Obstetrical and Gynaecological Society of Malaysia

THE OGSM newsletter

November 2010

Volume 2010 / 2011 Issue 2

INSIDE THIS ISSUE:

The President's Message

Dear Colleagues,

The year draws to an end soon and with it comes the acute realisation that this Council is almost halfway through its term of office. The Council members have been busy with fulfilling the scope and direction we had set as outlined in my first presidential message. Much of what we had pledged to do has been fulfilled and delineated within the pages of this newsletter.

The analysis of the members' survey that we undertook makes for interesting reading. It is indeed heartening to note that many took time to respond and we assure all of you that the Council has taken note of what you had to say, and pledges to address as many of these issues to the best of your expectations. I am particularly delighted that you (the members) ranked 'advocacy' as the top role the Society should be championing on behalf of our fraternity. We do well, but we should be doing much more in informing, educating and advocating on Women's Sexual / Reproductive Health and Rights. Recently, I have been working closely with the Reproductive Rights Advocacy Alliance Malaysia (RRAAM), a small but passionate group of NGOs and individuals working in this area, and will be unveiling an action plan (early next year) on behalf of the Society.

Renovation of our bigger premises (as endorsed at our last AGM) is in progress. The Council feels that this undertaking, (in addition to providing members with a bigger and more comfortable meeting point) will help the Society in positioning itself to play a bigger role in the regional and international arena. The discussions with the ASEAN Societies of Obstetrics and Gynaecology on establishing regional collaboration and networking are currently well under way.

Together with the President Elect and Dr Ravichandran, I represented the Society at a meeting of 25 Asia Pacific countries in Singapore on the 18 November 2010. The meeting which was initiated by AOFOG in collaboration with the European Society of Infectious Diseases in Obstetrics and Gynaecology (ESIDOG) was called to explore the possible founding of an Asia Pacific Interest Group / Society for Infectious Diseases in Obstetrics and Gynaecology. The meeting saw the

birth of the Asia Pacific Society of Infections in Gynaecology and Obstetrics (APSIGO) and the appointment of our President Elect, Dr Krishna Kumar as the Secretary General. This no doubt is yet another 'feather in the cap' for our Society.

By the time you receive the next Newsletter (due in February 2011), we will have seen the dawn of a new decade, one that will end with the much awaited (and touted) 2020, when Malaysia will achieve developed nation status. What does the future hold for all of us and the Society? It is rightly said that the only constant in life is 'change' and change we must, if we are to evolve and fulfill the needs and aspirations of our members. The future however is bright given the wealth of talent and ideas within our fraternity.

As we prepare for Christmas and the New Year, I hope that all of you have had a successful and fulfilling year with family, career and friends. And may 2011 bring all that you dream, aspire and hope for (and more).

Dr Hj Mohamad Farouk Abdullah
President
mfarouk_a@yahoo.com

Secretary's Report

How quickly time flies, it is now almost 6 months since the new Council took over. The Council has had 5 meetings so far, and the various subcommittees and respective organising committees of the upcoming conferences have had many more. You will find some updates on their preparation to date in this newsletter. You can also find a list of upcoming conferences which promise to be excellent, notably the OGSM Obstetrics Medico-Legal Workshop to be held in November this year, the 2nd Regional Conference in Nutrition in Obstetrics & Gynaecology and the 2nd Malaysian Reproductive Medicine Congress to be held next year.

Our inaugural e-newsletter went out on 18 August 2010 and it is hoped that members have found it useful and convenient. For those who had missed out on the first edition, you can follow this link http://www.ogsm.org.my/e-newsletter.php . In future, we hope to do away with the printed copy of the newsletter, in the hope of saving printing cost and reducing carbon foot print. In keeping with our earlier promise, there will be a newsletter every quarterly, providing members with more information on the happenings within the society.

The Council has also decided to provide all members with the Journal Article Summary Service (JASS), thanks to the efforts of Dr Eeson. JASS is a monthly journal which summarises the world literature relating to obstetrics and gynaecology (O & G). Like an academic medical journal club, all the best articles of the preceding month are selected, expertly summarised and sent to you. In this way, you will have the facts to keep you clinically up to date in all matters relating to the practice of O & G. This journal will in future be sent to you electronically (i.e. via email). Please update your latest email with the OGSM Secretariat in order to access this journal.

The OGSM, as an expert body representing the O & G practitioners in this country has also been asked to provide its input on the various issues affecting our practice. Dr Tang and Dr Sevellaraja are instrumental in providing information on what we deemed reasonable O & G fee structure for the Ministry of Health's Task Force for the revision of Fee Schedule for the Private Practitioner. The

proposed fee structure is available for scrutiny in the member's section in the OGSM website. Members who have forgotten their password can contact Mr Chong at administrator@ogsm.org.my

As for the relocation of the OGSM office to a larger premise, another contractor had been asked to submit a proposal, which has been accepted. In the interest of cost saving, most movable furniture will be reused. All members are also invited to contribute to the building of the new premises, which will have a larger meeting room and also a place for members to interact. Renovations should be completed by year end.

I would like to take this opportunity to wish everyone an early Merry Christmas and A Happy New Year, and may health, wealth and happiness flow in abundance in 2011.

Dr Wong Pak Seng
Hon. Secretary
wongpakseng@hotmail.com

Treasurer's Report

During the last AGM (and in many such meetings before), the question of whether the Society should consider investing its rather sizeable fixed deposits in more diverse financial instruments, be it property or other more versatile options was raised. There are many intriguing facets to this argument and indeed, there may be no real right or wrong answer. The Council, on its part, is duty bound to undertake due diligence on the various options available including studying the potential returns and attendant risks, but more importantly, must do so without losing sight of its primary responsibility, that is to oversee the well being of the fraternity and its members.

While this broad description of the purpose of the society's existence may be interpreted in numerous ways, one cannot deny the explicit link between achieving those noble objectives and the existence of a strong financial base. That said, it is undoubtedly a difficult task identifying the middle ground between acting like a 'land-owning organisation' (to borrow the term used by a distinguished senior member in a previous AGM), which does all it takes to increase the net financial worth of the Society, and behaving like a highly charitable organisation, dishing out goodies and freebies (also commonly referred to as 'subsidies') to the membership.

A month ago, as fulfillment of the Council's obligation to the membership, we met with a group of financial planners to discuss the possibility of investing some of the society's funds in alternative financial instruments such as bonds. Suffice to say, no decision can be made without consent obtained at the AGM (or EGM), but details of that discussion will be included in the final newsletter for your perusal and perhaps earnest deliberation during the next AGM. In the meantime, we thought it was reasonable to collate opinions from the various factions on both sides of the divide and outline them below, with the sole intention to help us think more coherently and decide what, if any, the next course of action should be.

The common arguments for supporting the conversion of our fixed deposit funds into other financial instruments (including property) in order to increase the Society's financial strength are:

1. Due to inflationary pressure, the value of liquid assets will reduce with time, as it is a commonly held belief that fixed deposits appreciate at a lesser rate than inflation. Hence divesting into other options may be beneficial, as the returns generated should be greater.

2. Progressive growth in the society's financial status is paramount for the continued survival of the Society. It cannot be assumed that the society will continue to make large profits from the Annual Congresses to offset the running costs of the Society, which incidentally, continues to escalate. The relatively poor profit generated in Sabah is a good example of

how easily our finances can be adversely affected.

3. Interest rates from our fixed deposits are variable, currently best described as nominal.

4. Our commercial units in Kuala Lumpur do yield reasonable rental income and good capital appreciation. Also, our track record on this front in general has been reasonably good. The loss of a tenant can be regarded as an acceptable phenomenon.

5. Finally, from a taxation perspective, divestment into instruments like bonds may allow us substantial savings from government taxes.

The arguments for maintaining the status quo are:

1. The more profitable investment tools carry a higher risk. Hence the inherent risk of losing what little we have. Certainly there is the possibility of investing in a 'capital guaranteed' option, but again the returns would be understandably less than other 'higher risk' options.

2. Despite our interest in the many exciting options available in the financial market, we remain but amateurs at best. Expert advice is essential, and therefore fees payable. This will inevitably eat into the profits generated. Hence, the final monetary benefit may be far less than otherwise construed.

3. Unless we diversify into 'safer' albeit 'less profitable' instruments, our investment will mandate constant monitoring, with a lingering possibility that rapid action will be required should market forces dictate. As a Society, this may be a difficult undertaking, as many of these manoeuvres require an extraordinary general meeting to be convened.

4. Investing in yet another property may be less risky especially if we choose wisely. But again, in recessionary periods, this income dwindles as rentals fall and tenants move to cheaper premises as occurred to us over the past few months. The resulting stress and concern generated may make current interest rates appear a gargantuan amount.

In conclusion, while the Council is ever willing to explore options as dictated by the membership, let us reassure all optimists and pessimists, liberals and conservatives, realists and idealists, and all proverbial fence sitters, that the Society will endeavour to differ from changing the status quo until the full sentiments of the membership are known and a thorough analysis of all options illuminates the path that we should follow.

Dr Eeson Sinthamoney
Hon. Treasurer
dreeson77@hotmail.com

Update on the 21st OGSM Congress, Penang, 2 to 5 June 2011

The 21st Congress of the Obstetrical and Gynaecological Society of Malaysia (OGSM) will be held at the Equatorial Hotel in Penang from Thursday, 2 June 2011 to Sunday, 5 June 2011. This venue was picked after careful assessment and site visits to other possible options.

As announced earlier, next year's Congress is a joint meeting between OGSM and the Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland (RCPI). The Institute of Obstetricians and Gynaecologists has agreed to fund the travel expenses of three speakers from Dublin to Penang.

A wide and varied scientific programme has been arranged and there will be topics of interest to all members of the society. I have been fortunate in being able to arrange travel funding for several speakers. Independent funding allows the saving of OGSM funds and avoids the need for pharmaceutical industry funding which sometimes may compromise the choice of topic and speaker.

The keynote address will be given by Professor Sir Sabaratnam Arulkumaran, Professor of Obstetrics and Gynaecology at St George's University of London and President Elect of FIGO. He will be speaking on the 'Impact of New Technologies on the Future of Obstetrics and Gynaecology'.

The Puvan Memorial Lecture will be given by Professor Colm O' Herlily, Professor of Obstetrics and Gynaecology at University College Dublin. Professor O' Herlily has done a lot of original work on pelvic floor damage related to pregnancy and labour. His lecture will be entitled 'Anal Damage following Vaginal Delivery – Can It be Prevented?'

Another speaker from Dublin, Dr Declan Keane, a Urogynaecologist who has been Past Master at the National Maternity Hospital, Holles Street will give two lectures, 'Progress with Prolapse' and 'Female Incontinence – A Cut and Dry Solution'.

Dr Michael Robson, Master of the National Maternity Hospital, Dublin who is an expert on labour will be the third Irish speaker. Dr Robson will speak on 'Management of Labour and Evidence Based Medicine' and 'Caesarean Section Audit'.

The fourth Irish speaker is Dr Michael Gannon, Consultant and Senior Lecturer in Obstetrics & Gynaecology from Midland Regional Hospital, Mullinger. Dr Gannon is the Secretary of the Institute of Obstetricians and Gynaecologists, RCPI and has special interest in endoscopic surgery. His topics will include 'No-touch Hysteroscopy' and 'Laparoscopic Hysterectomy – What are the Limits?'

The Royal College of Surgeons of Ireland has agreed to fund the travel expenses of Professor Sam Coulter-Smith, Clinical Professor of Obstetrics & Gynaecology, and Master of Rotunda Hospital, Dublin. Professor Coulter-Smith runs a special clinic dealing with patients with viral infections and patients at risk of viral infections in pregnancy. He will be speaking on his experience in this area.

The European Society of Infections in Obstetrics and Gynaecology will be collaborating on a symposium and funding the travel expenses of French gynaecologist Professor Philippe Judlin. He is the Chairman, Department of Gynaecology, Obstetrics

& Reproduction, Maternite Regionale Universitaire de Nancy, France. Professor Judlin has been involved in the development of new topical vaginal prebiotics, monitoring trials as well as being involved in the preparation of European clinical guidelines in the treatment of pelvic infection. He has two recent publications in this area in Current Opinion in Infectious Diseases and in the British Journal of Obstetrics and Gynaecology. Professor Judlin will be speaking on prebiotics and probiotics in vaginal infection as well as pelvic inflammatory disease.

Professor Roger Pepperall, Emeritus Professor of Melbourne University and currently Professor of Obstetrics & Gynaecology at Penang Medical College will speak on 'The Metabolic Syndrome: Implications for the Obstetrician and Gynaecologist'.

Dr Harith Lamki, who previously held the posts of Consultant at Royal Maternity Hospital, Belfast, Sims Black Professor and Postgraduate Director of the Royal College of Obstetricians and Gynaecologist, will also be participating. Dr Harith has wide experience in postgraduate training and examinations, and currently advises the Government of Oman in this area.

Other overseas speakers include Professor Pratap Kumar, an infertility specialist from India. Professor Pratap Kumar will review current techniques of ovarian stimulation and hyperstimulation, and also speak on current concepts in the treatment of ovarian hyperstimulation syndrome.

Associate Professor Jeffrey Loh from Singapore will lead a session with interactive key pads based on actual patients and cases entitled 'Gynaecological Oncology for the Non Gynaecological Oncologist'.

As usual, a number of local speakers will also be making presentations. Pre-congress events will take place on Thursday, 2 June 2011. There will be morning 'Meet the Experts' sessions on Saturday, 4 June 2011 and Sunday, 5 June 2011.

On the social front, organised events include an optional food tour by food writer and newspaper columnist Ms Helen Ong for members and accompanying persons on Friday, 3 June 2011. A local travel agent has also arranged an optional 'Heritage Tour' and 'Round the Island and Tropical Fruit Farm Tour' for accompanying persons on Friday, 3 June 2011 and Saturday, 4 June 2011 respectively.

A Welcome Reception will be held in the evening of Thursday, 2 June 2011. In keeping with our collaboration with colleagues from the Institute of Obstetricians and Gynaecologists from Dublin, the Banquet on Saturday, 4 June 2011 will have an Irish Theme.

I am sure you will find the scientific programme interesting and informative. It will be a great opportunity to socialise and meet with colleagues and friends from our fraternity. Mark your calendar, and welcome to Penang for the 21st Congress of OGSM 2011!

Dr Suresh Kumarasamy
Hon. Assistant Secretary
Scientific Chairman and Local Organising Chairman, 21st OGSM Congress 2011
sureshgynae@yahoo.com

Revision of Professional Fee Schedule for Private Practitioners

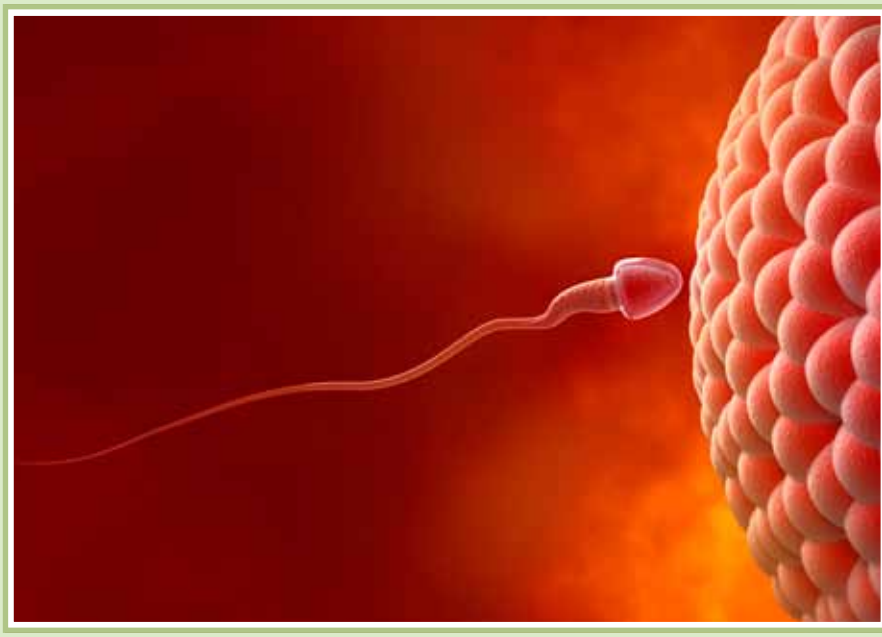
All esteemed members of the O&G Speciality,

As you may know, the Ministry of Health (MOH) has formed a task force to make changes to the present Private Medical Fee Schedule under the 13th Schedule as outlined in the Private Healthcare Facilities & Services Regulations 2006. The Malaysian Medical Association (MMA) and the Academy of Medicine of Malaysia (College of O&G is part of this) are part of this Task Force.

The MOH task force (OGSM is NOT represented as specialist societies are not invited to be part of the task force) has decided that the fees under the 13th Schedule will be meanwhile increased across the board by 30% as making a New Schedule will take too long.

On top of that, the 'missing' procedures that are not in the present Schedule will be added onto the present list. Minor changes to the present Schedule that reduce ambiguity are also allowed. With these additions, MOH hopes that the Fee Schedule will be as complete as possible. This is to REDUCE the problem of UNBUNDLING the PRESENT 13th Schedule, and the LAYERING of charges commonly practised by some doctors. These procedures' commonly accepted fees will also be increased by 30%.

The MOH Task Force has requested that we do not make huge increases to the fees charged. All present charges will be increased by 30% anyway (if approved). Dato' Dr Sivamohan, representing the Academy, has asked me to put together those ADDITIONAL items and changes, with their reasonable figure. These numbers have to



be fitted into the 5X5 look up table that was originally in the MMA FEE 4th Schedule. The proposed fee structure is available for scrutiny in the member's section in the OGSM website. Members who have forgotten their password can contact Mr Chong at administrator@ogsm.org.my

OGSM has been working on formulating a NEW Schedule based on the American CPT for sometime now. With this change in direction, we have put together a list of procedures that are not on the present Schedule, together with the suggested changes to the present Schedule. We have had feedback from some of our doctors and all those have been put into the new Schedule wherever possible. We have also taken into account the matter of unilateral vs bilateral procedures; laparoscopy vs open procedures, and suggested to separate the BSO from hysterectomy.

Please look through the list I have put together with Dr Selva; bear in mind though that this is still subject to the APPROVAL of the MOH Task Force. We are to use the 13th Schedule until all changes are approved.

The purpose of this is to keep our members informed. A lot of effort has been put into this PROPOSED NEW SCHEDULE for O&G; it will not satisfy everyone but if approved, we believe it will be a vast improvement to the present Schedule.

VERY IMPORTANT:

Please also NOTE that in the 13th Schedule, all VAGINAL deliveries were omitted; i.e. the value that we commonly use (SVD with episiotomy and 1st and 2nd degree tear = RM800) is from the MMA 4th Schedule and not the 13th Schedule which is LAW.

With that in mind and after taking into consideration what our members have been saying and the escalating cost of medico-legal expenses, I have taken the liberty to INCREASE the fees attached to all vaginal deliveries. I will need your consensus on that matter as it is of UTMOST importance. If it is to go ahead, OGSM will need your support.

Thank you, and I do hope that this new suggested Private Fee Schedule for O&G will be acceptable to the MOH Task Force. I am sure we will hear from the MOH if there is any news on this matter and we will certainly keep our members informed.

Dr Tang Boon Nee
Fee Schedule Representative, OGSM
tangboonnee@gmail.com

Dr S. Sevellaraja
Fee Schedule Representative, OGSM
drsselva@gmail.com

What we think of ourselves - An analysis of the members' survey

We recently undertook a survey of all members - a first endeavour of its kind ever, the primary intention of which was to garner feedback from our membership on a wide and varied range of issues of common interest, and with the secondary intention of eliciting opinions on possible future directions the society may take.

Questionnaires were sent out to all members, totalling 903 individuals. There were 125 respondents, therefore resulting in a response rate of 13.8 %. Although low, this figure is consistent with 2 previous surveys carried out over the past 18 months, the first of which was directed at all doctors in Selangor who were members of the Malaysian Medical Association and the other, targeted at all OGSM members.

Question 1: Designation

78.1% of the total respondents were consultants. More private consultants responded compared to their public service counterparts (50% versus 28% of total). Medical officers (service and trainee) only accounted for 8.8% of responses.

Question 2: Do you think OGSM has fulfilled its role thus far?

In was heartening to note that 86.8% of respondents felt that OGSM had (to varying extents) fulfilled its role thus far. The majority (56.2%) felt that while that was the case, there was much more that the society could achieve while a further 20.7% felt that we had only fulfilled half of our true potential. Thankfully, only 13.2% thought we hadn't fulfilled our role as a society while a single respondent declared that thus far we (OGSM) had little or no consequence on the well being of the fraternity.

Question 3: In what role do you think OGSM has faired best in the past years?

Quite expectedly, the majority of respondents (86.3%) agreed that OGSM had faired best in the two avenues that we seem to excel in, namely organising annual scientific meetings and AGM's (52.4%), and running courses / CME activities (33.9%). Interestingly, only few thought we faired well on other fronts (advocacy: 3.2%, CSR: 1.6% and social programmes: 6.5%). Certainly, none (0%) thought research coordination was our forte!

Question 4: What do you think should be the role OGSM plays on behalf of the fraternity?

Respondents were asked to prioritise the role the Society should play by ranking a list of 8 possible avenues. The largest single group of respondents (26.6%) ranked 'advocacy' as their most important priority (ranked 7 or 8), followed by 24.3% who rated 'running courses / CME activities' as their most important priority. This was followed by 'organising annual scientific meetings and AGM's by 17.1%.

More interestingly, with regards to the least important role (ranked 1 or 2) OGSM should play, 26.4% believed that Social programmes were of little importance while 19.8% felt subspecialty development should also be a low priority.

Question 5: Have you ever served as a Council member of OGSM or on any of the committees / subcommittees?

76.6% of the respondents had never served as a Council member or of any committee / subcommittee within the Society.

Question 6: If you have never served as a Council member of OGSM or on any committee / subcommittee, what would be the main reason for it?

32.6% responded 'don't know if there's anything I can offer', while 29.3% sited 'no time' as their reason, and 25% said that they had 'never been offered the opportunity'.

Question 7: Would you be interested to serve in any committee / subcommittee if you are invited and if it involves an area of your interest?
70.3% would be interested to serve in committees or sub-committees if invited and it involved an area of their interest.

Question 8: The OGSM has a sizeable amount of funds accumulated (with difficulty) over the years. How best do you think these funds should be utilised?
The two most common options selected were to subsidise registration fees for members attending courses / congresses (29.1%) and subsidise running of courses (30.7%). Interestingly, only 12.6% selected 'diversifying into other financial instruments' while only 8.8% selected 'purchase of another property'.

Conclusions and recommendations

1. It has long been perceived that the younger members of the Society were not adequately engaged and the survey confirms this. Council should take more proactive measures to elicit their opinions, identify their needs and facilitate constructing robust solutions to their problems. They are after all, future leaders of this esteemed organisation. Perhaps, our planned 'trainee's conference' would be a step in the right direction.

2. Members agree that the society is heading in the right direction but perhaps we sometimes need to remind ourselves that priorities do change with time. Surveys such as these may certainly help recalibrate our bearings.

3. While it is hardly surprising that most members felt we had done well in organising annual scientific meetings and other CME related activities, it is worthy to note that 'advocacy' was ranked highest in the list of possible roles the society could play, followed by CME related activities. Again, this information should help dictate future directions the Society may venture into.

4. While the majority of respondents had never served in the Council or any sub-committee before, it is heartening to note that the majority would be interested to do so. This is adequate justification for the Council to initiate more 'working groups' that may be given specific mandates and to recruit these interested members to serve in these groups. Thereby, the efficacy of the society as a whole may be more optimally exploited.

5. It is well known that the Society is in a financially advantageous position. Although there is ongoing debate on how best to preserve this wealth (refer to the Treasurer's Report), or indeed if there is actually a need to do so at all, it is perhaps a little amusing that the vast majority of respondents have been influenced by our local 'subsidy culture'. It would be worth noting that almost all courses organised by the society are run at cost, with the primary concern always being to avoid financial loss rather the generating profit. The Annual Congress is somewhat different as its primary (financial) aim is to generate profit as this is the main source of income that finances the annual running costs of the Society.

The Council thanks all members who participated in the survey for their time and effort and Ms. Jenny for tabulating the results. Council remains committed to enhancing communication, collating opinions and ideas and optimising participation with the greater vision of moving the fraternity to new frontiers.

Dr Eeson Sinthamoney
On behalf of the OGSM Council 2010/2011

GUIDELINES FOR REQUESTING OGSM NOMINATION(S) TO ATTEND CONFERENCES / SCIENTIFIC MEETINGS

Preamble

Doctors (within the public and private sector) often attend local and overseas conferences/scientific meetings under partial or full pharmaceutical industry sponsorship. This practice has in most cases not resulted in any untoward outcome but conceivably may expose them to accusations of reciprocal preferential prescribing patterns/purchases.

The Society has time and again been requested to identify a possible mechanism that would facilitate members obtaining financial support (from pharmaceutical companies) in a sufficiently transparent manner which would safeguard the moral, ethical (and possibly legal) concerns of all parties.

The current problem

1. The difficulties faced by doctors (especially in public service) in obtaining such sponsorship are real and the possible risks of subsequent wrongful accusations are often underestimated.

2. OGSM is seen as not doing enough to facilitate this process of legitimising sponsorship for members.

3. Currently, no documentation of the initial and/or subsequent communication between doctors and potential pharmaceutical sponsors is made available to the Society. Hence, should the Society issue letters of support, it risks being accused of favouritism.

The proposed mechanism

1. Doctors who have been approached by potential industry sponsors or (alternatively) industry sponsors keen to sponsor doctors' attendance at conferences/scientific meetings and would like the Society to facilitate this process will be invited to inform the Society in writing.

2. The Society at its discretion will communicate (directly) with the potential sponsor to verify/clarify any additional details required. This would include number of sponsorships available and 'non rigid" eligibility criteria if any.

3. A notice will be placed on the Society's website for no less than 14 days informing all members on the availability of this opportunity for sponsorship together with any sponsor stipulated criteria. The Society however reserves the right to refuse the participation of any sponsor if the stipulated criteria are deemed unreasonable or not in keeping with the general philosophy of the Society.

4. All members in benefit who fulfill the stipulated criteria will be eligible to apply for the sponsorship.

5. The OGSM Council will select successful applicants based on a number of criteria including (but not limited to) fulfillment of stipulated requirements, status of attendance (presenter versus normal delegate) and the number of previous sponsorships received. It is hoped that this will ensure fair and just distribution of opportunities to all members. Full stipulated criteria together with the names of successful applicants will be made available on the website.

6. All funds (from the sponsors) will be required to be disbursed to the Society (OGSM). All initial expenditures are to be paid for by the said doctor(s) and subsequently reimbursed by OGSM upon submission of receipts. Unutilised funds (if any) will be returned to the sponsors within two months of the event without any interest. As this is primarily a service to members of OGSM (only), no fee will be charged by/to all parties.

Conclusion

It is envisioned that this initiative will be of benefit to a large number of our members who are keen to attend important scientific meetings (particularly as a presenter) but are concerned about sponsorships from the pharmaceutical industry. The Council believes that the above proposal is sufficiently robust to ensure transparency and maintain our fraternity's credibility.

Dr Hj Mohamad Farouk Abdullah
President
mfarouk_a@yahoo.com

1. Laparoscopic Surgery Workshop for Endometriosis

A workshop was organised at the Mahkota Medical Centre on the 16 and 17 July 2010. The demonstrators were Prof Arnauld Wattiez from France and Dr S. Sevellaraja. A total of 71 gynaecologist and medical officers from around the country participated in the workshop. The aim of the workshop was to demonstrate how laparoscopic surgery should be performed for endometriosis.

A total of 6 cases were performed during the workshop. Three of them were from Hospital Melaka and another 3 were Dr Sevellaraja's cases. Mahkota Medical Centre waived all their fees for the patients undergoing surgery during the workshop. They also sponsored the meals and the venue for the workshop.

On the first day (16 July 2010) after the introduction of the Chief Executive Officer of Mahkota Medical Centre, Mr Timothy Chang, and Prof Wattiez to the participants, live demonstration commenced at 9 am. There was live transmission of the surgeries with 2-way communication from the operating theatre to the function room.

The first case was a 21-year-old single girl with bilateral kissing endometriomas. The aim of this surgical demonstration was to show how to perform laparoscopic surgery in single women without the use of a uterine manipulator and how to perform cystectomy with minimal damage to the ovaries. Prof Wattiez demonstrated the manner in which the uterus and the ovaries could be suspended using prolene sutures for optimal surgery. After the surgery, he gave a lecture on 'How to deal with pain in endometriosis surgically'.

The second case was a case of recurrent endometrioma with a large rectovaginal nodule. In this case, besides cystectomy the vaginal nodule was excised by entering the vagina. It also involved complete dissection of the right ureter before the vaginal nodule was excised.

The third case was a total laparoscopic hysterectomy done on a patient with adenomyosis. Dr Sevellaraja demonstrated the various ways of sealing the uterine arteries before the surgery. He also demonstrated different ways of dissecting out the ureters before the hysterectomy.

Laparoscopic Surgery Workshop for Endometriosis, 16-17 July 2010

That evening a course dinner was arranged at the Sea Farer's restaurant and about 50 participants attended the dinner.

The next day (17 July 2010) live surgery commenced at 8.30 a.m. The first case was a recurrent endometrioma. This lady had dense adhesion of the intestine to the uterus. She also had a large rectovaginal nodule and a large right endometrioma. Laparoscopic adhesiolysis was performed and the intestine was separated from the uterus. Laparoscopic excision of the nodule and right salpingoopherectomy was performed.

The next case was a case of bilateral endometrioma. Laparoscopic adhesiolysis and cystectomy were performed. Prof Wattiez left for the airport after the surgery.

The last case was a case of CIN3 for which Dr Sevellaraja and Dr Vijaendreh demonstrated a total laparoscopic hysterectomy.

All the participants enjoyed the skilful way by which Prof Wattiez handled endometriosis. Many participants also complimented the hospitality, food and facilities provided by Mahkota Medical Centre.

Dr S. Sevellaraja
Chairman, Endoscopic Subcommittee
drsselva@gmail.com

2. Outpatient Gynaecology Symposia

The Office Gynaecology Subcommittee had recently organised two symposia. An Outpatient Gynaecology Practice Symposium for Nurses was conducted at the Marriott Hotel, Miri, Sarawak on 17 July 2010. There were more than 180 participants and 15% of them were doctors (Medical officers, O&G specialists and GPs).

On 2 and 3 October 2010, an Outpatient Gynaecology Practice Symposium for Doctors was conducted at the Saujana Hotel Kuala Lumpur. There were about 150 participants comprising medical officers, specialists and GPs from different states. Sixteen lectures were delivered by 11 speakers including 3 foreign speakers.

Prof Jamiyah Hassan
Chairman, Office Gynaecology Subcommittee
jamiyah@ummc.edu.my

Outpatient Gynaecology Symposium, 2 and 3 October 2010

Faculty Dinner, 2 October 2010

3. OGSM FERTILITY AWARENESS, COUNSELING AND SCREENING PROGRAMME

Following the successful 1st Fertility Awareness, Counseling and Screening Programme (for the public) organised by the Society at the Boulevard Hotel, Kuala Lumpur on the 5 December 2009, the second in the series was held recently at the Mutiara Hotel, Johor Bahru on the 31 October 2010. The event was once again supported by Merck Serono.

The main objective was to increase public awareness regarding sub-fertility and treatment options available in this country as well as to provide an opportunity for face to face counseling and the initiation of basic screening investigations.

There were three main sessions. A series of 4 talks (Infertility: When It takes Too Long, Ovulation Induction: Getting Started, IUI: The Next step and ART: When Nature Needs A Hand) was presented by Dr Hj. Mohamad Farouk Abdullah, Dr Magendra Ramalingam and Dr Mansor Md Noor. Admission was free.

This was followed by the counseling and screening session, conducted by Sr. Inthrani and a team of 8 nurses from the Department of Obstetrics and

Gynaecology, Hospital Tengku Ampuan Rahimah, Klang. The team of Consultants was also available for further consultation during this session. Following the screening, couples received free/discounted vouchers for hormonal profiles, semen analysis and HSG.

A poster exhibition on Fertility and Fertility Myths (courtesy of our President, Dr Hj. Mohamad Farouk Abdullah) was a great hit, drawing many varied and lively queries and discussions. The event which concluded with a Q&A session (with the panel of speakers) was attended by 35 couples.

It is expected that the couples will take about 1 to 2 months to complete their screening investigations, and a follow-up 'meet the expert session' is planned to be held in Johor Bahru in January 2011 during which time, explanation of investigation results and appropriate treatment will be discussed.

Dr Magendra Ramalingam
OGSM Council Member 2010/2011
magendra@moh.gov.my

Review Article: Targeted therapies for gynaecological cancers

Introduction

The design of anticancer therapy is increasingly targeted at the molecular level of cancer cells and its environment. The rationale behind this is to improve clinical response while reducing the side effects associated with conventional cytotoxic chemotherapy. To understand the major biological therapies that are in clinical trials and are being developed, it is useful to appreciate the pathways that are targeted.

No doubt, for a clinician to grasp the ever increasing complexity of what happens at a molecular level is a daunting thought. This is not through the lack of trying or complacency. This is because the techniques / molecular methods used to study these pathways, the bioinformatics to interpret the information obtained and the complex relationship between molecular and clinical outcomes are evolving in an exponential manner. The clinician is faced with an ever increasing demand on him/her to be an expert in his/her area of specialty. Terms like 'from the bench to the bedside' and 'translational medicine' are increasingly used. In practice, by the time information from the 'bench' (a term used for scientific research) gets 'translated' (knowledge of science being incorporated into clinical practice) to the 'bedside' (patients), scientific discoveries at the 'bench' would have already evolved. To compound matters, the many different groups of scientists working on different aspects of cancer biology do not 'cross-talk' among themselves. While scientists debate about the molecular events, the buck stops with the clinician/specialist who ultimately has to offer the best possible care to his/her patient.

While there are many targets for biological therapies, this brief article will focus on angiogenesis and PI3K-AKT pathways. The reasons for this are two-fold: 1. Angiogenesis and PI3-AKT pathways are the most commonly targeted for gynaecological cancers and 2. They are good examples of how 'bench to the bedside' is not so straightforward.

‘New growth needs new vessels’ - angiogenesis in cancer and therapeutic targets

Angiogenesis plays an important role not just in physiological processes such as wound healing, ovulation, menstruation and embryogenesis but also in the pathological growth and progression of cancer. It is a complex multi-step process where new vessels develop from pre-existing ones. The understanding of the fundamental role of angiogenesis in cancer growth and metastasis has led to tremendous interest in research in its regulatory mechanisms and clinical implications in the management of cancer patients. Some of the signals that can trigger angiogenesis include hypoxia, change in pH, metabolic stress, and cytokines from inflammatory response which can all be modulated by certain oncogenes such as Src and Ras and hormones such as androgen, progestogens and oestrogen.

There are more than 40 known endogenous inducers and inhibitors of angiogenesis to date, VEGF (vascular endothelial growth factor) being the most well characterized one. Others include TGF, PD- EGF, TNF, EGF, PGF, NO, Cyclooxygenase and various tissue factors. These are secreted by different immune cells (macrophages, lymphocytes), fibroblasts, endothelial and also cancer cells itself. It comes as no surprise the development of molecules/drugs that target angiogenesis are so active (Figure 1).

The best characterized antiangiogenic agents is Bevacizumab (Avastin). Others include Imatinib (Glivec), Aflibercept, Sunitinib (Sutent), Sorafenib (Nexarvar) and Cediranib (Recentin). Phase II and III clinical trials are proving that the simple blockade of one pathway does not lead to the desired clinical response (Yap et al 2009) and this is possibly due to the fact that compensatory mechanisms are up-regulated. Therefore, for gynaecological cancers, while there is an air of optimism in the role of biological therapies, in practice, this has not been realized.

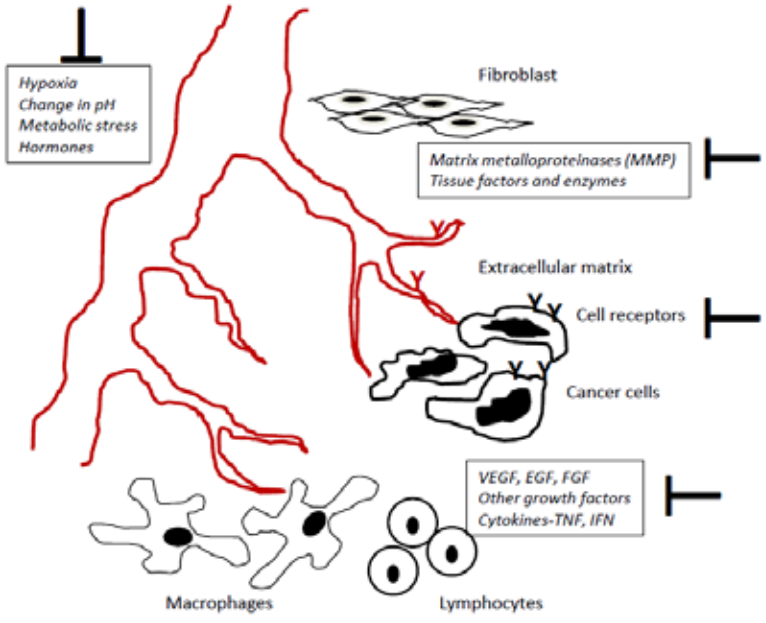


Figure 1. Angiogenesis and potential target sites

‘The life and death of cancer cells’- cell proliferation and apoptosis targeted therapy

At the risk of severely oversimplifying matters, an attempt would be made to discuss therapies that aim to inhibit cancer cell proliferation or encourage cell death (apoptosis). There are many key signaling pathways (JAK-STAT, RAS, NFKB, WnT) within a cell that will determine its fate. One such pathway is the PI3K (phosphatidylinositol-3-kinase)/AKT/mTOR signaling pathway that regulates metabolism, cell proliferation and apoptosis. This pathway is an attractive therapeutic target in cancer because it serves as a convergence point for many growth stimuli, and through its downstream substrates, controls cellular processes that contribute to the initiation and maintenance of cancer. It is so critical that a disruption in this tightly regulated pathway is not just implicated in human cancers but also in diabetes and autoimmune diseases. Examples of mTOR inhibitors are everolimus (RAD0001), tensorolimus and ridaforolimus. These drugs are already entering Phase II and III clinical trial for ovarian and endometrial cancer. For example, at the 13th IGCS meeting, the Phase II trials using single agent Ridaforolimus versus progestogen for the management of recurrent endometrial cancer was reported. This showed a modest benefit in terms of progression free survival. Phase III trials are awaited.

Interpreting data

‘Blocking an over-expressed cancer protein does not necessarily lead to improved clinical outcomes’

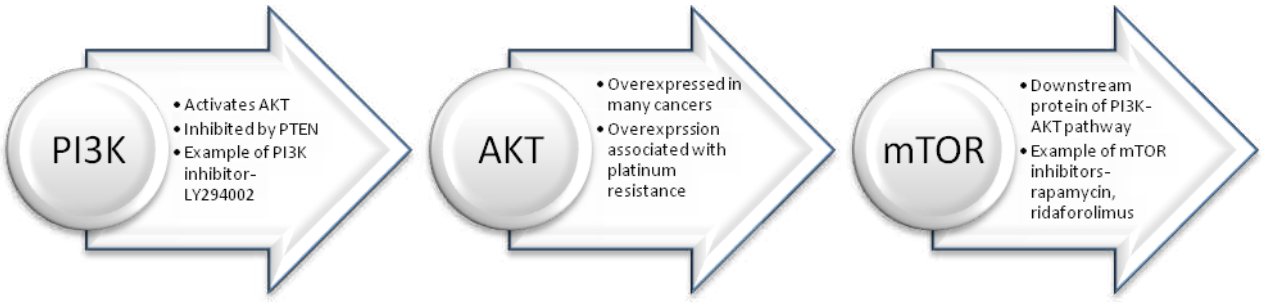


Figure 2. The PI3K/Akt/mTOR pathway that regulates tumorigenesis, including cellular proliferation, growth, survival and mobility.

There are cautionary tales with respect to targeted therapies. Blocking an overexpressed marker, does not necessarily translate to clinical response. For example, platelet derived growth factor and its receptor (PD-GFR and PDGFR) were found to be overexpressed in ovarian cancer. However, the use of Imatinib (which targets PDGFR and kit) was not only ineffective but resulted in negative outcomes in Phase II clinical trials where patients developed severe side effects (Posadas et al, 2007).

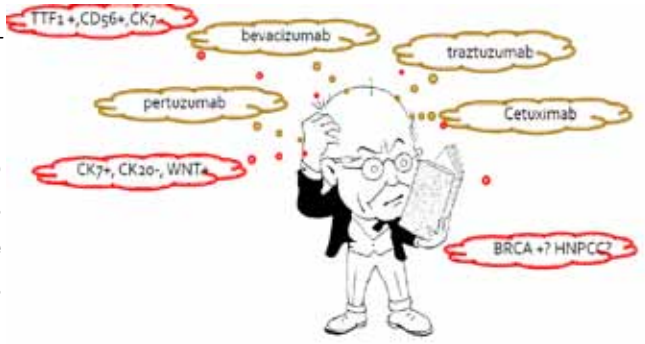
'Relative risks, hazard ratios, statistical significance DO NOT necessarily translate to better clinical outcomes'

As clinicians, it is our responsibility to translate scientific jargon to a language in which patients understand. Speaking in percentages and quoting statistics is often unhelpful. One such example is the addition of bevacizumab to carboplatin and paclitaxel. It was reported (13th biennial IGCS meeting) that women who received bevacizumab plus carboplatin and paclitaxel had a '15% lower risk of progression', 'a hazard ratio of 0.81 (p=0.0041), favouring the bevacizumab group'. What did this all mean in real terms? It translated to: women who were on carboplatin and paclitaxel had median progression free survival (PFS) of 17.3 months while the median PFS for those with the addition of bevacizumab was 19.0 months. While it is not up to the clinician to put a 'value' on the addition of 1.7 months of PFS, the clinician must also inform the patient of the side effects and not to mention the additional costs of more than RM500 000 per annum.

Conclusion

"Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing" Voltaire (*French philosopher)*

In the years to come, many more small-molecule inhibitors and monoclonal antibodies that target crucial cancer characteristics, including angiogenesis, survival, cell growth and metastases will enter into clinical trials. It is anticipated that these drugs will be used to target the horizontal and vertical signaling pathways to overcome compensatory mechanisms. The already complex pathways will no doubt get more complicated with the list of alternatives getting longer. While we may not understand the 'science' behind the therapies, as clinicians, we have to responsibly decipher the rationale, risk-benefit, cost-effectiveness and offer the best possible care to each individual patient.



References:

Timothy A. Yap, Craig P. Carden & Stan B. Kaye. Beyond chemotherapy: targeted therapies in ovarian cancer Nature Reviews Cancer 9, 167-181 (2009)

Posadas, E. M. et al. A prospective analysis ofimatinib-induced c-KIT modulation in ovarian cancer: a phase II clinical study with proteomic profiling. Cancer110, 309–317 (2007)

Prof Woo Yin Ling
University Malaya Medical Centre
yinling_woo@yahoo.com

IRCAD - A CENTRE OF EXCELLENCE FOR TRAINING IN MINIMALLY INVASIVE SURGERY

IRCAD (Institute of Research against Digestive Cancer) was started 16 years ago by Prof Jacques Marescaux, a general surgeon. It is located in Strasbourg on the eastern part of France bordering Germany. Within IRCAD is the European Institute of Telesurgery (EITS) which trains 3500 surgeons of more than a hundred different nationalities yearly. Today in 2010, more than 120,000 surgeons are active members of WebSurg, the virtual university on the internet where professionals can access numerous surgical videos for free. Prof Marescaux has brought in the best surgeons in Europe to head the various departments; the head of gynaecological training is Prof Anauld Wattiez, whom I had recently invited to demonstrate laparoscopic surgery for endometriosis in Melaka.

I also had the opportunity of attending 2 workshops in IRCAD and would like to share my experience with all OGSM members.

Current techniques in the treatment of severe endometriosis, 6 – 8 September 2010

The 3 - day workshop consisted of lectures, live demonstrations and animal workshops. The highlight was the 4 different types of live surgeries demonstrated. Prof Konickx from Belgium demonstrated laser ablation and excision of endometrioma. Prof Wattiez demonstrated ureteric dissection, excision and reanastomosis, and sigmoid resection and reanastomosis on a case of severe endometriosis, partial cystectomy and repair on a case of bladder endometriosis, and finally a case of excision of rectovaginal endometriosis.

The animal workshop was on live mini pigs where different aspects of surgery could be practiced. A live animal was given to every two participants with 1 preceptor to each station. There were altogether 16 stations, where we performed bladder incision and repair, ureteric reimplantation, pelvic lymphadenectomy and bowel excision and reanastomosis.

There were 20 experts from Europe and USA who gave lectures during the workshop. I had the privilege of talking to many of them to understand the current thinking on endometriosis treatment and surgery.

New insights in prolapse surgery: Vaginal and laparoscopy, 25 – 27 October 2010

Surgery for Pelvic Organ Prolapse is an area that I am most confused about and I attended this 3 - day workshop to understand which is the best surgery for POP. I came back realising that there is no perfect surgery, and that the choice is up to the individual surgeon. In this workshop, Prof Wattiez tried to give a balanced view of the different options available. There are 4 types of surgeries available. The first is vaginal surgery without meshes (only sutures), the second, vaginal surgery with meshes, the third, laparoscopic surgery with meshes, and the last, laparoscopic surgery without meshes.

This workshop consisted of lectures, live surgery demonstration, practicing suturing on pelvic trainers and animal workshop. The live surgeries were conducted by:

1) Prof Wattiez, (performed the first laparoscopic sacrocolpoplexy in the world in 1991) who demonstrated a laparoscopic subtotal hysterectomy and placement of meshes to the puborectalis and vagina, and to the sacrum.

2) Prof Cosson (the inventor of Prolift) who performed an anterior Prolift on a vault prolapse with cystocoele.

3) Prof Wattiez who demonstrated 2 cases of laparoscopic sacrocolpoplexy without removal of the uterus; it was done brilliantly.

You can get all details of the workshops and courses from WebSurg (www.websurg.com and http://www.eits.fr/courses/advanced/gynecological.php? PHPSESSID=c70a0c215b011ad31033d433a5ee715f). Each course fee is about Euro 1686 (for 2011). For more information on traveling to Strasbourg, you can contact me directly.

On the whole, I thoroughly enjoyed the workshops. One not only gets to observe brilliant live surgeries in high definition, but is also able to meet and discuss with experts from many parts of the world. It is my dream someday to have a centre of excellence of a similar nature in Malaysia where we can teach, train and promote minimally invasive surgery to surgeons in this region.

Dr S. Sevellaraja
drsselva@gmail.com

Institute of Research against Digestive Cancer (IRCAD), Strasbourg

Nobel Prize in the field of reproductive medicine - finally

After a long delay of some thirty years and many nominations later, Professor Robert G. Edwards has been awarded the Nobel Prize in Physiology or Medicine 2010 which will be presented to him on 10 December 2010.

The Nobel Committee recognised Professor Edwards's role in the development of human in-vitro fertilization (IVF) as a medical advancement in the treatment of many types of infertility. The Committee also pointed out two other areas in which Professor Edwards played an important role, i.e. laying down the foundations for the concept of genetic diagnosis before embryo transfer and the eventual development of the field of embryonic stem (ES) cells.

Having had foundations of extracorporeal fertilization laid down by his predecessors and peers, Professor Edwards set upon the monumental task of creating the first 'test tube baby' when the many intricate details of the IVF process was still basically unknown at that time. Not only was his work controversial and drew a lot of criticisms from ethicists, religious leaders, politicians and fellow scientists, there were so many steps to resolve.

His perseverance and dedication to his work was remarkable. Professor Edwards had to prepare sperm for fertilization in vitro. He recognised that the seminal plasma was not supportive of fertilization and that the sperm had to first undergo a process called capacitation before it could penetrate the egg. One of his Ph.D. students, Barry Bavister developed a buffer system for fertilization of hamster eggs. Using the same buffer system, Professor Edwards was able to demonstrate that they were able to fertilize human eggs in vitro and obtain early embryos. This was published in Nature in 1969.

He also needed to obtain mature eggs from a woman just before ovulation. Browsing through the library, he came across a paper in the Lancet written by Mr Patrick Steptoe, a pioneering gynaecologist in the field of laparoscopy. He soon communicated with Mr Steptoe who explained that with his laparoscope, he was able to visualise the ovaries and that he could aspirate large follicles to collect their eggs and allow patients to go home in minimal time. This was the start of one of the most famous collaborations between a scientist and physician ever and like they say, the rest was history.

Infertile couples were invited to participate in this pioneering treatment. Mr Steptoe ran an infertility clinic in Oldham District General Hospital where he was based. Prof Edwards' collaboration with him would mean a decade of commuting to and fro, from Cambridge to Oldham and back, a distance of over 200 miles. The first pregnancy was in 1976, which unfortunately ended as an ectopic pregnancy. By now, the concept of extracorporeal fertilization in humans had stirred interests all over the world. Wood and Leeton in Australia actually reported the first biochemical pregnancy in 1975. Professor Edwards and Mr Steptoe remained focused and it took them over 100 couples before the first sustained pregnancy was obtained in 1977. One notable member of their team was a nurse called Jean Purdy who learned to prepare culture media, control laboratory discipline and assisted Mr Steptoe during laparoscopy. She instigated a crucial change in their work, a shift from basic research in IVF to a meticulous clinical embryology discipline with a foundation in quality control.

The world's first IVF baby, Louise Brown was born in Oldham District General Hospital, near Manchester on 25 July 1976. In announcing the birth of the most famous baby in the world today, Professor Edwards and Mr Steptoe published a short letter in the Lancet, a remarkably simple, historical and understated document. Two very important things stood out in the announcement. The first was that the transferred embryo was an 8 –cell embryo obtained from an egg collected from a natural cycle. This was a departure from the previous attempts where blastocysts were

transferred, as it was thought at that time that the uterus could not accept embryos transferred at an earlier stage. We now know that this is only true in animal models. The second was the fact that Louise Brown's mother had diseased Fallopian tubes, which were both removed prior to commencement of treatment. This proved beyond doubt that the pregnancy was indeed from IVF and an embryo replacement.

By 1980, a new discipline was emerging, a field we now refer to as ART, assisted reproductive technology. He and Mr Steptoe opened the world's first IVF clinic near Cambridge in an old land-house called Bourn Hall. Bourn Hall Clinic flourished and a number of new ART developments were introduced there such as applying IVF in men with infertility and blastocyst freezing.

Professor Edwards founded the European Society for Human Reproduction and Embryology (ESHRE) and became its first Chairman. He also introduced a tradition of alternating a scientist and a medical doctor for the leadership. In 1991, he retired from the Professorship at the Department of Physiology, Development and Neurosciences at Cambridge University at the age of 66.

Despite his age, he continued to contribute to the field of ART by giving lectures in international conferences until lately. He is the founder and Editor Emeritus of a new journal called the Reproductive Biomedicine Online.

It is beyond doubt that the Nobel Prize presented to him is the highest recognition of his efforts to alleviate infertility in mankind. It was a monumental achievement by any standards. Professor Edwards, with his undefeated courage and optimism will always be remembered as the founder of human IVF. Congratulations Professor Edwards!

Dr Wong Pak Seng
Hon. Secretary
wongpakseng@hotmail.com

JUST FOR LAUGHS...

Doctor, Lawyer and a Priest

An old man lying on his deathbed summoned his doctor, lawyer and his priest. He handed each of them an envelope containing $30,000. "Gentlemen, they say you can't take it with you but I am going to try. When they lower my casket into the ground I want each of you to toss in the envelope I gave you."

After the funeral the doctor confessed to the other two "We needed money to build a new clinic, so I kept $20,000 and only threw in $10,000." The Priest also confessed "We needed renovations at the church so I kept $10,000 and only threw in $20,000."

The lawyer shook his head in disgust. "Gentlemen I am ashamed of you...I threw in a cheque for the full amount".

Wrong one

A man comes into the ER and yells "My wife's going to have her baby in the cab!"

The ER physician, desperate to help the lady, grabs his stuff, rushes out to the cab, lifts up the lady's dress when he looks at the lady's shocked face. The physician then realises his blunder and turns pink with embarrassment. There were several cabs lined up and obviously he was in the wrong one!

Doctor, when can we resume sexual intercourse?

While the Obstetrician is awaiting third stage after a delivery:
Husband: Dr, when can we resume sexual intercourse?
Obstetrician: Well…, it is customary to wait until after the placenta is delivered.

The Burned Out OBGYN

A gynecologist had become fed up with malpractice insurance and was on the verge of being burned out. Hoping to try another career where skillful hands would be beneficial, he decided to change careers and became an auto mechanic. He found out from the local technical college what was involved, signed up for evening classes, attended diligently and learned all he could.

When the time for the practical exam approached, the gynecologist prepared carefully for weeks, and completed the exam with tremendous skill. When the results came back, he was surprised to find that he had obtained a score of 150%.

Fearing an error, he called the instructor saying, "I don't want to appear ungrateful for such an outstanding result, but I wondered if there has been an error that needs adjusting?"

The instructor said, "During the exam, you took the engine apart perfectly, which was worth 50% of the total mark. You put the engine back together again perfectly which is also worth 50% of the mark." The instructor went on to say, "I gave you an extra 50% because you did all of it through the muffler.

Calendar of Events

2010

RCOG-OGSM Life Saving Skills Course 2010
11-12 December 2010,
Hospital Tengku Ampuan Rahimah, Klang
Tel: +(603) 6201 3009 Fax: +(603) 6201 7009
Email: ogsm@myjaring.net
http://www.ogsm.org.my

2011

Part 1 MRCOG Intensive Course
15-18 February 2011, Hotel Singgahsana, Petaling Jaya
Tel: +(603) 6201 3009 Fax: +(603) 6201 7009
Email: ogsm@myjaring.net
http://www.ogsm.org.my

2nd Regional Conference: Nutrition in Obstetrics & Gynaecology
4-6 March 2011, Le Meridien Hotel,
Kuala Lumpur, Malaysia
Tel: +603-6201 3009 Fax: +603-6201 7009
Email: ogsm@myjaring.net
http://www.ogsm.org.my

8th Malaysian Congress on Menopause (MCOM) 2011
5–6 March 2011,
Grand Dorsett Subang Hotel, Subang Jaya
Tel: +603 9171 8188 Fax: +603 9171 8177
Email: mcom2011@micepodium.com
http://www.menopause.org.my

18th Annual Congress of the Perinatal Society of Malaysia
17-20 March 2011, Bayview Beach Resort, Penang
http://www.perinatal-malaysia.org

2nd Malaysian Reproductive Medicine Congress
25-27 March 2011, Kuala Lumpur Convention Centre
Tel: +603-2615 5452 (Ext 6770) Fax: +603-2694 8980
Email: ivfghkl@yahoo.com

21st Malaysian Congress of O&G
2-5 June 2011, Hotel Equatorial, Pulau Pinang, Malaysia
Tel: +(603) 6201 3009 Fax: +(603) 6201 7009
Email: ogsm@myjaring.net
http://www.ogsm.org.my

2011

8th Singapore International Congress of Obstetrics and Gynaecology 2011
24-27 August 2011,
Raffles City Convention Centre, Singapore
Tel: +65 63464402 Fax: +65 63464403
E-mail: info@sicog2011.com
http://www.sicog2011.com

XXII Asian and Oceanic Congress of Obstetrics and Gynaecology (AOCOG 2011)
23-27 September 2011, Taipei, Taiwan
Tel: +886-2-2508-1825 Fax: +886-2-2508-3570
Email: service@aocog2011.org.tw
http://www.aocog2011.org.tw

9th RCOG International Scientific Meeting
27-30 September 2011, Athens, Greece
Tel.: +30 210 74.14.700 - Fax: +30 210 72.57.532
Email: info@rcog2011.com
http://www.rcog2011.com/

7th Asia Pacific Congress in Maternal Fetal Medicine
14-16 October 2011, Kuala Lumpur Convention Centre
Email: apcmfm2011kl@gmail.com

2012

10th RCOG International Scientific Meeting
6-8 June 2012, Borneo Convention Centre,
Kuching, Sarawak
Tel: +603-6201 3009 Fax: +603-6201 7009
Email: info@rcog2012.com
http://www.rcog2012.com

XX FIGO World Congress 2012
7-12 October 2012, Rome, Italy
Email: congress@figo.org
http://www.figo.org

Obstetrical and Gynaecological Society of Malaysia
Suite C-07-02, Plaza Mont Kiara, No 2, Jalan Kiara,
Mont Kiara, 50480 Kuala Lumpur, Malaysia
Tel: +(603) 6201 3009 Fax: +(603) 6201 7009
Email: ogsm@myjaring.net Website: www.ogsm.org.my

"There is no obvious scientific reason why Bio-Oil should be so effective at improving the appearance of scars. However, notwithstanding this fact, the results obtained when using the product for this application, supported by the recent clinical trials, are unquestionable."

John Knowlton Past President of the Society of Cosmetic Chemists of Great Britain

Bio-Oil's efficacy in helping to improve the appearance of scars was supported solely by anecdotal evidence until 2006, when clinical trials confirmed its effectiveness. Bio-Oil's mechanism of action is still however largely unknown. It was developed in 1987 by a German cosmetic scientist who used plant oils and vitamins as the product's active ingredients – the benefits of which tend to be known more through 2000-year-old folklore than scientific studies. What is understood though is that the inclusion in the formulation of the breakthrough delivery ingredient PurCellin Oil™ ensures that the plant oils and vitamins are absorbed into the skin.

Plant oils and vitamins are thick and sticky by nature and have a tendency to remain on the skin's surface, rendering them ineffective. PurCellin Oil™'s ability to deliver these ingredients is considered a key contributing factor to Bio-Oil's efficacy.

Bio-Oil® should be applied twice daily, massaging in a circular motion until fully absorbed. It is available from pharmacies from RM32.95 (60ml). Results will vary from individual to individual. For further information, please contact Nuvanta Sdn Bhd at 03-5569 4337 or visit www.bio-oil.com.

Results of clinical trials: Medical University of South Africa, Photobiology Laboratory, 2006. 1) Scars: Independent expert clinician recorded an improvement in appearance in 65% of the panelists at 4 weeks (24 panelists aged 18-60, comprising 22 females & 2 males). 2) Striae: Independent expert clinician recorded an improvement in appearance in 50% of the panelists at 8 weeks (20 panelists age 18-55, all female). The results were single-blind with intra-subject comparison under controlled conditions.
Key ingredients: Calendula oil, Lavender oil, Rosemary oil, Chamomile oil, Vitamin E, Vitamin A, PurCellin Oil™ (PurCellin Oil™ is a synthetic recreation of the preen gland oil of ducks). *IRI Infoscan 52 w/e 6 December 2006.

NO.1 SELLING SCAR PRODUCT IN THE UK*

UNION-SWISS | SUCCESSFULLY TREATING SKIN SINCE 1954