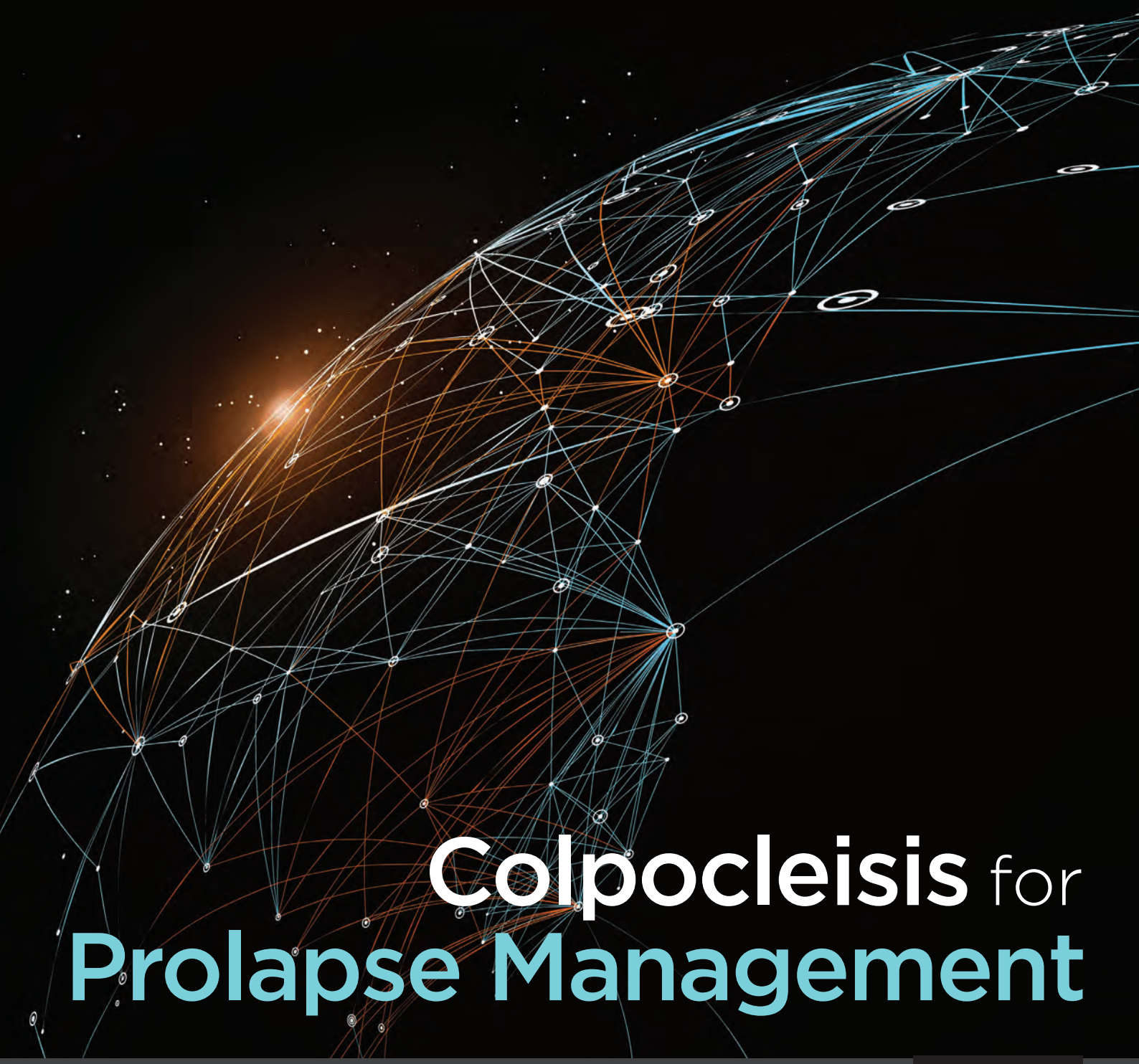
CONNECT

Obstetrical and Gynaecological Society of Malaysia

2018/2019 Council Issue 2

EMBRACING, ENGAGING & INFORMING



Colpocleisis for Prolapse Management

Interesting statistics in Malaysian ObGyn

Light at the end of the tunnel

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Deepavali wishes to all
Nom de Guerre

Editorial Team

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Dr Ng Beng Kwang
Ms Premalatha B
Prof Dr Nazimah Idris
Mr Chong KL

Creative : **Pronto Ad Sdn Bhd**

Editor's Message

First and foremost, I would like to express my utmost gratitude to the President and fellow council members for giving me this honoured opportunity to manage the OGSM newsletter.

"Bridging the gap within the O&G fraternity in Malaysia" is the glamourous motto for our rebranded newsletter "CONNECT". As its name implies, "CONNECT" aims to unite all 1,300 OGSM members, by 'Embracing, Engaging, and Informing' each and every member in the fraternity.

As promised, it is our ultimate goal to provide an engaging platform for all members to exchange ideas as well as keep each other abreast with the latest updates. We will strive to generate at least eight issues of "CONNECT" throughout this current term. This is, to allow each doctor the opportunity to channel their precious thoughts and ideas; to help improve our fraternity.

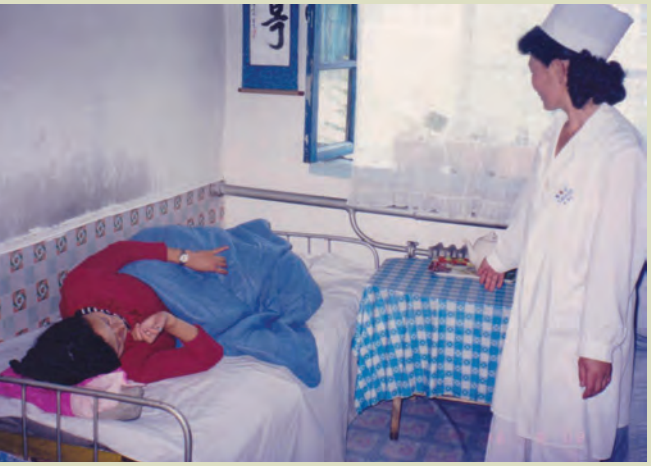
As the quote by Wayne Huizenga goes: "Some people dream of success, while other people get up every morning and make it happen." I foresee the 'dream' of keeping everyone in the loop with "CONNECT". This newsletter will realise the valuable contributions from each and every single one of you.

Thank you.

Dr Ng Beng Kwang

Some Thoughts On O&G Training **Then & Now**

Professor Dato'
Dr Ravindran Jegasothy
MAHSA University



I must first thank Dr Eeson Sinthamoney for his request to write my thoughts down on training in O&G. Having worked together with him at the Maternity Hospital in Kuala Lumpur, I know he is very passionate about training.

My interest in O&G was kindled by the systematic approach of teaching in that subject by the teachers then at the University of Malaya, where I did my undergraduate training. The team was led by Professor TA Sinnathuray, who was a stickler for discipline and punctuality. He was methodical, thorough and could convey the learning points effectively. It helped too that most O&G patients were healthy and one could look forward to a happy outcome for the anxious husband and family members who were waiting outside the labour wards. Back then, the father friendly hospitals were still some distance away!

The desire to specialise in O&G was further reinforced by the O&G specialist, Dr Yeoh Hock Lye who single handedly ran the unit at the Alor Setar Hospital with a Registrar, MO Trainee and Medical Officers. He has since migrated to Australia. House Officers numbered about four to five officers and was reduced to two when I went into Paediatrics rotation. This meant every night we had to be on call as two House Officers were required if there was to be an exchange transfusion. It is prudent to remember that there was no call allowance in those days. However, we looked forward to work as such was the camaraderie and the teaching that went on during the ward rounds in all clinical departments.

The real thrill of working in the labour wards were the midwives who commanded the floor. One got the impression that the baby would be delivered on the command of the midwife! Everything was so orderly that there was no hesitation or apprehension on the part of junior doctors, especially with the cool calmness of the midwives. But the noise was something else. I still remember the booming voice of a particular midwife who would restore order if she felt control was slipping!

Training to be a specialist at the time that I trained required twenty-four months of supervised training in a recognised hospital. In many major hospitals in this country, you could train for eighteen months and then do a six months supernumerary posting at the Maternity Hospital Kuala Lumpur. There was a rudimentary log book but we did have to prepare a case commentary book of 20 cases that we personally managed. (ten obstetrics and ten gynaecology, with a varied case mix and modes of delivery). This case commentary book was used to evaluate whether the candidate had sufficient knowledge as well as the critical thinking skills to discuss the way the cases were managed. Besides these case commentaries, we also had the two long compulsory commentaries in an obstetric and gynaecologic topic. These could be a review of the literature on a topic but later, it was required to have a research study on any clinical problem.

Surgical skill training was very much "on the job training". You were introduced to the etiquette and the procedures of the operation suite by the sister of the operating theatre (OT) and her team. Soon, they too became your good friends as we spent two days a week in the elective theatres and even more time in the emergency theatres. Once you got the basics right, you were assigned to assist the consultant in major cases such as hysterectomies, laparoscopies, tubal ligations, dilatation and curettage. Once you were thought to be competent by the consultant, you were assigned theatre lists on your own. Soon, one could do hysterectomies on your own but do expect the boss to look over your shoulder once in a while as the consultant was also in the theatre all the time! This was an excellent form of training and helped to build your confidence in handling cases.

I still remember my first case of uterine rupture as a Registrar. The lady was admitted with obstructed labour and I diagnosed uterine rupture based on the pallor, tender abdomen and absent fetal heart. It was back in those days before the ultrasound scan was present in the labour ward. As was the practice and instruction then, I phoned the consultant at 2am and I was instructed to get the blood support and prepare her for

surgery. He mentioned that he will come to do the surgery as I had not done a case of uterine rupture before. When the case was wheeled into the OT, she was anaesthetised and draped.

As my consultant had not arrived yet, I thought it may save time for me to open the abdomen as my consultant would surely come in soon. He came soon after and completed the surgery. After that, while writing the operative notes, he ticked me off in private for having opened the abdomen before his arrival and taught me the importance of the tamponade effect in restricting blood loss. Once this was released by opening the abdomen, haemostasis must be secured rapidly. This was a lesson that has stood me in good stead forever in the hundreds of cases of haemorrhage that I have encountered in my professional career.

In my opinion, the current way in which postgraduates are being trained suffers from a lack of personal supervision and role modelling of the yesteryears. Maybe this is due to increased numbers and the focus on administrative KPIs like waiting times in the clinic and timely submission of medical reports etc. The priority should be on clinical training and that can only be done effectively by the apprenticeship model previously employed. Current systems of filling the log book and ensuring sufficient cases are logged may work, but often the soft skills of clinical medicine and surgical judgement may not be sufficiently acquired. I have seen when I served on the gazettement committee of the Ministry of Health, O&G specialists may have done just two abdominal hysterectomies and assisted one vaginal hysterectomy in the six-month gazettement period. Such a specialist will not have the confidence to function effectively as a leader of the team. Such a specialist would be the one who would tell the medical officer to start the case and call when they run into difficulties.

One possible reason for this scenario is that clinicians of current days are loaded with too much administrative work. Some of this kind of work is also vital for development of the services such as clinical audit, morbidity and mortality reports. Perhaps the time has come to start developing systems of making people focussed on what they are good at and become masters at that. One should have the option to choose a clinical track that ensures your main work is clinically focussed. Others may choose a research track or an administrative track. Different KPIs could be developed for each track and promotional prospects looked at for each area. I would foresee we may have to look at having a clinical head of department and an administrative deputy head who is empowered to make administrative decisions.

Clinical leadership and patient safety efforts are skills that must be prioritised for postgraduate training in the current times. There is so much more knowledge that is required knowledge for the current specialists in O&G. Algorithms, artificial intelligence and mobile devices are available at one's fingertips to help in patient management. There has to be mastery of these modalities and training must be attuned to this.

Let me illustrate with a personal example of the axiom that "knowledge is power". I attach a rare photograph of an obstetric patient with her nurse in North Korea, officially known as the Democratic People's Republic of Korea (DPRK). I had the opportunity of doing a consultancy in North Korea for four years under the auspices of the IPPF and WHO. DPRK is a country where the common people do not have access to books from the rest of the world and cannot access the internet. At the time that I visited, visitors had to surrender their mobile devices at the airport and collect it back when you leave the country.

Back then, the belief was that a postpartum woman cannot receive any visitors for one week and needed to remain in hospital to prevent infections. The mother was separated from her baby after delivery. Even the husband could not see her and could only view the baby from behind a glass wall. It took a bit of convincing to persuade them that current practices in the rest of the world wass to minimise the stay of the woman in hospital and that rooming-in of the baby was the norm. The other photo shows some of the staff at a small district hospital.

Groups of DPRK doctors and nurses undertook visits to Seremban Hospital where I was working then to learn current obstetric practices. These groups then became the change agents when they returned to their country. I learnt first-hand that "knowledge is power" and "seeing is believing". I sincerely believe that these concepts are as relevant to postgraduate training as they are to everyday life. This memorable episode in my life also prompted a visit from the Special Branch to interview me as to the reasons I had North Koreans visiting Seremban Hospital!

I feel strongly that soft skills, surgical acumen and leadership skills were better learnt in the yesteryears. It was possibly due to the apprenticeship model in those days. Traditional forms of apprenticeship have been focussed on the instruction and development of the apprentice in the workplace. The focus is very much on the development of the individual, through engagement with the supervising expert. It does not accommodate the idea that the expert may learn from the apprentice and that the apprentice may in fact shape the practice in which they both engage in. I sincerely felt then that my consultant also learnt from me, especially with regards on how to handle personalities and there was mutual respect between us.

Now we know that contemporary views of apprenticeship, building on socio-cultural theories of learning accommodate not only the reciprocal nature of learning between 'apprentice and master', but also the contributions made by others in the professional community. New formulations of apprenticeship are emerging that enable us to look beyond the novice – expert dualism and consider a social apprenticeship that much more actively recognises the contributions made by the wider community of the workplace.

The workplace is important. We all have different experiences of work and workplaces. We influence our workplace and it influences and shapes us. The workplace can be a nurturing environment where knowledge and skills are fostered, extended and developed through work activity and our interactions with others. Equally, it can be a dysfunctional environment that stifles creativity, dampens professional motivation and leads to psychological and physical ill health. Witness the current housemanship issues. The serious question that needs to be asked now is on which end of the spectrum are our current work places at.

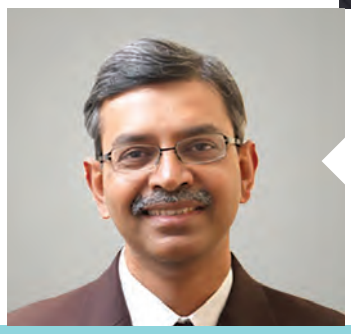
As a conclusion, both the past and the present workplace and environment have their strengths and weaknesses. One cannot conclude that one period of time was better than the other. However, one needs to look back to go forward. If you do not, you miss the valuable lessons that one can learn. There needs to be a strong political and professional will to ensure that our workplaces remain healthy and nurturing.

OGSM Subcommittee Chairs

Maternal Fetal Medicine

Dr TP Baskaran

An obstetrician and gynaecologist, sub-specialising in maternal foetal medicine, Dr Baskaran is the Medical Director and Consultant at the Foetal Scan Centre in Kuala Lumpur.



Gynae Endoscopy

Dr S Selva (Sevellaraja Supermaniam)

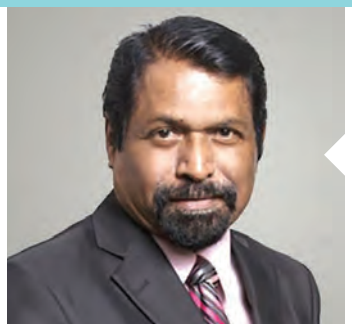
A consultant obstetrician and gynaecologist attached to Mahkota Medical Centre in Melaka, he is a subspecialist in Reproductive Medicine and runs the IVF centre at the hospital. His passion is advanced laparoscopic surgery and Dr Selva aims to educate the public on laparoscopic surgery as well as teach laparoscopic surgery to gynaecologists.

Reproductive Medicine

Dr Mohamed Hatta bin Mohamed Tarmizi

A consultant obstetrician and gynaecologist; and reproductive medicine and infertility specialist at the Obstetrics and Gynaecology department in the Sabah Women's and Children's Hospital (SWACH), Kota Kinabalu. Dr Mohamed Hatta was responsible in setting up the public IVF Lab and Fertility services in Sabah in 2010. He currently heads the unit there.

In the coming term, he would like to promote the development of knowledge and training in reproductive medicine among the members of the Society. He would like to see the development of legislation related to assisted reproductive medicine in Malaysia.



Medico-legal Matters

Professor Dato' Dr NKS Tharmaseelan

A Professor in the Department of Obstetrics and Gynaecology in the Melaka Manipal Medical College, Professor Dato' Dr NKS Tharmaseelan is the Chair for the Medico-legal Affairs Committee of the OGSM. In the coming term, he proposes to have the following:

- Regular medico-legal articles in the OGSM newsletter, CONNECT.
- Regular medico-legal workshops, discussions, talks in collaboration with the Medico-legal Society of Malaysia (MLSM) and other NGOs related to medico-legal matters.
- Meet with the various indemnity organisations to discuss and resolve issues; problems etc. with regards to indemnity coverage.
- Town hall meetings with MLSM, legal experts, NGOs and the Judiciary with regards to Medico-legal matters.

Menopause

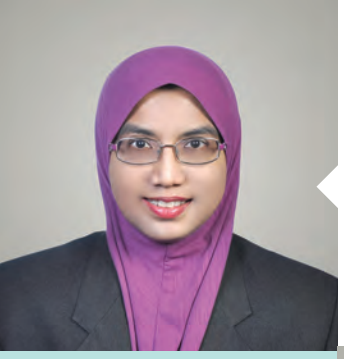
Dr Premitha Damodaran

An obstetrician and gynaecologist in the private sector, Dr Premitha is pursuing her interest in menopausal health in the coming term by concentrating on the development of the Clinical Practice Guidelines on Menopause Management in Malaysia. This would be under the umbrella of the Obstetrical and Gynaecological Society of Malaysia along with the Malaysian Menopause Society.

Everyday Practices in Obs & Gyn (EPOG)

Dr Wong Choon Meng

A graduate of KMC Manipal before obtaining his MRCOG in 2000, Dr Wong underwent a baptism of fire from Kuantan to Klang and UHMC, before ending up as a neighbourhood private practitioner of our arts in Kuala Lumpur.



Paediatric and Adolescent Gynaecology

Associate Professor Dr Ani Amelia Dato Zainuddin

A consultant obstetrician and gynaecologist attached to the Department of O&G, HCTM UKMMC, Associate Professor Dr Ani Amelia is the Head of the Paediatric and Adolescent Gynaecology (PAG) Unit. Just appointed as the Head of the PAG subcommittee in OGSM, she would like to continue to expand the awareness and education of this emerging subspecialty in obstetrics and gynaecology in the coming term.

Urogynaecology

Dr Aruku Naidu

A consultant obstetrician and gynaecologist, and urogynaecologist attached to Hospital Raja Permaisuri Bainun in Ipoh, Dr Aruku is the Chairman for the urogynaecology subcommittee for last decade. In the coming term, he would like to conduct roadshows and create awareness of the importance of managing obstetric anal sphincter injuries (OASIS).

Sexual & Reproductive Health & Rights

Dato' Dr Hj. Mohamad Farouk Abdullah

A Consultant OBGYN and reproductive medicine specialist in independent practice, he is a passionate advocate and activist for women's rights. In the coming term, he will address "Unmet Needs in SRHR".

Gynae-oncology

Dr Suresh Kumarasamy

A gynaecologist/gynaecological oncologist attached to Gleneagles Penang, Dr Suresh would like to continue organising educational and social activities among the obstetrics and gynaecological fraternity in Penang. This is to encourage fellowship and continued medical knowledge among colleagues in Penang.

Corporate Social Responsibility (CSR)

Dr Goh Huay-yee

An obstetrician and gynaecologist at ParkCity Medical Centre, Dr Goh has served as CSR Chair since 2012. Believing firmly in the power of health education and the value of humanitarian aid for the underprivileged, these principles will guide the CSR activities planned for the coming term.

Family Planning

Dr John Teo Beng Ho

A private obstetrician and gynaecologist attached to Klinik Pakar Wanita dan Perbidanan Lintas Square, Kota Kinabalu in Sabah, Dr John Teo would like to advocate increasing contraceptive training and knowledge among healthcare professionals as an integral component of women healthcare in the coming term.

Trainee Matters

Dr Hoo Mei Lin

A Consultant Obstetrician and Gynaecologist in Thomson Hospital Kota Damansara. Passionate in Training and Trainees as they are our future!

Intensive Course In Obstetric Emergencies (iCOE)

Dr Gunasegaran PT Rajan

A Consultant Obstetrician and Gynaecologist at KPJ Damansara Hospital. A past president of OGSM and involved with iCOE from the onset.

Interesting statistics in Malaysian ObGyn - Data from the NSR

How many Obstetricians and Gynaecologists are there in Malaysia?

Total registered as O&G **984**

What is the breakdown of practitioner from Government, private and university?

Government = **287**

Private = **590**

University = **107**

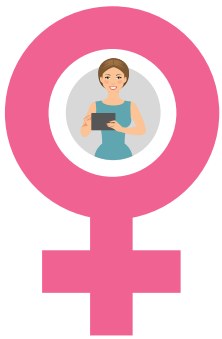
What is the statistic by state?

Kedah **51**
Pulau Pinang **77**
Perak **65**
Negeri Sembilan **44**
W.P Putrajaya **9**
W.P Kuala Lumpur **179**
Selangor **211**
Melaka **32**
Johor **89**

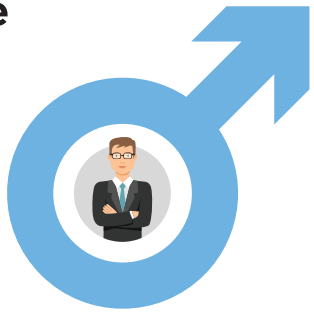
Perlis **9**
Kelantan **42**
Terengganu **24**
Pahang **43**

Sabah **44**
W.P Labuan **2**
Sarawak **63**

Male or Female ObGyns?



Female **444**



Male **540**

How old are we?

Below 60 Years old **800**

60 Years and above **184**

Colpocleisis for Prolapse Management

A Viable Option

Dr Aruku Naidu *MD, FRCOG, CU*

Pelvic organ prolapses (POP) in elderly postmenopausal women are expected to increase as the aging population grows. Often, this group of population will have concurrent multiple comorbid that hinders them from undergoing major surgical repair. Though conservative management using vaginal pessaries may offer some help, a number of them discontinue the treatment due to various reasons i.e. persistent vaginal discharge, vaginal mucosa erosion, pessary expulsion and other reasons.[1,2]

Massive pelvic organ prolapse or vault prolapse following previous hysterectomy might not be resolved using conservative management. Surgical management is unavoidable. Conventional repair may not give a good result and may have a higher recurrence rate, especially in cases with previous surgery for prolapses. Various techniques include abdominal sacral colpopexy and various types of commercialised meshes has been invented, hoping to achieve better results and lesser recurrence rate. The use of mesh kits is surrounded by controversies and at this current stage, it is not a viable option. Abdominal sacral colpopexy gives a lower recurrence rate in apical defect but it requires laparotomy. Though it can be performed laparoscopically, a skilful surgeon is needed.[3,4,5]

Colpocleisis is an effective, simple and short procedure that can be performed under general anaesthetic (GA), regional or local anaesthesia to resolve advanced or massive pelvic organ prolapse. This could offer elderly, frail women and those unfit for prolonged surgery an alternative option.[2,3] The term colpocleisis is derived from Greek; colpo meaning folds or hollow and cleisis meaning closure. The first reported case by Gerardin occurred in 1823. The current techniques used are modified versions of the cases described by Leon LeFort in 1877.[5]

As the procedure involves closing up the vagina, it is suitable only for those women who no longer desire to maintain coital function. This procedure has a relatively good success rate (90 to 95 percent) with a high rate of patient satisfaction. The operation can be carried out in patients, with or without uterus. There are two type of colpocleisis i.e. the partial/LeFort variant colpocleisis or the total/complete colpocleisis.[6]

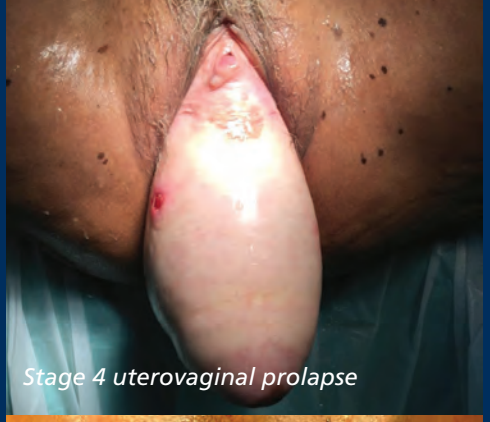
The colpocleisis operation usually involves elderly and frail women, therefore it is very important to optimise a patient's medical conditions prior to the operation. In patients with partial colpocleisis, one should consider performing transvaginal scan (TVS), endometrial sampling and Pap Smear before surgery to rule out any cervical or uterine abnormalities. The assessment for occult stress urinary incontinence (SUI) should also be performed and if present one should consider inserting a mid-urethral sling (MUS). The assessment of upper urinary tract system should be considered with the pre and post-operative renal (KUB) ultrasound. This is important because there is 7.1 to 22.4 percent risk of patients having a hydronephrosis and 3.3 percent risk of having renal impairment prior to surgery. One should also discuss the loss of vaginal length as there is a 10 percent regret rate after the operation. Other surgical considerations include antibiotics, deep vein thrombosis (DVT) prophylaxis and indwelling catheter for 24 to 48 hours.[5]

The intraoperative considerations include injecting vaginal mucosa with 0.025 percent bupivacaine or 2 percent Lidocaine with 1:200,000 epinephrine to create plane and minimise bleeding. Keep the operating plane of dissection superficial to

pubocervical and rectovaginal fascia. Consider insert of an indwelling catheter to provide better understanding of the anatomy. The incision made should be about 4 to 5 cm away from the urethral meatus. If MUS is needed, use different incisions to avoid sling migration to the bladder neck. Also consider performing a routine check cystoscopy to exclude bladder injury and to assess ureteral patency. One should also consider performing a distal levatorplasty and perineorrhaphy to reduce the size of genital hiatus.[4,5]

The significant post-operative complications occur in 5 percent of patients. Most of the post-operative morbidity and mortality are due to effects of age and the frail condition of patients; usually due to cardiac, thromboembolism and cerebrovascular events. Minor complications have been reported as 15 percent and the surgical mortality is 1: 400 patients.[6,7]

In summary, colpocleisis is an excellent option for frail, fragile and medically compromised patients. It is a viable option for patients with massive stage 4 prolapses and patients who have failed all other options. Colpocleisis is an excellent option, for it offers between 90 to 95 percent subjective and objective cure rates.



Stage 4 uterovaginal prolapse

After complete colpocleisis

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Management of Rectovaginal Fistula

1. **Michael Pak-Kai Wong**
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2. **Ismail Sagap**
MB ChBao (Ireland), FRCS (Edinburg), MS (UKM), FAM (Malaysia)

Senior Lecturer & Consultant Colorectal Surgeon, Hospital Canselor Tuanku Muhriz, UKM Medical Centre

Rectovaginal fistula (RVF) is an abnormal connection formed between the anus/rectum and vagina. The term anovaginal fistula may also be used when the internal fistula opening is found below the anorectal angle. Unfortunate women with this condition often complain of cumbersome soiling and itchiness within the vagina and is associated with dyspareunia, elements of depression and stress. RVF could also lead to recurrent urinary tract infection and sepsis.

In Malaysia and most developing countries, rectovaginal fistula occurs as a resultant from obstetrics trauma. However, RVF may be due to radiation effect, anorectal malignancy, trauma or it may be part of Crohn's disease (CD). In a Western population with a higher prevalence of Crohn's disease, they have reported the incidence of RVF of 10 percent of the diseased population.[1]

In treating RVF, it is pertinent to control the aetiological disease process such as that of the Crohn's inflammation and eradicate intercurrent sepsis that is associated with the fistulation. Consequently, the fistula may be surgically intervened in a delayed manner.

Broad spectrum antibiotics and stool bulking agents may be used during the initial phase of fistula development whenever septic complication from urinary tract infection is anticipated. It is uncommon to incorporate a diversion stoma, except in the case of difficult septic control of Crohn's disease.

Surgical treatment of RVF includes transabdominal, transperineal, transanal and transvaginal approaches. The main principles of repair involve separation of the affected organ layer within the fistula opening and filling the gap or space with a barrier created with fresh and healthy tissue or synthetic biological mesh.

The women who have obstetrics RVF should have a detailed assessment of their anal sphincter by anal manometry and an endoanal ultrasound study. It is important to emphasise pelvic floor exercise anal sphincter strengthening before embarking on surgical intervention. During this treatment period, psychological counselling should also be given to motivate them to endure through the agony of the disease. From our experience, anal incontinence has been the most significant fear among these women.
A full thickness advancement flap may be used for a lower location RVF. This could be performed either within the vagina or the rectum. The primary healing rate for transvaginal full thickness advancement flap and rectal flaps were reported as 60 percent and 56.3 percent respectively.[2]

The standard approach towards obstetrics RVF with incontinence is overlapping sphincteroplasty. It has been used effectively, and according to a recent Cochrane review, this technique produced lower faecal urgency and anal incontinence along with faster fistula healing rate compared to those who underwent primary repairs that use interposition of healthy tissues.

For the higher location RVF, the Martius flap operation is a reasonable option to consider. This involves inserting a labial pedicled fat pad in between the perineal body, after separation of the fistula opening from the involved organs. This has resulted in 65 percent and 75 percent of primary healing rates for the RVF related to Crohn's disease and other aetiologies respectively.[3] Another commonly performed surgery is the use of Gracilis muscle interposition. While the technique produces 75 percent primary fistula healing, it did not seem to have a good healing outcome for patients with Crohn's disease according to Wexner et al.[3] In addition, both the Martius flap and Gracilis interposition should not impose incontinence issues when anal sphincter dissection is not particularly involved.

Our approach towards postprocedural care and counselling for our young patients with RVF has been the usual advice on careful coitus during the immediate postoperative period with proper contraceptive plans for at least two years. This will allow sufficient time for the wound to heal and cultivate confidence in preparation for the next pregnancy.

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Risk Reducing Salpingooophorectomy in Women with BRCA Gene Mutation

Dr Chew Kah Teik

Ovarian cancer is the fifth most common type of cancer amongst women in Malaysia.[1] The estimated risk of ovarian cancer among women with breast cancer susceptibility gene BRCA 1 is 20 to 50 percent and about 10 to 15 percent among those with BRCA 2 mutation.[2] Unlike cervical cancer, there is no prevailing single effective screening tool that can be used to screen women at risk of ovarian cancer. Although various options have been proposed, such as detailed family history screening, ultrasound scan and serum CA 125, there is no solid evidence to support efficacy of such screening methods. Hence, risk-reducing salpingo oophorectomy (RRSO) has been recommended as an effective prophylaxis measurement to reduce lifetime risk of ovarian cancer in women with BRCA 1 and BRCA 2 gene mutation.

What is RRSO?

It is a surgical procedure where both the fallopian tubes and ovaries are removed, without clinical evidence of lesion, in a woman with BRCA 1 and/or BRCA 2 gene mutation.

Which is the preferred approach to RRSO?

In modern medicine, laparoscopic approach RRSO is preferred in view of the lower morbidity compared to laparotomy.

When is the optimal time for RRSO?

For a woman with BRCA 1 gene mutation, it is recommended that RRSO is performed at the age of 35 to 40 years, or as soon as possible once childbearing is complete. In women with BRCA 1 gene mutation, the prevalence of ovarian cancer is extremely rare before 30 years of age, reaches 2 to 3 percent at the age of 40, and increases to 14.2 percent at the age of 50.[3,4] The benefit of RRSO reduces with age in women with the BRCA 1 gene mutation.

For women with BRCA 2 gene mutation, the prevalence of ovarian cancer is about 2 to 3 percent at the age of 50. Thus, it is acceptable that RRSO can be delayed till the age of between 40 to 45 in women with BRCA 2 gene mutation.

What are the benefits of RRSO?

Besides reducing the risk of ovarian cancer by 80 to 90 percent, RRSO also reduces 26 to 60 percent of all cause mortality related to ovarian and breast cancer.[3,5]

What are the complications and side effects of RRSO?

In general, RRSO is a safe surgical procedure. The most common side effect is related to surgical menopause symptoms such as hot flush, osteoporosis, increased risk of cardiovascular disease, reduced libido and cognitive changes.[6]

Should concurrent hysterectomy be performed?

Currently, there is still lack of clear association between BRCA gene mutation and endometrial cancer.[7] Nevertheless, hysterectomy may be beneficial in women with Lynch syndrome and those who plan to take tamoxifen. However, there is still lack of data to support hysterectomy at the same setting of RRSO.

Should we give these women hormone replacement therapy (HRT) after RRSO?

In women with surgical menopause, HRT should be individualised with close monitoring. All women should be counselled with regards to menopause and management options before opting for RRSO.

Are there other alternatives besides RRSO?

Prophylactic salpingectomy with delayed oophorectomy may be a cost-effective option offering a more favourable life expectancy.[8] Another strategy is chemoprevention with oral contraceptive pills, however limited data is available at present.

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Poor Ovarian Response: **Light At The End Of The Tunnel**

Dr Muhammad Azrai Abu

Poor ovarian response (POR) or previously called poor ovarian reserve still remains a clinical therapeutic challenge despite advances in modern assisted reproductive method (ART). The prevalence of this condition is difficult to determine as the population is still not yet homogenous until recently, but estimated ranging from 9 and 24 percent.[1] POR is well known to be associated with diminished ovarian reserve following advances in age or damages done by specific disease, drugs or surgery.[2]

The biggest issue in POR previously is lacking of consensus on its definition, which limits the ideal treatment. Initially, Bologna criteria developed by ESHRE consensus group in 2011 aims to standardise the definition of POR.[2] Ovarian reserve markers like serum Anti-Müllerian hormone (AMH) or antral follicle count (AFC) is pivotal investigation criteria in POR patients.[3] However, inadequately considering age related impact of oocyte quality and ignorance of FSHR or LHR polymorphism or the presence of variant LH with a good ovarian reserve is making this definition less specific. Hence, no proposed recommendation was made by the consensus group until 2016 when patient-oriented strategies encompassing individualised oocyte number (POSEIDON) classification was developed focusing on age, antral follicle count and /or AMH and ovarian response, if previous stimulation was performed. The expected poor responder patient according to the age of the patient is classified as either POSEIDON Group 3 or 4 with suggested ideal management recommendation.[4]

The first line treatment for expected POR is usage of long GnRH agonist down regulation protocol unless double stimulation protocol is favoured.[5] Ovarian rejuvenation achieved before each ovarian stimulation significantly increased the number of mature oocytes by one oocyte with lower cancellation rate compared to the GnRH antagonist protocol. Later, the cumulative live birth rate can be increased by 5 percent with additional one oocyte retrieved.[6]

Regarding starting dosage of gonadotrophin, stimulation rather than natural cycle should be the preferred treatment proposed in POSEIDON Group 3 and 4. Although higher initial dosing does not result in a higher number of oocytes collected as follicles cannot generate de novo, the cumulative live birth rate of six natural IVF cycles is only 7 percent compared to one stimulated cycle using a daily dose of 300 IU which resulted in a live birth rate of 11 percent.[4] Furthermore, the concern towards increase embryonic aneuploidy rates with higher stimulation can be neglected following evidence from young oocyte donors. Combination of follicular and luteal phase ovarian stimulations called DuoStim or Shanghai protocol is one of the promising approaches to maximise the number of oocytes retrieved in a single ovarian cycle.[7] This will provide more opportunities to collect better oocyte outcome, resulting in embryos having similar development potential especially for the cases that repeatedly did not have oocytes retrieved or have viable embryos using conventional IVF regimens. A better preparation protocol during frozen embryo transfer centred on luteal phase support and endometrial receptivity will enhanced the cumulative live birth rate.

Adjuvant therapies using growth hormone, androgens and LH supplements in achieving synergistic effects on follicular development still show equivocal results. Promising treatment using stem cell or platelet rich plasma protein for development of new oocyte is the way forward to manage patients with POR after more clinical evidence is made available later.[8]

Approach in treatment of the expected POR patient should be individualised. Method of stimulation protocol either using GnRH analogue, gonadotropin type and dose, ovulation trigger, and the possible use of adjuvant therapies must be counterbalanced with patient safety and costs with optimising time to live birth.

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Women's Health Initiative Study, 16 years later!

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Many women look forward to menopause. It's freedom without having to worry about menstruation and contraception anymore. They feel happy with the thought that all the reproductive problems are over - the fibroids and endometriosis will disappear! Some of them may not have anticipated the problems associated with menopause. They become gullible to the opportunist who advocates them with non-evidence based therapies, that at the best only have a placebo effect or therapies that may lead to unexpected or unrecognised side effects.

Menopause management has undergone enormous change over the last few decades. Sixteen years have passed since the publication of the first results of the Women's Health Initiative (WHI) Study in 2002[1], which demonstrated that oestrogen plus progestin increased the risk for cardiovascular complications, deep vein thrombosis and breast cancer, and oestrogen alone increased the risk for stroke and deep vein thrombosis; but not coronary heart disease or cancer. However, both prevented fractures.

The fear and confusion regarding the use of hormonal therapy (HT) after menopause is still lingering in the public and health care providers until today. It has been well documented that since the initial publication of WHI Study, hormonal use has decreased substantially.[2]

Now, after sixteen years of WHI report, we see these changes regarding menopausal management:

1. The dramatic loss of public confidence for HT to alleviate troublesome menopausal symptoms.[3]
2. The uncertainty of the health care providers (HCP) in management of menopause symptoms and chronic menopause complications.[4]
3. The use of the term Menopause Hormone Therapy (MHT) rather than Hormonal Replacement Therapy by the International Menopause Society (IMS).[5]
4. The increasing number of women suffering from acute menopausal symptoms[3] and long-term menopausal complications.
5. The increasing number of patients suffering from osteoporosis and fractures attending the orthopaedics' clinics[6,7]; the increasing number of patients suffering from genito-urinary syndrome of menopause (GSM); the increasing number of patients suffering from atrophic vaginitis attending the gynaecologists' clinics; the increasing number of patients suffering from recurrent Urinary Tract Infection (UTI) attending the urologists' clinics.[8]
6. The development of new menopausal regimens, oestrogen and progestogens which are moving towards non-oral routes to reduce the risk of thromboembolism and breast cancer.[9,10]
7. More evidence and data of HT benefits on cognitive function, dementia, and Parkinsonism.[11,12]
8. The rise of Bio-Identical Hormonal Replacement Therapy (BIHRT) products for the treatment of menopause, although these products are not supported by North American Menopause Society (NAMS) and International Menopause Society (IMS).[13]
9. The evolution and development of FDA approved medications for menopause, Selective Tissue Estrogen Activity Regulator (STEAR) example. Tibolone[14], Selective Estrogen Receptor Modulator (SERM) example raloxifene[15], ospemifene[16,17]; Tissue-Selective Estrogen Complexes (TSEC) example bazedoxifene with Conjugated Ethinyl Estradiol (CEE).[18]
10. The rise of alternative therapies for menopause: soy isoflavone, sea buckthorn oil, black cohosh, red clover etc.[19,20,21]
11. The awareness of supplements intake example calcium, omega oil.[22]
12. The emphasis on healthy life style, diet and exercise to live well in menopause.[23]
13. IMS guidelines and recommendation for menopause management, published in 2004, 2007, 2010, 2011, 2013 and 2016.[5,24]

Oestrogen therapy is evidently the best therapy for relieving climacteric symptoms and if given from near menopause and in the likely therapeutic window of benefit, the therapy may have long-term advantages. However, the risks of oestrogen have been inflated by the popular press and those purveying alternative therapies.

Published studies like KEEPS, ELITE, DOPS, ESTHER etc. in the last few years are now confirming the window of opportunity in early menopause when cardiovascular harm is avoided and benefits for primary prevention of osteoporosis fractures coronary artery disease and a reduction in all-cause of mortality for women can be achieved. These studies strongly suggest that it is the progestogen component of HT that is more significant in any increase in breast cancer risk rather than the oestrogen. Modern progestogens, natural progesterone, local intrauterine progestogen delivery systems, for example Mirena and the substitution of progestogens with SERMs to optimise metabolic and breast effects are widely used now.[25,26]

It is our duty as healthcare providers to follow the evidence based recommendations of IMS guidelines to ensure and provide optimal care for all women in midlife and beyond. And we should continue to disseminate our knowledge to the public directly or indirectly through the press or social media regarding evidence based therapy for these women.

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Implement sex education without delay

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OCTOBER 15 — This morning I woke up to the news that an 18-year-old girl died while giving birth in a house in Perak and the police had sent her body for a post mortem. Her baby also did not make it.

I don't even know her religion or her race and I don't really want to know. All I know is that a young girl with so much promise, so much potential died simply because she had sex and got pregnant. That's the fatal mistake she made and she paid with her life.

We don't need to wait for the results of the post mortem for her cause of death; it's lack of sexual education, lack of access to contraceptives, lack of societal acceptance of teenage pregnancies and the wrenching stigma that surrounds cases like her.

We don't even need to ask why because we already know why.

We don't even need to ask what to do because we know what to do.

Call me an idealist, call me a deluded crusader, call me whatever you want to call me, I don't really care.

But what I care about is no other girl will lose her life or a baby dumped and buried alive or eaten by rodents because society and the authorities continue to preach from their moral high chairs.

So spare me the rhetoric, the preaching, the half past six approach and superficial attempts at solving this problem and look at that girl and her baby and do the right thing.

It's time we do some soul searching as a nation.

Are our face saving and morality so important that it's worth more than the girl's life?

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https://www.malaymail.com/s/1683083/implement-sex-education-without-delay-john-teo

Enhancing Women's Well-being Through Healthcare

Ms Felicity Mishan Ng Yiwey, *International Medical University*

WOMEN'S EMPOWERMENT - A strong, bold, stand-alone phrase that has garnered much attention in today's world. Many people have questioned the movement and the need for such highlight. Some have even argued its stance. They tell you that 'change is far, so rest your case' or they say, 'keep quiet, girls don't question, make your peace', but for how long can we allow these words to speak louder than the struggles girls all over the world face every day?

We hear stories of Malala Yousafzai, a brilliant advocate for girls, shot in the head for her fight for girls' education. We hear of 200 Nigerian girls kidnapped by terrorists because these girls were adamant in wanting an education and we hear of girls denied healthcare, for simply being girls. Even in our own beloved country, we hear of young girls, barely teenagers, forced into marriage and motherhood while the boys are allowed to enjoy their childhood. While nothing compares to the struggles these girls face, I too have faced gender discrimination and have sadly fallen into a trap where I let these voices overpower my very own.

Truly, there has not been a better time for this movement to take centre stage. We are at the height of development, with new technologies being put in place in the telecommunication, transportation and most importantly, the healthcare industry. We have been able to listen to their stories, to reach out to these women and their families. We have been able to transport facilities enabling us to educate and empower these women to reach greater heights. Through this, I have always wondered where Malaysia stands in the battle of gender equality. My main interest was the healthcare system and where better to begin with, other than my Obstetrics and Gynaecology (ObGyn) posting.

Dear readers, I am a fourth-year medical student who has just completed my eight weeks posting with the ObGyn department. I have always been a passionate advocate for women's rights and gender equality. On the international front, I have heard stories from many incredibly brave girls and women from all over the world. These people have shared their survivor stories of rape, human trafficking, child marriage and girls' right to medical care and education. These women come out and empower other women and they educate the society on what constitutes a fundamental right of gender equality. I had decided to take this ObGyn posting as an opportunity to learn about the healthcare services provided to women and to empower any female patient at the hospital, to the very best of my abilities. Other than to familiarise myself with my potential working place, I saw it as an adjunct to further stimulate my interest in women's rights and gender equality movements, including the possibility of providing improvements to the healthcare system in Malaysia.

I began my posting in the Obstetrics ward. Wide eyed, motivated and excited, I read up on the services provided by MOH to women who consider pregnancy, who are pregnant and who have delivered. I thought the system in place was excellent with the vast array of policies, strategies and programmes sensitive to cultural, educational and socio-economic backgrounds that catered for women all over the country. Implementation and quality of service was reflected by the national maternal mortality ratio (MMR). There has been a steady drop in numbers since our independence. From 1967 to 1970, the MMR has been reduced from 280 to 141 per 100,000 live births, and by the 1990s, it declined further. Thereafter, the nation witnessed a whooping success of 31 deaths per 100,000 live births in 2008, followed by the current lifetime risk of 1 in 1200 maternal deaths in Malaysia. The statistics speak for themselves and it clearly reflects the improvements we have made over the past years.

On top of that, it is a highly accessible, affordable and convenient means for pregnant women to seek medical care. Being Malaysian, I am proud of services my country has to offer but I cannot help but think about the women in countries where gender discrimination is at its height coupled with poorly developed healthcare system. Then again, is our high standard healthcare policy made easy for ALL the women in Malaysia? I do not think so.

As for female foreign workers in Malaysia, being foreign already makes them subjects of discrimination. What more being foreign and a woman at the same time? The equation is hard to comprehend. From personal experiences, these women are commonly viewed negatively, being portrayed as women with no class, no dignity and no future. While discrimination also applies to male foreign workers, the extent of this article is limited to the Maternal and Child Healthcare (MCH) services provided in Malaysia. For these women, their access to healthcare is inconvenient, tedious and incredibly expensive. To make things worse, healthcare staff are required to report any illegal immigrants to the authorities even when these women are at their most vulnerable state. Although this is again a global issue that needs attention, we should be the front liners and make a difference with the MCH services. We are proud of the statistics but if women are still being discriminated for their nationality and gender in our very own country, we are back to square one.

As I encounter and listen to more stories, I realise what it truly feels like to be a woman. Women are strong, brave, delicate creatures. We are human beings first, and female next. A global effort is already in place to ensure that justice is served where due, but it all begins with an individual and the changes a single person can make. I continue to empower the women I meet, by sharing the stories I have heard and by treating these women with kindness and compassion. I think it is a contagious movement and I hope someday, this small effort that I have made within this small circle will be impactful. I have narrated the situation in Malaysia and I am hopeful for the future. May our country continue to show improvements and be an example to other countries globally.

Challenges As A Young Academic

Dr Ng Beng Kwang

In our current world, university hospitals serve as important platform for educational training, scientific research and public service. Academic medicine training pathways are changing rapidly. I would like to share my humble experience as a clinical lecturer, in the hope that this may provide useful insights for those considering a clinical academic career.

a. Coping with Change

Shifting from solely clinical to clinical academic post requires substantial and tedious effort. You are expected to negotiate a successful path in both domains, in order to be considered reasonably competent. Bridging the two institutions is always associated with bureaucratic niggles, and occasionally difficulties with contractual arrangements. You may sometimes feel you belong to neither institution.

Nonetheless, noticeable amount of skepticism surrounds clinical academics, to name a few: "You can be a successful clinician or a successful academic, but it's very difficult to be good at both" or "The trouble with academic registrars is that they are never around".

On the positive side, I found the wide variety of activities stimulating, challenging, and rewarding. To be able to discover, learn and teach, and at the same time treat, is definitely an experience that a purely clinical training post cannot offer.

b. Balancing Commitments

The job spectrum for a clinical academician is somewhat extraordinary, as we are given the privilege to teach and to treat. Good time management skills appear to be a crucial aspect in this regard, given the need to constantly juggle between clinical, research, and teaching commitments and manage ongoing activities in each of these areas. It is undoubtedly demanding. However, the journey will always be rewarding.

c. Sustaining Writing and Publication

Some key skills or attributes are helpful in an academic role and writing is one such skill, given that much of what a clinical academic does revolves around writing in the form of grant applications and preparing manuscripts, reviews, and so on.

Apart from writing, academics are oftentimes faced with tight deadlines, multiple competing time commitments, or even dealing with academic problems that may initially appear beyond one's grasp. Being able to cope with rejection is also essential. For instance, not all applications for funding will succeed nor will every manuscript be accepted for publication; and all these are part and parcel of academic life.

Sustaining writing and publications is probably the most burdensome and challenging part for budding academics. Some may even find it an almost unattainable task. This may be the commonest reason halting young doctors from joining the field. However, maintaining clear focus and to be fully committed; along with appropriate facilitated supervision from seniors, this almost impossible task will definitely become more realistic. This achievement will definitely bring you not just personal satisfaction but also contribute towards improving the quality of future medical care.

d. Lack of Access to Resources

With ongoing financing reforms, universities are now 'commercialised'. Academics from respective universities are expected to be less dependent on public grants. They are encouraged to source and generate independent funding for their own research. Obtaining research funding poses a great challenge and is an essential element of an academic career. This is specially so in recent years, where the grants allocated for research have been considerably reduced.

e. Personal Life Changes

With the advancement of technology, incorporating work into personal time is probably unavoidable at times. However, being able to work from home can sometime be more pleasant and has proven to be more productive. The arrangement should be made flexible to meet the demanding deadlines. Of course, credit is to be given to your understanding spouse and having strong family support.

f. Doubts about Academic Careers

The number of academics has remarkably increased in recent decades. This situation no doubt has directly impacted the welfare of academics, including promotion and career building. As a result, younger generation medical doctors are seeking better opportunities in the private sector, where they are offered better remuneration.

Conclusion

Despite all the hurdles mentioned, the future for younger academicians is still promising and rewarding. The job satisfaction as a "researcher-teacher-healer" is beyond words. With unceasing passion, resilience, wise time management and progressively developing academic skills, I can assure you these 'almost infeasible' tasks will soon become reality and you will enjoy every bit of these along your journey.

"And Finally..."

Dr Eeson Sinthamoney

While the word 'communication' is rather easily defined as "a process by which information is exchanged between individuals through a common system of symbols, signs, or behaviour", what is rather more complex and intriguing is the understanding of what constitutes 'effective' communication.

We are all well aware of the importance of effective communication in medicine. Many of us have been accused of 'perceived' wrongdoing when in actual fact, poor communication is the culprit.

It is our belief that efficient and effective communication is crucial beyond the boundaries of clinical medicine. It helps foster a good working relationship within the fraternity, keeps us continuously updated, informed and for those actively involved in the running of the society, it improves morale and efficiency.

It is this guiding principle that has motivated us to relook our society newsletter, "CONNECT". We hope that you have noticed the subtle changes. Rest assured that it remains a work in progress. Change, after all, is a dynamic process.

For change to be effective and useful, it requires the support of all parties. Over the past few weeks, we have been reaching out to many of you, senior consultants, young trainees, academicians or otherwise, sub-specialists and generalists. We are humbled by your enthusiasm and willingness to participate in our efforts to make our newsletter better. If society members were the metaphorical building bricks, the office administrators would be the pillars and the council the roof. Perhaps this newsletter would then be the cement and plastering that gives our proverbial 'house' the finesse and finishing that would be the envy of other fraternities!

Diwali

Wishes To All

Heavy hooded lids, envelops sleepy darkness.
Hammers and tongs, bells and gongs,
self-induced din in blackness.
Dried out throat, curried mutton bloat,
over indulgence rises to gloat.
A good sleep not, nausea and flatulence fraught,
a price to pay.
The night before, drinks galore,
recovery morning today.
Light peeps through, cracking open lids.
Casting away the darkness,
it slowly and surely did.
Easing away the hungover blues,
sorting out the wake up cues.
So now cleansed by the healing light,
able to enjoy this day's delight.
So with everything cheery and bright,
Happy Diwali to all in heart, beyond sight.

~Nom de Guerre~
The author of this literary masterpiece is a Senior Consultant Obstetrician and Gynaecologist in the public sector and prefers to remain anonymous!

Visanne®

targeted therapy for Endometriosis[1,2]

- Equivalent pain relief to GnRH agonist in endometriosis-associated pain symptoms.[2,3,4]
- Long-term treatment option with proven sustained pain relief.[5]
- A targeted treatment for endometriosis without the troubling hypoestrogenic side effects such as hot flushes and loss of bone density.[1,2,3,5]

References: 1. Köhler 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.** Strowitzki T, et al. Dienogest in the treatment of endometriosis-associated pelvic pain: a 12-week, randomized, double-blind, placebo-controlled study. Eur J Obstet Gynecol Reprod Biol. 2010 Aug;151(2):193-8. **4.** Strowitzki T, et al. Detailed analysis of a randomized, multicenter, comparative trial of dienogest versus leuprolide acetate in endometriosis. Int J Gynaecol Obstet. 2012 Jun;117(3):228-33. **5.** Petraglia F,et al. Reduced pelvic pain in women with endometriosis: efficacy of long-term dienogest treatment. Arch Gynecol Obstet (2012) 285:167–173.

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

Full prescribing information is available on request
For Healthcare Professionals Only

Visanne®
dienogest 2mg

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