

12- Pack

A father and his son go into the grocery store when they happen upon the condom aisle. The son asks his father why there are so many different boxes of condoms. The father replies, ''Well, you see that 3-pack? That's for when you're in high school. You have 2 for Friday night and 1 for Saturday night.''

The son then asks his father, ''What's the 6-pack for?''
The father replies, ''Well, that's for when you're in college. You have 2 for Friday night, 2 for Saturday night, and 2 for Sunday morning.''

Then the son asks his father what the 12-pack is for.
The father replies, ''Well, that's for when you're married. You have one for January, one for February, one for March, one for.....''

Calendar of Events

LOCAL

Urogynaecology Update
19 September 2004
Penang Medical College, Penang
Tel: 04-200 2427 (Dr Sivakumar S Balakrishnan)

1st National Seminar on Critical Care in Obstetrics
11 - 12 December 2004
Heritage Hotel, Ipoh
Tel: 05-5222 480 (Dr Japaraj)
Email: japaraj@hotmail.com

5th Malaysian Congress on Menopause
Sunway Lagoon Resort Hotel, Selangor
21 - 24 April 2005
Tel: 03-7688 5588 Fax: 03-7688 5599
Email: mad@organon.com.my;drchoon@pd.jaring.my
http://www.menopause.org.my

15th Malaysian Congress of O&G
Venue: TBA
2 - 5 June 2005
Tel: 03-6201 3009 Fax: 03-6201 7009
Email: ogsm@po.jaring.my

INTERNATIONAL

Transvaginal Endoscopy
29 September 2004
Gleneagles Hospital, Singapore
Tel: (65) 6470 3399 Fax: (65) 6470 3393
Email: miscentre@gleneagles.com.sg

10th Biennial International Gynecologic Cancer Society Meeting
3 - 7 October 2004
Edinburgh, Scotland
Tel: +41 22 9080488 Fax: +41 22 7322850
E-mail: igcs-10@kenes.com

19th European Congress of Perinatal Medicine
14 - 16 October 2004
Athens Hilton Hotel, Greece
Tel: +30 210 6889100 Fax: +30 210 6844777
E-mail: perinatal2004@cnc.gr
http://www.perinatal2004.gr

19th Scientific Meeting of RTCOG in Collaboration with RANZCOG
20 - 22 October 2004
Pattaya, Thailand
Tel: +66 2716 5721 Fax: +66 2716 5720
E-mail: sc_rtcog@rtcog.or.th

Training Course in Gynaecological Endoscopy (Focus: Hysterecscopy, Tubal Surgery and Oncology)
15 - 19 November 2004
Kiel, Germany
Tel: +49 431 597 2086 Fax: +49 431 597 2116
Email: endo-office@email.uni-kiel.de

The World Congress on Controversies in Obstetrics, Gynecology, & Infertility
25 - 28 November 2004
Bangkok, Thailand
Tel: +41 22 908 0488 Fax: +41 22 732 2850
E-mail: cogi@kenes.com
http://www.kenes.com/controversies

14th Annual Congress of the International Society for Gynecologic Endoscopy
2 - 6 April 2005
London, United Kingdom
Tel: +44 (0) 20 8743 3106 Fax: +44 (0) 20 8743 1010
Email: info@isge2005.org
http://www.isge2005.org

6th RCOG International Scientific Meeting
27 - 30 September 2005
Cairo, Egypt
Tel: +202 405 3575 Fax: +202 402 0609
Email: pioneerev@hotmail.com
http://www.rcog2005.com

XIXth Asia and Oceanic Congress of O&G
1 - 5 October 2005
Seoul, Korea
Tel: +82 3471 8555 Fax: +82 2 521 8683
Email: aocog2005@insession.co.kr

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Email: ogsm@po.jaring.my Website: www.ogsm.org.my