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AOCOG 2019 YGA Experience

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Editorial Team

Editor : **Dr Eeson Sinthamoney**
Dr Ng Beng Kwang
Prof Dr Nazimah Idris
Dr Voon Hian Yan
Ms Premalatha B
Mr Chong KL

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

An Overview of Breast Cancer in Malaysia: The Oncofertility Perspective

Breast cancer is still the leading cancer in Malaysia. It comprised 17.3% of all cancers followed by lung cancer (10.7%) and colon cancer (8.0%), as reported by Globocan, World Health Organization (WHO) in 2018[1]. Overall, 26.1% was diagnosed among adolescent and young adults (AYA); 15-44 year olds (34.9%) in general adults; 45-54 and 55-64 year olds (24.4%) in the elderly. At least 87.5% of breast cancer in Malaysia was diagnosed as early as stage I, which reflects on the excellent 5-year survival rate of 66.8%, especially in the AYA group[2].

However, 3 to 10% of these women had been exposed to gonadotoxic drugs during the treatment period[3]. This resulted in higher incidence of chemotherapy-induced subfertility, which leads to a devastating quality of life despite an excellent overall survival[4]. Hence, the services of oncofertility are deemed essential to offer fertility preservation (FP) services before potential gonadotoxic treatment. Thus, an early referral to an oncofertility centre is paramount to evaluate the best option of fertility preservation tailored to their age, cancer stage and marital status[5].

Dr Mohd Faizal Ahmad
Clinical Lecturer and Specialist
Reproductive Unit, UKM Medical Centre

Since the 1990s, the cryopreservation techniques were already applied for FP[6-7]. To date, the established preservation method for FP is embryo cryopreservation with 30 to 40% pregnancy rate, followed by oocytes cryopreservation with 4.5-12% pregnancy rates. On the other hand, Ovarian Tissue Cryopreservation (OTC) is still considered experimental in Malaysia and confers at least 20 to 30% pregnancy rates per transplantation with more than 100 pregnancies reported worldwide[8-10].

In the limited time before chemotherapy, ovarian stimulation can be done for breast cancer women by using a Random Start (RS) protocol that can be initiated regardless of the menstrual phase. It will reduce the delay in receiving primary cancer treatment while opting for FP. The combination stimulation regime with aromatase inhibitor (AI) was also conducted in hormonal positive receptor women to control the increment level of oestradiol during the stimulation period. Nevertheless, the oocytes, embryo numbers and the quality outcome with this protocol was found to be similar to the conventional protocol. To date, the safety of ovarian stimulation among breast cancer was proven. There was no increase in recurrent tumours during stimulation and subsequent pregnancy[5]. If there is no time for stimulation, FP with OTC can be advocated. It is a non-invasive intervention, and it can be done as a combination with primary cancer operation. Currently, OTC is already available in Malaysia. Therefore, cryopreservation should be considered for all breast cancer women in Malaysia who request FP treatment.

Despite the recommendation by various societies, FP referral for breast cancer women in Malaysia remains low. The focus of quality of life among cancer survivors does not highlight the critical aspect of fertility, but mainly concentrates on primary cancer recurrence[11]. Since our cancer management had tremendously improved, and early detection was made possible, the implementation of FP referral should be established. The collaboration of oncologist, breast endocrine surgeon and oncofertility specialists are essential to form a standard guideline and create an FP referral system in Malaysia. This strategy acts as an integrated management plan to enhance health services and improve quality of life among breast cancer survivors.

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Contraception and Menstrual Issues in the Intellectually Disabled Adolescents

Dr Nurkhairulnisa binti Abu Ishak is an O&G Specialist and Clinical Lecturer at the International Islamic University of Malaysia Medical Centre (IIUMMC), Kuantan. She is currently undergoing her subspecialty training in Paediatric and Adolescent Gynaecology (PAG) at UKMMC.

Assoc Prof Ani Amelia Dato' Zainuddin is the head of the Paediatric and Adolescent Gynaecology (PAG) unit in UKMMC. UKMMC is a recognised training centre for the subspecialty of PAG by the International Federation of PAG (FIGIJ).

Intellectual disability (ID) is characterised by significant limitations in intellectual functions (generally measured as the IQ of 70-75 or less) and adaptive behaviour including conceptual, social and practical skills that originate before the age of 18. Care for adolescents with ID require special considerations for unique needs related to their cognitive and physical abilities. These adolescents and their caregivers require more support and guidance during their reproductive years[5].

The age of menarche for adolescents with disabilities is the same as the general population[1,7]. Major concerns in the literature for adolescents with disabilities after menarche are menstrual hygiene, premenstrual disorders, abnormal uterine bleeding and sexual abuse. Menstrual hygiene may involve excessive self-stimulation and masturbation in the severely disabled where they masturbate during menses or smear staff and the surroundings[8]. Premenstrual syndrome symptoms in this population include an increase in behaviour problems, seizures, tantrums, crying spells as well as

self-abusive behaviour in the week before and first few days of menses. Those with disabilities are two to three times more likely to experience sexual abuse than their peers without disabilities. Thus, vigilance towards potential abuse is important[1].

Several decades ago, the sterilisation of adolescents with ID was performed before puberty and usually involved hysterectomy as caregivers were worried about the major concerns mentioned above[2,5]. However, there has been outrage at this practice. In many countries, strict controls have been placed on the sterilisation of people with disability. It is reserved for genuine medical indications or when all restrictive options have been tried and failed.

Most adolescents with ID can learn to manage their own menstruation with appropriate education and support from caregivers. However, if a decision is made to use contraception due to any of the above concerns, it is important to ensure that the girl and her caregivers are fully informed of the available choices as well as the advantages and disadvantages of each[2,3].

The oral contraceptive pill (OCP) can be taken by most girls with ID. It is effective in reducing bleeding and dysmenorrhea. Support by caregivers is needed to ensure it is taken regularly. Some medications for epilepsy interact with OCP[2]. The risk of deep vein thrombosis is increased so it may not be suitable for girls with impaired mobility. Levonorgestrel intrauterine system (IUS) provides effective long term contraception and markedly reduced menstruation. With appropriate explanation and consent, it is a preferred contraception in ID adolescents, however general anaesthesia may be needed for insertion[2,5].

The contraceptive patch may cause menstrual suppression with continuous usage, however it is easily removed by adolescents with ID and is less efficient with obesity. Etonogestrel subdermal implants may also be useful as they cause less weight gain and osteopenia but more menstrual irregularities. Depot medroxyprogesterone acetate (DMPA) is effective in suppressing menstruation, however it is known to cause osteopenia and weight gain. Thus, long term use requires careful consideration. Vaginal contraceptive ring is less suitable in adolescents with ID as it is difficult to insert, especially in fine motor or mobility issues[1]. Barrier methods may be particularly difficult for these adolescents to understand and use effectively, however it may help reduce the risk of sexually transmitted infections[4].

In conclusion, effective use of contraception in adolescents with ID, both for the treatment of gynaecological conditions and for effective prevention of unwanted pregnancy, can be genuinely life-changing for the patients and their caregivers. However, premenarchal suppression is not recommended since in most cases, adolescents and caregivers can generally cope, and they only require support at regular intervals. With appropriate education and good social support, adolescents with ID are capable of safe reproductive health. Health professionals have the responsibility of offering all relevant contraception options and individualising the management according to their needs.

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Speaking up on Endometriosis

Ms Surita Mogan
President
Persatuan Endometriosis Malaysia
(MyEndosis)

"Period pain should be something normal". Women are often told that the pain they experience is part of their lives and they should just live with the pain. And because of this, many have ignored their painful periods thinking that it is nothing serious until the next cycle. But what if the pain they are experiencing affects their daily routine to a point that they can't be productive? Should they still bear with the pain and toughen up?

According to an article in the Journal of Reproductive Medicine, endometriosis is defined as the presence of endometrial glandular and stromal cells outside their normal location in the uterus. Commonly affected areas in the abdomino-pelvic cavity include the ovaries, the cul-de-sac and other types of pelvic peritoneum, bowel and diaphragm[1].

In the medical world, endometriosis is a common condition that causes pain and infertility. It can lead to absenteeism as well as multiple surgeries with a consequent risk of impaired fertility, constituting a major public health cost[2]. Despite the existence of numerous national and international guidelines, the management of endometriosis remains suboptimal[2].

In women with dysmenorrhea, the incidence of endometriosis ranges from 40% to 60%, and in women with subfertility, it ranges from 20% to 30%[3]. Yet, the term 'endometriosis' is still foreign to the general public. This may be due to misinterpreting the pain as period pain. Coupled with the taboo associated with the period, awareness in Malaysia is alarmingly low[4].

The struggle

Physical pain aside, endometriosis comes with a great deal of emotional burden. Since awareness is low, not many are able to empathise with women who possess this condition. Relationship problems may also arise due to fertility issues. On top of that, the unbearable pain and excessive bleeding affects her productivity and career prospects. Many even develop depression from having to deal with these emotional problems alone[5].

Dr Eeson Sinthamoney explained that depending on the extent of the disease, as it becomes progressively more severe, frequent medical leave or absenteeism can become the norm which is hardly a preferable approach when building a career. Infertility is also common in women with endometriosis and the possible amount of time spent in fertility clinics can put a damper on marriages and work[6].

When did it all begin?

As a patient myself, the worst part of the ordeal was convincing people that the pain is real. It wasn't until I turned 27, nine years after the onset of my symptoms, that I was finally informed that I have endometriosis. Since my diagnosis, I went through repeated surgeries, faced significant challenges in conceiving and was constantly on pain and hormonal medication to manage endometriosis.

Frustrated with the unfair judgment of women with endometriosis, speaking up on behalf of patients is the only option to raise awareness and put a face on the debilitating effects of endometriosis. After suffering with endometriosis for 26 years, alone and without the necessary help and support from society, helping other women (especially young girls) break the barrier on speaking about menstrual health is the next direction in life.

Light at the end of the tunnel

With the help of a dedicated group of people, Persatuan Endometriosis Malaysia (MyEndosis), was formed in 2014. Affiliated with the World Endomarch movement in America, the mission of the association is to provide emotional support and information to women who suffer from endometriosis. Besides this, the aim of the association is to create better awareness of this disease amongst the general public, women with endometriosis and the medical profession.

The most important challenge is to inform society that there is no cure for endometriosis, and it is a lifelong condition that should be managed and monitored closely by healthcare practitioners. Working closely with hospitals, MyEndosis organises events every year in March, the awareness month for endometriosis. Events organised in the past did manage to garner attention from the public and create a cohesive relationship among patients and healthcare providers. Events such as talks and workshops help develop positive reaction to healthcare treatment of endometriosis and eliminate the shame of addressing women's reproductive diseases.

Besides organising events, the Facebook closed group MyEndosis and the Facebook page Endomarch Malaysia are platforms created to unite Malaysian women with endometriosis and their supporters to take a stand against ignorance on the subject. Belonging to a community has definitely helped these women since they are able to share their stories and provide support for each other without fear of judgment. There is no denying the fact that social network sites of today, such as Facebook, are found to facilitate communication among health stakeholders, including patients, caregivers and health care professionals (Farmer, Bruckner, Cook, 2009)

Battle cry

The biggest role of MyEndosis is to highlight to society the long term damage endometriosis does to a women's physical and mental health. Coupled with the need to end the silence, MyEndosis believes that women in Malaysia should have the right to choose the best option to deal with endometriosis, and most importantly, to have a healthcare policy to help patients manage their condition financially.

MyEndosis can be contacted by email at **endomarch.malaysia@gmail.com** or by mobile at **+6013-369 0375.**

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Assoc Prof Ng Beng Kwang

KL-Selangor State OGSM Representative

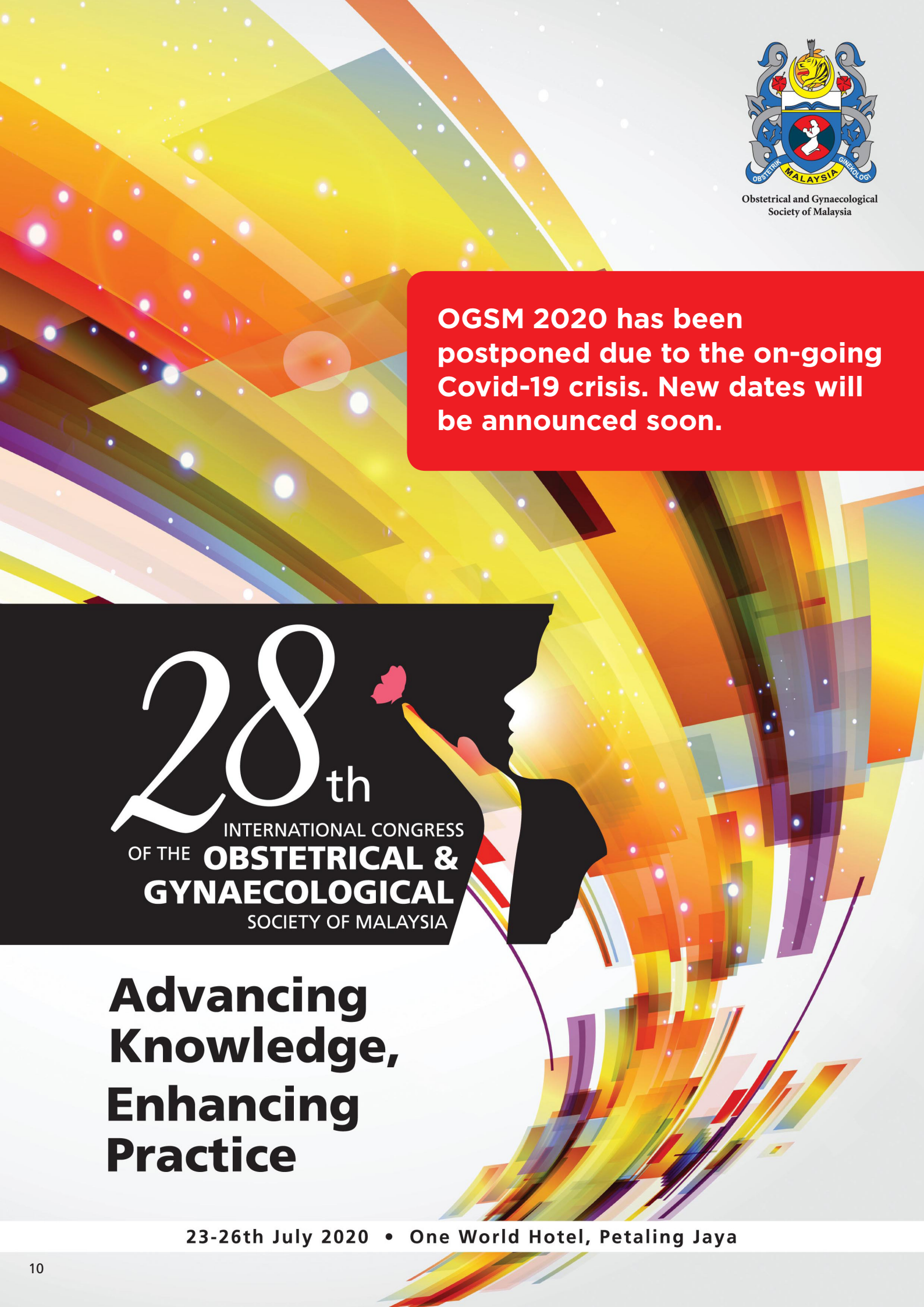
KL-Selangor State OGSM Fellowship Night

This event was held on the 5th of February 2020 at the OGSM Office, Plaza Mont Kiara. Approximately thirty OGSM members attended the event. We were honoured to have two distinguished speakers, i.e., Dr Alison Wright and Dr Muniswaran Ganesan.

Dr Alison Wright is the immediate past RCOG Vice-President. Currently, she is the NHS England Clinical Champion for personalised care and Consultant Obstetrician and Gynaecologist at the Royal Free Teaching Hospital in London. Dr Wright is committed to improving services for women worldwide by collaboration, particularly through supporting the implementation of evidence-based guidelines, high quality training and involving women themselves in their care. She had enlightened us about 'Intrapartum decision making in the 21st century'. The rising rate of caesarean section, quality and safety in the second stage of labour and personalised care were among the topics discussed.

Dr Muniswaran is a Consultant Obstetrician and Gynaecologist at the Women & Children's Hospital Kuala Lumpur. He is also the head of the Maternal Feto-Medicine unit, WCHKL. He is actively involved in coaching our MRCOG trainees and Intensive Course in Obstetric Emergencies (ICOE). Dr Munis discussed 'Intrapartum care and review of evidence'. He highlighted many issues about controversies during intrapartum care; from admission, labour and delivery to postpartum management. From his talk, he mentioned 'Respectful Childbirth' and stressed on few aspects such as humanising birth, individualised care, informed decision and respectful care.

The event began at 7.00 pm and adjourned at 9.00 pm. We had a great discussion with active participation from the audience. The fellowship night ended with delicious local Indian cuisine as well as networking with exchanges of ideas among participants.


Obstetrical and Gynaecological Society of Malaysia
OGSM 2020 has been postponed due to the on-going Covid-19 crisis. New dates will be announced soon.
28th
INTERNATIONAL CONGRESS
OF THE OBSTETRICAL & GYNAECOLOGICAL
SOCIETY OF MALAYSIA
Advancing Knowledge, Enhancing Practice
23-26th July 2020 • One World Hotel, Petaling Jaya

Simulation Workshop on Complicated Caesarean Section: An ICOE Event

Dr Nurul Syuhada is a junior medical officer who has served in Bintulu Hospital and Sarawak General Hospital. She takes pride in her resilience and openness to new challenges.

Caesarean section is part and parcel of life as an obstetrics and gynaecology trainee. When given the opportunity to attend the one-day event held at the Allied Healthcare Centre of Excellence (AHCOE) organised by the ICOE arm of OGSM, I jumped at the opportunity.

The workshop on the 11th of January had about 40 other participants from various hospitals all over Malaysia (and some as far as Indonesia). Despite having different roles/seniority from medical officers to specialists/consultants, we were able to mix and mingle in between sessions, exchanging experiences and ideas with colleagues who share the same interests for obstetrics and gynaecology.

Furthermore, this workshop has improved my knowledge and application of the Robson's 10-Group Classification with its easy to understand scenario-based discussion led by the trainers. My skills and confidence when handling second-stage caesarean section have also increased with their numerous hands-on stations, allowing each participant a chance to practice and apply specific manoeuvres. Simulation of steps such as extending uterine incision with inverted-T, J-shaped, push and pull methods and the Patwardhan technique would otherwise have been too intimidating to perform for the first time in a real life situation. A video presentation on basic caesarean section may initially appear simple but it reassured me that my methods are up-to-date and evidenced-based, such as the uterine closure is now with continuous sutures and no longer with interlocking sutures. All

information was taught and closely guided by trainers with years of experience, boasting big names in the obstetrics and gynaecology society.

This course was held at AHCOE, a state-of-the-art facility complete with a simulation operation theatre, labour ward and intensive care unit. Equipped with video cameras and speakers for audio and visual playbacks of re-enactments and drills allowed participants to analyse their performance and perform better under real life situations. This can never be done anywhere except at facilities that are as good as this one. The course also made full use of technology to engage and obtain live feedback from participants by having a simple online quiz assessing our knowledge before and after each session as well as a quiz at the end of the course to evaluate our satisfaction and opinions for improvements.

This course has taught me to anticipate and plan ahead when facing a complicated caesarean section, taking into account all factors such as abdominal entry, uterine incision and method of baby delivery. I highly recommend this course to O&G trainees who wish to expand their surgical skills and gain confidence while performing a caesarean section.

Two days after the course, I had one transverse lie and one 2nd stage caesarean section during my on-call! Thanks to the tips, I was able to deliver the babies with ease. Thank you once again for the effort and time spent in organising this course. – Dr Wong Soon Jeck, HOSPITAL MIRI

The tips and tricks taught were very useful. They endowed me with extra skills that only experience could teach! – Dr Nur Shairah Abd Rahman, HOSPITAL SG BULOH

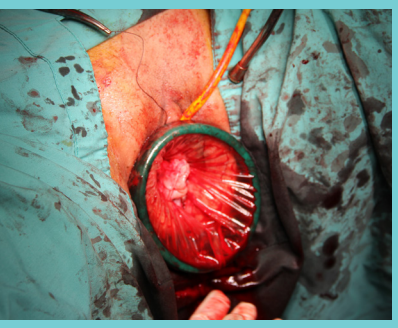
vNOTES Hysterectomy

Dr Sevellaraja Supermaniam, FRCOG (UK) MRM (UW Sydney) FICS (USA), is a Consultant Obstetrician and Gynaecologist, and a subspecialist in Reproductive Medicine.

NOTES (Natural Orifice Transluminal Endoscopic Surgery) encompasses surgery performed via the stomach (transgastric), anus (transanal), urethra (transurethral) and vagina (transvaginal). Reddy & Rao et al. performed the first transgastric appendectomy in humans using a flexible endoscope[1]. The use of transgastric, transanal and transurethral approach is not as popular as the transvaginal approach. Many surgeries have been performed by the transvaginal. In surgery, namely, cholecystectomy, appendectomy, sigmoidectomy, nephrectomy, splenectomy, liver resection and sleeve gastrectomy. In gynaecology, it has been used for hysterectomy, salpingectomy, ovarian cystectomy, myomectomy, lymphadectomy and sacrocolpopexy[2-7]. In 2012, Su et al. reported the first vNOTES hysterectomy through a posterior colpotomy in 16 patients with benign uterine diseases[2]. Since then, vNOTES (especially hysterectomy) is steadily becoming more popular.

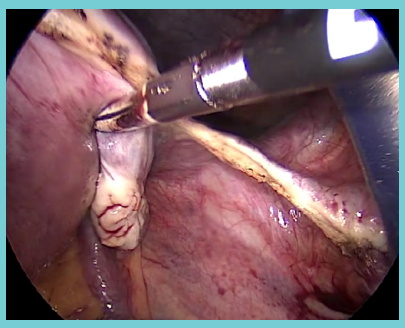
The Asia Pacific Association of Gynaecological Endoscopy Society organises vNOTES workshops. I attended the 2nd workshop last year in Bangkok. It was a 3 days hands-on workshop. We were taught how to perform vNOTES hysterectomy. Having attained this skill, I began performing vNOTES hysterectomies in April 2019. So far, I have accomplished 29 vNOTES hysterectomies.

The surgery commences by first infiltrating the cervix with diluted adrenaline. Next, a circumferential incision is made around the cervix, and the vagina is separated from the cervix. The uterosacral ligaments are bilaterally clamped, cut and sutured to bring down the cervix. Posterior colpotomy is performed and the cardinals are then clamped, cut and ligated. Anterior colpotomy is performed. Sutures are placed on the peritoneum anteriorly and posteriorly. The uterine is then clamped, cut and ligated. A Lagis wound retractor and lap base are placed. Trocars are placed and laparoscopy is performed. The upper pedicles (which include the ovarian ligament and tubes or the infundibulopelvic ligaments) are coagulated and cut. The uterus is then removed vaginally. Haemostasis is attained and the vaginal vault is subsequently closed. Cystoscopy is conducted to determine a jet of urine coming out of the ureteric orifices, indicating uninjured ureters.

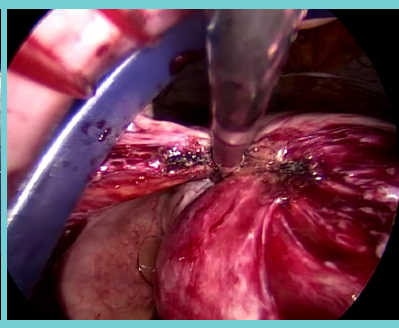


Wound retractor placed

Largis port with the trocars

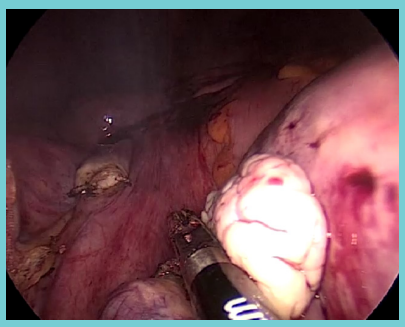


Left ureter seen under the left IP ligamant

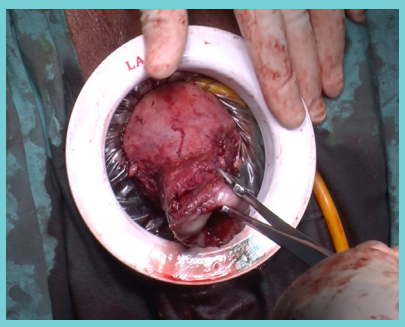


Right cardinals cut

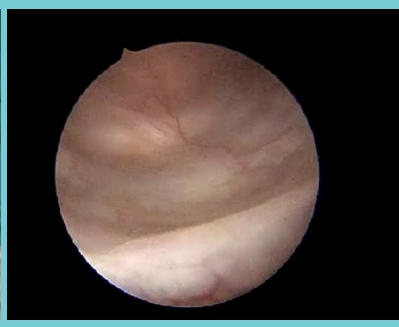
Performing surgery



Right IP ligamant cut



Uterus removed



Cystoscopy done

Selection of patients is important when starting to perform vNOTES. The best case to begin with would be a small uterus with no previous caesarean sections. It is also important to select cases with no adhesions in the POD because of the difficulty in performing a posterior culdotomy. In previous caesarean section cases, the Lagis port is placed before the anterior colpotomy and the peritoneum is approached from the lateral position just above the uterine artery. This can be difficult, and with practice, the flapping of the peritoneum can be seen to indicate that the peritoneum can be perforated.

Conclusion

vNOTES can assist in converting a laparoscopic hysterectomy to vaginal hysterectomy. Performing laparoscopy vaginally requires practice because the anatomy appears different from the vagina as opposed to conventional laparoscopy. Do look out for a video on vNOTES at www.youtube.com/drsselva.

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ASIA & OCEANIA CONGRESS OF O&G MANILA 2019 THE YGA EXPERIENCE

11th-14th NOVEMBER

Dr Voon Hian Yan is a Maternal Fetal Medicine Fellow serving in Sarawak GH & tries his best to advocate evidence-based practice. He will contribute a series of articles based on recent development which he feels may improve one's practice. Hian Yan is periodically reminded by his better half/personal ophthalmologist to have his "vision" reassessed from time to time, inspiring the title of his column in CONNECT, "REFLECT TO REFRACT"

REFLECT TO REFRACT

The Shan S Ratnam Young Gynaecologist Award (YGA) is awarded once every two years in conjunction with the Asia & Oceania Federation of Obstetrics & Gynaecology (AOFOG) Congress and I was humbled to be the Obstetrical & Gynaecological Society of Malaysia's (OGSM) nominee in Manila 2019. Instituted in 1991 during the tenure of Prof Masahiko Mizuno's presidency, it was renamed in 2001 after the demise of its president-elect, Professor Emeritus Shan S Ratnam, who had been the federation's secretary general for more than two decades.

Nominated by their national societies, the YGA was given to obstetricians & gynaecologists below 40 years of age, had contributed to their national societies and demonstrated leadership qualities. A research submission as primary author was mandatory as one of the main highlights of the AOFOG Congress was the YGA Oral Paper presentation.

At the end of 7 fun-filled days, the YGAs were honored during President's night (coincidentally the sitting president was our previous OGSM president, Dr Ravi Chandran). The top 10 research papers by the YGAs then squared- off for an oral presentation where new friends became "frenemies". It was gratifying as my paper entitled "Antibiotic prophylaxis in ragged placental membranes: a prospective, multicentre, randomized trial" won 2nd runner-up and the prize was awarded by Professor Arulkumaran himself.

This chance to fly the nation's flag high and network with others across the region would not have been possible without the support of mentors, colleagues, friends and family (and patients: our greatest teachers). Thank you once again OGSM for the opportunity!

The 2019 edition of the YGA programme was headed by Dr Ryan B. Capitulo (YGA Philippine 2011) comprising of nominees from the host country, Singapore, Hong Kong, Korea, Mongolia, Laos, Australia and other countries from the Pacific such as Fiji, Tonga and Papua New Guinea. The 7-day YGA programme included 5 modules encompassing leadership, maternal health in Asia and Oceania region, maternal health in the community, best practices and health promotion. YGAs visited the Western Pacific WHO headquarters, Health Department of the Philippines, Bataan region for the community outreach programme and also several renowned medical schools in Manila (spelt MAYNILA in Tagalog). The University of Santo Tomas, which was constructed to be earthquake-proof, site of sermons by 3 different Catholic popes and predated the Harvard University (Santo Tomas is the oldest university under the American flag) also played host. On the final day, we participated in the fundraiser by the Philippine Obstetrical and Gynecological Society marathon to "Outrun Cervical Cancer".

Year	YGA Recipient	Host City
2019	Voon Hian Yan	Manila
2017	Quek Yek Song Salleha Khalid	Hong Kong
2015	Muniswaran Ganeshan	Kuching
2013	Shilpa Nambiar Balakrishnan	Bangkok
2005	Japaraj Robert Peter	Seoul
2002	Soon Ruey B.K. Lim	Bangalore

Source: AOFOG Secretariat

Preparatory Assistance Courses for Trainees
Mentoring Our Future

Obstetrical and Gynaecological Society of Malaysia

Part 3 Circuits Course

DATE: 28th - 29th March, 2020
VENUE: Perdana University
Clinical Skills Unit
Block D, Level 1
MAEPS Building,
MARDI Complex, Jalan MAEPS Perdana,
43400 Serdang Selangor

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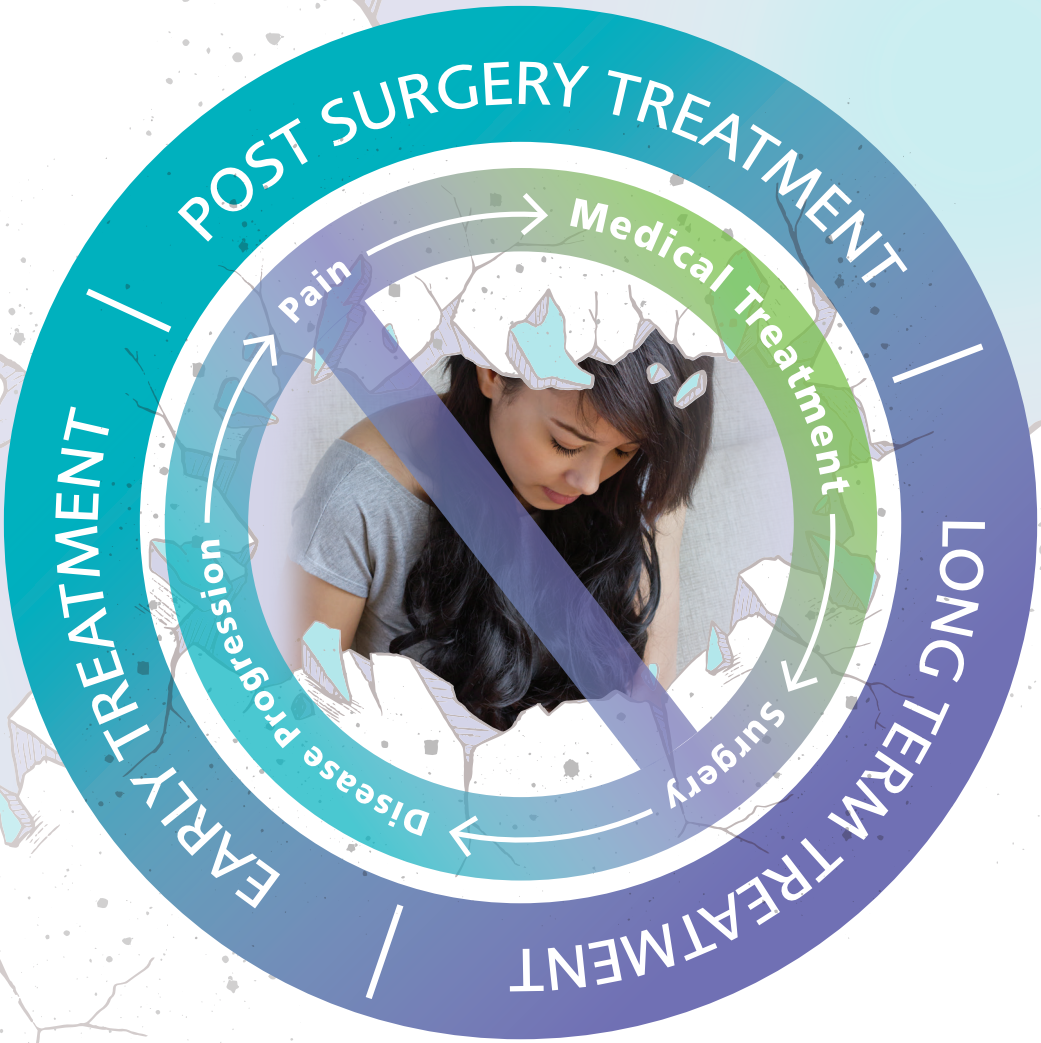
19th ICOE Doctor **03rd & 04th April 2020**	**POSTPONED** New Dates: **26th and 27th of September 2020**
TOT 2020 **05th April 2020**	**POSTPONED** New Dates: **25th of September 2020**

Obstetrical and Gynaecological Society of Malaysia

MOM
MALAYSIAN OBSTETRIC MEDICINE
SCIENTIFIC CONGRESS 2

POSTPONED • New Dates: 6th - 8th of November 2020



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REFERENCES: 1. Kohler G, et al. A dose-ranging study to determine the efficacy and safety of 1,2 and 4 mg of dienogest daily for endometriosis. Int J Gynaecol Obstet. 2010 Jan;108(1):21-5. **2.** Strowitzki T, et al. Dienogest is as effective as leuprolide acetate in treating the painful symptoms of endometriosis: a 24-week, randomized, multicentre, open-label trial. Hum Reprod. 2010 Mar;25(3):633-41. **3.** Kitawaki J, et al. Eur J Obstet Gynecol Reprod Bio. 2011 Aug;157(2):212-6. **4.** Morotti M, et al. Eur J Obstet Gynecol Reprod Biol. 2014 Dec;183:188-92. **5.** Imai A, et al. in Endometriosis - Basic Concepts and Current Research Trends, Prof Koel Chaudhury (Ed.), ISBN:978-953-51-052404, InTech.

ABBREVIATED PRESCRIBING INFORMATION **Brand name of product** Visanne 2 mg tablets (Dienogest). **Indications** Treatment of endometriosis. **Contraindications** Active venous thromboembolic disorder, past or present arterial & cardiovascular disease (eg myocardial infarction, cerebrovascular accident, ischemic heart disease); diabetes mellitus with vascular involvement; presence or history of severe hepatic disease & liver tumors; known or suspected sex hormone-dependent malignancies; undiagnosed vaginal bleeding. Pregnancy & lactation. Children prior to menarche. Hypersensitivity to the active substances or to any of the excipients. **Special warnings and special precautions for use** Serious uterine bleeding; Changes in bleeding pattern may occur; Circulatory disorders including those at risk of VTE; discontinue use if any symptoms of arterial or venous thrombotic events occur. Breast cancer, liver tumors. Osteoporosis. History of depression; Hypertension. Discontinue use upon recurrence of cholestatic jaundice &/or pruritus which occurred 1st during pregnancy or previous use of sex steroids, Diabetes Mellitus especially gestational diabetes mellitus, chloasma (especially chloasma gravidarium); Persistent ovarian follicles. Rare hereditary problems of galactose intolerance, Lapp lactose deficiency or glucose-galactose malabsorption. Regular physical & gynecological examination during use. Adolescents (menarche to 18 yr). **Undesirable effects** Common: Metabolism and nutrition disorders: weight increase, Psychiatric disorders: depressed mood, sleep disorder, nervousness, loss of libido, altered mood, Nervous system disorders: headache, migraine, Gastrointestinal disorders: nausea, abdominal pain, flatulence , abdominal distension, vomiting, Skin and subcutaneous tissue disorders: acne , alopecia, Musculoskeletal and connective tissue disorders: back pain, Reproductive system and breast disorders: breast discomfort, ovarian cyst, hot flushes, uterine / vaginal bleeding including spotting, General disorders and Administration site conditions: asthenic conditions, irritability. **For further prescribing information, please contact** Bayer Co. (Malaysia) Sdn Bhd B-19-1& B-19-2, The Ascent Paradigm, No. 1, Jalan SS7/26A, Kelana Jaya, 47301, Petaling Jaya, Selangor. Subject to medical prescription. **Date of text revision** 14.03.2016

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