Obstetrical & Gynaecological Society of Malaysia

The OGSM newsletter

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THE OGSM COUNCIL, SUBCOMMITTEES & STATE COORDINATORS

COUNCIL 2007/2008

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The President's Message

Last weekend, Malaysians witnessed the most interesting general elections. I am not aware of any OGSM members who contested in the elections, but 3 of my University Malaya classmates have been elected as representatives.

The council has been busy dealing with the issues at hand. Dr Baskaran and his committee are busy organizing the next congress, which will be held at Gentings from the 5th to the 8th of June 2008. It is going to be an exciting event with the involvement of the Royal College of Obstetricians and Gynaecologists. We would like to welcome everyone to attend the meeting.

Purchase of buildings

The Society is acquiring 2 additional properties at Plaza Mont Kiara, namely units A-05-09 and A-05-10 and has paid 2% of the purchase price for them. Based on the Society's Constitution, any immovable properties acquired by the Society shall be vested in trustees upon the execution of a Deed of Trust by such trustees. However, the Trust Deed for the Society's present property, i.e. unit C-07-02 at Plaza Mont Kiara was not executed. Accordingly, the Society held a Special General Meeting on the 13/3/08 for the purpose of appointing such persons as thought fit to be trustees for all properties of the Society (i.e. units C-07-02, A-05-09 and A-05-10 at Plaza Mont Kiara and all other future properties to be acquired by the Society).

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Dr Lim Cheng Lim, who was not present at the Special General Meeting, had tendered his resignation as trustee of the Society. The other 2 trustees present during the meeting, namely Datuk Dr N Subramanian and Dato' Dr P Boopalan informed the House that they too would like to resign as trustees of the Society with immediate effect. Since all 3 trustees of the Society had resigned, the House debated on the number of trustees to be appointed as per the Society's constitution, which allows a minimum of 2 and a maximum of 5 trustees. The house voted unanimously to have 5 new trustees for the Society. The House appointed the following 5 trustees, namely.

1. Dato' Dr Alex Mathews
2. Dr Ng Kwee Boon
3. Dr Sheik Johari Bux Bin S.Y. Bux
4. Dr Gunasegaran P.T. Rajan
5. Datuk Dr Abdul Aziz Yahya

The House further appointed Dr S Sevellaraja, the current President to sign the Trust Deed on behalf of the Society

AOFOG

Dr. Ravi Chandran has been nominated by the OGSM Council to continue for another term as the OGSM representative at the AOFOG Council. The next AOCOG meeting will be at the Sky City Hotel, Auckland, New Zealand from the 26th to 30th March 2009. In the previous AOCOG meeting in Japan, Professor Dato' Dr Sivanesaratnam presented the prestigious SS Ratnam Memorial Lecture entitled "Ovarian Cancer – Is there Hope for Women". Prof Siva was also elevated to Fellowship of the AOFOG and this fellowship will be conferred at the AOCOG 2009. We would like to congratulate Prof Siva and this is also an honour to OGSM.

AOFOG is in the process of raising USD 1 million for the AOFOG educational fund. We would like donations from members for this educational fund. All donations should be directed to "Obstetrical and Gynaecological Society of Malaysia".

We did not succeed in our bid to host the 2011 AOCOG meeting. Taiwan was awarded the meeting. Dr. Ravi Chandran commented that the bidding for AOFOG is not as easy as it used to be and Council is still undecided as to whether to bid for the 2013 meeting.

The Young Gynaecologist Award is a prestigious award presented during AOCOG meeting. We did not have a nominee for this award in Japan. We would like young gynaecologists to send their resume to Council for selection. Even though funding is limited, 1 award recipient may be funded for the trip to Auckland.

Puvan Foundation

A fun walk will be organized on the 6/4/08. Previously the date of the walk was to have been on the 9th March 2008, the day after Women's Day (8 March 2008) but this has to be postponed due to the General Elections. Please join us for this walk.

OGSM-RCOG Live Saving Skills Course

This workshop will be held on 2- 5th June 2008. So far MOH has agreed to sponsor 30 doctors for this workshop. Places for this workshop are limited and we encourage members to register early to avoid disappointment because registration will be on a first-come first- served basis.

Regards and best wishes for 2008

Dr S. Sevellaraja
President

Secretary's Report

Newsletter
We have started the new format of the newsletter but not all sections have been successful. The President's, Secretary's and Treasurer's pages continue as previous editions. The subspecialty column has taken off and we hope that it continues to expand. Dr Baskaran has added his report on the next OGSM scientific meeting and what is expected. The letters to the editor has started and it is hoped that it will bring more members forward with their views and opinions. This may be the only other channel that we as members of the OGSM can show what we feel and believe in and may help the Council in making decisions over the year. We hope to get Dr Farouk's help in putting at least the Ministry of Health's event of diary as the initial diary of events and build on it.

18th OGSM Congress
The annual scientific conference will be held in the First World Hotel in Genting from the 5th to the 8th of June, 2008. Please sign up early and get your rooms as this will be during school holidays and the rooms might vanish fast. The details of the conference is in Dr. Baskaran's report. The initial announcement has already been sent out. Please join us to make it a successful event as well as the usual meet old friends event. There are added events in pre and post conferences that will be held around this event to make it more interesting.

Newspaper Reports
Recently there have been many reports with regards to doctors, patients or general health issues which involve the Obstetrics and Gynaecology fraternity. In general, the OGSM has been silent as we only write back if there is an obvious and direct involvement for the OGSM. We would like to know what members think and if we should respond to these newspaper articles. What stand should we take? Do we represent the fraternity by putting out statements that represent the society as our standing opinion or position? Would the Council be representing the general body if it has to make decisions in haste? Would we be open to litigation in our stand? Do we need to get legal opinions and have a legal firm representing us? This will definitely increase the cost of running the society which is already escalating.

Elections
There has been a lot mentioned about the elections. Are we keen to change the way we conduct elections. Would we want to follow like the MMA? Would we want the whole general body to have an opportunity to nominate and vote for the principal office bearers before the general meeting which would just formalise their appointment at the meeting. Would we like to have a rotation policy among the private sector, universities and doctors from the Ministry of Health? This could be a discussion point.
If any member is really keen to change, he or she could put up a resolution to change the constitution appropriately to change the way the elections are run. However, it will require the approval of the Registrar of Societies before it can be implemented.

Future Conferences
The Asia Oceania Congress of Obstetrics and Gynaecology 2009 will be held in Sky City Hotel, Auckland, New Zealand from the 26th to 30th March, 2009. There has been a request for submission of papers in the symposium, free communications or poster presentations.

FIGO will be held in Cape Town, South Africa from 4 to 9 October 2009. Interested members can get more details from the internet at www.figo2009.org.za.

Dr H. Krishna Kumar
Hon. Secretary

18th Malaysian Congress of O & G

The preparations for the 18th Congress of the Obstetrical & Gynaecological Society of Malaysia is in the final stages. By now you would have received the final announcement. We are now putting in the final touches. If you had looked at the final programme you would have noticed a few changes.

The Scientific Programme under the able leadership of Prof Muhammad Abdul Jamil and with the help of the ever-resourceful Dr Helena Lim had put up a unique and intensive programme. There are many more symposiums in the many aspects of Obstetrics and Gynaecology. There are also the popular meet the experts sessions and debates.

This year we have decided to have the Congress in collaboration with the Royal College of Obstetricians and Gynaecologists, United Kingdom. We had on many occasions worked with them informally and they had been very accommodative. This time we had decided to have a more formal collaboration.

The Informal Night on Friday night had been scrapped, as over the years we had found the attendance to be wanting. Feel free to attend the many entertainment events organised by the Genting's Resort. There are one or two events, which we will be selling tickets to, at the Secretariat. You can also use the time to meet up with old friends.

Dr Farouk Abdullah who is our social chairman had warned us to be prepared for a very unusual Annual Dinner. With such a hefty entertainment budget you can be ensured of an excellent night.

There is a good number of Pre-Congress and Post-Congress Workshops organised for Specialists, Registrars and Nurses. Be sure to sign up for one of them.

I bid you a warm welcome to the 18th Malaysian Congress of O & G. Keep the whole first week of June free. Be prepared for fun, fellowship and enlightenment.

Dr A. Baskaran
Organising Chairman

Perak OGSM Fellowship Night 2008

This annual event was held in the Syuen Hotel on 23/02/2008. It was attended by around 60 doctors from all over Perak. We were lucky to have Dr Raman Subramaniam as the guest speaker for this event. He gave us a talk on Modern Management of Menopause which was both enlightening and entertaining.

After the talk we had an informal discussion between the government O&G specialists and the private O&G specialists. The discussion, which was chaired by the State Health Director, Dato' Dr Radzin, was centered on improving the O&G services in the state of Perak. After the discussion, we adjourned to a sumptuous buffet dinner. The members took time to have fellowship with one another through the night. Many felt that this kind of meeting should be held more often.

Dr Japaraj Robert Peter

OGSM Maternal Fetal Medicine Subcommittee Meeting in Saujana Resort on 1st and 2nd of December 2007

This meeting was the third one, since its inception 2 years ago. The weekend meeting was held in a beautiful hotel and brought together many of the OGSM members who have a special interest in Maternal Fetal Medicine. It was attended by around 30 members. The program for the meeting was an interesting one and it covered both the areas of Maternal Medicine and Fetal Medicine. The theme for the meeting was "Fetal Chest Abnormalities". On the first day, we had the privilege of having some very sought after speakers such as Prof Emeritus Dato' Dr. Mustaffa Embong to talk to us on "Current Management Strategies in GDM" and also a talk on "Fetal Cardiac Anomalies" by Dr Min Kang (Pediatric cardiologist). The participants were so engrossed with the talks and discussion that the meeting finished at 11.00 pm on the first day. There were also some industry sponsored talks that were given by the OGSM members.

As in the past meetings, many of the members of the subcommittee presented their studies and shared some of the cases that they had seen. The presence of the senior MFM specialists and the informal style of meeting (round table style with coffee and tea) allowed much discussion and learning to take place. The subcommittee members also felt that such meetings should be held at least once every six months as there is so much to share, in terms of experience and expertise. The members also felt that an annual MFM meeting held for all members of the OGSM should also be organized to cater for the other OGSM members. We hope to organize this by the end of the year.

All in all, the Third OGSM Maternal Fetal Medicine Subcommittee Meeting was a huge success and I would like to congratulate and thank the UKM Maternal Fetal Medicine team (especially Prof Jamil, Dr Norzilawati, Dr Shuhaila and the others) for making this a memorable, informative and enjoyable meeting.

Dr Japaraj Robert Peter
OGSM Maternal Fetal Medicine Subcommittee Chairman
japaraj@hotmail.com

I read with interest the article by Dr Gunasegaran P T Rajan on the election of council members. I have been a member of OGSM for more than 30 years and my impression has been that the election of office bearers has been decided by the same small group that rotate the positions among themselves believing that they are the only ones that can steer the society in the "RIGHT" direction. Now Dr Guna has also voiced the same concerns, but to confirm my believe there is now a suggestion to allow the presidents to stay in office for 2 years and also to allow the same person to be re-elected.

The society may like to know another disturbing development. Notices for clinical meetings tend to arrive after the dates of the proposed meetings or not at all. Even if they do arrive and you ring the organisers to confirm your attendance, you are given the third degree. The case in point is the meeting to be held on the 10th of November 2007 at Le Meridian. Old members are not hard up for a free meal. I hope concerns are addressed without resort to malice.

Regards,
Dr Jammal Ahmad Essa

ARE YOU AN EVIDENCE BASED OBSTETRICIAN?

Evidence Based Practice (EBP) is the integration of best research evidence with clinical expertise and patient values (Sackett et al. 2000). Best research evidence is most often acquired from systematic reviews of randomised controlled trials. The Cochrane Database of Systematic Reviews is by far the world's most well known library or collection of properly conducted systematic reviews. The systematic reviews are regularly updated. While it may not contain all the answers that we ask in relation to obstetric problems, it certainly contains many evidence based answers to our day to day obstetric problems. It is important for us obstetricians to regularly update our knowledge on the available EBPs in obstetric care as it guides us in giving the best possible care to our patients. The following are a summary of some of the systematic reviews that have appeared in the Cochrane Database over the last few years. I am sure that you know all of them (many of the patients know them too, as it is available in the internet - so they may be expecting you to follow them too)

1. Number of antenatal visits for low risk cases: A reduction in the number of antenatal care visits with or without an increased emphasis on the content of the visits could be implemented without any increase in adverse biological maternal and perinatal outcomes.

2. Continuity of care: Studies of continuity of care show beneficial effects. It is not clear whether these are due to greater continuity of care, or to midwifery care.

3. Women carrying their own case notes improves their sense of control and satisfaction and the availability of antenatal records.

4. Smoking cessation programs in pregnancy reduce the proportion of women who continue to smoke, and reduce low birth weight and preterm birth.

5. Prophylactic antibiotics for LSCS: The reduction of endometritis by two thirds to three quarters and a decrease in wound infections justifies a policy of recommending prophylactic antibiotics to women undergoing elective or non-elective cesarean section.

6. Prophylactic antibiotics for LSCS: Both ampicillin and first generation cephalosporins have similar efficacy in reducing postoperative endometritis. There does not appear to be added benefit in utilizing a more broad spectrum agent or a multiple dose regimen.

7. Oral intake after LSCS: Drinking and eating again soon after caesarean section does not seem to cause women any problems, and may even speed recovery.

8. Type of skin incision for LSCS: The Joel-Cohen incision has advantages compared to the Pfannenstiel incision. These are less fever, pain and analgesic requirements; less blood loss; shorter duration of surgery and hospital stay. These advantages for the mother could be extrapolated to savings for the health system.

9. To stitch or not to stitch the peritoneum: Not stitching the peritoneum after caesarean section shows less fever for mothers and takes less time, but possible disadvantages are unclear.

10. Skin-to-skin contact between mother and baby at birth reduces crying, improves mother-baby interaction, keeps the baby warmer, and helps women breastfeed successfully.

11. Antibiotics for post delivery endometritis: Intravenous gentamicin plus clindamycin more effective than other antibiotics for endometritis after childbirth.

12. Routine vs. restrictive episiotomy: Restrictive episiotomy policies appear to have a number of benefits compared to routine episiotomy policies. There is less posterior perineal trauma, less suturing and fewer complications, no difference for most pain measures and severe vaginal or perineal trauma, but there was an increased risk of anterior perineal trauma with restrictive episiotomy.

13. Position in the second stage of labour for women without epidural anaesthesia: The tentative findings of this review suggest several possible benefits for upright posture, with the possibility of increased risk of blood loss greater than 500 ml. Women should be encouraged to give birth in the position they find most comfortable.

14. Management of 3rd stage of labour: Routine 'active management' is superior to 'expectant management' in terms of blood loss, post partum haemorrhage and other serious complications of the third stage of labour. Active management is, however, associated with an increased risk of unpleasant side effects (eg nausea and vomiting), and hypertension, where ergometrine is used. Active management should be the routine management of choice for women expecting to deliver a baby by vaginal delivery in a maternity hospital.

15. Early vs, delayed cord clamping in preterm deliveries: Delaying cord clamping by 30 to 120 seconds, rather than early clamping, seems to be associated with less need for transfusion and less intraventricular haemorrhage.

16. Controlled cord traction, after awaiting signs of placental separation, should remain the third component of the active management of third stage of labour, and follow the routine administration of a uterotonic drug and cord clamping.

17. Syntometrine vs. syntocinon: Ergometrine-oxytocin (Syntometrine ®) is more effective than oxytocin (Syntocinon ®) in reducing blood loss during the delivery of the placenta, but has more side-effects.

18. Continuous support during labour should be the norm, rather than the exception. All women should be allowed and encouraged to have support people with them continuously during labour. In general, continuous support from a caregiver during labour appears to confer the greatest benefits when the provider is not an employee of the institution, when epidural analgesia is not routinely used, and when support begins in early labour.

19. Enema during labour: This evidence does not support the routine use of enemas during labour; therefore, such practice should be discouraged

20. Routine perineal shaving in labour: There is no evidence of benefit from routine perineal shaving in labour.

21. Routine amniotomy: Evidence does not support the routine amniotomy for women in spontaneous labour.

22. The use of Doppler ultrasound in high risk pregnancies appears to improve a number of obstetric care outcomes and appears promising in helping to reducing perinatal deaths.

23. Amniocentesis vs. Chorionic Villous Sampling (CVS): Second trimester amniocentesis is safer than transcervical CVS and early amniocentesis. If earlier diagnosis is required, transabdominal CVS is preferable to early amniocentesis or transcervical CVS. In circumstances where transabdominal CVS may be technically difficult the preferred options are transcervical CVS in the first trimester or second trimester amniocentesis.

24. Routine ultrasound in early pregnancy appears to enable better gestational age assessment, earlier detection of multiple pregnancies and earlier detection of clinically unsuspected fetal malformation at a time when termination of pregnancy is possible.

25. Continuous cardiotocography during labour is associated with a reduction in neonatal seizures, but no significant differences in cerebral palsy, infant mortality or other standard measures of neonatal well-being. However, continuous cardiotocography was associated with an increase in caesarean sections and instrumental vaginal births. The real challenge is how best to convey this uncertainty to women to enable them to make an informed choice without compromising the normality of labour.

26. Prevention of Rhesus Iso-Immunisation: Anti-D given during pregnancy at 28 and 34 weeks of pregnancy reduces incidence of antibody formation and probably also reduces immunisation of women.

27. External cephalic version from 36 weeks reduces the chance of breech presentation at birth and caesarean section.

28. Routine tocolysis for external cephalic version at term:
There is evidence from this review to support the use of tocolysis in clinical practice to reduce the failure rate of external cephalic version (ECV) at term. Whether tocolysis should be used routinely, or selectively when initial ECV attempts fail, has not been adequately addressed.

29. Delivery of term breeches: Planned caesarean section compared with planned vaginal birth reduced perinatal or neonatal death or serious neonatal morbidity, at the expense of somewhat increased maternal morbidity.

30. Timing of delivery for diabetics on insulin: Induction of labour at 38 weeks pregnancy for women with diabetes treated with insulin lowers the chances of delivering a large baby.

31. Postdatism: A policy of labour induction after 41 completed weeks or later compared to awaiting spontaneous labour either indefinitely or at least one week is associated with fewer perinatal deaths.

32. Sweep and stretch: Routine use of sweeping of membranes from 38 weeks of pregnancy onwards does not seem to produce clinically important benefits. When used as a means for induction of labour, the reduction in the use of more formal methods of induction needs to be balanced against women's discomfort and other adverse effects.

33. Antibiotic treatment in asymptomatic bacteriuria is effective in reducing the risk of pyelonephritis in pregnancy. A reduction in low birthweight is consistent with current theories about the role of infection in adverse pregnancy outcomes, but this association should be interpreted with caution given the poor quality of the included studies.

34. Intrapartum antibiotic treatment of women colonized with group B streptococcus appears to reduce neonatal infection.

35. Topical treatment for vaginal candidiasis: Topical imidazole appears to be more effective than nystatin for treating symptomatic vaginal candidiasis in pregnancy. Treatments for seven days may be necessary in pregnancy rather than the shorter courses more commonly used in non-pregnant women.

36. Exclusive breastfeeding for six months (versus three to four months) reduces gastrointestinal infection, does not impair growth, and helps the mother lose weight.

37. Support for breastfeeding mothers: Additional professional support was effective in prolonging any breastfeeding, but its effects on exclusive breastfeeding were less clear.

38. Prevention of pre-eclampsia: Antiplatelet agents, largely low-dose aspirin, have moderate benefits when used for prevention of pre-eclampsia and its consequences.

39. Prevention of pre-eclampsia: Calcium supplementation (most of the included studies used large doses – 2gm per day) appears to almost halve the risk of pre-eclampsia, and to reduce the rare occurrence of the composite outcome 'death or serious morbidity'. There were no other clear benefits, or harms.

40. Prevention of eclampsia: For women with preeclampsia, magnesium sulphate more than halves the risk of eclampsia, and probably reduces the risk of maternal death.

41. Treatment of eclampsia: Magnesium sulphate appears to be substantially more effective than diazepam for treatment of eclampsia.

42. Treatment for antiphospholipid syndrome: Combined unfractionated heparin and aspirin may reduce pregnancy loss by 54%.

43. Role of progestrone to prevent miscarriage: There is no evidence to support the routine use of progestogen to prevent miscarriage in early to mid pregnancy.

44. Surgical management of first trimester miscariage: Vacuum aspiration is safe, quick to perform, and less painful than sharp curettage, and should be recommended for use in the management of incomplete abortion.

45. Role of progestrone to treat threatened miscarriage: Based on scarce data from two methodologically poor trials, there is no evidence to support the routine use of progestogens for the treatment of threatened miscarriage.

46. Medical treatment for early fetal death (less than 24 weeks): Available evidence from randomised trials supports the use of vaginal misoprostol as a medical treatment to terminate non-viable pregnancies before 24 weeks.

47. Cesaraen section for second twin not presenting as cephalic: Caesarean section for the birth of a second twin not presenting cephalically is associated with increased maternal febrile morbidity with, as yet, no identified improvement in neonatal outcome. This policy should not be adopted except within the context of further controlled trials.

48. Bed rest in multiple pregnancy: There is currently not enough evidence to support a policy of routine hospitalisation for bed rest in multiple pregnancy. No reduction in the risk of preterm birth or perinatal death is evident, although there is a suggestion that fetal growth is improved. For women with an uncomplicated twin pregnancy the results of this review suggest that it may be harmful in that the risk of very preterm birth is increased.

49. Periconceptional folate supplementation has a strong protective effect against neural tube defects.

50. Vacuum vs. forceps delivery: Use of the vacuum extractor rather than forceps for assisted delivery appears to reduce maternal morbidity. The reduction in cephalhaematoma and retinal haemorrhages seen with forceps may be a compensatory benefit.

51. Metal cup vs. soft cup: Metal cups appear to be more suitable for 'occipito-posterior', transverse and difficult 'occipito-anterior' position deliveries. The soft cups seem to be appropriate for straightforward deliveries.

52. Pain during labour: Acupuncture and hypnosis may be beneficial for the management of pain during labour; however, the number of women studied has been small.

53. Pain during labour: Epidural analgesia appears to be effective in reducing pain during labour. However, women who use this form of pain relief are at increased risk of having an instrumental delivery.

54. Pain after delivery: NSAID rectal suppositories are associated with less pain up to 24 hours after birth, and less additional analgesia is required.

55. Antenatal perineal massage reduces the likelihood of perineal trauma (mainly episiotomies) and the reporting of ongoing perineal pain and is generally well accepted by women. As such, women should be made aware of the likely benefit of perineal massage and provided with information on how to massage.

56. Suture material for perineal repair: Absorbable synthetic suture material (in the form of polyglycolic acid and polyglactin sutures) for perineal repair following childbirth appears to decrease women's experience of short-term pain.

57. Continous vs. interrupted technique: The continuous suturing techniques for perineal closure, compared to interrupted methods, are associated with less short-term pain. Moreover, if the continuous technique is used for all layers (vagina, perineal muscles and skin) compared to perineal skin only, the reduction in pain is even greater.

58. Retained placenta: Umbilical vein injection of saline solution plus oxytocin appears to be effective in the management of retained placenta. Saline solution alone does not appear be more effective than expectant management.

59. Antibiotics for term prelabour rupture of membrane (PROM): Antibiotics when membranes rupture before labour at term may lower infections for pregnant women, but more research is needed on safety and impact on babies.

60. Antibiotics for preterm PROM: Antibiotic administration following preterm PROM is associated with a delay in delivery and a reduction in major markers of neonatal morbidity. These data support the routine use of antibiotics in pPROM.

61. Itching during pregnancy: Aspirin appears to be more effective than chlorpheniramine for relief of itching in pregnancy when no rash is present. If there is a rash, chlorpheniramine may be more effective.

62. Prevention of stretch marks: Trofolastin cream appears to help prevent the development of stretch marks in pregnancy in some women.

63. Pregnancy associated cramps: If a woman finds cramp troublesome in pregnancy, the best evidence is for magnesium lactate or citrate taken as 5mmol in the morning and 10mmol in the evening. Sodium supplements may decrease the number of cramp attacks experienced by women in pregnancy but the effect is slight. Calcium is of no benefit.

64. Anti-emetic for nausea in early pregnancy: Anti-emetic medication appears to reduce the frequency of nausea in early pregnancy. There is some evidence of adverse effects, but there is very little information on effects on fetal outcomes from randomised controlled trials. Of newer treatments, pyridoxine (vitamin B6) appears to be more effective in reducing the severity of nausea.

65. Back and pelvic pain: Adding pregnancy-specific exercises, physiotherapy or acupuncture to usual prenatal care appears to relieve back or pelvic pain more than usual prenatal care alone, although the effects are small.

66. Treatment for constipation during pregnancy: Dietary supplements of fibre in the form of bran or wheat fibre are likely to help women experiencing constipation in pregnancy. If the problem fails to resolve, stimulant laxatives are likely to prove more effective.

67. Antenatal corticosteroids to accelerate fetal lung maturation in women at risk of preterm birth: The evidence from this new review supports the continued use of a single course of antenatal corticosteroids to accelerate fetal lung maturation in women at risk of preterm birth. A single course of antenatal corticosteroids should be considered routine for preterm delivery with few exceptions.

68. Repeat dose(s) of prenatal corticosteroids reduce the occurrence and severity of neonatal lung disease and the risk of serious health problems in the first few weeks of life. These short-term benefits for babies support the use of repeat dose(s)

of prenatal corticosteroids for women at risk of preterm birth. However, these benefits are associated with a reduction in some measures of weight, and head circumference at birth, and there is still insufficient evidence on the longer-term benefits and risks.

69. Maintenance therapy after threatened preterm labour: The role of maintenance therapy with calcium channel blockers for preventing preterm birth is not clear.

70. Maintenance therapy after threatened preterm labour: Available evidence does not support the use of oral betamimetics for maintenance therapy after threatened preterm labour.

71. Cervical stitch (cerclage) may help prevent miscarriage due to a cervical factor, but has not been shown to benefit other women.

72. Intramuscular progesterone for prevention of preterm labour: Intramuscular progesterone is associated with a reduction in the risk of preterm birth less than 37 weeks' gestation, and infant birthweight less than 2500 grams but there is insufficient information about potential harms.

73. Tocolytic agent: When tocolysis is indicated for women in preterm labour, calcium channel blockers are preferable to other tocolytic agents compared, mainly betamimetics.

74. Prophylactic antibiotic treatment for preterm labour: This review fails to demonstrate a clear overall benefit from prophylactic antibiotic treatment for preterm labour with intact membranes on neonatal outcomes and raises concerns about increased neonatal mortality for those who received antibiotics.

75. Atosiban as tocolysis: This review failed to demonstrate the superiority of atosiban over betamimetics or placebo in terms of tocolytic efficacy or infant outcomes. The finding of an increase in infant deaths in one placebo controlled trial warrants caution. A recent Cochrane review suggests that calcium channel blockers (mainly nifedipine) are associated with better neonatal outcome and fewer maternal side-effects than betamimetics.

The above summary of best evidences in obstetric care is only a summary. There are many more systematic reviews that are in the Cochrane Library. Please refer to the Cochrane Library for the full write up for each of the evidences above. The Cochrane Library can be accessed at www.thecochranelibrary.com. Once you are at the main page, you can search your topic of interest under the search box or alternatively click on Browse Cochrane Review by Topics and go to Pregnancy and Childbirth for systematic reviews (SR) on obstetric care. Once you have chosen your desired title, there will be 2 columns for you to see. The left column allows you to choose the details of the SR such as the abstract, plain language summary (for those of us who are too lazy to read the whole thing), description of studies, tables etc.

The access to www.thecochranelibrary.com is free for all Malaysians till the end of 2008. This is due to the involvement of some of the Malaysian Hospitals (including Ipoh Hospital and HUSM) in a large multinational research project known as the SEA ORCHID project which is looking at the role of EBP in improving reproductive and child health outcomes in a few countries in the region. Please go to www.seaorchid.org for further information. The Cochrane Collaboration is also looking for interested doctors from Malaysia to do systematic reviews to add to the Cochrane library. Please email me if you are interested and I will tell you how you can be involved. It's so easy that even I am doing a systematic review now.

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Gynaecology Oncology in Malaysia: Where are we heading?

Dr Mohd Rushdan Md Noor
Consultant Gynae Oncologist
Chairman, Gynae Oncology Subcommittee, OGSM

Introduction

Cancer is a serious health problem that is faced worldwide. The incidence of cancer is predicted to be on the rise with time. There will be 15 million cancer cases by the year 2020 according to projections by IARC. Lung cancer is the commonest malignancy worldwide. Among the female cancers, breast cancer tops the list and is followed by cervical cancer. Cancer does not only cause death but also creates a lot of suffering. The cost for implementing preventive measures and treatment are tremendous and pose a great financial burden to any nation. Cancer has serious implications and therefore many efforts have been taken to reduce the burden of this disease. Preventive measures are among the efforts that had been undertaken to battle cancer. Besides this, many new therapeutic modalities have been discovered and thus giving hope to cancer sufferers.

To ensure that cancer patients receive the best treatment, a proper training program for specialists in Oncology has been developed. Gynaecological Oncology has been in existence for a long time now and is continuously developing around the globe. Similarly, Gynaecological Oncology in Malaysia has undergone transformation to its current state. This article aims to highlight the progress of Gynaecological Oncology in Malaysia that has taken place and what is our future direction. Much emphasis will be paid to the development of Gynaecological Oncology services in Malaysia and measures to be taken so that we will not be left behind in the flow of progress in a global perspective.

Progress of Gynaecology Oncology in Malaysia: The past and present

Gynaecological oncology services in Malaysia have been in existence for quite some time. In the early stages, there was no structured subspeciality training programme in Gynaecology Oncology in Malaysia. University Hospital Kuala Lumpur under the leadership of Prof Dato' Dr Sivanesaratnam was the only center for comprehensive gyanecological cancer treatment at one time. Most centers in other hospital are handled by O&G specialists with special interest in Gynaecological Oncology. Even if there were trained Gynaecological Oncologists, it was only a matter of time till they left for the greener pastures of private practice. As a result, most cancer patients ended up being referred to Kuala Lumpur for further treatment. Patients with poor socio-economic background had been neglected and did not receive proper treatment.

Gynaecology Oncology Subspeciality Training Programme in the Ministry of Health

Quality of healthcare is paramount in any field of specialty. One of the most important prerequisites to provide best treatment is to produce trained personnel. Gynaecological Cancer is best dealt by trained Gynaecological Oncologist. Realizing the importance of having a structured Gynae Oncology subspeciality training programme, the Ministry Of Health, with the initiative from JKKPOG had embarked on planning the framework of such training programme until it was implemented in 2000. The three year subspeciality training programme comprises two years of local training and one year overseas training in recognized centre. Several overseas centres have been identified such as Gynaecological Oncology Unit KK Women's & Children's Hospital, Singapore, Gynaecological Oncology centers in Australia, Hong Kong and United Kingdom. Upon completion of the three year training program, candidates are required to submit their log book, certification from the trainers and proof of publication of at least two research works to the JKKPOG committee. These

documents will be scrutinized by the selected committee members of JKKPOG. If the committee is satisfied with the submission, the name and documents concerned will be forwarded to the Ministry of Health for Gazettement approved by Director General of Health. At the moment there are at least two Gynaecological Oncology Subspecialists that have been gazetted through this subspecialty training program. It is estimated that 6 candidates will be trained in this program annually. There are currently 8 O&G Specialists in this training program and 6 more new trainees are recruited for the 2008 intake. Based on this development, by the year 2010 there will be at least 10 gazetted Gynaecological Oncology sub-specialists will complete their training and will provide their services throughout Malaysia. These figures do not take into account Gynaecological Oncologists in Academic Institutions such as UM, UKM, USM and UIA. Currently we have at least 9 Gynaecological Oncologists from these academic institutions. There are also Gynaecological Oncology specialists who are working in Private Hospitals.

Gynaecological cancer prevention in Malaysia

Cervical cancer prevention in Malaysia as with other countries is carried out through cervical cancer screening. Pap smear coverage in our nation is quite low in the region of about 26-30%. In certain areas it may reach up to 50%. Infrastructure and manpower are the main hindrance in achieving a desirable coverage. We do not have an organized cervical cancer screening program. The ministry of Health has taken the initiative to launch a pilot project on a call-recall system which began in late 2006. This project is still ongoing in certain districts including Klang and Mersing, Johore. This pilot project will reveal if the call-recall system will truly improve the quality and coverage of pap smear screening in the future. With the support from WHO, the Ministry of Health is also embarking on another pilot project utilizing Visual Inspection with Acetic Acid (VIA) as an alternative method of cervical cancer screening incorporating the use of Cryotherapy as a treatment modality for VIA positive. This project is in the early stage of implementation in Sik, Kedah. Both these initiatives should be given due credit as the beginning of a systematic cervical cancer prevention program in our country.

The usage of HPV vaccine was approved by the national pharmaceutical enforcement division in October 2006. This vaccine is currently available in some private hospitals and clinics. Although it is still unavailable in the Government Hospitals, the Ministry of Health is seriously contemplating a national HPV vaccination program. Meanwhile the MOH is adopting a wait and see approach. Currently there are two ongoing studies on cost effectiveness of HPV vaccination and HPV typing for local women in Malaysia which are conducted by UKM. A few hospitals are involved in these studies including HKL and Hospital Sultanah Bahiyah.

The cancer prevention program will be a wasted effort if not complemented with training in colposcopy. The JKKPOG with the assistance from Gynaecological Oncology subcommittee of OGSM has come up with a structured colposcopic training program to train specialists to perform colposcopy and its related procedures competently. This training includes a structured colposcopy workshop and the participants will be assessed at the end of the workshop. The candidates are also required to log in 50 cases and perform at least 10 colposcopic procedures. Having successfully completed that, the candidate will be considered to be given certificate of accreditation as Colposcopist. The very first workshop was conducted in Kuala Terengganu on 26th-27th October. Seven O&G Specialists from Terengganu and Pahang have registered under this training program.

There are no specific preventive measures for ovarian and endometrial cancer. The current approach is essentially to increase awareness of cancer detection as well as practicing healthy lifestyle which includes reducing food that has high fat content. Endometrial cancer may be prevented with timely treatment of its precancerous lesion i.e. endometrial hyperplasia and the usage of appropriate hormones in the menopausal women.

Future direction in Gynaecology Oncology services in Malaysia

Based on our current progress it can be concluded that the Gynaecological Oncology service in Malaysia is heading in the right direction. However it is essential to strengthen this service with more progressive efforts with a teamwork approach. We need to break out of a cocoon and maintain networking with foreign countries like Singapore, Thailand, and Indonesia, etc. Training programs, CME and conferences need to be upgraded and conducted consistently. The GO subcommittee from OGSM and JKPPOG (KKM) need to work hand in hand in every Gynaecological Oncology related activity so that every member of the O&G fraternity whether from Government or Private Hospitals, will stand to benefit from this cooperation. I strongly believe that we will achieve our goal to provide effective cancer prevention and treatment for the women of our nation.

Concept of regional centre

The concept of developing a regional centre for Gynaecological Oncology services in our country should be given serious consideration.

Besides providing the best gynaecological oncology service, this concept will provide a solution for overlapping financial allocation and equipment. Gynaecological Oncology services are vast and involve many disciplines and does not just centre on surgery alone as assumed by many. Preventive measures, cancer detection and treatment as well as palliative care are the core of GO services. Having a team of Gynaecological Oncology Specialists in any one centre is essential as this will maintain continuity of care and services in the event of movement of manpower. Adequate patient's volume in an established Regional Center will provide a platform for training and ultimately will become the center of excellent in Gynaecological Oncology. Perhaps, one day this established centre can be recognized as the full training center in Gynaecological Oncology and we do not have to spend more money for overseas training. The regional centre concept should be maintained and developed if we wish to stand on par with our neighbouring countries or other developed nations.

Gynaecology Oncology Subcommittee, OGSM

Gynaecology Oncology subcommittee of OGSM which has been in existence at the very beginning proved to be a good approach. The previous members of the subcommittee have carried out their responsibility with full commitment and this is evidenced by the progress made in this field to this date. The Gynaecology Oncology subcommittee of OGSM for this year will have members comprising Gynaecological Oncologists all over Malaysia. A teamwork approach will ensure continuity of planned activities. The elected Gynae Oncologists will be responsible for their individual portfolio which includes training, CME, cancer prevention, pre-invasive disease and publicity. Cooperation and communication with Gynaecological Oncology subcommittee in JKPPOG will be maintained to ensure no overlapping in activities and role between these two bodies. One of the programs

that had been conducted was the HSB-KKH Pelvic Surgery Workshop. This workshop was jointly organized with MOH, OGSM and the GO centre of KK Women's & Children's Hospital Singapore. The workshop that was held on 25th-26th August 2007 was officiated by Dato' Dr Hjh Noorimi Morad. There were 70 participants from throughout Malaysia including from Academic institutions. The second training programme in the series of Colposcopy Workshops was held in Kuala Terengganu on 26-27th October 2007. A regional concept has been adopted in running the colposcopy workshops. Each region will be represented by at least two Gynaecological Oncologists / Gynaecologists who will be responsible in organizing the workshop. We hope to produce many colposcopists in the future who will work as a team with a common mission and vision to treat precancerous conditions of the lower genital tract.

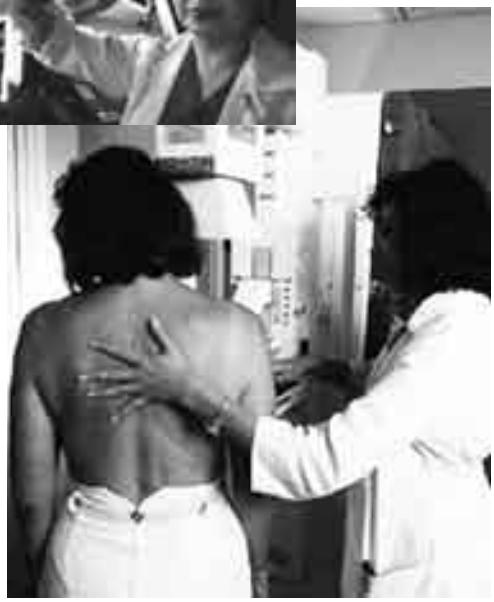
Gynae Oncology Subcommittee is committed to ensure the following activities will be implemented from end 2007 and 2008. We have identified individuals who will be responsible in organizing such activities:

1. **Gynae Oncology Update : OGSM Newsletter**
2. **National Gynaecology Oncology Symposium (Annually)**
3. **National Gynaecological Preinvasive Workshop (Annually)**
4. **Annual OGSM meeting**

The National Gynaecological Oncology Symposium was held in Alor Star in 2005 and in Kuantan, Pahang in the year 2007. This Symposium serves as a platform for gynaecological oncology specialists from Government Hospitals, Private Hospitals and the Academic Institutions throughout Malaysia to gather and interact with one another. We too have guest speakers from countries like Singapore and Thailand. The National Gynaecological Preinvasive Workshop provides knowledge on the various gynaecological preinvasive conditions which include vulva and vagina. The first workshop was held in Alor Star in 2006. We hope one day we will be able to organize Gynaecology Oncology Scientific Meeting which will involve more specialists and medical officers throughout Malaysia and perhaps from the Asian region.

Conclusion

Gynaecological Oncology will undergo tremendous progress (with God's will) if it heads in the direction that has been outlined above. However, all efforts will prove to be futile if there is no cooperation among members within this fraternity in the Government Hospital, Private Hospital and the Academic Institution. Teamwork and cooperation between OGSM, JKPPOG and MOH is essential if we expect to see progress in this challenging field. Each member of OGSM and MOH should remove all negative views and feelings and work as a team. I call upon members of this fraternity to work together and join our efforts in order to achieve our noble goal.



Calendar of Events

2nd Congress of the Asia Pacific Initiative on Reproduction (ASPIRE) & 6th Biennial Meeting of the Pacific Rim Society for Fertility & Sterility (PRSFS) 2008
11-13 April 2008,
Suntec City Convention Centre, Singapore
T : +65 8123 3249
F : +65 6234 1089
E : enquiries@aspire2008.com
http://www.aspire2008.com

KL-Selangor
OGSM Fellowship Night
25 April 2008,
Kuala Lumpur Shangri-La
T : 03-6201 3009
F : 03-6201 7009
E : ogsm@myjaring.net

10th Congress of the European Society of Contraception
30 April – 3 May 2008,
Prague, Czech Republic
T : +32 2 582 08 52
F : +32 2 582 55 15
E : congress@contraception-esc.com
http://www.contraception-esc.com

15th Congress of the FAOPS 2008
20-24 May 2008,
Nagoya, Japan
F : +81 52 842 3449
E : faops2008@med.nagoya-cu.ac.jp
http://www.faops15.umin.jp

East Coast Urogynaecology Workshop
22-23 May 2008,
Hospital Tengku Ampuan Afzan, Kuantan
T : 012-627 1079 (Dr Ayu Aszliana)
T : 013-915 8178 (S/N Noor Hazumi)

OGSM – RCOG
Live Saving Skills Course
2-5 June 2008,
Eastin Hotel, Petaling Jaya
T : 03-6201 3009
F : 03-6201 7009
E : ogsm@myjaring.net

18th Malaysian Congress of O&G
5-8 June 2008,
Genting International Convention Centre
T : 03-6201 3009
F : 03-6201 7009
E : ogsm@myjaring.net
http://www.ogsm.org.my

Sri Lanka College of Obstetricians & Gynaecologists
41st Annual Scientific Sessions
27-29 June 2008,
Hotel Galadari, Colombo, Sri Lanka
T : +9411 268 9036
F : +9411 268 9036
E : slcog@sltnet.lk
http://www.slcog.lk

Fenning Medical Education's MRCOG Part 2 Course
27-29 June 2008,
Kuala Lumpur

Fenning Medical Education's MRCOG Part 1 Course
30 June – 1 July 2008,
Kuala Lumpur
T : 012-280 6205 (Dr Helena Lim)
E : info@tealefenning.co.uk
http://www.tealefenning.co.uk

National Gynae-Oncology Seminar
Emerging Themes in Gynaecology Oncology – The Way Forward
15-17 August 2008,
University Malaya Medical Centre
T : 03-7949 2049
F : 03-7955 1741
E : ogum.secretariat@gmail.com

12th Biennial Meeting International Gynecologic Cancer Society – IGCS
25-28 October 2008, Bangkok, Thailand
T : +41 22 908 0488
F : +41 22 732 2850
E : igcs-12@kenes.com
http://www.kenes.com/igcs

XXI Asia & Oceania Congress of Obstetrics & Gynaecology
27-30 March 2009,
Auckland, New Zealand
T : +64 9 835 1532
F : +64 9 835 1539
E : aocogranzcog2009@cmsl.co.nz
http://www.aocogranzcog2009.co.nz/

XIX FIGO World Congress of Gynecology and Obstetrics
4-9 October 2009,
Cape Town, South Africa
E : marta@figo.org
http://www.figo2009.org.za

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