2012/2013 ISSUE 1

OGSM NEWSLETTER

FROM THE PRESIDENT'S DESK

Dear Colleague,

The Kuching AGM elected a council with four new members. To date we have had 4 council meetings to address some of the issues affecting our profession as well as to continue to run routine programs like CME.

My own start as President was a baptism by fire. My first duty on the morning after the installation was to stand in (at short notice) to deliver one of the Plenary Lectures at the RCOG International Meeting. The original speaker from the UK had passport problems and was unable to travel to Malaysia.

I would like to comment on the following:

Membership

Dr Thaneemalai, our secretary, has been tasked with "cleaning up" the membership list as we have many members in default of subscriptions, some for many years. The secretariat has been contacting members and I urge members to give Dr Thaneemalai and the secretariat staff your cooperation regarding outstanding dues. Of course there is Life Membership which only costs RM 1000. It is essential that all in our membership list are in benefit so as not to run the risk of deregistration.

New website & newsletter

One of my frustrations has been the inefficiency and problems with the OGSM website as members had difficulty paying subscriptions online. We now have a new webmaster and to reflect changing times a newly designed website. Check out the website (*http://www.ogsm.org.my).* If you experience any difficulties please contact the OGSM secretariat.

Dr Goh Huay-Yee has been working with the webmaster in ensuring that the website fulfils OGSM member's needs. This has taken much effort and I would like to extend my appreciation to her. The newsletter, as you will notice, has also has been revamped and it is edited by Dr Hoo Mei Lin. I would like to also thank her for her excellent effort.

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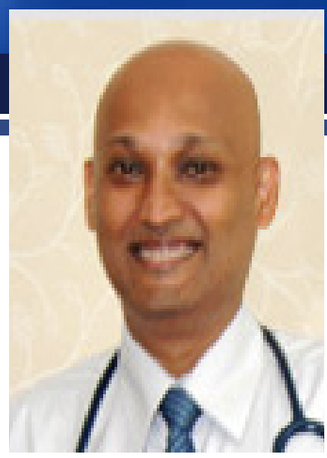
SECRETARY'S REPORT



The new OGSM council had their first council meeting the day after the 49th Annual General Meeting. The young, energetic council members were assigned and took charge of their respective portfolios. OGSM subcommittee chairpersons and State Coordinators have also been appointed. The OGSM funding guidelines enables our State Coordinators to arrange academic and fellowship activities. Regional members are advised to liaise with these newly appointed persons to organise regular events.

Shankar Sammanthamurthy; our Assistant Secretary; has been put to task to revamp the OGSM website. We aim to make it more user friendly for our members. One of our main objective is to enable members to pay their annual subscriptions and update their profile online.

Mei Lin is now overlooking the OGSM newsletter. Look out for the issues quarterly. In our efforts to reduce our carbon footprint, the newsletter will also be available online. The 10th RCOG International Scientific Congress was a huge success. We had one thousand four hundred delegates registered. The scientific was excellent with valuble updates. The social program was a huge success.. The work on the next Malaysian International Congress 2013 is already in full swing. It will be held in the Shangri-La Hotel, Kuala Lumpur. OGSM is aiming to organise quite a few short courses over the course of the year. Look out for the announcements in the newsletter and the website. All members are kindly reminded to pay their annual subscription fees and update their membership details. If you find it hard to pay annual subscription, why not consider becoming a Life Member; it will be more convenient and cost effective. We are updating our members list and please be forewarned that if your subscription is not up to date, you may get a reminder phone call from the secretariat.

Thaneemalai Jeganathan
Honorary Secretary

THE OGSM WEBSITE REVAMPED

In line with OGSM's continued efforts to be more accessible to our members, we have revamped the OGSM website. We aim to make it user-friendly and relevant to you.

Now on the website, you can manage your membership, update your contact details and yes, you can even pay your subscriptions online. There is no need to hunt down Mr Chong at the OGSM Congress or endure long queues at the post office to mail that cheque. Updating your membership dues is just a click away.

The website will continue to update you about upcoming conferences, fellowship nights and other events. The OGSM newsletter is now also on the website. A podcast of selected fellowship night lectures will be made available to you here if you are unable to attend.

As we are updating all members' details on the website, you will be required to login for the first time using your NRIC number. The default password is 123456. You will then be prompted to change this password during your first login . Please ensure your profile information is correct and up to date at this time.

The website is still a work in progress and we welcome feedback from you. You can do this by either emailing us at ogsm@myjaring.net or using the links on the website. We hope that you will find the website useful.

TREASURER'S REPORT

Dear colleagues,

As the new council finds its feet and contemplates new endeavours for their term in office, the society has reached yet another milestone. From a financial stand point, our net worth has breached the RM5 million mark. In comparison to many other medical specialty societies, we are truly well-off. That said, the discourse during the last AGM in Kucing has made the sentiments of the grass-root membership abundantly clear. Despite our financial wellbeing, members are not in a spend-thrift mood. A resolution of ours was thoroughly debated. In my opinion, their chosen viewpoint is mature, wise and well founded. Certainly, being financially well-off places the society in an extremely advantageous position. We are able to plan all types of activities and bid for the privilege to organize important international conferences. We are able to invite distinguished guests from faraway lands to visit us and share their experiences and we have ample resources to play the role of a well-heeled host. That said, with this great wealth, also comes a gargantuan responsibility.

I often remind myself that we act on behalf of over 900 members. Certainly only less than 20% of these members are 'active', the definition of this term being members who actually both involve themselves in activities and also care to give us their opinions and attend the AGM's. A further 30% may partake in the society's scientific meetings and other educational activities but say little else. Therefore, there is a silent majority within the membership whose needs and opinions must also be acknowledged and addressed. It is after all OUR money! It is this that leads me to make a point about ensuring financial prudency and enhancing transparency in the society's financial transactions.

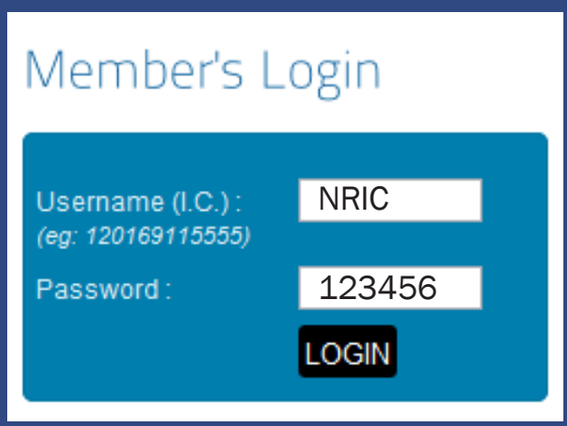
It will not be difficult to lose a substantial amount of our wealth by simply using bad judgement. An example may be a decision to host a large international conference which ends up with poor participation. The loss incurred may necessarily be borne by the society. This is an inherent risk in all our bids but thus far we have fared very well, our recent meeting in Kucing being a fine example. Suffice to say, it is often a judgment call, that too after assessing all the intricate fundamentals in the equation.

The thrust of our efforts for this term will be to re-examine our recently implemented financial guidelines, identify shortcomings (there always are!) and make the necessary improvements and additions and perhaps also to expand on these guidelines to in-cooperate other elements that will enhance financial integrity. We would also be exploring the possible advantages of establishing an educational trust fund, especially from a taxation perspective. For all state representatives, we implore you to utilize the funds allocated to enhance interaction and build friendship within the fraternity in your state and please always remember that we represent all members and not just a select few.

Finally, I wish all our Muslim members a pleasant and rewarding month of 'Ramadan' and a 'Selamat Hari Raya'.

Thank you and best wishes to all.

Eeson Sinthamoney
Honorary Treasurer



FOR YOUR FIRST LOGIN AT THE REVAMPED OGSM WEBSITE

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Default password = 123456

THE ROLE OF THE OBSTETRICIAN IN PREVENTING CEREBRAL PALSY AND PROTECTING ONESELF FROM LITIGATION

Professor Roger Pepperell
Professor Emeritus in Obstetrics and Gynaecology,
University of Melbourne.

The overall incidence of cerebral palsy (CP) is about 0.2% (2 in every 1000 births). The cause can be genetic, a problem during the antenatal period which may or may not be recognized, a problem occurring during labour (particularly hypoxia), or a problem occurring after delivery, usually in the first 1-2 years of life (cerebral haemorrhage, infection, infarction etc). There is general agreement that intrapartum hypoxia is the cause in about 10% of cases, with some of this hypoxia being preventable, some not recognised although it should have been, and some not acted on quickly enough. High payouts are now common where inadequate care has been defined by the Courts, with the largest payout for CP in Australia being $16.2 million in 2004 and the largest in Malaysia being 5.4 MR in 2011. Because of these payouts, many obstetricians are considering whether Obstetric care by them should be ceased. In order to consider this topic in detail, 4 separate matters are being covered in this presentation.

1. Causes of neonatal encephalopathy, a common precursor to the subsequent development of CP.
2. Epidemiologic associations of CP.
3. International Consensus Statements concerning intrapartum hypoxia as the cause of CP.
4. Methods obstetricians should use to protect themselves from litigation, in case a child develops CP.

1. Neonatal encephalopathy.

Although seizures in the neonatal period are relatively common (3-4/1000 neonates) and have a variety of causes (intracranial haemorrhage, hypogycaemia, hypocalcaemia, hypomagnesaemia, intracranial infection, cerebral developmental problems, and benign causes which may be related to a positive family history) where the seizures are due to hypoxia (commonly referred to as Hypoxic Ischaemic Encephalopathy) the subsequent likely development of cerebral palsy is increased.

The antenatal and intrapartum risk factors for Newborn Encephalopathy, as defined in two articles by Badawi et al, in the British Medical Journal in 1998 (B Med J 317: 1549-1553, and B Med J 317: 1554-1558) produced Adjusted Odds Ratios (RR) as illustrated in table 1.

Table 1: Antenatal and intrapartum risk factors for newborn encephalopathy

Risk Factor	RR
No labour or elective Caesarean Section	0.17
Abnormal Placental appearance	2.07
Emergency Caesarean Section	2.17
Instrumental delivery	2.34
Family History of seizures	2.55
Family History of nervous disorders	2.77
Antenatal viral illness	2.97
General anaesthesia for delivery	3.08
Moderate/severe antepartum haemorrhage Intrapartum fever	3.82
OP presentation	4.29
IUGR (3rd to 9th percentile)	4.37
Infertility treatment	4.43
Acute intrapartum event	4.44
Severe pre-eclampsia	6.30
Maternal thyroid disease (treated or untreated)	9.70
IUGR (<3rd percentile)	38.23

These relative risks clearly defined the most severe predisposing risk factor for neonatal encephalopathy was severe IUGR, but other problems defined in the antenatal period, including genetic problems, pre-eclampsia, antepartum haemorrhage, and even infertility treatment were also important matters to consider. This group had previously published data on the risk of CP in multiple pregnancies (BMJ 1993; 307:1239-43) when they indicated the risk of CP in singleton pregnancies was 1.6/1000 births, whereas it was 7.4/1000 births in twins and 26.7/1000 births in triplets.

2. Epidemiologic associations with Cerebral Palsy.

In a recent publication by the Australian Collaborative Cerebral Palsy Research Group (Obstetrics and Gynecology 118: 576-582, 2011) various epidemiologic risk factors for cerebral palsy were evaluated in 587 individuals in Australia with cerebral palsy and compared these with 1154 non-cerebral palsy controls. Many of these risk factors had been described by Badawi as being risk factors for Newborn Encephalopathy however many others were new or had been described as possible associations by other individuals. The risk factors detailed by the ACCPRG are detailed in the Table 2.

By far the most important risk factors for CP were delivery before 32 weeks of gestation (when the normal birth weight is about 1500g), low Apgar scores at 5 minutes of age, severe IUGR, multiple pregnancy and breech presentation, with some infections also being implicated. Fortunately the common maternal infections in pregnancy (urinary tract infection, URTI and gastroenteritis) were not found to be risk factors for CP.

Table 2: Risk factors for Newborn Encephalopathy by ACCPRG

Infection:		Odds ratio	Confidence	P interval (95%)
Any antenatal infection		1.71	1.39 – 2.11	<0.001
URTI	(0-20 weeks)	1.26	0.90 – 1.77	.18 NS
	(21-40 weeks)	1.13	0.80 - 1.59	.50 NS
	(Within 1 week post-partum)	1.38	0.52 – 3.65	.51 NS
Urinary tract infection		1.53	0.91 – 2.57	.11 NS
Herpes at 0-20 weeks		2	1.01 – 3.94	0.04
Other infections at 21-40 weeks		3.98	2.20 – 7.22	<0.001
Labour & Delivery complicated by infection		2.95	1.65 – 5.26	<0.001
Birth weight and incidence of CP				
Less than 3rd centile		11.75	6.25 – 22.08	<0.001
4-5th centile		2.63	1.22 – 5.68	0.01
6-10th centile		2.13	1.26 – 3.62	0.004
10-19th centile		1.67	1.09 – 2.54	0.02
Premature delivery				
<32 weeks cf all gestational ages		59.2	28.87 – 121.38	<0.001
<32 weeks cf >36 weeks		70.62	34.38 – 145.04	<0.001
32-36 weeks cf all gestational ages		3.33	2.33 – 4.75	<0.001
32-36 weeks cf >36 weeks		5.02	3.49 – 7.21	<0.001
Other risk factors				
Twins compared with singletons		6.62	4.00 – 10.94	<0.001
Relative with CP cf other rels without CP		1.61	1.12 – 2.32	0.01
Breech cf Cephalic presentation		2.48	1.76 – 3.49	<0.001
Vaginal breech delivery cf cephalic NVD		8.36	3.30 – 21.19	<0.001
Emergency CS breech cf cephalic NVD		4.48	2.62 – 7.65	<0.001
Elective CS breech cf cephalic NVD		1.32	0.75 – 2.34	.34 NS
Disappearing twin on US cf singleton		1.98	0.82 – 4.79	.12 NS
Bleeding at any time in pregnancy		2.04	1.61 - 2.58	<0.001
Nuchal cord or entanglement		1.86	1.28 – 2.71	0.001
Drug use cf no drug use		2.22	1.14 – 4.30	0.02
Smoking cf non-smoking		1.37	1.02 – 1.85	0.04
Apgar score <4 at 1 minute cf >8.		20.27	11.29 – 36.42	<0.001
Apgar score <4 at 5 minutes cf >8.		51.27	12.20 – 215.47	<0.001
Male compared to female sex.		1.68	1.38 – 2.06	<0.001
Emergency CS delivery cf NVD		2.42	1.88 – 3.12	<0.001
Elective CS delivery cf NVD		1.39	1.00 – 1.94	0.05
Any miscarriage cf none		1.25	1.00 – 1.57	0.05
Three or more miscarriages cf none		2.3	1.38 – 3.82	0.001

CP = cerebral palsy	URTI = upper respiratory tract infection	CS = Caesarean section
US = ultrasound	NVD = spontaneous normal vaginal delivery	cf = compared with

3. International Consensus Statements concerning intrapartum hypoxia as the cause of cerebral palsy.

Two international consensus statements have been produced and published. The first was published in 1999, and the second in 2003. Each defined essential criteria necessary to prove intrapartum hypoxia had occurred, and criteria suggesting intrapartum hypoxia had occurred.

The essential criteria detailed in the first of these publications were as follows:

(MacLennan A. :- a template for defining a causal relation between acute intrapartum events and cerebral palsy: international consensus statement. B Med J 1999; 319: 1054-1059)

(a) Evidence of a metabolic acidosis in the fetus during the intrapartum period, umbilical arterial cord blood, or very early neonatal blood samples (pH <7.00 and base deficit ≥ 12 mmol/L).

(b) Early onset of severe or moderate neonatal encephalopathy in infants of >34 weeks gestation.

(c) Cerebral palsy of the spastic quadriplegic or dyskinetic type. Findings which were deemed to be non-specific were as follows.

(d) A sentinel (signal) hypoxic event occurring immediately before or during labour.

(e) A sudden, rapid and sustained deterioration of the fetal heart rate pattern usually after the hypoxic sentinel event when the pattern was previously normal.

(f) Apgar scores of 0-6 for longer than 5 minutes.

(g) Early evidence of multi-system involvement e.g. respiratory, renal, haematologic.

(h) Early imaging evidence of acute cerebral abnormality.

In the second study, which was produced by experts and released by the American College of Obstetrics and Gynaecology and the American Academy of Paediatrics in 2003, the essential criteria were similar but not identical, an extra essential criterion was added, and the non-specific criteria were also modified. These criteria are also detailed below:
The essential criteria defined were

(a) Evidence of a metabolic acidosis in fetal umbilical arterial cord blood obtained at delivery. The same values as detailed above in the International Consensus Statement were defined. (This Task Force excluded the use of pH results on samples performed in the early neonatal period because of the potential for these to be much less abnormal than the cord blood values because of the effect of the resuscitation process and the treatment given, or worse than the cord blood values due to inadequate resuscitation).

(b) and **(c)** Identical to the International Consensus Statement above

(d) Exclusion of other identifiable etiologies such as trauma, coagulation disorders, infectious conditions or genetic disorders. The criteria suggestive of an intrapartum timing were similar to those of the International Consensus statement above, with the first being identical, this being the need for a sentinel hypoxic event before or during labour, however the remaining 4 criteria were slightly modified. These 4 are detailed as 6-9 below.

(e) A sudden and sustained fetal bradycardia, or the absence of fetal heart rate variability, in the presence of persistentlate variable decelerations, usually after a hypoxic sentinel event when the pattern was previously normal. These criteria are more detailed than those of the previous International Consensus Statement.

(f) Apgar scores of 0-3 beyond five minutes. This Apgar score is much lower than that in the 1998 International Consensus Statement.

(g) Onset of multisystem involvement within 72 hours of birth.

(h) Early imaging study showing evidence of acute non-focal cerebral abnormality.

Two other publications concerning CTG abnormalities associated with cerebral palsy, indicated moderate fetal heart rate baseline variability was associated with an umbilical artery pH of > 7.15, and that except for hypoxia due to a sustained bradycardia, newborn acidemia associated with decreased baseline variability develops over about 1 hour (Parer et al, JMFNMed vol 19). In the second publication, by Nelson et al, NEJM 1996: 334: 613-8, the only CTG abnormalities associated with CP were those of recurrent late or prolonged decelerations or profound loss of short-term fetal heart rate baseline variability.

4. How should Obstetricians have protected themselves from litigation , should a baby delivered by them subsequently develop cerebral palsy?

The general criticisms levelled against an Obstetrician or Hospital when a CP case goes to Court, are that there was inadequate fetal heart rate monitoring, an inappropriate mode of delivery, delay in expediting delivery, or inadequate resuscitation of the baby often due the absence of a Paediatrician at the time of delivery.

Continuous CTG monitoring is not used universally in all labours although it should be used when the fetus is known to be at increased risk of hypoxia such as when labour is being induced or augmented (particularly when prostaglandin preparations or syntocinon infusions are being used) when there is maternal hypertension, pre-eclampsia, a previous antepartum haemorrhage or maternal diabetes, when meconium staining of the liquor or a fetal heart rate abnormality is defined by non-CTG methods, and when an epidural anaesthetic in being used for pain relief in labour. Most hospitals have developed lists of pregnancy complications where continuous CTG monitoring is deemed mandatory.

Where CTG monitoring is being used, it is important that all staff (midwives and Obstetricians) take into account the various features evident on the CTG (baseline rate, baseline variability, presence or absence of reactive accelerations, and the presence and timing of any decelerations evident) but ALSO the frequency of the uterine contractions particularly where labour is being induced or augmented by a syntocinon infusion. Even if the CTG is normal, if the contraction frequency exceeds 4 in 10 minutes, consideration should be given to reducing the infusion rate or ceasing it altogether, because the uterine contraction frequency in unstimulated labours rarely exceeds 4 in 10 minutes. If the CTG remains abnormal after the syntocinon has been ceased, or becomes abnormal when syntocinon is not being given, the place of fetal scalp pH assessment needs to be considered to indicate whether it is safe to allow the labour to continue or whether urgent delivery probably by Caesarean Section is required. Where the cervix is less than 5cm dilated, fetal scalp pH assessments would rarely be performed, but urgent delivery by Caesarean Section usually recommended, whereas if the cervix is 8-9cm dilated, and the pH is >7.25, labour would often be allowed to continue, as delivery would generally be possible within 1-2 hours.

The criticism of inadequate mode of delivery usually is because the plaintiff believes a Caesarean section should have been done, and was not. It is rare for a case to be run on the grounds that it was inappropriate for a Caesarean section to have been performed and this is the cause of the CP.

Delay in expediting delivery. This is usually suggested by the plaintiff because the time interval between when the decision was made that urgent delivery was necessary and when the baby was finally born, was excessively long. Most plaintiffs and their lawyers are unaware of the time taken to gain consent for the procedure, transfer the patient to the operating theatre, get the appropriate staff in attendance (nursing staff, anaesthetist, paediatrician, surgical assistant, especially if they have to be called in from outside the Hospital complex etc) and the fact that even in tertiary referral hospitals the decision to delivery time is rarely less than 30 minutes and in many hospitals is more than 1 hour. Data on this time interval in level 1, 2 and 3 hospitals in South Australia was published by Spencer and MacLennan in ANZJOG 2001: 41:7-11, and defines these time intervals accurately.

Where possible a Paediatrician should be in attendance in the Operating Theatre or the Delivery Suite, when there is probable fetal distress, or an anticipated difficult delivery, although the initial resuscitation should be able to be adequately performed by the Obstetrician or the midwife. Unless the baby has an Apgar Score of zero, when cardiopulmonary resuscitation is clearly necessary, the initial resuscitation is usually achieved satisfactorily by administering oxygen by frog-breathing or the use of a bag and mask, with the need for actual endotracheal intubation being able to be postponed for up to 5 minutes, and by then a Paediatrician is usually able to be in attendance.

All of the above managements refer to care in labour and delivery. In addition to these managements, care during the antenatal period should be clearly modified where a known predisposing cause for CP exists. This would be as follows:

i. If a twin pregnancy is present, the specialized care of such pregnancies should be instituted, and delivery expedited at appropriate gestations depending on the chorionicity of the pregnancy. It is also important to check that one or both babies are not developing IUGR, and that the Twin Twin Transfusion Syndrome (TTTS) is not occurring in monochorionic twin pregnancies.

ii. If premature labour occurs, particularly before 32 weeks of gestation, the patient should attend early in order that attempts are likely to be successful in inhibiting labour, in addition to allowing the administration of glucocorticoid therapy. Where delivery is expected to occur before 32 weeks of gestation, for any of a number of reasons, the place of maternal magnesium sulphate therapy in the 24 hours prior to delivery also need to be considered.

iii. If IUGR is defined, check the subsequent growth pattern and decide how long to let the pregnancy go on for, in addition to probably delivering the growth restricted baby by Caesarean Section.

iv. If the membranes rupture prematurely, antibiotic therapy should be instituted until it is proven there is no evidence of chorioamnionitis.

At the time of delivery, irrespective of how this is achieved, doubly clamp the umbilical cord. If the Apgar score is less than 6 at 5 minutes of age, collect an arterial blood sample from the clamped area of the cord, and have the pH and base excess defined. If this is clearly abnormal (such as a pH <7.15 or a base excess level in excess of 12 mmol/L) the resuscitation from the paediatrician will probably be changed and head cooling possibly instituted, whereas if these results are normal intrapartum hypoxia in the immediate pre-delivery phase of labour has been excluded. This is therefore important data to obtain to influence neonatal care and make litigation on the grounds of intrapartum hypoxia inappropriate if the pH and base excess levels are normal.

Where the baby is clearly growth restricted at birth, adequate paediatric care needs to define the probable cause of this, in addition to checking for low glucose, calcium and magnesium levels.

INTERNATIONAL CONSORTIUM ON EMERGENCY CONTRACEPTION

NEW GUIDELINES ON EMERGENCY CONTRACEPTION

The International Consortium for Emergency Contraception was founded in 1996 and its mission is to expand access to emergency contraception, with an emphasis on developing countries. The Consortium has produced these medical and service delivery guidelines about oral emergency contraceptive pills to assist family planning programs and providers in assuring that the women they serve can use these regimens effectively and safely. This document reflects the latest available evidence and has been reviewed by internationally recognized reproductive health experts. Local programs are welcome to adapt these guidelines as needed to comply with national or other requirements.

These guidelines do not discuss the use of the copper-bearing intrauterine device for emergency contraception. This device is the most effective emergency contraceptive option and should be offered to women when appropriate. Further information about this option is available on the ICEC website (www.emergencycontraception.org) and the Emergency Contraception website managed by Princeton University and the Association of Reproductive Health Professionals (www.not-2-late.com).

Indication: Emergency Contraceptive Pills (ECPs) are indicated to prevent pregnancy after unprotected or inadequately protected sex.

ECP Regimens: Three regimens are packaged and labeled specifically for emergency contraception.

- Levonorgestrel 1.5 mg, or levonorgestrel 0.75 mg taken twice 12 hours apart
- Ulipristal acetate 30 mg
- Mifepristone 10-50 mg

Take the pills within 5 days after sex, as soon as possible after the sex act.

How ECPs Work: The primary mechanism is disruption of ovulation. Other mechanisms have been postulated but are not well supported by data. No evidence supports the theory that ECPs interfere with the implantation of a fertilized egg. ECPs do not cause abortion of an existing pregnancy.

ECP Efficacy: The levonorgestrel regimen reduces pregnancy risk by at least half and possibly by as much as 80-90% for one act of unprotected intercourse. The ulipristal and mifepristone regimens are more effective than the levonorgestrel regimen.

Safety: ECPs have no known medically serious complications. Side effects may include altered bleeding patterns, nausea, headache, abdominal pain, breast tenderness, dizziness, and fatigue. ECPs do not appear to be harmful if inadvertently taken in pregnancy.

Precautions and Contraindications: ECPs have no medical contraindications. Do not take ECPs if you are pregnant because they will not work. Clinical Screening: You do not need any examinations or laboratory tests before taking ECPs.

ECP Use After More Than One Sex Act: Take ECPs after each unprotected sex act; do not wait until a series of acts has occurred. Use only one ECP treatment at a time (e.g., within a 12 hour period).

Repeated ECP Use: Use ECPs as often as needed. However, deliberate use of ECPs as a regular, routine contraceptive method is not recommended because more effective methods exist for this purpose.

Drug Interactions: Concurrent use of some drugs may reduce ECP efficacy. However, the ECP regimen is the same whether or not you are using these drugs.

Follow-up after ECP Use: No scheduled follow-up is required after ECP use. But if you have not had a menstrual period by 3 weeks after taking ECPs, consider that you may be pregnant.

Starting or Resuming Regular Contraceptives after ECP Use: ECPs are not designed to provide contraceptive protection at sex acts that occur in the future. Using a regular contraceptive after taking ECPs is CRITICAL to minimizing your pregnancy risk. Start hormonal methods (oral contraceptives, patch, vaginal ring, injectables, implants, levonorgestrel intrauterine system) either immediately or after your next menstrual period; if you wait, use a barrier method such as condoms in the interim. Copperbearing IUDs provide highly effective emergency contraception, so you do not need oral ECPs if you get this type of IUD within 5 days after sex. Do not rely on fertility awareness methods until you have had at least one normal menstrual period.

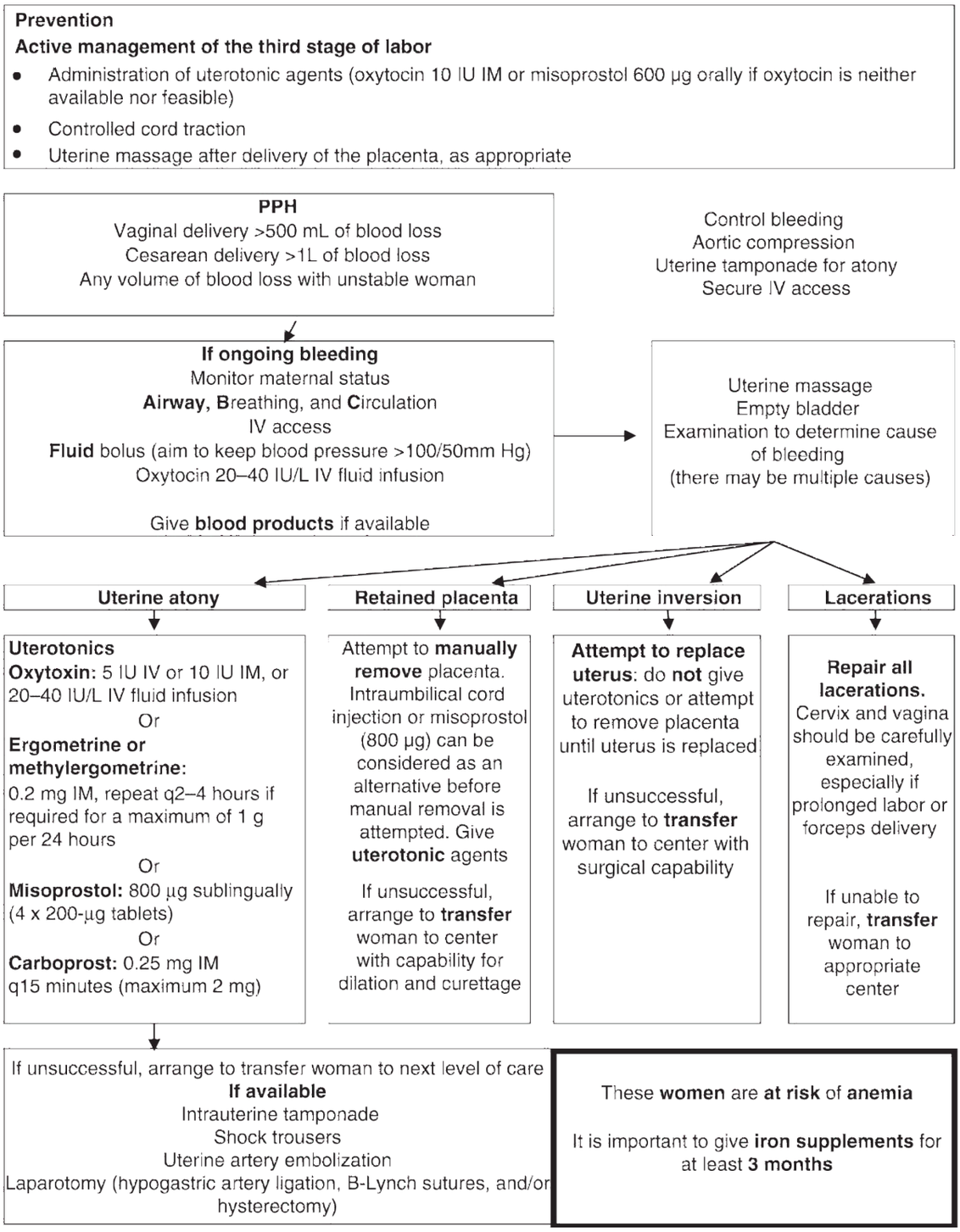
Resources

i. International Consortium for Emergency Contraception website: www.emergencycontraception.org

ii. The Emergency Contraception website, managed by Princeton University and the Association of Reproductive Health Professionals: www.not-2-late.com

THE PREVENTION AND TREATMENT OF POST PARTUM HAEMORRHAGE IN LOW RESOURCE SETTINGS

FIGO is actively contributing to the global effort to reduce maternal death and disability around the world. This statement reflects the best available evidence, drawn from scientific literature and expert opinion, on the prevention and treatment of PPH in low-resource settings. Approximately 30% (in some countries, over 50%) of direct maternal deaths worldwide are due to hemorrhage, mostly in the postpartum period [3]. Most maternal deaths due to PPH occur in low income countries in settings (both hospital and community) where there are no birth attendants or where birth attendants lack the necessary skills or equipment to prevent and manage PPH and shock. The Millennium Development Goal of reducing the maternal mortality ratio by 75% by 2015 will remain beyond our reach unless we prioritize the prevention and treatment of PPH in low-resource areas [4].



PRIVATE FEE SCHEDULE

CHARGE WHAT IS DUE YOU

All of us who has been working in private practice for a while, would realize that there is increasing pressure from private hospitals, Medical Care Organisations, to charge less than the stipulated fee by the Private Healthcare Act. These organizations exert pressures in direct and indirect ways:

- Contract with doctors that stipulate that a certain percentage of discount must be given automatically to patients, these discounts are usually given at the centralized charging centres operated by most hospitals. Most doctors have become 'numb' and 'unquestioning' to these practices and have accepted that by the 'contract' they have signed, they have to abide by that practice. These automatic discounts can range anything from 5-25%.
- Pressures from MCO that may grant contracts to hospitals that are willing to 'suppress' the fees of their consultants.
- Commercial pressure from your fellow colleagues who are willing to charge lower than the fee schedule. The fact that many private practises are of course also businesses, to keep business afloat, one may have to be competitive in charges.

At the same time our members are under pressure from increasing costs of practice and cover for medical litigation. I often hear members complain about the stagnation of the proposed fee schedule changes.

3 matters must be highlighted:

1. Although a new fee schedule has been proposed to the Ministry of Health, we are still unsure of its implementation.
2. Many of our members are still not charging the maximum of fees allowed for under the present Private Healthcare Act.
3. The cost of medical litigation insurance will likely only increase, and not decrease; unlike countries like Singapore and Hong Kong.

In light of this, I would like to draw your attention to a very important paper by Malaysian Medical Council (MMC) approved in January 2012. The paper is "MMC's Stand on Managed Care". This is reproduced in full on our website; www.ogsm.org.my. In particular, I would like to highlight a paragraph in this long document:

'The Thirteenth Schedule of the Regulations (2006) to the Private Healthcare Facilities and Services Act contains the professional fees for procedures carried out in private hospitals and other healthcare facilities. These fees are accepted as the maximum professional fees chargeable. Managed care organisations or third party payers sometimes request for discounts on the professional fees by private arrangement with the private hospitals as an inducement to refer corporate patients. Managed care organisations or third party payers sometimes restrict a patient's right of choice of a registered practitioner or health care facility. The MMC's position is that both these practices are unethical.

I hope that members will take the above matters into consideration when they are negotiating with their hospitals for new contracts. If there has been any restriction on the part of the hospitals' contracts to the doctors' charges, I believe you have ground for a renegotiation.

I also urge members to 'not outdo' each other in charging less than what is reasonable just to stay competitive. I know this is a difficult decision but as everyone catches up; I believe it will benefit all in this challenging times.

In the background of all these is the ever increasing cost of medical litigation coverage. It is the duty of OGSM to remind everyone to be adequately covered.

Tang Boon Nee
PRESIDENT ELECT

full guideline available on OGSM website

THE MALAYSIAN JOURNAL OF OBSTETRICS AND GYNAECOLOGY (MJOG)

Most members especially the younger trainees are familiar with the MJOG. This is the official scientific publication of our society and was first published in the early 90s. Over the years, about 30 issues have been published and the last publication was in June 2011.

The most recent editor of our journal was Prof. Zainul Rashid from HUKM and he has successfully helmed the editorial board since 2001. Over the years, the society and the editorial board have worked hard to optimize the journal especially with regards to its impact factor.

Several attempts have been made to get the journal indexed as it was felt that this would be an important driving force in allowing the journal to obtain an impact factor. However, this has proven to be difficult as the journal cannot be published on a regular basis due to a lack of good quality articles. This has resulted in a 'chicken and egg' dilemma whereby authors with well written papers shun the journal due to the lack of an impact factor and this has inevitably resulted in the journal stagnating over the years.

The issue of the journal has been visited on numerous occasions over the last three years and a more recent decision to do away with the hard copies (RM9,500/1,000 copies excluding postage) and instead convert entirely to a 'free-for-all' on-line version was seen as a positive move that would not only save costs but also significantly help us obtain/ improve on our readership and ratings. We have however not had a journal published yet since this decision was made due to a lack of articles. The current council has again discussed the issue and have reached some preliminary conclusions.

The Official Handover

These are as follows:

1. The journal may be important to some members / trainees who must have some publications but are unfortunately unable to get their work published in more established journals.
2. Despite our best efforts the journal has continued to stagnate over the years.
3. Many Malaysian universities have now published their own journals and therefore the MJOG will likely be further sidelined as a consequence.
4. The presence of other newer journals may make the MJOG redundant.
5. The decision to convert to an 'on-line' version is good and reduces the financial consequences to the society.
6. Professor Zainul Rashid has requested he be allowed to relinquish his position as Editor of the journal and there is therefore a need to identify a new Editor.
7. The council is willing to entertain the possibility of discontinuing the MJOG but understands that there is significant history behind the MJOG and this is therefore an important decision that must involve the views of the membership.

We would therefore like to request the following of our members:

- Give us your opinion as to whether the MJOG should be discontinued or otherwise
- If the journal were to continue publication, could you suggest names of members who would be suitable candidates to fill the post of journal editor
- Suggest ways in which the journal may be allowed to grow in stature and impact.

We would be grateful if you could provide this feedback by the 10 October 2012, by email at ogsm@myjaring.net

Eeson Sinthamoney

UPDATE ON THE SCIENTIFIC PROGRAM OF THE 2013 CONGRESS

Planning for the scientific program for this meeting started many months ago. A unique feature of this meeting will include special symposia by a number of overseas specialty societies. The Societies that have confirmed participation are the Royal College of Obstetricians & Gynaecologists, London (RCOG), Royal Australian & New Zealand College of Obstetricans & Gynaecologists (RANZCOG), South African Society of Obstetricians & Gynaecologists, Federation of Obstetrical & Gynaecological Societies of India/Indian College of Obstetrics & Gynaecology and Asian Society of Gynaecologic Oncology. Most of the travel expenses for the speakers representing these societies will be bourne by the respective societies.

The members of the International faculty include the President of FIGO, the President Elect of AOCOG, the senior vice-president of RCOG and the Presidents of RANZCOG and OGSS. The faculty will include, Prof J. J. Walker, Prof Lesley Regan and Dr Teoh Ming Keng (U.K.), Dr. Fionnuala Breathnach (Ireland), Professors Ajay Rane and Micheal Permezel (Australia), Prof Cindy Farquar (New Zealand), Prof Peter Roos (South Africa), Prof Alan Alperstein (South Africa), Prof Knox Ritchie (Canada), Prof. Toshiharu Kamura (Japan), Prof Seung-Cheol Kim and Prof Joo-Hyun Nam (Korea), Prof Pratap Kumar, Dr. Kurien Joseph, Dr Hema Divakar, Dr Suchitra Pandit and Dr Sanjay Gupte (India) as well as Dr Fong Yoke Fai (Singapore).

Precongress workshops on maternal medicine, minimal access surgery and urogynaecology are planned.

Suresh Kumarasamy
Congress President

OGSM AT THE UNIVERSITY CONGRESS OF OBSTETRICS & GYNAECOLOGY, SINGAPORE

The Department of Obstetrics and Gynaecology of the National University of Singapore recently celebrated its 90th Anniversary with an international congress between 25/5/12 and 27/5/12. It was a very well organized conference with over 70 people in the faculty and 400 participants.

I found that an interesting aspect of the conference was that a number of doctors who had previously trained and worked in the department contributed financially towards the costs of running the meeting.

OGSM was the only international society invited to have a symposium at the meeting. The OGSM symposium focused on medico-legal issues and the speakers were myself, Dr S. Raman and Dr Tang Boon Nee. We used the occasion to have a “dry run” of the OGSM symposium which will be held in Rome in October 2012.

Suresh Kumarasamy
OGSM President

10TH RCOG INTERNATIONAL SCIENTIFIC CONGRESS 2012

5-8 June 2012, Kuching, Sarawak

The 10th RCOG International Scientific Congress concluded with a resounding success in all aspects especially for the OGSM.

The Congress

It started with the organising team arriving on Sunday, June 3rd and immediately getting on to work with site visits and briefings. The overseas RCOG team arrived on June 4th and joined us for some of the meetings. The site visit proved crucial as we were able to rehearse the room turn around, scientific sessions, audio-visual and the opening ceremony. Briefings to the speaker coordinators and the volunteers were also conducted. One important decision made on site was to have the registration at Pullman on Tuesday, June 5th to reduce the congestion on day 1 at the Borneo Convention Centre Kuching (BCCK). This proved vital in ensuring the smooth flow of the registration on day 1.

Monday, June 4th

Monday, June 4th saw the ASEAN Life Saving Skills Seminar in Hilton Kuching where Heads of ASEAN Societies of O&G were present. There were heads from Thailand, Philippines, Indonesia, Cambodia and Myanmar. OGSM, RCOG and LSTM (Liverpool School of Tropical Medicine) were also represented. This was a success with plenty of discussion and exchange of views on the possibility of OGSM conducting these courses in these countries. The group concluded that the immediate focus should be on Myanmar and Cambodia.

The Pre-Congress Workshop on Robotics and Laparoscopic Surgery was conducted at the Sarawak General Hospital with 40 participants. The faculty included Dr Joseph Ng, Prof Fabio Ghezzi, Prof J Donnez and Dr Anthony Siow. The Urology Department, Sarawak General Hospital loaned us the Da Vinci robot. It received very good feedback.

At the BCCK, the exhibitors started their build-up and this extra day, courtesy of BCCK was useful for them.



Tuesday, June 5th

The RCOG had their International Chairs Meeting at the Hilton Kuching and it was well attended and proceeded smoothly from 9 a.m. to 4 p.m.

The other Pre-Congress Workshops also took place with the Workshop on Risk Management and Patient Safety being attended by 52 participants. This was also a very good success and the recommendation was to repeat the workshop next year. Discussions were taking place beyond time.

The BJOG Author Workshop had poor participation of 21 participants. It nevertheless proceeded well and was concluded satisfactorily.

The Contraception Workshop also had poor participation of 40 but the workshop itself was a success.

The Nursing Forum on Obstetric Emergencies was successful as a programme but the participation of 40 could have been better. One feedback was that the venue was quite far away from the city and they would have preferred the workshop at one of the hotels in Kuching.

We had reduced the registration fees for these workshops as a means to encourage registrations and the refund for those who had paid earlier proved to be a problem. The other problem was delegates wanting CME points for these workshops which we had not anticipated .

The Exhibitors had done a splendid job and completed the build-up with their grand and unique designs on time.

A Speakers' Fellowship was held at the BCCK Restaurant at 7 p.m. courtesy of BCCK. About 80 people comprising Speakers, RCOG Overseas Chairs, Organising Committee, RCOG Officers and spouses attended the Fellowship. The setting was casual and the restaurant was decorated elegantly and provided the perfect impetus to the start of the next day.

June 6th, Wednesday

The first day of the Congress kicked off superbly with the registration process proceeding smoothly and the Plenary starting on time. All scientific sessions proceeded without a hitch with speakers keeping to time and all speakers turning up. There were no AV problems and the central uploading system proved friendly and efficient. There were no issues with the tea and lunch breaks in terms of efficiency and adequacy of food and staff. There were some complaints on the food being substandard and cold. The poster session also went smoothly and we were experimenting the electronic poster system for the first time. 20 desktop monitors were used and delegates could also view them from the websites.

The Opening Ceremony was graced by the YAB Pehin Sri Haji Abdul Taib Mahmud who proceeded to declare open the exhibition as well. The evening continued with the Admission of Fellows by the RCOG.

The Welcome Reception was very well received with delegates mingling and networking with plenty of snacks and drinks available. There were also interactive stations with tattoo, bamboo dances, handicraft and sape music.

The evening ended with a 8-minute fireworks display which was a fitting highlight.

June 7th, Thursday

The scientific sessions continued without problems and the transport arrangements worked smoothly. The Enrichment Lecture was by Dato' Sri Idris Jala on "Transformation: Business Not As Usual". His eloquence, engaging and sometimes motivational talk went beyond time and was surprisingly a highlight.

The OGSM Hospitality Room was beginning to draw more crowd for complementary snacks and beverages.

The British Malaysia Forum was included on a request from some consultants from the UK and it was conducted in the form of Lectures, Videos and a Hands-on Workshop on Obstetric Emergencies. It was popular and exceeded time. There were also dissatisfaction that not everyone got a chance and was poorly controlled.

The OGSM AGM started at 4 p.m. and ended with election of new office bearers.

The Charity Gala Dinner was at the Pullman and attended by 600 delegates and sponsors. The funds raised were for local charity. The theme of the ballroom was "Rainforest" and the cuisine was western. Delegates were dressed in traditional Sarawakian headgear and this set the party mood. Akasha and the Sarawak Cultural Village (SCV) provided enthralling entertainment and the evening ended with the delegates dancing away till past midnight.

June 8th, Friday

The RCOG and OGSM continued their CSR project with 'Plant a Tree' project at the Sarawak Forestry Reserve and this turned out to be an excellent idea. The 100 trees are there for all to visit anytime.

The scientific sessions continued smoothly and with about 400 delegates still present at the Closing Ceremony. The closing was brief and cheques from the Charity Gala Dinner were handed out to a Women for Women Sarawak NGO, the Orang Utan Sanctuary and SMILE.

The exhibitors started their tear down and the Organising Committee had a brief meeting before departure.

The Committee

The project started with the bid in 2009 and since January 2010 therehad been 20 organising committee meetings. The committee comprised of Drs Gunasegaran Rajan (Chair), Ravi Chandran (Scientific), Tang Boon Nee (Business Manager), Eeson Sinthamoney (Finance Manager), Thaneemalai Jeganathan (Publicity), Krishna Kumar (Secretary), Goh Huay-Yee (Registration), Hoo Mei Lin (Social Programme), Harris N Suharjono (Logistics/Transport), Murali Ganesalingam (Pre-Congress Workshops, Prof A Kulenthran (RCOG Representative). In the earlier days, the committee was assisted by Drs Mohamad Farouk Abdullah and Wong Pak Seng.

The Scientic Programme subcommittee was made up of Drs Raman Subramaniam, Nazimah Idris, Sharifah Sulaiha, Woo Yin Ling. The Pre-Congress subcommittee included Drs Lavitha Sivapatham, Dr Low Wea Haw and Dr Shilpa Nambiar. Dr Wong Choon Meng helped the Publicitiy team. A Working Title Events (AWT), headed by Gregg Parker, was appointed the Professional Congress Organiser (PCO). They executed the planning and administration and have played a crucial role in the organisation. OGSM was expertly assisted by Chong and his assistant Jenny. The RCOG team involved Dr Paul Fogarty (Treasurer) and Mrs Lynn Whitley (Head of Conferences, RCOG). There was minimal involvement of the RCOG UK throughout the 3 years. 4 Teleconferences were made in the last one year and they had declared during the Closing Ceremony “this will go down in history as one of our best Congresses ever”. The committee has been working tirelessly and voluntarily in spite of them being busy in their own clinical duties.

The Venue

The Borneo Convention Centre Kuching (BCCK) was ideal for a Congress of this magnitude and it had all the components required for an international meeting, especially staffing and audio-visual for the scientific sessions.

Transport

The shuttle service with buses leaving at specified times from 4 locations worked very well and the service provided by the Kuching Police on easing the traffic with outriders make it efficient and memorable. There were also ample taxis available. The airport greet and transfer service provided received positive feedback from delegates.

Accommodation

The Congress Hotel was Pullman which was fully occupied and provided satisfactory service to all delegates. Other hotels included Hilton, Merdeka Palace, Grand Margherita, Riverside Majestic and Four Points by Sheraton. Overall there were no complaints on the accommodation.

Registration

We had 1366 delegates and 59 accompanying persons from 54 countries. The largest delegation came from Malaysia (505) followed by UK (256) and Australia (78). If we included the number of exhibitors and their spouses there were at least 2000 people in Kuching. OGSM members were subsidised 50% of their fees. The OGSM had allocated a total of RM 100,000 to this subsidy and it was not fully utilised.

Scientific

There were 4 scientific streams. There were a total of 7 plenaries, 12 symposia, 2 controversies, 2 debates, 11 lunch symposia, 2 industry breakfasts and 3 enrichment lectures. 700 abstracts were received and 558 were accepted. Of these 421 were posters, 122 were Orals and 15 videos. The online abstract submission systems purchased by the OGSM was robust enough to accept, edit and view.

Exhibitors

The Metallic Exhibitors included: Platinum: GlaxoSmithKline; Gold: Fonterra, Merck Sharp & Dohme and Samsung Medison; Silver: Bayer, Danone, Friesland, GE, Nestle and Celcom. The total number of exhibitors were 54 organisations.

Volunteers

There were 80 student volunteers who were all given apple green T-shirts to wear and placed at various strategic locations. This proved to be a big hit and received several positive comments.

Budget

There have been a grant from the Sarawak Convention Bureau, the Malaysian Convention & Exhibition Bureau, the RCOG as well as the OGSM. The OGSM loan of RM100.000 was never used. The GBP20,000 loan from the RCOG was returned. The total income was RM 3,568,950.00. The total expenses was RM3,550,702.08. The total profit was RM18,247.92 which is to be shared 50-50 with the RCOG. On top of this profit the OGSM had a fixed commission of RM362,900. There was OGSM secretarial fees RM 210,000.

The figures are still being updated and is tentative at the moment. With all these the OGSM is expected to earn close to a million ringgit.

Media

The media coverage was mediocre and was largely in Sarawak. The media agency hired performed below satisfaction.

Acknowledgement

I am indebted to my committee who are totally committed and had dedicated their time and effort to prepare for this important meeting. I must also thank Mr. Chong, Jenny and the OGSM Council who have been most supportive.

The full report can be obtained from OGSM.

Delegate break down by country

Malaysia	505	Hong Kong	18	Sudan	5	Jordan	2
United Kingdom	256	Vietnam	18	Bangladesh	5	Yemen	2
Australia	78	Indonesia	12	USA	4	Austria	1
Saudi Arabia	43	Myanmar	12	Egypt	3	Fiji	1
India	42	Canada	9	Nepal	3	Belgium	1
UAE	40	Thailand	9	Taiwan	3	Iran	1
Philippines	40	Slovakia	9	Kuwait	3	Lebanon	1
Sri Lanka	34	Brunei	8	Iraq	2	Lithuania	1
Pakistan	31	Qatar	8	Bahamas	2	Mauritius	1
China	32	Oman	7	Bulgaria	2	Libya	1
Czech Republic	29	Ireland	7	Italy	2	Netherlands	1
Singapore	27	Japan	7	Norway	2	Romania	1
New Zealand	21	Korea	6	Switzerland	2	Azerbaijan	1

cont from. page 1

RCOG International Meeting

The recent RCOG International meeting was a resounding success. On behalf of the members of OGSM, I would like to congratulate Dr Gunasegaran and his team for their efforts. A lot of time and meticulous planning went into this meeting, earning OGSM a handsome profit in the process as well, which will be put back to good use for the members.

Medical Indemnity

All of us are impacted by rising medical indemnity costs. The MPS premium for obstetrics in 2000 was RM 6,970 per year. In 2012 it had increased to RM 62,630, an almost ten fold increase in a little more than 10 years. Many members are finding the subscriptions unaffordable. I have written to MPS asking for the option of premiums adjusted to the number of deliveries an obstetrician undertakes per year to be considered. This is based on the presumption that the more women one delivers, the higher the risk of complications and subsequent medico-legal sequelae.

The initial response unfortunately has not been favorable. MPS said that all obstetric members in Malaysia are actually being subsidised by members from other specialties in lower risk groups and if they charge subscriptions that truly reflects the risk we are exposed to, premiums may become unaffordable for many members.

This issue was brought up again with Dr Teoh Ming Keng, Head of Medical Services, Asia for MPS during the dialogue at the Fellowship held on 14/7/12. Dr Teoh said that adjusting risk based on number of deliveries was a too simplistic an approach as the obstetrician delivering many women may be practicing in an location where the population was less affluent and educated and therefore less likely to sue when a less than favorable outcome occurred. He states that a premium based on the individual risk of a practitioner may be possible with data available to MPS. This is in fact, being discussed within MPS. He was however unable to make any commitments on when and if it would be implemented.

There have been very high payouts in recent Malaysian cases involving cerebral palsy. Medico-legal issues are one of the most important issues facing our profession and to help deal with this problem in a coordinated manner, a sub-committee under Dr Tang Boon Nee has been created. A number of senior members have also agreed to serve on a committee to assist members on medico-legal issues. The operational guidelines are being drawn up currently.

Tax Matters

The present scenario is one where taxpayers who claim tax relief from medical indemnity payments have to pay tax on awards given by the court in the event they are sued and lose cases. I personally find this ludicrous. The public ruling (3/2009) from the income tax department has been placed on the OGSM website. Other professional groups like lawyers, engineers etc face the same problems as us. I have been advised by the President of the Institute of Taxation of Malaysia not to pursue this issue under the umbrella of OGSM but for all the specialties to unite under MMA to champion our cause.

The process to appeal against this regulation involves an initial appeal with the Income Tax Commission, and if this is not successful, obtain a court judgement in our favour. The Bar Council has just done this, acting on behalf of a legal firm in Melaka who had to pay tax on an insurance payout. The appeal with the Income Tax Commission was unsuccessful, and the matter is now before the courts. It is expected that the issue will be resolved in the courts within the next two years. If the lawyers are successful in this case, it will be a precedent that we can use for our benefit. The fact that the Medical (Amendment) Bill, 2012 currently before Parliament makes it compulsory for a doctor to have indemnity may also assist us in the long term.

FIGO Meeting and General Assembly

This will be held between 7/10/12 and 12/10/12 in Rome. OGSM has been given the privilege to run a symposium on medico-legal matters on the morning of 9/10/12. As you are aware, Datuk Dr Aziz Yahya is standing for the post of President Elect of FIGO. I, on behalf of OGSM, together with the Malaysian Ambassador to the Republic of Italy, will be hosting a gathering for key delegates of the General Assembly to help support his bid. Members who are attending the FIGO meeting are requested to inform Mr Chong at the OGSM secretariat so that a coordinated effort can be made to secure Datuk Dr Aziz's election to this post.

Fellowship

I believe that the society's office in Mont Kiara belongs to all members and it should be used for more than just secretarial work and council meetings. I intend to organise a number of Fellowships during the year to enable members to get together and socialise in an informal setting. During the fellowship on 14.7.12, Emeritus Professor Roger Pepperell from Melbourne, spoke on Cerebral Palsy. A podcast of his lecture will be available in the OGSM website and a comprehensive write up of his talk is included in this newsletter. Another Fellowship is tentatively planned on October or November this year.

50th Year

Our Society is now 50 years old, being formed in 1963 and originally called the Obstetrical & Gynaecological Society of the Federation of Malaya. It was registered with the Registrar of Societies and affiliated to FIGO the same year. In 1965, the name of the society was changed to the Obstetrical & Gynaecological Society of Malaysia. To celebrate this momentous occasion, an International Congress of Obstetrics and Gynaecology will be organized at the Shangri-la Hotel, Kuala Lumpur between 30.5.13 and 2.6.13. The organising Chairperson is Dr Tang Boon Nee and the theme will be "50 years of Excellence in Women's Health". A number of international societies will be running symposia during the congress. Further details of the scientific program are in this newsletter.

E-mail addresses

The secretariat has only current e-mail addressess of 77% of OGSM members. If you have not been receiving e-mails over the past few months with updates and information, this means that your e-mail address in not with us. Kindly update us with your current e-mail by informing Mr Chong or Jenny at ogsm@myjaring.net My aim is to to convert most of our communication to the electronic form to reduce costs as well as for environmental reasons.

Other issues

Following the collaboration between OGSM and our Irish colleagues at the 21st OGSM conference in Penang last year, I am working towards having Malaysia as a centre for the MRCPI (Obstetrics & Gynaecology) Part 2 Theory examination. If all goes well, the first examination will be in September 2013.

There are a number of issues that affect our specialty, addressing many of these issues require time as well as effort and results may not be achieved in the one year term of the President. The President Elect and I have had discussions to try to identify the important issues that need to be addressed so that there will be continuity in our efforts. Projects that are being planned include getting a new office system to support the growing needs of our members. Dr Tang will represent our specialty as a member of the MMA's fee schedule committee.

I would like to thank my many friends and colleagues who have communicated with me with advice and ideas both solicited and unsolicited (but nevertheless welcomed with gratitude!). I look forward to the cooperation and the support of members of OGSM in our efforts to improve the standards of practice of Obstetrics & Gynaecology in Malaysia as well as address some of the problems that we as a profession are facing.

I would like to take this opportunity to wish all our Muslim members "Selamat Hari Raya Aidil Fithri".

Suresh Kumarasamy
President

FELLOWSHIP NIGHT WITH EMERITUS PROFESSOR ROGER PEPPERELL

Podcast available on OGSM website

INTRODUCING YOUR NEW OGSM COUNCIL

PRESIDENT
Suresh Kumarasamy

Suresh is currently an Adjunct Associate Professor with Penang Medical College as well as a consultant in Gleneagles Penang. Although he is a sub-specialist in Gynaecological Oncology, he maintains an interest in other areas of our specialty particularly relating to gynaecological surgery. Based in Penang, he loves good food and travelling.

IMMEDIATE PAST PRESIDENT
Krishna Kumar

Krishna graduated from University Malaya and thereafter has worked in numerous hospitals around Malaysia. He is currently attached to Hospital Tuanku Ja'afar Seremban as a Materno-Fetal Consultant. Outside of O&G, he enjoys collecting first day covers.

PRESIDENT ELECT
Tang Boon Nee

Boon Nee currently works in Sime Darby Medical Centre, Subang Jaya and although she is a full time private practitioner, her interest lies in making the specialty a better discipline for all. A graduate from the University of Adelaide, she is a well known face in OGSM. In her spare time (if she has any), she loves watching Chinese tv series or movies.

HON SECRETARY
Thaneemalai Jeganathan

Thanee is currently working at DEMC Specialist Hospital in Shah Alam, Selangor. He graduated from Thanjavur Medical College, South India and then served in the armed forces for seven years. He completed his postgraduate training at University Malaya Medical Centre and later worked as a lecturer in University Malaya before venturing into private practice. He is an extremely dedicated member of council and tackles every job given to him wholeheartedly.

HON TREASURER
Eeson Sinthamoney

Eeson is no stranger to OGSM and returns unopposed to the Hon. Treasurer's post this year. He graduated from University Sains Malaysia and since then has worked in 11 hospitals in 3 countries over the past 16 years. After subspecialising in Reproductive Medicine, he now practices in Pantai Hospital Kuala Lumpur. He marches on in life to the motto: "nothing ventured, nothing gained; if you don't try, you'll never know!"

ASSISTANT HON SECRETARY
Shankar Sammanthamurthy

Shankar graduated from the University of Madras and is currently practicing in Lam Wah Ee Hospital, Penang. Proudly a generalist; he has a special interest in laparoscopic surgery. A proud Red Devil's supporter, he is an avid soccer fan and loves a good game.

COUNCIL MEMBER
Nazimah Idris

Nazimah is an Associate Professor at the International Medical University Malaysia and also divides her time between Hospital Tuanku Ja'afar Seremban; Hospital Port Dickson and Hospital Tuanku Ampuan Najihah, Kuala Pilah. She is currently pursuing a Masters in Medical Education with Dundee University. When she is able, she loves watching old movies, especially that of P Ramlee. She also has a huge collection of medical joke books.

COUNCIL MEMBER
Hoo Mei Lin

After her tour of duty around Malaysia with the Ministry of Health, Mei Lin can be now found at Tropicana Medical Centre. She enjoys being a generalist but maintains a special interest in laparoscopic surgery. A graduate from the University of New South Wales, Australia; she is happiest when pottering around her kitchen trying to cook for her family and friends.

COUNCIL MEMBER
Goh Huay-Yee

Huay-Yee is a graduate from the University of Melbourne and since returning to Malaysia, has worked in Selayang Hospital. Despite serving in a busy government hospital, she tries to find time to indulge in art, music, reading and food (eating and creating).

COUNCIL MEMBER
Shilpa Nambiar

Shilpa is a specialist in Hospital Ampang with an interest in maternal medicine. Despite her busy schedule in a government hospital, she is actively involved in teaching and training postgraduate candidates. When not working, she can be found watching live music, theatre and dancing salsa. She is a graduate from University Sains Malaysia.